

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: 14-1326	Period: From 07/01/2017 To 06/30/2018	Worksheet S Parts I-III Date/Time Prepared: 11/20/2018 1:25 pm
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PART I - COST REPORT STATUS

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

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

6. Date Received:
 7. Contractor No.
 8. Initial Report for this Provider CCN
 9. Final Report for this Provider CCN

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

Date: 11/20/2018 Time: 1:25 pm

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 HAMILTON MEMORIAL HOSPITAL (14-1326) for the cost reporting period beginning 07/01/2017 and ending 06/30/2018 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

(Signed) VICTORIA WOODROW
 Officer or Administrator of Provider(s)

CHIEF EXECUTIVE OFFICER
 Title

(Dated when report is electronically signed.)
 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	7,848	-18,094	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	111,152	0		0	5.00
6.00 Swing bed - NF	0				0	6.00
10.00 RHC I - HAMILTON MEMORIAL FAM CLINIC	0		-46,617		0	10.00
10.01 RHC II - CARMEL FAMILY CLINIC	0		-6,005		0	10.01
10.02 RHC III - DOWNTOWN FAMILY CLINIC	0		2,746		0	10.02
200.00 Total	0	119,000	-67,970	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: 14-1326		Period: From 07/01/2017 To 06/30/2018		Worksheet S-2 Part I Date/Time Prepared: 11/20/2018 12:36 pm					
1.00 Hospital and Hospital Health Care Complex Address:		2.00 PO Box:		3.00 State: IL Zip Code: 62859		4.00 County: HAMILTON					
1.00 Street: 611 SOUTH MARSHALL		2.00 City: MCLEANSBORO									
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			
3.00 Hospital and Hospital-Based Component Identification:											
3.00	Hospital	HAMILTON MEMORIAL HOSPITAL	141326	99914	1	05/01/2003	N	0	N	3.00	
4.00	Subprovider - IPF									4.00	
5.00	Subprovider - IRF									5.00	
6.00	Subprovider - (Other)									6.00	
7.00	Swing Beds - SNF	HAMILTON MEMORIAL HOSP SWING BED	14Z326	99914		05/01/2003	N	0	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	HAMILTON MEMORIAL FAMILY CLINIC	143477	99914		01/11/2006	N	0	N	15.00	
15.01	Hospital-Based Health Clinic - RHC II	HAMILTON MEMORIAL FAMILY CLINIC NC	148529	99914		05/06/2013	N	0	N	15.01	
15.02	Hospital-Based Health Clinic - RHC III	DOWNTOWN FAMILY CLINIC	148556	99914		03/01/2016	N	0	N	15.02	
16.00	Hospital-Based Health Clinic - FQHC									16.00	
17.00	Hospital-Based (CMHC) I									17.00	
18.00	Renal Dialysis									18.00	
19.00	Other									19.00	
						From:	To:				
						1.00	2.00				
20.00	Cost Reporting Period (mm/dd/yyyy)					07/01/2017	06/30/2018		20.00		
21.00	Type of Control (see instructions)					11			21.00		
Inpatient PPS Information											
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2) (Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					N	N		22.00		
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					N	N		22.01		
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.					N	N		22.02		
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N	N		22.03		
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.						3	N		23.00	
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days				
		1.00	2.00	3.00	4.00	5.00	6.00				
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.					0	0	0	0	0	0

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		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of- State Medicaid paid days	Out-of- State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days		
		1.00	2.00	3.00	4.00	5.00	6.00		
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	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)					N		37.01	
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.							38.00	
						Y/N	Y/N		
						1.00	2.00		
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i) or (ii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i) or (ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)					N	N	39.00	
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)					N	N	40.00	
						V	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.								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.								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	
Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.							
64.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)			0.00	0.00	0.000000	64.00

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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
75.00	Inpatient Rehabilitation Facility PPS 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.		Y	Y	98.00	
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. 1? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.		Y	Y	98.01	
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.		Y	Y	98.02	
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.		N	N	98.03	
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.		N	N	98.04	
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.		Y	Y	98.05	
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.		Y	Y	98.06	
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.		Y		108.00	
			Physical	Occupational	Speech	Respiratory
			1.00	2.00	3.00	4.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.		Y	Y	Y	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: 14-1326	Period: From 07/01/2017 To 06/30/2018	Worksheet S-2 Part I Date/Time Prepared: 11/20/2018 12:36 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.	N				117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1				118.00
		Premiums	Losses	Insurance		
		1.00	2.00	3.00		
118.01	List amounts of malpractice premiums and paid losses:	130,400	0			118.01
		1.00	2.00			
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N				118.02
119.00	DO NOT USE THIS LINE					119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N		N		120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y				121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N				122.00
Transplant Center Information						
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N				125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.					134.00
All Providers						
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	N				140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1326		Period: From 07/01/2017 To 06/30/2018		Worksheet S-2 Part I Date/Time Prepared: 11/20/2018 12:36 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:	Contractor's Name:		Contractor's Number:		141.00			
142.00	Street:	PO Box:				142.00			
143.00	City:	State:		Zip Code:		143.00			
						1.00			
144.00	Are provider based physicians' costs included in Worksheet A?						Y	144.00	
						1.00	2.00		
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.							145.00	
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.						N	146.00	
						1.00			
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.						N	147.00	
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.						N	148.00	
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.						N	149.00	
		Part A	Part B	Title V	Title XIX				
		1.00	2.00	3.00	4.00				
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)									
155.00	Hospital	Y	Y	N	N			155.00	
156.00	Subprovider - IPF	N	N	N	N			156.00	
157.00	Subprovider - IRF	N	N	N	N			157.00	
158.00	SUBPROVIDER							158.00	
159.00	SNF	N	N	N	N			159.00	
160.00	HOME HEALTH AGENCY	N	N	N	N			160.00	
161.00	CMHC		N	N	N			161.00	
						1.00			
165.00	Multi campus Is this hospital part of a Multi campus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.						N	165.00	
		Name	County	State	Zip Code	CBSA	FTE/Campus		
		0	1.00	2.00	3.00	4.00	5.00		
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00	166.00	
						1.00			
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act									
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.						Y	167.00	
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)						0	168.00	
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)							168.01	
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)						0.00	169.00	
		Beginning		Ending					
		1.00		2.00					
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)						10/01/2016	09/30/2017	170.00
						1.00	2.00		
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)						N	0	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-1326		Period: From 07/01/2017 To 06/30/2018		Worksheet S-2 Part II Date/Time Prepared: 11/20/2018 12:36 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				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)	Y	08/31/2018	Y	08/31/2018		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N			17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N			18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N			19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-1326	Period: From 07/01/2017 To 06/30/2018	Worksheet S-2 Part II Date/Time Prepared: 11/20/2018 12:36 pm	
		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	21.00
					1.00
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been 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			Y	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.			N	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.			N	35.00
					Y/N
					Date
					1.00
					2.00
Home Office Costs					
36.00	Were home office costs claimed on the cost report?			N	36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.				37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.				38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.				39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.				40.00
					1.00
					2.00
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	KEVIN		WELLEN	41.00
42.00	Enter the employer/company name of the cost report preparer.	CLIFTONLARSONALLEN, LLP			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	314-925-4446		KEVIN.WELLEN@CLACONNECT.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 14-1326	Period: From 07/01/2017 To 06/30/2018	Worksheet S-2 Part II Date/Time Prepared: 11/20/2018 12:36 pm
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		3.00	
Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	DIRECTOR	41.00
42.00	Enter the employer/company name of the cost report preparer.		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.		43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-1326

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

Worksheet S-3
Part I
Date/Time Prepared:
11/20/2018 12:36 pm

Component	Worksheet A Line Number	No. of Beds	Bed Days Avai lable	CAH Hours	I/P Days / O/P Vi si ts / Tri ps	
					Title V	
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	25	9,125	29,184.00	0	1.00
2.00 HMO and other (see instructions)						2.00
3.00 HMO IPF Subprovider						3.00
4.00 HMO IRF Subprovider						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00 Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)		25	9,125	29,184.00	0	7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)		25	9,125	29,184.00	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 RHC I - HAMILTON MEMORIAL FAM CLINIC	88.00				0	26.00
26.01 RHC II - CARMEL FAMILY CLINIC	88.01				0	26.01
26.02 RHC III - DOWNTOWN FAMILY CLINIC	88.02				0	26.02
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		25				27.00
28.00 Observation Bed Days					0	28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)		0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00
33.01 LTCH site neutral days and discharges						33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-1326

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

Worksheet S-3
Part I
Date/Time Prepared:
11/20/2018 12:36 pm

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
	Title XVII	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)	966	91	1,216			1.00
2.00 HMO and other (see instructions)	0	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	1,533	0	1,587			5.00
6.00 Hospital Adults & Peds. Swing Bed NF		0	315			6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	2,499	91	3,118			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)	2,499	91	3,118	0.00	107.67	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	0	0			24.10
25.00 CMHC - CMHC						25.00
26.00 RHC I - HAMILTON MEMORIAL FAM CLINIC	3,115	0	9,083	0.00	12.16	26.00
26.01 RHC II - CARMEL FAMILY CLINIC	967	0	8,772	0.00	8.10	26.01
26.02 RHC III - DOWNTOWN FAMILY CLINIC	303	0	1,575	0.00	2.61	26.02
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	130.54	27.00
28.00 Observation Bed Days		43	326			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: 14-1326

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

Worksheet S-3
Part I
Date/Time Prepared:
11/20/2018 12:36 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	355	32	450	1.00
2.00	HMO and other (see instructions)			0	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	355	32	450	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	RHC I - HAMILTON MEMORIAL FAM CLINIC	0.00					26.00
26.01	RHC II - CARMEL FAMILY CLINIC	0.00					26.01
26.02	RHC III - DOWNTOWN FAMILY CLINIC	0.00					26.02
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: 14-1326 Component CCN: 14-3477		Period: From 07/01/2017 To 06/30/2018		Worksheet S-8 Date/Time Prepared: 11/20/2018 12:36 pm	
		RHC I		Cost			
				1.00			
1.00	1.00	Clinic Address and Identification Street		611 SOUTH MARSHALL		1.00	
		City		State		ZIP Code	
		1.00		2.00		3.00	
2.00	2.00	City, State, ZIP Code, County		MCLEANSBORO IL 62859		2.00	
				1.00			
3.00	3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban		0		3.00	
		Grant Award		Date			
		1.00		2.00			
4.00	4.00	Source of Federal Funds Community Health Center (Section 330(d), PHS Act)				4.00	
5.00	5.00	Migrant Health Center (Section 329(d), PHS Act)				5.00	
6.00	6.00	Health Services for the Homeless (Section 340(d), PHS Act)				6.00	
7.00	7.00	Appalachian Regional Commission				7.00	
8.00	8.00	Look-Alikes				8.00	
9.00	9.00	OTHER (SPECIFY)				9.00	
				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		08:00 17:00		08:00	
				1.00		2.00	
12.00	12.00	Have you received an approval for an exception to the productivity standard?		N		12.00	
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		HAMILTON		2.00	
		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		17:00 08:00		17:00 08:00	

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provider CCN: 14-1326 Component CCN: 14-3477		Period: From 07/01/2017 To 06/30/2018		Worksheet S-8 Date/Time Prepared: 11/20/2018 12:36 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	08:00	17:00				11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provider CCN: 14-1326 Component CCN: 14-8529		Period: From 07/01/2017 To 06/30/2018		Worksheet S-8 Date/Time Prepared: 11/20/2018 12:36 pm	
		RHC II		Cost			
				1.00			
1.00	110A EAST MAIN	City		State	ZIP Code	1.00	
2.00	NORRIS CITY	City, State, ZIP Code, County		IL	62869	2.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban			Grant Award	Date	0 3.00	
				1.00	2.00		
4.00	Community Health Center (Section 330(d), PHS Act)					4.00	
5.00	Migrant Health Center (Section 329(d), PHS Act)					5.00	
6.00	Health Services for the Homeless (Section 340(d), PHS Act)					6.00	
7.00	Appalachian Regional Commission					7.00	
8.00	Look-Alikes					8.00	
9.00	OTHER (SPECIFY)					9.00	
				1.00	2.00		
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2. (Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N		0 10.00	
		Sunday		Monday		Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
11.00	CLINIC			08:00	17:00	08:00	11.00
				1.00	2.00		
12.00	Have you received an approval for an exception to the productivity standard?			N		12.00	
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.			N		0 13.00	
				Provider name		CCN number	
				1.00		2.00	
14.00	RHC/FQHC name, CCN number	Y/N	V	XVIII	XIX	Total Visits	14.00
		1.00	2.00	3.00	4.00	5.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)			County			
				4.00			
2.00	WHITE	City, State, ZIP Code, County				2.00	
		Tuesday		Wednesday		Thursday	
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
11.00	CLINIC	17:00	08:00	17:00	08:00	17:00	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provider CCN: 14-1326 Component CCN: 14-8529		Period: From 07/01/2017 To 06/30/2018		Worksheet S-8 Date/Time Prepared: 11/20/2018 12:36 pm	
				RHC II		Cost	
		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
11.00	Facility hours of operations (1) CLINIC	08:00	15:00	09:00	15:00		11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provider CCN: 14-1326 Component CCN: 14-8556		Period: From 07/01/2017 To 06/30/2018		Worksheet S-8 Date/Time Prepared: 11/20/2018 12:36 pm	
		RHC III		Cost			
				1.00			
1.00	1.00	Clinic Address and Identification Street		206 S. WASHINGTON STREET		1.00	
		City		State		ZIP Code	
		1.00		2.00		3.00	
2.00	2.00	City, State, ZIP Code, County		MCLEANSBORO IL 62859		2.00	
				1.00			
3.00	3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban		0		3.00	
				Grant Award		Date	
				1.00		2.00	
4.00	4.00	Source of Federal Funds Community Health Center (Section 330(d), PHS Act)				4.00	
5.00	5.00	Migrant Health Center (Section 329(d), PHS Act)				5.00	
6.00	6.00	Health Services for the Homeless (Section 340(d), PHS Act)				6.00	
7.00	7.00	Appalachian Regional Commission				7.00	
8.00	8.00	Look-Alikes				8.00	
9.00	9.00	OTHER (SPECIFY)				9.00	
				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	
				1.00		2.00	
				3.00		4.00	
				5.00			
11.00	11.00	Facility hours of operations (1) CLINIC		08:00		17:30	
				08:00			
				1.00		2.00	
12.00	12.00	Have you received an approval for an exception to the productivity standard?		N		12.00	
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				Total Visits	
				Y/N		V	
				XVIII		XIX	
				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		HAMILTON			
				Tuesday		Wednesday	
				Thursday			
				to		to	
				6.00		7.00	
				8.00		9.00	
				10.00			
11.00	11.00	Facility hours of operations (1) CLINIC		17:30		08:00	
				17:30		08:00	
				17:30		17:30	

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provider CCN: 14-1326 Component CCN: 14-8556		Period: From 07/01/2017 To 06/30/2018		Worksheet S-8 Date/Time Prepared: 11/20/2018 12:36 pm	
				RHC III		Cost	
		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
11.00	Facility hours of operations (1) CLINIC						11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 14-1326	Period: From 07/01/2017 To 06/30/2018	Worksheet S-10 Date/Time Prepared: 11/20/2018 12:36 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)		0.447732	1.00	
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid		2,562,020	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		5,869,591	6.00	
7.00	Medicaid cost (line 1 times line 6)		2,628,004	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)		65,984	8.00	
Children's Health Insurance Program (CHIP) (see instructions for each line)					
9.00	Net revenue from stand-alone CHIP		24,128	9.00	
10.00	Stand-alone CHIP charges		67,660	10.00	
11.00	Stand-alone CHIP cost (line 1 times line 10)		30,294	11.00	
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)		6,166	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)		72,150	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)	157,709	0	157,709	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	70,611	0	70,611	21.00
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	70,611	0	70,611	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)		1,430,326		26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)		216,460		27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)		333,015		27.01
28.00	Non-Medicare bad debt expense (see instructions)		1,097,311		28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)		607,856		29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		678,467		30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		750,617		31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1326

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

Worksheet A

Date/Time Prepared:
11/20/2018 12:36 pm

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassified (See A-6)	Reclassified Trial Balance (col. 3 +/- col. 4)	
		1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	00100		976,771	976,771	1,095,251	2,072,022	1.00
2.00	00200		462,289	462,289	186,809	649,098	2.00
3.00	00300		0	0	0	0	3.00
4.00	00400	64,292	1,407,997	1,472,289	0	1,472,289	4.00
5.01	00540	0	22,025	22,025	6,913	28,938	5.01
5.02	00550	106,032	189,708	295,740	0	295,740	5.02
5.03	00560	46,726	3,242	49,968	0	49,968	5.03
5.04	00570	0	0	0	200,923	200,923	5.04
5.05	00580	320,901	326,709	647,610	-145,461	502,149	5.05
5.06	00590	280,015	653,851	933,866	-55,858	878,008	5.06
7.00	00700	124,031	617,499	741,530	9,854	751,384	7.00
8.00	00800	0	57,026	57,026	0	57,026	8.00
9.00	00900	128,756	27,287	156,043	0	156,043	9.00
10.00	01000	0	101,578	101,578	0	101,578	10.00
11.00	01100	0	0	0	0	0	11.00
13.00	01300	262,560	6,067	268,627	0	268,627	13.00
14.00	01400	0	64,994	64,994	-59,559	5,435	14.00
15.00	01500	179,952	340,600	520,552	-245,940	274,612	15.00
16.00	01600	171,958	48,593	220,551	0	220,551	16.00
17.00	01700	30,276	775	31,051	0	31,051	17.00
19.00	01900	155,132	5,940	161,072	0	161,072	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	1,215,799	305,152	1,520,951	-2,266	1,518,685	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	109,524	255,056	364,580	-117,734	246,846	50.00
53.00	05300	0	34,713	34,713	-19,606	15,107	53.00
54.00	05400	310,377	296,205	606,582	-23,881	582,701	54.00
58.00	05800	0	74,370	74,370	0	74,370	58.00
60.00	06000	471,303	668,645	1,139,948	0	1,139,948	60.00
64.00	06400	0	0	0	0	0	64.00
65.00	06500	97,421	37,687	135,108	-16,411	118,697	65.00
66.00	06600	460,959	168,474	629,433	-15	629,418	66.00
69.00	06900	0	20,655	20,655	0	20,655	69.00
71.00	07100	0	0	0	45,507	45,507	71.00
72.00	07200	0	0	0	26,875	26,875	72.00
73.00	07300	0	0	0	269,853	269,853	73.00
76.00	03610	0	31,950	31,950	0	31,950	76.00
76.01	03950	203,921	164,749	368,670	-7,011	361,659	76.01
76.97	07697	14,507	826	15,333	0	15,333	76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	1,124,258	289,500	1,413,758	-55,608	1,358,150	88.00
88.01	08801	562,968	267,595	830,563	-118,625	711,938	88.01
88.02	08802	126,557	61,384	187,941	-33,300	154,641	88.02
90.00	09000	0	0	0	0	0	90.00
91.00	09100	434,303	1,467,240	1,901,543	-14,646	1,886,897	91.00
92.00	09200						92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300		926,064	926,064	-926,064	0	113.00
118.00		7,002,528	10,383,216	17,385,744	0	17,385,744	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
194.00	07950	0	139,499	139,499	0	139,499	194.00
200.00		7,002,528	10,522,715	17,525,243	0	17,525,243	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1326

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

Worksheet A
Date/Time Prepared:
11/20/2018 12:36 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	-54,443	2,017,579	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-67,887	581,211	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-41,294	1,430,995	4.00
5.01	00540	NONPATIENT TELEPHONES	-4,326	24,612	5.01
5.02	00550	DATA PROCESSING	0	295,740	5.02
5.03	00560	PURCHASING RECEIVING AND STORES	-75	49,893	5.03
5.04	00570	ADMINISTRATIVE	0	200,923	5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	502,149	5.05
5.06	00590	OTHER ADMIN & GENERAL	-124,369	753,639	5.06
7.00	00700	OPERATION OF PLANT	0	751,384	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	57,026	8.00
9.00	00900	HOUSEKEEPING	0	156,043	9.00
10.00	01000	DIETARY	-10	101,568	10.00
11.00	01100	CAFETERIA	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	268,627	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	5,435	14.00
15.00	01500	PHARMACY	0	274,612	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-3,150	217,401	16.00
17.00	01700	SOCIAL SERVICE	0	31,051	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	161,072	19.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-450,420	1,068,265	30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-61,600	185,246	50.00
53.00	05300	ANESTHESIOLOGY	0	15,107	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-5,713	576,988	54.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	74,370	58.00
60.00	06000	LABORATORY	-103,212	1,036,736	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	118,697	65.00
66.00	06600	PHYSICAL THERAPY	-108,225	521,193	66.00
69.00	06900	ELECTROCARDIOLOGY	-12,444	8,211	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	-1,335	44,172	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	26,875	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-10,204	259,649	73.00
76.00	03610	SLEEP LAB	0	31,950	76.00
76.01	03950	SENIOR ENRICHMENT CENTER	0	361,659	76.01
76.97	07697	CARDIAC REHABILITATION	0	15,333	76.97
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RHC I - HAMILTON MEMORIAL FAM CLINIC	-43,850	1,314,300	88.00
88.01	08801	RHC II - CARMICAM FAMILY CLINIC	0	711,938	88.01
88.02	08802	RHC III - DOWNTOWN FAMILY CLINIC	0	154,641	88.02
90.00	09000	CLINIC	0	0	90.00
91.00	09100	EMERGENCY	-840,361	1,046,536	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-1,932,918	15,452,826	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
194.00	07950	340B DRUG COSTS	0	139,499	194.00
200.00		TOTAL (SUM OF LINES 118 through 199)	-1,932,918	15,592,325	200.00

		Increases				
Cost Center		Line #	Salary	Other		
2.00	3.00	4.00	5.00			
A - PROPERTY INSURANCE						
1.00	OTHER CAP REL COSTS	3.00	0	44,370	1.00	
2.00		0.00	0	0	2.00	
				44,370		
B - INTEREST EXPENSE						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	926,064	1.00	
				926,064		
C - ADMITTING						
1.00	ADMITTING	5.04	106,967	93,956	1.00	
			106,967	93,956		
D - IMPLANTS						
1.00	IMPLANTABLE DEVICES CHARGED TO PATIENTS	72.00	0	26,875	1.00	
				26,875		
E - RHC BILLING & BUS OFFICE						
1.00	CASHIERING/ACCOUNTS RECEIVABLE	5.05	55,462	0	1.00	
			55,462	0		
F - MEDICAL SUPPLIES						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	45,507	1.00	
2.00		0.00	0	0	2.00	
3.00		0.00	0	0	3.00	
4.00		0.00	0	0	4.00	
5.00		0.00	0	0	5.00	
				45,507		
G - DRUGS						
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	269,853	1.00	
2.00		0.00	0	0	2.00	
3.00		0.00	0	0	3.00	
4.00		0.00	0	0	4.00	
5.00		0.00	0	0	5.00	
6.00		0.00	0	0	6.00	
7.00		0.00	0	0	7.00	
8.00		0.00	0	0	8.00	
9.00		0.00	0	0	9.00	
				269,853		
H - TELEPHONE COSTS						
1.00	NONPATIENT TELEPHONES	5.01	0	6,913	1.00	
2.00		0.00	0	0	2.00	
3.00		0.00	0	0	3.00	
4.00		0.00	0	0	4.00	
				6,913		
I - RENT & LEASE EXPENSE						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	134,941	1.00	
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	176,685	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	
	TOTALS		0	311,626		
J - UTILITY EXPENSE						
1.00	OPERATION OF PLANT	7.00	0	17,228	1.00	
2.00		0.00	0	0	2.00	
3.00		0.00	0	0	3.00	
	TOTALS		0	17,228		
500.00	Grand Total: Increases		162,429	1,742,392	500.00	

RECLASSIFICATIONS

Provider CCN: 14-1326

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

Worksheet A-6
Date/Time Prepared:
11/20/2018 12:36 pm

		Decreases					
Cost Center		Line #	Salary	Other	Wkst. A-7 Ref.		
6.00		7.00	8.00	9.00	10.00		
A - PROPERTY INSURANCE							
1.00	OTHER ADMIN & GENERAL	5.06	0	44,370	12		1.00
2.00		0.00	0	0	12		2.00
0				44,370			
B - INTEREST EXPENSE							
1.00	INTEREST EXPENSE	113.00	0	926,064	11		1.00
0				926,064			
C - ADMITTING							
1.00	CASHIERING/ACCOUNTS RECEIVABLE	5.05	106,967	93,956	0		1.00
0			106,967	93,956			
D - IMPLANTS							
1.00	OPERATING ROOM	50.00	0	26,875	0		1.00
0				26,875			
E - RHC BILLING & BUS OFFICE							
1.00	RHC I - HAMILTON MEMORIAL FAM CLINIC	88.00	55,462	0	0		1.00
0			55,462	0			
F - MEDICAL SUPPLIES							
1.00	CENTRAL SERVICE & SUPPLY	14.00	0	696	0		1.00
2.00	OPERATING ROOM	50.00	0	22,658	0		2.00
3.00	ANESTHESIOLOGY	53.00	0	4,394	0		3.00
4.00	RESPIRATORY THERAPY	65.00	0	5,072	0		4.00
5.00	EMERGENCY	91.00	0	12,687	0		5.00
0				45,507			
G - DRUGS							
1.00	CENTRAL SERVICE & SUPPLY	14.00	0	58,863	0		1.00
2.00	PHARMACY	15.00	0	196,156	0		2.00
3.00	ADULTS & PEDIATRICS	30.00	0	2,266	0		3.00
4.00	OPERATING ROOM	50.00	0	256	0		4.00
5.00	ANESTHESIOLOGY	53.00	0	8	0		5.00
6.00	RADIOLOGY-DIAGNOSTIC	54.00	0	1,321	0		6.00
7.00	RESPIRATORY THERAPY	65.00	0	9,009	0		7.00
8.00	PHYSICAL THERAPY	66.00	0	15	0		8.00
9.00	EMERGENCY	91.00	0	1,959	0		9.00
0				269,853			
H - TELEPHONE COSTS							
1.00	RHC I - HAMILTON MEMORIAL FAM CLINIC	88.00	0	146	0		1.00
2.00	RHC II - CARMEL FAMILY CLINIC	88.01	0	5,360	0		2.00
3.00	RHC III - DOWNTOWN FAMILY CLINIC	88.02	0	446	0		3.00
4.00	SENIOR ENRICHMENT CENTER	76.01	0	961	0		4.00
0				6,913			
I - RENT & LEASE EXPENSE							
1.00	OTHER ADMIN & GENERAL	5.06	0	11,488	10		1.00
2.00	OPERATION OF PLANT	7.00	0	7,374	10		2.00
3.00	PHARMACY	15.00	0	49,784	0		3.00
4.00	OPERATING ROOM	50.00	0	67,945	0		4.00
5.00	ANESTHESIOLOGY	53.00	0	15,204	0		5.00
6.00	RADIOLOGY-DIAGNOSTIC	54.00	0	22,560	0		6.00
7.00	RESPIRATORY THERAPY	65.00	0	2,330	0		7.00
8.00	RHC II - CARMEL FAMILY CLINIC	88.01	0	104,606	0		8.00
9.00	RHC III - DOWNTOWN FAMILY CLINIC	88.02	0	30,335	0		9.00
TOTALS				311,626			
J - UTILITY EXPENSE							
1.00	SENIOR ENRICHMENT CENTER	76.01	0	6,050	0		1.00
2.00	RHC II - CARMEL FAMILY CLINIC	88.01	0	8,659	0		2.00
3.00	RHC III - DOWNTOWN FAMILY CLINIC	88.02	0	2,519	0		3.00
TOTALS				17,228			
500.00	Grand Total: Decreases		162,429	1,742,392			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1326

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

Worksheet A-7
Part I
Date/Time Prepared:
11/20/2018 12:36 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	69,760	0	0	0	0	1.00
2.00	Land Improvements	499,729	0	0	0	0	2.00
3.00	Buildings and Fixtures	21,710,219	0	0	0	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	5,670,401	218,051	0	218,051	29,121	6.00
7.00	HIT designated Assets	727,424	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	28,677,533	218,051	0	218,051	29,121	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	28,677,533	218,051	0	218,051	29,121	10.00
		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	69,760	0				1.00
2.00	Land Improvements	499,729	0				2.00
3.00	Buildings and Fixtures	21,710,219	0				3.00
4.00	Building Improvements	0	0				4.00
5.00	Fixed Equipment	0	0				5.00
6.00	Movable Equipment	5,859,331	0				6.00
7.00	HIT designated Assets	727,424	0				7.00
8.00	Subtotal (sum of lines 1-7)	28,866,463	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	28,866,463	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1326

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

Worksheet A-7
Part II
Date/Time Prepared:
11/20/2018 12:36 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	976,771	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	462,289	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	1,439,060	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	976,771				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	462,289				2.00
3.00	Total (sum of lines 1-2)	0	1,439,060				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1326

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

Worksheet A-7
Part III
Date/Time Prepared:
11/20/2018 12:36 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	22,279,708	0	22,279,708	0.771820	34,246	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	6,586,755	0	6,586,755	0.228180	10,124	2.00
3.00	Total (sum of lines 1-2)	28,866,463	0	28,866,463	1.000000	44,370	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of col.s. 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	34,246	976,771	134,941	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	10,124	399,115	171,972	2.00
3.00	Total (sum of lines 1-2)	0	0	44,370	1,375,886	306,913	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of col.s. 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	871,621	34,246	0	0	2,017,579	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	10,124	0	0	581,211	2.00
3.00	Total (sum of lines 1-2)	871,621	44,370	0	0	2,598,790	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1326

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

Worksheet A-8

Date/Time Prepared:
11/20/2018 12:36 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	
1.00 Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-72,722	CAP REL COSTS-BLDG & FIXT		1.00	11 1.00
2.00 Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP		2.00	0 2.00
3.00 Investment income - other (chapter 2)		0			0.00	0 3.00
4.00 Trade, quantity, and time discounts (chapter 8)	B	-75	PURCHASING RECEIVING AND STORES		5.03	0 4.00
5.00 Refunds and rebates of expenses (chapter 8)		0			0.00	0 5.00
6.00 Rental of provider space by suppliers (chapter 8)		0			0.00	0 6.00
7.00 Telephone services (pay stations excluded) (chapter 21)		0			0.00	0 7.00
8.00 Television and radio service (chapter 21)	A	-6,745	OTHER ADMIN & GENERAL		5.06	0 8.00
9.00 Parking lot (chapter 21)		0			0.00	0 9.00
10.00 Provider-based physician adjustment	A-8-2	-1,365,038				0 10.00
11.00 Sale of scrap, waste, etc. (chapter 23)		0			0.00	0 11.00
12.00 Related organization transactions (chapter 10)	A-8-1	0				0 12.00
13.00 Laundry and linen service		0			0.00	0 13.00
14.00 Cafeteria-employees and guests	B	-10	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	-1,335	MEDICAL SUPPLIES CHARGED TO PATIENTS		71.00	0 16.00
17.00 Sale of drugs to other than patients	B	-10,204	DRUGS CHARGED TO PATIENTS		73.00	0 17.00
18.00 Sale of medical records and abstracts	B	-3,150	MEDICAL RECORDS & LIBRARY		16.00	0 18.00
19.00 Nursing and allied health education (tuition, fees, books, etc.)		0			0.00	0 19.00
20.00 Vending machines	B	-1,206	OTHER ADMIN & GENERAL		5.06	0 20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)		0			0.00	0 21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0			0.00	0 22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY		65.00	23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY		66.00	24.00
25.00 Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***		114.00	25.00
26.00 Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT		1.00	0 26.00
27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP		2.00	0 27.00
28.00 Non-physician Anesthetist		0	NONPHYSICIAN ANESTHETISTS		19.00	28.00
29.00 Physicians' assistant		0			0.00	0 29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***		67.00	30.00
30.99 Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS		30.00	30.99
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***		68.00	31.00
32.00 CAH HIT Adjustment for Depreciation and Interest	A	-63,174	CAP REL COSTS-MVBLE EQUIP		2.00	9 32.00
33.00 WOMENS WELLNESS	B	-91,742	LABORATORY		60.00	0 33.00

Provider CCN: 14-1326 Period: From 07/01/2017 To 06/30/2018 Worksheet A-8
 Date/Time Prepared: 11/20/2018 12:36 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	
33.01 THERAPY PROVIDED TO VNA	B	-108,225	PHYSICAL THERAPY	66.00	0	33.01
33.02 NURSING CENTER TELEPHONE SERVICES	B	-1,710	NONPATIENT TELEPHONES	5.01	0	33.02
33.03 NURSING CENTER LAB SERVICES	B	-11,470	LABORATORY	60.00	0	33.03
34.00 NON-ALLOWABLE FUNDRAISING	A	-99,080	OTHER ADMIN & GENERAL	5.06	0	34.00
34.01 NON-ALLOWABLE ADVERTISING	A	-4,189	OTHER ADMIN & GENERAL	5.06	0	34.01
34.02 NON-ALLOWABLE FUNDRAISING BENEFITS	A	-316	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	34.02
34.03 NON-ALLOWABLE FUNDRAISING RENTAL	A	-4,713	CAP REL COSTS-MVBLE EQUIP	2.00	10	34.03
35.00 NON-ALLOWABLE LOBBYING DUES	A	-6,659	OTHER ADMIN & GENERAL	5.06	0	35.00
35.01 NON-ALLOWABLE PATIENT TELEPHONE EXPE	A	-2,616	NONPATIENT TELEPHONES	5.01	0	35.01
36.00 BOND ISSUANCE COSTS	A	18,279	CAP REL COSTS-BLDG & FIXT	1.00	11	36.00
37.00 PHYSICIAN RECRUITMENT	A	-6,490	OTHER ADMIN & GENERAL	5.06	0	37.00
38.00 NON-RHC SALARIES	A	-43,850	RHC I - HAMILTON MEMORIAL FAM CLINIC	88.00	0	38.00
38.01 NON-RHC BENEFITS	A	-4,999	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	38.01
39.00 AMBULANCE COSTS IN ER	A	-5,500	EMERGENCY	91.00	0	39.00
40.00 PHYSICIAN BENEFITS	A	-35,979	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	40.00
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-1,932,918				50.00

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

(2) Basis for adjustment (see instructions).

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

B. Amount Received - if cost cannot be determined.

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 14-1326

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

Worksheet A-8-2

Date/Time Prepared:
11/20/2018 12:36 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	ADULTS & PEDIATRICS	450,420	450,420	0	0	0	1.00
2.00	50.00	OPERATING ROOM	61,600	61,600	0	0	0	2.00
3.00	54.00	RADIOLOGY-DIAGNOSTIC	5,713	5,713	0	0	0	3.00
4.00	60.00	LABORATORY	11,694	0	11,694	0	0	4.00
5.00	69.00	ELECTROCARDIOLOGY	12,444	12,444	0	0	0	5.00
6.00	76.01	SENIOR ENRICHMENT CENTER	30,455	0	30,455	0	0	6.00
7.00	91.00	EMERGENCY	48,000	0	48,000	0	0	7.00
8.00	91.00	EMERGENCY	1,263,600	834,861	428,739	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			1,883,926	1,365,038	518,888	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	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	50.00	OPERATING ROOM	0	0	0	0	0	2.00
3.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	3.00
4.00	60.00	LABORATORY	0	0	0	0	0	4.00
5.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	5.00
6.00	76.01	SENIOR ENRICHMENT CENTER	0	0	0	0	0	6.00
7.00	91.00	EMERGENCY	0	0	0	0	0	7.00
8.00	91.00	EMERGENCY	0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment	
	1.00	2.00	15.00	16.00	17.00	18.00	
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	450,420	1.00
2.00	50.00	OPERATING ROOM	0	0	0	61,600	2.00
3.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	5,713	3.00
4.00	60.00	LABORATORY	0	0	0	0	4.00
5.00	69.00	ELECTROCARDIOLOGY	0	0	0	12,444	5.00
6.00	76.01	SENIOR ENRICHMENT CENTER	0	0	0	0	6.00
7.00	91.00	EMERGENCY	0	0	0	0	7.00
8.00	91.00	EMERGENCY	0	0	0	834,861	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	1,365,038	200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 14-1326		Period: From 07/01/2017 To 06/30/2018		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 11/20/2018 12:36 pm	
		Physical Therapy		Cost			
						1.00	
PART I - GENERAL INFORMATION							
1.00	Total number of weeks worked (excluding aides) (see instructions)					52	1.00
2.00	Line 1 multiplied by 15 hours per week					780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					13	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00
7.00	Standard travel expense rate					5.40	7.00
8.00	Optional travel expense rate per mile					0.00	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	78.25	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	80.83	0.00	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	40.42	40.42	0.00			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01
						1.00	
Part II - SALARY EQUIVALENCY COMPUTATION							
14.00	Supervisors (column 1, line 9 times column 1, line 10)					0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					6,325	15.00
16.00	Assistants (column 3, line 9 times column 3, line 10)					0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					6,325	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)					0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)					0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)					6,325	20.00
If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.							
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)					80.83	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					63,047	22.00
23.00	Total salary equivalency (see instructions)					63,047	23.00
PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE							
Standard Travel Allowance							
24.00	Therapists (line 3 times column 2, line 11)					525	24.00
25.00	Assistants (line 4 times column 3, line 11)					0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					525	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					70	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					595	28.00
Optional Travel Allowance and Optional Travel Expense							
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)					0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)					0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)					0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)					595	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
PART IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE							
Standard Travel Expense							
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00
Optional Travel Allowance and Optional Travel Expense							
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.							
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 14-1326				Period: From 07/01/2017 To 06/30/2018		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 11/20/2018 12:36 pm	
						Physical Therapy		Cost	
						1.00			
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)							0	46.00
		Therapists	Assistants	Aides	Trainees	Total			
		1.00	2.00	3.00	4.00	5.00			
PART V - OVERTIME COMPUTATION									
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00		0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00	0.00		0.00	48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00	0.00		0.00	49.00
CALCULATION OF LIMIT									
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00		0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50 (see instructions)	0.00	0.00	0.00	0.00	0.00		0.00	51.00
DETERMINATION OF OVERTIME ALLOWANCE									
52.00	Adjusted hourly salary equivalency amount (see instructions)	80.83	0.00	0.00	0.00	0.00		0.00	52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0	0		0	53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0	0		0	54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0	0		0	55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0		0	56.00
						1.00			
Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT									
57.00	Salary equivalency amount (from line 23)							63,047	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))							595	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)							0	59.00
60.00	Overtime allowance (from column 5, line 56)							0	60.00
61.00	Equipment cost (see instructions)							0	61.00
62.00	Supplies (see instructions)							0	62.00
63.00	Total allowance (sum of lines 57-62)							63,642	63.00
64.00	Total cost of outside supplier services (from your records)							4,319	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)							0	65.00
LINE 33 CALCULATION									
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others							525	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others							70	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27							595	100.02
LINE 34 CALCULATION									
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others							70	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others							0	101.01
101.02	Line 34 = sum of lines 27 and 31							70	101.02
LINE 35 CALCULATION									
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others							0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others							0	102.01
102.02	Line 35 = sum of lines 31 and 32							0	102.02

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 14-1326		Period: From 07/01/2017 To 06/30/2018		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 11/20/2018 12:36 pm	
				Occupational Therapy		Cost	
						1.00	
PART I - GENERAL INFORMATION							
1.00	Total number of weeks worked (excluding aides) (see instructions)					52	1.00
2.00	Line 1 multiplied by 15 hours per week					780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					241	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00
7.00	Standard travel expense rate					5.40	7.00
8.00	Optional travel expense rate per mile					0.00	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	1,935.90	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	76.61	0.00	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	38.31	38.31	0.00			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01
						1.00	
Part II - SALARY EQUIVALENCY COMPUTATION							
14.00	Supervisors (column 1, line 9 times column 1, line 10)					0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					148,309	15.00
16.00	Assistants (column 3, line 9 times column 3, line 10)					0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					148,309	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)					0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)					0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)					148,309	20.00
If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.							
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)					0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					0	22.00
23.00	Total salary equivalency (see instructions)					148,309	23.00
PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE							
Standard Travel Allowance							
24.00	Therapists (line 3 times column 2, line 11)					9,233	24.00
25.00	Assistants (line 4 times column 3, line 11)					0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					9,233	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					1,301	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					10,534	28.00
Optional Travel Allowance and Optional Travel Expense							
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)					0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)					0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)					0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)					10,534	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE							
Standard Travel Expense							
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00
Optional Travel Allowance and Optional Travel Expense							
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.							
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 14-1326		Period: From 07/01/2017 To 06/30/2018		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 11/20/2018 12:36 pm	
				Occupational Therapy		Cost	
						1.00	
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00
		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
PART V - OVERTIME COMPUTATION							
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
CALCULATION OF LIMIT							
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
DETERMINATION OF OVERTIME ALLOWANCE							
52.00	Adjusted hourly salary equivalency amount (see instructions)	76.61	0.00	0.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00
						1.00	
Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT							
57.00	Salary equivalency amount (from line 23)					148,309	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35)					10,534	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)					0	59.00
60.00	Overtime allowance (from column 5, line 56)					0	60.00
61.00	Equipment cost (see instructions)					0	61.00
62.00	Supplies (see instructions)					0	62.00
63.00	Total allowance (sum of lines 57-62)					158,843	63.00
64.00	Total cost of outside supplier services (from your records)					109,568	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)					0	65.00
LINE 33 CALCULATION							
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others					9,233	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others					1,301	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27					10,534	100.02
LINE 34 CALCULATION							
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others					1,301	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others					0	101.01
101.02	Line 34 = sum of lines 27 and 31					1,301	101.02
LINE 35 CALCULATION							
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others					0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others					0	102.01
102.02	Line 35 = sum of lines 31 and 32					0	102.02

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 14-1326		Period: From 07/01/2017 To 06/30/2018		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 11/20/2018 12:36 pm	
				Speech Pathology		Cost	
						1.00	
PART I - GENERAL INFORMATION							
1.00	Total number of weeks worked (excluding aides) (see instructions)					52	1.00
2.00	Line 1 multiplied by 15 hours per week					780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					199	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00
7.00	Standard travel expense rate					5.40	7.00
8.00	Optional travel expense rate per mile					0.00	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	660.00	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	73.61	0.00	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	36.81	36.81	0.00			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01
						1.00	
Part II - SALARY EQUIVALENCY COMPUTATION							
14.00	Supervisors (column 1, line 9 times column 1, line 10)					0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					48,583	15.00
16.00	Assistants (column 3, line 9 times column 3, line 10)					0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					48,583	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)					0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)					0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)					48,583	20.00
If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.							
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)					73.61	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					57,416	22.00
23.00	Total salary equivalency (see instructions)					57,416	23.00
PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE							
Standard Travel Allowance							
24.00	Therapists (line 3 times column 2, line 11)					7,325	24.00
25.00	Assistants (line 4 times column 3, line 11)					0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					7,325	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					1,075	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					8,400	28.00
Optional Travel Allowance and Optional Travel Expense							
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)					0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)					0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)					0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)					8,400	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
PART IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE							
Standard Travel Expense							
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00
Optional Travel Allowance and Optional Travel Expense							
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.							
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 14-1326				Period: From 07/01/2017 To 06/30/2018		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 11/20/2018 12:36 pm	
		Speech Pathology				Cost			
						1.00			
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0		46.00	
		Therapists	Assistants	Aides	Trainees	Total			
		1.00	2.00	3.00	4.00	5.00			
PART V - OVERTIME COMPUTATION									
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00		
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00	0.00	48.00		
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00	0.00	49.00		
CALCULATION OF LIMIT									
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00		
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50 (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00		
DETERMINATION OF OVERTIME ALLOWANCE									
52.00	Adjusted hourly salary equivalency amount (see instructions)	73.61	0.00	0.00	0.00	0.00	52.00		
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0	0	53.00		
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0	0	54.00		
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0	0	55.00		
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00		
						1.00			
Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT									
57.00	Salary equivalency amount (from line 23)					57,416		57.00	
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))					8,400		58.00	
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)					0		59.00	
60.00	Overtime allowance (from column 5, line 56)					0		60.00	
61.00	Equipment cost (see instructions)					0		61.00	
62.00	Supplies (see instructions)					0		62.00	
63.00	Total allowance (sum of lines 57-62)					65,816		63.00	
64.00	Total cost of outside supplier services (from your records)					34,593		64.00	
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)					0		65.00	
LINE 33 CALCULATION									
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others					7,325		100.00	
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others					1,075		100.01	
100.02	Line 33 = line 28 = sum of lines 26 and 27					8,400		100.02	
LINE 34 CALCULATION									
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others					1,075		101.00	
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others					0		101.01	
101.02	Line 34 = sum of lines 27 and 31					1,075		101.02	
LINE 35 CALCULATION									
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others					0		102.00	
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others					0		102.01	
102.02	Line 35 = sum of lines 31 and 32					0		102.02	

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1326

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

Worksheet B
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Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	NONPATIENT TELEPHONES	
		BLDG & FIXT	MVBLE EQUIP			
	0	1.00	2.00	4.00	5.01	
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	2,017,579	2,017,579			1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP	581,211		581,211		2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	1,430,995	7,209	227	1,438,431	4.00
5.01 00540	NONPATIENT TELEPHONES	24,612	961	0	0	25,573 5.01
5.02 00550	DATA PROCESSING	295,740	25,280	121,891	22,947	656 5.02
5.03 00560	PURCHASING RECEIVING AND STORES	49,893	54,549	365	10,112	262 5.03
5.04 00570	ADMINISTRATIVE	200,923	3,364	0	23,150	525 5.04
5.05 00580	CASHIERING/ACCOUNTS RECEIVABLE	502,149	34,844	0	58,303	1,311 5.05
5.06 00590	OTHER ADMIN & GENERAL	753,639	215,768	12,336	60,284	1,967 5.06
7.00 00700	OPERATION OF PLANT	751,384	171,095	19,660	26,843	525 7.00
8.00 00800	LAUNDRY & LINEN SERVICE	57,026	22,973	415	0	131 8.00
9.00 00900	HOUSEKEEPING	156,043	0	0	27,865	0 9.00
10.00 01000	DIETARY	101,568	0	335	0	0 10.00
11.00 01100	CAFETERIA	0	0	0	0	0 11.00
13.00 01300	NURSING ADMINISTRATION	268,627	38,352	799	56,823	787 13.00
14.00 01400	CENTRAL SERVICE & SUPPLY	5,435	0	0	0	0 14.00
15.00 01500	PHARMACY	274,612	28,187	52,182	38,945	262 15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	217,401	29,966	1,138	37,215	1,049 16.00
17.00 01700	SOCIAL SERVICE	31,051	2,307	0	6,552	131 17.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	161,072	0	0	33,574	0 19.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	1,068,265	320,923	20,515	209,785	4,066 30.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	185,246	161,003	102,942	23,703	1,180 50.00
53.00 05300	ANESTHESIOLOGY	15,107	0	17,576	0	131 53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	576,988	105,829	138,416	67,172	1,443 54.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	74,370	0	0	0	0 58.00
60.00 06000	LABORATORY	1,036,736	41,452	16,001	101,999	1,180 60.00
64.00 06400	INTRAVENOUS THERAPY	0	0	0	0	0 64.00
65.00 06500	RESPIRATORY THERAPY	118,697	16,821	22,021	21,084	787 65.00
66.00 06600	PHYSICAL THERAPY	521,193	108,016	8,411	99,761	918 66.00
69.00 06900	ELECTROCARDIOLOGY	8,211	0	0	0	0 69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	44,172	0	0	0	0 71.00
72.00 07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	26,875	0	0	0	0 72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	259,649	0	0	0	0 73.00
76.00 03610	SLEEP LAB	31,950	9,011	0	0	131 76.00
76.01 03950	SENIOR ENRICHMENT CENTER	361,659	82,664	213	44,133	918 76.01
76.97 07697	CARDIAC REHABILITATION	15,333	8,363	0	3,140	0 76.97
OUTPATIENT SERVICE COST CENTERS						
88.00 08800	RHC I - HAMILTON MEMORIAL FAM CLINIC	1,314,300	165,833	7,329	221,822	2,754 88.00
88.01 08801	RHC II - CARMEL FAMILY CLINIC	711,938	46,282	8,565	121,838	1,967 88.01
88.02 08802	RHC III - DOWNTOWN FAMILY CLINIC	154,641	57,673	684	27,389	393 88.02
90.00 09000	CLINIC	0	0	0	0	0 90.00
91.00 09100	EMERGENCY	1,046,536	110,491	29,190	93,992	1,574 91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					113.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	15,452,826	1,869,216	581,211	1,438,431	25,048 118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	9,516	0	0	0 190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	138,847	0	0	525 192.00
194.00 07950	340B DRUG COSTS	139,499	0	0	0	0 194.00
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers		0	0	0	0 201.00
202.00	TOTAL (sum lines 118 through 201)	15,592,325	2,017,579	581,211	1,438,431	25,573 202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1326

Period:
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Cost Center Description			DATA PROCESSING	PURCHASING RECEIVING AND STORES	ADMINITTING	CASHIERING/ACCOUNTS RECEIVABLE	Subtotal	
			5.02	5.03	5.04	5.05	5A.05	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING	466,514					5.02
5.03	00560	PURCHASING RECEIVING AND STORES	6,059	121,240				5.03
5.04	00570	ADMINITTING	15,147	676	243,785			5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	33,322	1,373	0	631,302		5.05
5.06	00590	OTHER ADMIN & GENERAL	21,205	1,320	0	0	1,066,519	5.06
7.00	00700	OPERATION OF PLANT	6,059	3,344	0	0	978,910	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	230	0	0	80,775	8.00
9.00	00900	HOUSEKEEPING	0	2,173	0	0	186,081	9.00
10.00	01000	DIETARY	0	358	0	0	102,261	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	24,234	185	0	0	389,807	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	590	0	0	6,025	14.00
15.00	01500	PHARMACY	9,088	1,031	0	0	404,307	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	21,205	1,244	0	0	309,218	16.00
17.00	01700	SOCIAL SERVICE	0	65	0	0	40,106	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	194,646	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	48,469	9,690	57,168	31,453	1,770,334	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	24,234	4,950	1,253	10,292	514,803	50.00
53.00	05300	ANESTHESIOLOGY	3,029	713	1,091	3,286	40,933	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	18,176	5,106	12,478	140,886	1,066,494	54.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	590	11,587	86,547	58.00
60.00	06000	LABORATORY	24,234	63,980	36,790	162,089	1,484,461	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	15,147	1,201	5,357	4,905	206,020	65.00
66.00	06600	PHYSICAL THERAPY	27,264	880	34,242	38,268	838,953	66.00
69.00	06900	ELECTROCARDIOLOGY	0	115	833	7,584	16,743	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	4,938	13,235	10,426	72,771	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	2,916	0	3,880	33,671	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	80,663	55,657	395,969	73.00
76.00	03610	SLEEP LAB	0	0	0	5,324	46,416	76.00
76.01	03950	SENIOR ENRICHMENT CENTER	24,234	1,843	0	25,169	540,833	76.01
76.97	07697	CARDIAC REHABILITATION	0	90	0	1,627	28,553	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RHC I - HAMILTON MEMORIAL FAM CLINIC	60,588	1,884	0	19,066	1,793,576	88.00
88.01	08801	RHC II - CARMICAM FAMILY CLINIC	42,410	1,459	0	21,438	955,897	88.01
88.02	08802	RHC III - DOWNTOWN FAMILY CLINIC	0	285	0	2,925	243,990	88.02
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	42,410	8,601	85	75,440	1,408,319	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	466,514	121,240	243,785	631,302	15,303,938	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	9,516	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	139,372	192.00
194.00	07950	340B DRUG COSTS	0	0	0	0	139,499	194.00
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	466,514	121,240	243,785	631,302	15,592,325	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1326

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

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Cost Center Description		OTHER ADMIN & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.06	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.01	00540						5.01
5.02	00550						5.02
5.03	00560						5.03
5.04	00570						5.04
5.05	00580						5.05
5.06	00590	1,066,519					5.06
7.00	00700	71,874	1,050,784				7.00
8.00	00800	5,931	16,045	102,751			8.00
9.00	00900	13,662	0	0	199,743		9.00
10.00	01000	7,508	0	0	0	109,769	10.00
11.00	01100	0	0	0	0	0	11.00
13.00	01300	28,620	26,786	0	562	0	13.00
14.00	01400	442	0	0	0	0	14.00
15.00	01500	29,685	19,687	0	0	0	15.00
16.00	01600	22,703	20,929	0	0	0	16.00
17.00	01700	2,945	1,611	0	0	0	17.00
19.00	01900	14,291	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	129,981	224,140	78,691	61,518	109,769	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	37,798	112,448	3,666	17,593	0	50.00
53.00	05300	3,005	0	0	0	0	53.00
54.00	05400	78,304	73,914	1,741	9,963	0	54.00
58.00	05800	6,354	0	173	0	0	58.00
60.00	06000	108,992	28,951	0	7,545	0	60.00
64.00	06400	0	0	0	0	0	64.00
65.00	06500	15,126	11,748	0	0	0	65.00
66.00	06600	61,598	75,441	14,008	13,761	0	66.00
69.00	06900	1,229	0	0	0	0	69.00
71.00	07100	5,343	0	0	0	0	71.00
72.00	07200	2,472	0	0	0	0	72.00
73.00	07300	29,073	0	0	0	0	73.00
76.00	03610	3,408	6,294	0	0	0	76.00
76.01	03950	39,709	57,734	0	7,579	0	76.01
76.97	07697	2,096	5,841	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	131,696	115,821	816	32,734	0	88.00
88.01	08801	70,184	32,325	0	0	0	88.01
88.02	08802	17,914	40,280	0	2,521	0	88.02
90.00	09000	0	0	0	0	0	90.00
91.00	09100	103,402	77,169	3,656	45,967	0	91.00
92.00	09200						92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		1,045,345	947,164	102,751	199,743	109,769	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	699	6,646	0	0	0	190.00
192.00	19200	10,233	96,974	0	0	0	192.00
194.00	07950	10,242	0	0	0	0	194.00
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		1,066,519	1,050,784	102,751	199,743	109,769	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICE & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY		
		11.00	13.00	14.00	15.00	16.00		
GENERAL SERVICE COST CENTERS								
1.00	00100						1.00	
2.00	00200						2.00	
4.00	00400						4.00	
5.01	00540						5.01	
5.02	00550						5.02	
5.03	00560						5.03	
5.04	00570						5.04	
5.05	00580						5.05	
5.06	00590						5.06	
7.00	00700						7.00	
8.00	00800						8.00	
9.00	00900						9.00	
10.00	01000						10.00	
11.00	01100	0					11.00	
13.00	01300	0	445,775				13.00	
14.00	01400	0	0	6,467			14.00	
15.00	01500	0	0	0	453,679		15.00	
16.00	01600	0	0	0	0	352,850	16.00	
17.00	01700	0	0	0	0	0	17.00	
19.00	01900	0	0	0	0	0	19.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	0	313,105	0	0	117,634	30.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	0	21,895	0	0	0	50.00	
53.00	05300	0	0	0	0	0	53.00	
54.00	05400	0	0	0	0	0	54.00	
58.00	05800	0	0	0	0	0	58.00	
60.00	06000	0	0	0	0	125,677	60.00	
64.00	06400	0	0	0	0	0	64.00	
65.00	06500	0	0	0	0	0	65.00	
66.00	06600	0	0	0	0	0	66.00	
69.00	06900	0	0	0	0	0	69.00	
71.00	07100	0	0	4,066	0	0	71.00	
72.00	07200	0	0	2,401	0	0	72.00	
73.00	07300	0	0	0	453,679	0	73.00	
76.00	03610	0	0	0	0	0	76.00	
76.01	03950	0	0	0	0	0	76.01	
76.97	07697	0	0	0	0	0	76.97	
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	0	0	0	0	0	88.00	
88.01	08801	0	0	0	0	0	88.01	
88.02	08802	0	0	0	0	0	88.02	
90.00	09000	0	0	0	0	0	90.00	
91.00	09100	0	110,775	0	0	109,539	91.00	
92.00	09200	0	0	0	0	0	92.00	
SPECIAL PURPOSE COST CENTERS								
113.00	11300	0	0	0	0	0	113.00	
118.00	SUBTOTALS (SUM OF LINES 1 through 117)		0	445,775	6,467	453,679	352,850	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	
194.00	07950	0	0	0	0	0	194.00	
200.00	Cross Foot Adjustments		0	0	0	0	200.00	
201.00	Negative Cost Centers		0	0	0	0	201.00	
202.00	TOTAL (sum lines 118 through 201)		0	445,775	6,467	453,679	352,850	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1326

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

Worksheet B
Part I
Date/Time Prepared:
11/20/2018 12:36 pm

Cost Center Description		SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		17.00	19.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.01	00540						5.01
5.02	00550						5.02
5.03	00560						5.03
5.04	00570						5.04
5.05	00580						5.05
5.06	00590						5.06
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100						11.00
13.00	01300						13.00
14.00	01400						14.00
15.00	01500						15.00
16.00	01600						16.00
17.00	01700	44,662					17.00
19.00	01900	0	208,937				19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	18,076	0	2,823,248	-15,430	2,807,818	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	0	0	708,203	0	708,203	50.00
53.00	05300	0	208,937	252,875	0	252,875	53.00
54.00	05400	0	0	1,230,416	0	1,230,416	54.00
58.00	05800	0	0	93,074	0	93,074	58.00
60.00	06000	0	0	1,755,626	0	1,755,626	60.00
64.00	06400	0	0	0	15,430	15,430	64.00
65.00	06500	0	0	232,894	0	232,894	65.00
66.00	06600	3,334	0	1,007,095	0	1,007,095	66.00
69.00	06900	0	0	17,972	0	17,972	69.00
71.00	07100	0	0	82,180	0	82,180	71.00
72.00	07200	0	0	38,544	0	38,544	72.00
73.00	07300	0	0	878,721	0	878,721	73.00
76.00	03610	0	0	56,118	0	56,118	76.00
76.01	03950	0	0	645,855	0	645,855	76.01
76.97	07697	0	0	36,490	0	36,490	76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	14,741	0	2,089,384	0	2,089,384	88.00
88.01	08801	0	0	1,058,406	0	1,058,406	88.01
88.02	08802	0	0	304,705	0	304,705	88.02
90.00	09000	0	0	0	0	0	90.00
91.00	09100	8,511	0	1,867,338	0	1,867,338	91.00
92.00	09200	0	0	0	0	0	92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		44,662	208,937	15,179,144	0	15,179,144	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	16,861	0	16,861	190.00
192.00	19200	0	0	246,579	0	246,579	192.00
194.00	07950	0	0	149,741	0	149,741	194.00
200.00				0	0	0	200.00
201.00		0	0	0	0	0	201.00
202.00		44,662	208,937	15,592,325	0	15,592,325	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1326

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

Worksheet B
Part II
Date/Time Prepared:
11/20/2018 12:36 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	7,209	227	7,436	7,436 4.00
5.01 00540	NONPATIENT TELEPHONES	0	961	0	961	0 5.01
5.02 00550	DATA PROCESSING	0	25,280	121,891	147,171	119 5.02
5.03 00560	PURCHASING RECEIVING AND STORES	0	54,549	365	54,914	52 5.03
5.04 00570	ADMITTING	0	3,364	0	3,364	120 5.04
5.05 00580	CASHIERING/ACCOUNTS RECEIVABLE	0	34,844	0	34,844	301 5.05
5.06 00590	OTHER ADMIN & GENERAL	0	215,768	12,336	228,104	312 5.06
7.00 00700	OPERATION OF PLANT	0	171,095	19,660	190,755	139 7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	22,973	415	23,388	0 8.00
9.00 00900	HOUSEKEEPING	0	0	0	0	144 9.00
10.00 01000	DIETARY	0	0	335	335	0 10.00
11.00 01100	CAFETERIA	0	0	0	0	0 11.00
13.00 01300	NURSING ADMINISTRATION	0	38,352	799	39,151	294 13.00
14.00 01400	CENTRAL SERVICE & SUPPLY	0	0	0	0	0 14.00
15.00 01500	PHARMACY	0	28,187	52,182	80,369	201 15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	29,966	1,138	31,104	192 16.00
17.00 01700	SOCIAL SERVICE	0	2,307	0	2,307	34 17.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	174 19.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	0	320,923	20,515	341,438	1,085 30.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	0	161,003	102,942	263,945	123 50.00
53.00 05300	ANESTHESIOLOGY	0	0	17,576	17,576	0 53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	105,829	138,416	244,245	347 54.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0 58.00
60.00 06000	LABORATORY	0	41,452	16,001	57,453	527 60.00
64.00 06400	INTRAVENOUS THERAPY	0	0	0	0	0 64.00
65.00 06500	RESPIRATORY THERAPY	0	16,821	22,021	38,842	109 65.00
66.00 06600	PHYSICAL THERAPY	0	108,016	8,411	116,427	516 66.00
69.00 06900	ELECTROCARDIOLOGY	0	0	0	0	0 69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0 71.00
72.00 07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0 72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0 73.00
76.00 03610	SLEEP LAB	0	9,011	0	9,011	0 76.00
76.01 03950	SENIOR ENRICHMENT CENTER	0	82,664	213	82,877	228 76.01
76.97 07697	CARDIAC REHABILITATION	0	8,363	0	8,363	16 76.97
OUTPATIENT SERVICE COST CENTERS						
88.00 08800	RHC I - HAMILTON MEMORIAL FAM CLINIC	0	165,833	7,329	173,162	1,145 88.00
88.01 08801	RHC II - CARMi FAMILY CLINIC	0	46,282	8,565	54,847	630 88.01
88.02 08802	RHC III - DOWNTOWN FAMILY CLINIC	0	57,673	684	58,357	142 88.02
90.00 09000	CLINIC	0	0	0	0	0 90.00
91.00 09100	EMERGENCY	0	110,491	29,190	139,681	486 91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0 92.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE	0	0	0	0	0 113.00
118.00 11800	SUBTOTALS (SUM OF LINES 1 through 117)	0	1,869,216	581,211	2,450,427	7,436 118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	9,516	0	9,516	0 190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	138,847	0	138,847	0 192.00
194.00 07950	340B DRUG COSTS	0	0	0	0	0 194.00
200.00	Cross Foot Adjustments	0	0	0	0	0 200.00
201.00	Negative Cost Centers	0	0	0	0	0 201.00
202.00	TOTAL (sum lines 118 through 201)	0	2,017,579	581,211	2,598,790	7,436 202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1326

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

Worksheet B Part II Date/Time Prepared: 11/20/2018 12:36 pm

Cost Center Description		NONPATIENT TELEPHONES	DATA PROCESSING	PURCHASING RECEIVING AND STORES	ADMINISTRATIVE	CASHIERING/ACCOUNTS RECEIVABLE	
		5.01	5.02	5.03	5.04	5.05	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.01	00540	961					5.01
5.02	00550	25	147,315				5.02
5.03	00560	10	1,913	56,889			5.03
5.04	00570	20	4,783	317	8,604		5.04
5.05	00580	49	10,522	644	0	46,360	5.05
5.06	00590	74	6,696	619	0	0	5.06
7.00	00700	20	1,913	1,569	0	0	7.00
8.00	00800	5	0	108	0	0	8.00
9.00	00900	0	0	1,019	0	0	9.00
10.00	01000	0	0	168	0	0	10.00
11.00	01100	0	0	0	0	0	11.00
13.00	01300	30	7,653	87	0	0	13.00
14.00	01400	0	0	277	0	0	14.00
15.00	01500	10	2,870	484	0	0	15.00
16.00	01600	39	6,696	584	0	0	16.00
17.00	01700	5	0	31	0	0	17.00
19.00	01900	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	153	15,305	4,547	2,017	2,309	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	44	7,653	2,323	44	756	50.00
53.00	05300	5	957	334	39	241	53.00
54.00	05400	54	5,740	2,396	440	10,343	54.00
58.00	05800	0	0	0	21	851	58.00
60.00	06000	44	7,653	30,021	1,298	11,913	60.00
64.00	06400	0	0	0	0	0	64.00
65.00	06500	30	4,783	564	189	360	65.00
66.00	06600	34	8,609	413	1,208	2,809	66.00
69.00	06900	0	0	54	29	557	69.00
71.00	07100	0	0	2,317	467	765	71.00
72.00	07200	0	0	1,368	0	285	72.00
73.00	07300	0	0	0	2,849	4,086	73.00
76.00	03610	5	0	0	0	391	76.00
76.01	03950	34	7,653	865	0	1,848	76.01
76.97	07697	0	0	42	0	119	76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	103	19,132	884	0	1,400	88.00
88.01	08801	74	13,392	684	0	1,574	88.01
88.02	08802	15	0	134	0	215	88.02
90.00	09000	0	0	0	0	0	90.00
91.00	09100	59	13,392	4,036	3	5,538	91.00
92.00	09200						92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		941	147,315	56,889	8,604	46,360	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	20	0	0	0	0	192.00
194.00	07950	0	0	0	0	0	194.00
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		961	147,315	56,889	8,604	46,360	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1326

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

Worksheet B
Part II
Date/Time Prepared:
11/20/2018 12:36 pm

Cost Center Description		OTHER ADMIN & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.06	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.01	00540						5.01
5.02	00550						5.02
5.03	00560						5.03
5.04	00570						5.04
5.05	00580						5.05
5.06	00590	235,805					5.06
7.00	00700	15,892	210,288				7.00
8.00	00800	1,311	3,211	28,023			8.00
9.00	00900	3,021	0	0	4,184		9.00
10.00	01000	1,660	0	0	0	2,163	10.00
11.00	01100	0	0	0	0	0	11.00
13.00	01300	6,328	5,361	0	12	0	13.00
14.00	01400	98	0	0	0	0	14.00
15.00	01500	6,564	3,940	0	0	0	15.00
16.00	01600	5,020	4,188	0	0	0	16.00
17.00	01700	651	322	0	0	0	17.00
19.00	01900	3,160	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	28,740	44,854	21,461	1,287	2,163	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	8,357	22,504	1,000	369	0	50.00
53.00	05300	665	0	0	0	0	53.00
54.00	05400	17,313	14,792	475	209	0	54.00
58.00	05800	1,405	0	47	0	0	58.00
60.00	06000	24,099	5,794	0	158	0	60.00
64.00	06400	0	0	0	0	0	64.00
65.00	06500	3,345	2,351	0	0	0	65.00
66.00	06600	13,620	15,098	3,820	288	0	66.00
69.00	06900	272	0	0	0	0	69.00
71.00	07100	1,181	0	0	0	0	71.00
72.00	07200	547	0	0	0	0	72.00
73.00	07300	6,428	0	0	0	0	73.00
76.00	03610	754	1,260	0	0	0	76.00
76.01	03950	8,780	11,554	0	159	0	76.01
76.97	07697	464	1,169	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	29,106	23,179	223	686	0	88.00
88.01	08801	15,518	6,469	0	0	0	88.01
88.02	08802	3,961	8,061	0	53	0	88.02
90.00	09000	0	0	0	0	0	90.00
91.00	09100	22,863	15,444	997	963	0	91.00
92.00	09200						92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		231,123	189,551	28,023	4,184	2,163	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	154	1,330	0	0	0	190.00
192.00	19200	2,263	19,407	0	0	0	192.00
194.00	07950	2,265	0	0	0	0	194.00
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		235,805	210,288	28,023	4,184	2,163	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1326

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

Worksheet B
Part II
Date/Time Prepared:
11/20/2018 12:36 pm

Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICE & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY		
		11.00	13.00	14.00	15.00	16.00		
GENERAL SERVICE COST CENTERS								
1.00	00100						1.00	
2.00	00200						2.00	
4.00	00400						4.00	
5.01	00540						5.01	
5.02	00550						5.02	
5.03	00560						5.03	
5.04	00570						5.04	
5.05	00580						5.05	
5.06	00590						5.06	
7.00	00700						7.00	
8.00	00800						8.00	
9.00	00900						9.00	
10.00	01000						10.00	
11.00	01100	0					11.00	
13.00	01300	0	58,916				13.00	
14.00	01400	0	0	375			14.00	
15.00	01500	0	0	0	94,438		15.00	
16.00	01600	0	0	0	0	47,823	16.00	
17.00	01700	0	0	0	0	0	17.00	
19.00	01900	0	0	0	0	0	19.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	0	41,381	0	0	15,943	30.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	0	2,894	0	0	0	50.00	
53.00	05300	0	0	0	0	0	53.00	
54.00	05400	0	0	0	0	0	54.00	
58.00	05800	0	0	0	0	0	58.00	
60.00	06000	0	0	0	0	17,034	60.00	
64.00	06400	0	0	0	0	0	64.00	
65.00	06500	0	0	0	0	0	65.00	
66.00	06600	0	0	0	0	0	66.00	
69.00	06900	0	0	0	0	0	69.00	
71.00	07100	0	0	236	0	0	71.00	
72.00	07200	0	0	139	0	0	72.00	
73.00	07300	0	0	0	94,438	0	73.00	
76.00	03610	0	0	0	0	0	76.00	
76.01	03950	0	0	0	0	0	76.01	
76.97	07697	0	0	0	0	0	76.97	
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	0	0	0	0	0	88.00	
88.01	08801	0	0	0	0	0	88.01	
88.02	08802	0	0	0	0	0	88.02	
90.00	09000	0	0	0	0	0	90.00	
91.00	09100	0	14,641	0	0	14,846	91.00	
92.00	09200	0	0	0	0	0	92.00	
SPECIAL PURPOSE COST CENTERS								
113.00	11300	0	0	0	0	0	113.00	
118.00	SUBTOTALS (SUM OF LINES 1 through 117)		0	58,916	375	94,438	47,823	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	
194.00	07950	0	0	0	0	0	194.00	
200.00	Cross Foot Adjustments		0	0	0	0	200.00	
201.00	Negative Cost Centers		0	0	0	0	201.00	
202.00	TOTAL (sum lines 118 through 201)		0	58,916	375	94,438	47,823	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1326

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

Worksheet B
Part II
Date/Time Prepared:
11/20/2018 12:36 pm

Cost Center Description		SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		17.00	19.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.01	00540						5.01
5.02	00550						5.02
5.03	00560						5.03
5.04	00570						5.04
5.05	00580						5.05
5.06	00590						5.06
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100						11.00
13.00	01300						13.00
14.00	01400						14.00
15.00	01500						15.00
16.00	01600						16.00
17.00	01700						17.00
19.00	01900						19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000						30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000						50.00
53.00	05300						53.00
54.00	05400						54.00
58.00	05800						58.00
60.00	06000						60.00
64.00	06400						64.00
65.00	06500						65.00
66.00	06600						66.00
69.00	06900						69.00
71.00	07100						71.00
72.00	07200						72.00
73.00	07300						73.00
76.00	03610						76.00
76.01	03950						76.01
76.97	07697						76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	08800						88.00
88.01	08801						88.01
88.02	08802						88.02
90.00	09000						90.00
91.00	09100						91.00
92.00	09200						92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00							118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000						190.00
192.00	19200						192.00
194.00	07950						194.00
200.00							200.00
201.00							201.00
202.00							202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1326

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

Worksheet B-1

Date/Time Prepared:
11/20/2018 12:36 pm

Cost Center Description	CAPITAL RELATED COSTS					EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	NONPATIENT TELEPHONES (NUMBER OF PHONES)	DATA PROCESSING (MACHINES)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)							
	1.00	2.00	4.00	5.01	5.02				
GENERAL SERVICE COST CENTERS									
1.00 00100	CAP REL COSTS-BLDG & FIXT	83,960							1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP		571,087						2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	300	223	6,646,465					4.00
5.01 00540	NONPATIENT TELEPHONES	40	0	0	195				5.01
5.02 00550	DATA PROCESSING	1,052	119,768	106,032	5		154		5.02
5.03 00560	PURCHASING RECEIVING AND STORES	2,270	359	46,726	2		2		5.03
5.04 00570	ADMINISTRATIVE	140	0	106,967	4		5		5.04
5.05 00580	CASHIERING/ACCOUNTS RECEIVABLE	1,450	0	269,396	10		11		5.05
5.06 00590	OTHER ADMIN & GENERAL	8,979	12,121	278,551	15		7		5.06
7.00 00700	OPERATION OF PLANT	7,120	19,318	124,031	4		2		7.00
8.00 00800	LAUNDRY & LINEN SERVICE	956	408	0	1		0		8.00
9.00 00900	HOUSEKEEPING	0	0	128,756	0		0		9.00
10.00 01000	DIETARY	0	329	0	0		0		10.00
11.00 01100	CAFETERIA	0	0	0	0		0		11.00
13.00 01300	NURSING ADMINISTRATION	1,596	785	262,560	6		8		13.00
14.00 01400	CENTRAL SERVICE & SUPPLY	0	0	0	0		0		14.00
15.00 01500	PHARMACY	1,173	51,273	179,952	2		3		15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	1,247	1,118	171,958	8		7		16.00
17.00 01700	SOCIAL SERVICE	96	0	30,276	1		0		17.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	155,132	0		0		19.00
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00 03000	ADULTS & PEDIATRICS	13,355	20,158	969,342	31		16		30.00
ANCILLARY SERVICE COST CENTERS									
50.00 05000	OPERATING ROOM	6,700	101,149	109,524	9		8		50.00
53.00 05300	ANESTHESIOLOGY	0	17,270	0	1		1		53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	4,404	136,005	310,377	11		6		54.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0		0		58.00
60.00 06000	LABORATORY	1,725	15,722	471,303	9		8		60.00
64.00 06400	INTRAVENOUS THERAPY	0	0	0	0		0		64.00
65.00 06500	RESPIRATORY THERAPY	700	21,637	97,421	6		5		65.00
66.00 06600	PHYSICAL THERAPY	4,495	8,264	460,959	7		9		66.00
69.00 06900	ELECTROCARDIOLOGY	0	0	0	0		0		69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0		0		71.00
72.00 07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0		0		72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0		0		73.00
76.00 03610	SLEEP LAB	375	0	0	1		0		76.00
76.01 03950	SENIOR ENRICHMENT CENTER	3,440	209	203,921	7		8		76.01
76.97 07697	CARDIAC REHABILITATION	348	0	14,507	0		0		76.97
OUTPATIENT SERVICE COST CENTERS									
88.00 08800	RHC I - HAMILTON MEMORIAL FAM CLINIC	6,901	7,201	1,024,946	21		20		88.00
88.01 08801	RHC II - CARMEL FAMILY CLINIC	1,926	8,416	562,968	15		14		88.01
88.02 08802	RHC III - DOWNTOWN FAMILY CLINIC	2,400	672	126,557	3		0		88.02
90.00 09000	CLINIC	0	0	0	0		0		90.00
91.00 09100	EMERGENCY	4,598	28,682	434,303	12		14		91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)								92.00
SPECIAL PURPOSE COST CENTERS									
113.00 11300	INTEREST EXPENSE								113.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	77,786	571,087	6,646,465	191		154		118.00
NONREIMBURSABLE COST CENTERS									
190.00 19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	396	0	0	0		0		190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	5,778	0	0	4		0		192.00
194.00 07950	340B DRUG COSTS	0	0	0	0		0		194.00
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)	2,017,579	581,211	1,438,431	25,573		466,514		202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	24.030241	1.017728	0.216420	131.143590		3,029.311688		203.00
204.00	Cost to be allocated (per Wkst. B, Part II)			7,436	961		147,315		204.00
205.00	Unit cost multiplier (Wkst. B, Part II)			0.001119	4.928205		956.590909		205.00
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)								206.00
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)								207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1326

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

Worksheet B-1

Date/Time Prepared:
11/20/2018 12:36 pm

Cost Center Description			PURCHASING RECEIVING AND STORES (COST OF SUPPLIES)	ADMITTING (INPATIENT CHARGES)	CASHIERING/ACCOUNTS RECEIVABLE (GROSS CHARGES)	Reconciliation	OTHER ADMIN & GENERAL (ACCUM. COST)	
			5.03	5.04	5.05	5A.06	5.06	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES	1,117,371					5.03
5.04	00570	ADMITTING	6,234	5,194,792				5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	12,656	0	33,902,273			5.05
5.06	00590	OTHER ADMIN & GENERAL	12,163	0	0	-1,066,519	14,525,806	5.06
7.00	00700	OPERATION OF PLANT	30,817	0	0	0	978,910	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,123	0	0	0	80,775	8.00
9.00	00900	HOUSEKEEPING	20,024	0	0	0	186,081	9.00
10.00	01000	DIETARY	3,297	0	0	0	102,261	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,708	0	0	0	389,807	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	5,435	0	0	0	6,025	14.00
15.00	01500	PHARMACY	9,500	0	0	0	404,307	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	11,465	0	0	0	309,218	16.00
17.00	01700	SOCIAL SERVICE	600	0	0	0	40,106	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	194,646	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	89,303	1,218,177	1,689,104	0	1,770,334	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	45,622	26,690	552,691	0	514,803	50.00
53.00	05300	ANESTHESIOLOGY	6,567	23,253	176,480	0	40,933	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	47,055	265,883	7,565,986	0	1,066,494	54.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	12,565	622,250	0	86,547	58.00
60.00	06000	LABORATORY	589,679	783,956	8,704,250	0	1,484,461	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	11,071	114,151	263,412	0	206,020	65.00
66.00	06600	PHYSICAL THERAPY	8,106	729,655	2,055,074	0	838,953	66.00
69.00	06900	ELECTROCARDIOLOGY	1,059	17,747	407,302	0	16,743	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	45,507	282,016	559,903	0	72,771	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	26,875	0	208,375	0	33,671	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,718,886	2,988,937	0	395,969	73.00
76.00	03610	SLEEP LAB	0	0	285,922	0	46,416	76.00
76.01	03950	SENIOR ENRICHMENT CENTER	16,981	0	1,351,621	0	540,833	76.01
76.97	07697	CARDIAC REHABILITATION	826	0	87,381	0	28,553	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RHC I - HAMILTON MEMORIAL FAM CLINIC	17,362	0	1,023,912	0	1,793,576	88.00
88.01	08801	RHC II - CARMICAM FAMILY CLINIC	13,444	0	1,151,259	0	955,897	88.01
88.02	08802	RHC III - DOWNTOWN FAMILY CLINIC	2,624	0	157,068	0	243,990	88.02
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	79,268	1,813	4,051,346	0	1,408,319	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,117,371	5,194,792	33,902,273	-1,066,519	14,237,419	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	9,516	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	139,372	192.00
194.00	07950	340B DRUG COSTS	0	0	0	0	139,499	194.00
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)	121,240	243,785	631,302		1,066,519	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.108505	0.046929	0.018621		0.073422	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	56,889	8,604	46,360		235,805	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.050913	0.001656	0.001367		0.016234	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1326

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

Worksheet B-1

Date/Time Prepared:
11/20/2018 12:36 pm

Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (FTES)	
		7.00	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00540	NONPATIENT TELEPHONES					5.01
5.02	00550	DATA PROCESSING					5.02
5.03	00560	PURCHASING RECEIVING AND STORES					5.03
5.04	00570	ADMINISTRATIVE					5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE					5.05
5.06	00590	OTHER ADMIN & GENERAL					5.06
7.00	00700	OPERATION OF PLANT	62,609				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	956	92,660			8.00
9.00	00900	HOUSEKEEPING	0	0	11,728		9.00
10.00	01000	DIETARY	0	0	0	11,833	10.00
11.00	01100	CAFETERIA	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,596	0	33	0	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	0	0	0	14.00
15.00	01500	PHARMACY	1,173	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,247	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	96	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	13,355	70,963	3,612	11,833	0 30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	6,700	3,306	1,033	0	0 50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,404	1,570	585	0	0 54.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	156	0	0	0 58.00
60.00	06000	LABORATORY	1,725	0	443	0	0 60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0 64.00
65.00	06500	RESPIRATORY THERAPY	700	0	0	0	0 65.00
66.00	06600	PHYSICAL THERAPY	4,495	12,632	808	0	0 66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0 69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0 71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0 73.00
76.00	03610	SLEEP LAB	375	0	0	0	0 76.00
76.01	03950	SENIOR ENRICHMENT CENTER	3,440	0	445	0	0 76.01
76.97	07697	CARDIAC REHABILITATION	348	0	0	0	0 76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RHC I - HAMILTON MEMORIAL FAM CLINIC	6,901	736	1,922	0	0 88.00
88.01	08801	RHC II - CARMEL FAMILY CLINIC	1,926	0	0	0	0 88.01
88.02	08802	RHC III - DOWNTOWN FAMILY CLINIC	2,400	0	148	0	0 88.02
90.00	09000	CLINIC	0	0	0	0	0 90.00
91.00	09100	EMERGENCY	4,598	3,297	2,699	0	0 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0 92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	56,435	92,660	11,728	11,833	0 118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	396	0	0	0	0 190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	5,778	0	0	0	0 192.00
194.00	07950	340B DRUG COSTS	0	0	0	0	0 194.00
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)	1,050,784	102,751	199,743	109,769	0 202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	16.783274	1.108904	17.031293	9.276515	0.000000 203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	210,288	28,023	4,184	2,163	0 204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	3.358750	0.302428	0.356753	0.182794	0.000000 205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)					206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)					207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1326

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

Worksheet B-1

Date/Time Prepared:
11/20/2018 12:36 pm

Cost Center Description		NURSING ADMINISTRATION (DIRECT NURSING HOURS)	CENTRAL SERVICE & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (TIME SPENT)	
		13.00	14.00	15.00	16.00	17.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.01	00540						5.01
5.02	00550						5.02
5.03	00560						5.03
5.04	00570						5.04
5.05	00580						5.05
5.06	00590						5.06
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100						11.00
13.00	01300	73,968					13.00
14.00	01400	0	72,382				14.00
15.00	01500	0	0	269,853			15.00
16.00	01600	0	0	0	34,435		16.00
17.00	01700	0	0	0	0	1,527	17.00
19.00	01900	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	51,954	0	0	11,480	618	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	3,633	0	0	0	0	50.00
53.00	05300	0	0	0	0	0	53.00
54.00	05400	0	0	0	0	0	54.00
58.00	05800	0	0	0	0	0	58.00
60.00	06000	0	0	0	12,265	0	60.00
64.00	06400	0	0	0	0	0	64.00
65.00	06500	0	0	0	0	0	65.00
66.00	06600	0	0	0	0	114	66.00
69.00	06900	0	0	0	0	0	69.00
71.00	07100	0	45,507	0	0	0	71.00
72.00	07200	0	26,875	0	0	0	72.00
73.00	07300	0	0	269,853	0	0	73.00
76.00	03610	0	0	0	0	0	76.00
76.01	03950	0	0	0	0	0	76.01
76.97	07697	0	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	0	0	0	0	504	88.00
88.01	08801	0	0	0	0	0	88.01
88.02	08802	0	0	0	0	0	88.02
90.00	09000	0	0	0	0	0	90.00
91.00	09100	18,381	0	0	10,690	291	91.00
92.00	09200						92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		73,968	72,382	269,853	34,435	1,527	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
194.00	07950	0	0	0	0	0	194.00
200.00							200.00
201.00							201.00
202.00		445,775	6,467	453,679	352,850	44,662	202.00
203.00		6.026593	0.089345	1.681208	10.246842	29.248199	203.00
204.00		58,916	375	94,438	47,823	3,350	204.00
205.00		0.796507	0.005181	0.349961	1.388790	2.193844	205.00
206.00							206.00
207.00							207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1326

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

Worksheet B-1
Date/Time Prepared:
11/20/2018 12:36 pm

Cost Center Description		NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	
		19.00	
GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4.00
5.01	00540	NONPATIENT TELEPHONES	5.01
5.02	00550	DATA PROCESSING	5.02
5.03	00560	PURCHASING RECEIVING AND STORES	5.03
5.04	00570	ADMINISTRATIVE	5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	5.05
5.06	00590	OTHER ADMIN & GENERAL	5.06
7.00	00700	OPERATION OF PLANT	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	8.00
9.00	00900	HOUSEKEEPING	9.00
10.00	01000	DIETARY	10.00
11.00	01100	CAFETERIA	11.00
13.00	01300	NURSING ADMINISTRATION	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	14.00
15.00	01500	PHARMACY	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
17.00	01700	SOCIAL SERVICE	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	19.00
		100	
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	30.00
		0	
ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	50.00
53.00	05300	ANESTHESIOLOGY	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	58.00
60.00	06000	LABORATORY	60.00
64.00	06400	INTRAVENOUS THERAPY	64.00
65.00	06500	RESPIRATORY THERAPY	65.00
66.00	06600	PHYSICAL THERAPY	66.00
69.00	06900	ELECTROCARDIOLOGY	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
76.00	03610	SLEEP LAB	76.00
76.01	03950	SENIOR ENRICHMENT CENTER	76.01
76.97	07697	CARDIAC REHABILITATION	76.97
OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RHC I - HAMILTON MEMORIAL FAM CLINIC	88.00
88.01	08801	RHC II - CARMEL FAMILY CLINIC	88.01
88.02	08802	RHC III - DOWNTOWN FAMILY CLINIC	88.02
90.00	09000	CLINIC	90.00
91.00	09100	EMERGENCY	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	92.00
SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	118.00
		100	
NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	192.00
194.00	07950	340B DRUG COSTS	194.00
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)	202.00
		208,937	
203.00		Unit cost multiplier (Wkst. B, Part I)	203.00
		2,089.370000	
204.00		Cost to be allocated (per Wkst. B, Part II)	204.00
		3,334	
205.00		Unit cost multiplier (Wkst. B, Part II)	205.00
		33.340000	
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

Provider CCN: 14-1326

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

Worksheet B-2

Date/Time Prepared:
11/20/2018 12:36 pm

	Description	Worksheet		Amount	
		CODE	Line No.		
	1.00	2.00	3.00	4.00	
1.00	ADJ FOR EPO COSTS IN RENAL DIALYSIS		1 74.00	0	1.00
2.00	ADJ FOR EPO COSTS IN HOME PROGRAM		1 94.00	0	2.00
3.00	ADJ FOR ARANESP COSTS IN RENAL DIALYSIS		1 74.00	0	3.00
4.00	ADJ FOR ARANESP COSTS IN HOME PROGRAM		1 94.00	0	4.00
5.00	ADJ FOR ESA COSTS IN RENAL DIALYSIS		1 74.00	0	5.00
6.00	ADJ FOR ESA COSTS IN HOME PROGRAM		1 94.00	0	6.00
7.00	IV THERAPY		1 30.00	-15,430	7.00
8.00	IV THERAPY		1 64.00	15,430	8.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1326

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

Worksheet C
Part I
Date/Time Prepared:
11/20/2018 12:36 pm

		Title XVIII		Hospital		Cost
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
			Total Costs	RCE Disallowance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	2,807,818		2,807,818	0	0 30.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	708,203		708,203	0	0 50.00
53.00	05300 ANESTHESIOLOGY	252,875		252,875	0	0 53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	1,230,416		1,230,416	0	0 54.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	93,074		93,074	0	0 58.00
60.00	06000 LABORATORY	1,755,626		1,755,626	0	0 60.00
64.00	06400 INTRAVENOUS THERAPY	15,430		15,430	0	0 64.00
65.00	06500 RESPIRATORY THERAPY	232,894	0	232,894	0	0 65.00
66.00	06600 PHYSICAL THERAPY	1,007,095	0	1,007,095	0	0 66.00
69.00	06900 ELECTROCARDIOLOGY	17,972		17,972	0	0 69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	82,180		82,180	0	0 71.00
72.00	07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	38,544		38,544	0	0 72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	878,721		878,721	0	0 73.00
76.00	03610 SLEEP LAB	56,118		56,118	0	0 76.00
76.01	03950 SENIOR ENRICHMENT CENTER	645,855		645,855	0	0 76.01
76.97	07697 CARDIAC REHABILITATION	36,490		36,490	0	0 76.97
OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RHC I - HAMILTON MEMORIAL FAM CLINIC	2,089,384		2,089,384	0	0 88.00
88.01	08801 RHC II - CARMI FAMILY CLINIC	1,058,406		1,058,406	0	0 88.01
88.02	08802 RHC III - DOWNTOWN FAMILY CLINIC	304,705		304,705	0	0 88.02
90.00	09000 CLINIC	0		0	0	0 90.00
91.00	09100 EMERGENCY	1,867,338		1,867,338	0	0 91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	287,437		287,437	0	0 92.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300 INTEREST EXPENSE					113.00
200.00	Subtotal (see instructions)	15,466,581	0	15,466,581	0	0 200.00
201.00	Less Observation Beds	287,437		287,437		0 201.00
202.00	Total (see instructions)	15,179,144	0	15,179,144	0	0 202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1326

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

Worksheet C
Part I
Date/Time Prepared:
11/20/2018 12:36 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	1,211,147		1,211,147			30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	26,690	526,001	552,691	1.281372	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	23,253	153,227	176,480	1.432882	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	265,883	7,300,103	7,565,986	0.162625	0.000000	54.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	12,565	609,685	622,250	0.149577	0.000000	58.00
60.00	06000	LABORATORY	783,956	7,920,294	8,704,250	0.201698	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	3,088	107,426	110,514	0.139620	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	114,151	149,261	263,412	0.884143	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	729,655	1,325,419	2,055,074	0.490053	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	17,747	389,555	407,302	0.044125	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	282,016	277,887	559,903	0.146775	0.000000	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	208,375	208,375	0.184974	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,718,886	1,270,051	2,988,937	0.293991	0.000000	73.00
76.00	03610	SLEEP LAB	0	285,922	285,922	0.196270	0.000000	76.00
76.01	03950	SENIOR ENRICHMENT CENTER	0	1,351,621	1,351,621	0.477837	0.000000	76.01
76.97	07697	CARDIAC REHABILITATION	0	87,381	87,381	0.417597	0.000000	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RHC I - HAMILTON MEMORIAL FAM CLINIC	0	1,023,912	1,023,912			88.00
88.01	08801	RHC II - CARMIC FAMILY CLINIC	0	1,151,259	1,151,259			88.01
88.02	08802	RHC III - DOWNTOWN FAMILY CLINIC	0	157,068	157,068			88.02
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
91.00	09100	EMERGENCY	1,813	4,049,533	4,051,346	0.460918	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	3,942	363,501	367,443	0.782263	0.000000	92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	5,194,792	28,707,481	33,902,273			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	5,194,792	28,707,481	33,902,273			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES	Provider CCN: 14-1326	Period: From 07/01/2017 To 06/30/2018	Worksheet C Part I Date/Time Prepared: 11/20/2018 12:36 pm
	Title XVIII	Hospital	Cost

Cost Center Description		PPS Inpatient Ratio	
		11.00	
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000 ADULTS & PEDIATRICS		30.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000 OPERATING ROOM	0.000000	50.00
53.00	05300 ANESTHESIOLOGY	0.000000	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000	54.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	58.00
60.00	06000 LABORATORY	0.000000	60.00
64.00	06400 INTRAVENOUS THERAPY	0.000000	64.00
65.00	06500 RESPIRATORY THERAPY	0.000000	65.00
66.00	06600 PHYSICAL THERAPY	0.000000	66.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	71.00
72.00	07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.000000	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000	73.00
76.00	03610 SLEEP LAB	0.000000	76.00
76.01	03950 SENIOR ENRICHMENT CENTER	0.000000	76.01
76.97	07697 CARDIAC REHABILITATION	0.000000	76.97
OUTPATIENT SERVICE COST CENTERS			
88.00	08800 RHC I - HAMILTON MEMORIAL FAM CLINIC		88.00
88.01	08801 RHC II - CARMEL FAMILY CLINIC		88.01
88.02	08802 RHC III - DOWNTOWN FAMILY CLINIC		88.02
90.00	09000 CLINIC	0.000000	90.00
91.00	09100 EMERGENCY	0.000000	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	92.00
SPECIAL PURPOSE COST CENTERS			
113.00	11300 INTEREST EXPENSE		113.00
200.00	Subtotal (see instructions)		200.00
201.00	Less Observation Beds		201.00
202.00	Total (see instructions)		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1326

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

Worksheet C
Part I
Date/Time Prepared:
11/20/2018 12:36 pm

		Title XIX		Hospital			
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs				
			Total Costs	RCE Disallowance	Total Costs		
	1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	2,807,818		2,807,818	0	2,807,818	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	708,203		708,203	0	708,203	50.00
53.00	05300 ANESTHESIOLOGY	252,875		252,875	0	252,875	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	1,230,416		1,230,416	0	1,230,416	54.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	93,074		93,074	0	93,074	58.00
60.00	06000 LABORATORY	1,755,626		1,755,626	0	1,755,626	60.00
64.00	06400 INTRAVENOUS THERAPY	15,430		15,430	0	15,430	64.00
65.00	06500 RESPIRATORY THERAPY	232,894	0	232,894	0	232,894	65.00
66.00	06600 PHYSICAL THERAPY	1,007,095	0	1,007,095	0	1,007,095	66.00
69.00	06900 ELECTROCARDIOLOGY	17,972		17,972	0	17,972	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	82,180		82,180	0	82,180	71.00
72.00	07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	38,544		38,544	0	38,544	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	878,721		878,721	0	878,721	73.00
76.00	03610 SLEEP LAB	56,118		56,118	0	56,118	76.00
76.01	03950 SENIOR ENRICHMENT CENTER	645,855		645,855	0	645,855	76.01
76.97	07697 CARDIAC REHABILITATION	36,490		36,490	0	36,490	76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RHC I - HAMILTON MEMORIAL FAM CLINIC	2,089,384		2,089,384	0	2,089,384	88.00
88.01	08801 RHC II - CARMEL FAMILY CLINIC	1,058,406		1,058,406	0	1,058,406	88.01
88.02	08802 RHC III - DOWNTOWN FAMILY CLINIC	304,705		304,705	0	304,705	88.02
90.00	09000 CLINIC	0		0	0	0	90.00
91.00	09100 EMERGENCY	1,867,338		1,867,338	0	1,867,338	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	287,437		287,437	0	287,437	92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300 INTEREST EXPENSE						113.00
200.00	Subtotal (see instructions)	15,466,581	0	15,466,581	0	15,466,581	200.00
201.00	Less Observation Beds	287,437		287,437		287,437	201.00
202.00	Total (see instructions)	15,179,144	0	15,179,144	0	15,179,144	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1326

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

Worksheet C
Part I
Date/Time Prepared:
11/20/2018 12:36 pm

Cost Center Description		Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
		Inpatient	Outpatient	Total (col. 6 + col. 7)			
		6.00	7.00	8.00			
Title XIX		Hospital					
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	1,211,147		1,211,147			30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	26,690	526,001	552,691	1.281372	0.000000	50.00
53.00	05300 ANESTHESIOLOGY	23,253	153,227	176,480	1.432882	0.000000	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	265,883	7,300,103	7,565,986	0.162625	0.000000	54.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	12,565	609,685	622,250	0.149577	0.000000	58.00
60.00	06000 LABORATORY	783,956	7,920,294	8,704,250	0.201698	0.000000	60.00
64.00	06400 INTRAVENOUS THERAPY	3,088	107,426	110,514	0.139620	0.000000	64.00
65.00	06500 RESPIRATORY THERAPY	114,151	149,261	263,412	0.884143	0.000000	65.00
66.00	06600 PHYSICAL THERAPY	729,655	1,325,419	2,055,074	0.490053	0.000000	66.00
69.00	06900 ELECTROCARDIOLOGY	17,747	389,555	407,302	0.044125	0.000000	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	282,016	277,887	559,903	0.146775	0.000000	71.00
72.00	07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	208,375	208,375	0.184974	0.000000	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	1,718,886	1,270,051	2,988,937	0.293991	0.000000	73.00
76.00	03610 SLEEP LAB	0	285,922	285,922	0.196270	0.000000	76.00
76.01	03950 SENIOR ENRICHMENT CENTER	0	1,351,621	1,351,621	0.477837	0.000000	76.01
76.97	07697 CARDIAC REHABILITATION	0	87,381	87,381	0.417597	0.000000	76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RHC I - HAMILTON MEMORIAL FAM CLINIC	0	1,023,912	1,023,912	2.040589	0.000000	88.00
88.01	08801 RHC II - CARMEL FAMILY CLINIC	0	1,151,259	1,151,259	0.919347	0.000000	88.01
88.02	08802 RHC III - DOWNTOWN FAMILY CLINIC	0	157,068	157,068	1.939956	0.000000	88.02
90.00	09000 CLINIC	0	0	0	0.000000	0.000000	90.00
91.00	09100 EMERGENCY	1,813	4,049,533	4,051,346	0.460918	0.000000	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	3,942	363,501	367,443	0.782263	0.000000	92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300 INTEREST EXPENSE						113.00
200.00	Subtotal (see instructions)	5,194,792	28,707,481	33,902,273			200.00
201.00	Less Observation Beds						201.00
202.00	Total (see instructions)	5,194,792	28,707,481	33,902,273			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 14-1326	Period: From 07/01/2017 To 06/30/2018	Worksheet C Part I Date/Time Prepared: 11/20/2018 12:36 pm
		Title XIX	Hospital	

Cost Center Description		PPS Inpatient Ratio		
		11.00		
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS			30.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.000000		50.00
53.00	05300 ANESTHESIOLOGY	0.000000		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000		54.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000		58.00
60.00	06000 LABORATORY	0.000000		60.00
64.00	06400 INTRAVENOUS THERAPY	0.000000		64.00
65.00	06500 RESPIRATORY THERAPY	0.000000		65.00
66.00	06600 PHYSICAL THERAPY	0.000000		66.00
69.00	06900 ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.000000		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000		73.00
76.00	03610 SLEEP LAB	0.000000		76.00
76.01	03950 SENIOR ENRICHMENT CENTER	0.000000		76.01
76.97	07697 CARDIAC REHABILITATION	0.000000		76.97
OUTPATIENT SERVICE COST CENTERS				
88.00	08800 RHC I - HAMILTON MEMORIAL FAM CLINIC	0.000000		88.00
88.01	08801 RHC II - CARMIC FAMILY CLINIC	0.000000		88.01
88.02	08802 RHC III - DOWNTOWN FAMILY CLINIC	0.000000		88.02
90.00	09000 CLINIC	0.000000		90.00
91.00	09100 EMERGENCY	0.000000		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
SPECIAL PURPOSE COST CENTERS				
113.00	11300 INTEREST EXPENSE			113.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-1326

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

Worksheet D
Part II
Date/Time Prepared:
11/20/2018 12:36 pm

Cost Center Description		Title XVIII			Hospital	Cost		
		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	310,012	552,691	0.560914	0	0	50.00
53.00	05300	ANESTHESIOLOGY	19,817	176,480	0.112290	21,935	2,463	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	296,354	7,565,986	0.039169	135,755	5,317	54.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	2,324	622,250	0.003735	10,052	38	58.00
60.00	06000	LABORATORY	155,994	8,704,250	0.017922	451,073	8,084	60.00
64.00	06400	INTRAVENOUS THERAPY	0	110,514	0.000000	1,128	0	64.00
65.00	06500	RESPIRATORY THERAPY	50,573	263,412	0.191992	56,453	10,839	65.00
66.00	06600	PHYSICAL THERAPY	163,092	2,055,074	0.079361	69,678	5,530	66.00
69.00	06900	ELECTROCARDIOLOGY	912	407,302	0.002239	13,032	29	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,966	559,903	0.008869	133,510	1,184	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	2,339	208,375	0.011225	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	107,801	2,988,937	0.036067	628,764	22,678	73.00
76.00	03610	SLEEP LAB	11,421	285,922	0.039944	0	0	76.00
76.01	03950	SENIOR ENRICHMENT CENTER	113,998	1,351,621	0.084342	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	10,173	87,381	0.116421	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RHC I - HAMILTON MEMORIAL FAM CLINIC	250,126	1,023,912	0.244285	0	0	88.00
88.01	08801	RHC II - CARMEL FAMILY CLINIC	93,188	1,151,259	0.080944	0	0	88.01
88.02	08802	RHC III - DOWNTOWN FAMILY CLINIC	70,938	157,068	0.451639	0	0	88.02
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
91.00	09100	EMERGENCY	233,587	4,051,346	0.057657	1,813	105	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	53,646	367,443	0.145998	3,942	576	92.00
200.00		Total (lines 50 through 199)	1,951,261	32,691,126		1,527,135	56,843	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1326

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

Worksheet D
Part IV
Date/Time Prepared:
11/20/2018 12:36 pm

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	50.00	
53.00	05300	ANESTHESIOLOGY	208,937	0	0	0	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00	
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00	
60.00	06000	LABORATORY	0	0	0	0	60.00	
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00	
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00	
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00	
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00	
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00	
76.00	03610	SLEEP LAB	0	0	0	0	76.00	
76.01	03950	SENIOR ENRICHMENT CENTER	0	0	0	0	76.01	
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	76.97	
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RHC I - HAMILTON MEMORIAL FAM CLINIC	0	0	0	0	88.00	
88.01	08801	RHC II - CARMEL FAMILY CLINIC	0	0	0	0	88.01	
88.02	08802	RHC III - DOWNTOWN FAMILY CLINIC	0	0	0	0	88.02	
90.00	09000	CLINIC	0	0	0	0	90.00	
91.00	09100	EMERGENCY	0	0	0	0	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00	
200.00		Total (lines 50 through 199)	208,937	0	0	0	200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1326

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

Worksheet D
Part IV
Date/Time Prepared:
11/20/2018 12:36 pm

Cost Center Description		Title XVIII			Hospital		Ratio of Cost to Charges (col. 5 ÷ col. 7)	
		All Other Medical Education Cost	Total Cost (sum of col. 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Cost		
		4.00	5.00	6.00	7.00	8.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	552,691	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	208,937	0	176,480	1.183913	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	7,565,986	0.000000	54.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	622,250	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	8,704,250	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	110,514	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	263,412	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	2,055,074	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	407,302	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	559,903	0.000000	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	208,375	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	2,988,937	0.000000	73.00
76.00	03610	SLEEP LAB	0	0	0	285,922	0.000000	76.00
76.01	03950	SENIOR ENRICHMENT CENTER	0	0	0	1,351,621	0.000000	76.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	87,381	0.000000	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RHC I - HAMILTON MEMORIAL FAM CLINIC	0	0	0	1,023,912	0.000000	88.00
88.01	08801	RHC II - CARMIC FAMILY CLINIC	0	0	0	1,151,259	0.000000	88.01
88.02	08802	RHC III - DOWNTOWN FAMILY CLINIC	0	0	0	157,068	0.000000	88.02
90.00	09000	CLINIC	0	0	0	0	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	4,051,346	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	367,443	0.000000	92.00
200.00		Total (lines 50 through 199)	0	208,937	0	32,691,126		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1326

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

Worksheet D
Part IV
Date/Time Prepared:
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Cost Center Description		Title XVIII			Hospital		Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
		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	21,935	25,969	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	135,755	0	0	0	54.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	10,052	0	0	0	58.00
60.00	06000	LABORATORY	0.000000	451,073	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	1,128	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	56,453	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	69,678	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	13,032	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	133,510	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	628,764	0	0	0	73.00
76.00	03610	SLEEP LAB	0.000000	0	0	0	0	76.00
76.01	03950	SENIOR ENRICHMENT CENTER	0.000000	0	0	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RHC I - HAMILTON MEMORIAL FAM CLINIC	0.000000	0	0	0	0	88.00
88.01	08801	RHC II - CARMEL FAMILY CLINIC	0.000000	0	0	0	0	88.01
88.02	08802	RHC III - DOWNTOWN FAMILY CLINIC	0.000000	0	0	0	0	88.02
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.000000	1,813	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	3,942	0	0	0	92.00
200.00		Total (lines 50 through 199)		1,527,135	25,969	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1326

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

Worksheet D
Part V
Date/Time Prepared:
11/20/2018 12:36 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	1.281372	0	344,852	0	0	50.00
53.00	05300	ANESTHESIOLOGY	1.432882	0	118,639	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.162625	0	3,226,226	0	0	54.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.149577	0	163,712	0	0	58.00
60.00	06000	LABORATORY	0.201698	0	4,074,587	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.139620	0	62,945	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.884143	0	81,135	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.490053	0	550,323	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.044125	0	202,173	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.146775	0	133,636	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.184974	0	148,363	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.293991	0	743,733	0	0	73.00
76.00	03610	SLEEP LAB	0.196270	0	149,152	0	0	76.00
76.01	03950	SENIOR ENRICHMENT CENTER	0.477837	0	1,312,351	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	0.417597	0	20,777	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RHC I - HAMILTON MEMORIAL FAM CLINIC	0.000000				0	88.00
88.01	08801	RHC II - CARMIC FAMILY CLINIC	0.000000				0	88.01
88.02	08802	RHC III - DOWNTOWN FAMILY CLINIC	0.000000				0	88.02
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.460918	0	1,642,055	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.782263	0	243,406	0	0	92.00
200.00		Subtotal (see instructions)		0	13,218,065	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0	0	201.00
202.00		Net Charges (line 200 - line 201)		0	13,218,065	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 14-1326	Period: From 07/01/2017 To 06/30/2018	Worksheet D Part V Date/Time Prepared: 11/20/2018 12:36 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	441,884	0		50.00
53.00 05300 ANESTHESIOLOGY	169,996	0		53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	524,665	0		54.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	24,488	0		58.00
60.00 06000 LABORATORY	821,836	0		60.00
64.00 06400 INTRAVENOUS THERAPY	8,788	0		64.00
65.00 06500 RESPIRATORY THERAPY	71,735	0		65.00
66.00 06600 PHYSICAL THERAPY	269,687	0		66.00
69.00 06900 ELECTROCARDIOLOGY	8,921	0		69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	19,614	0		71.00
72.00 07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	27,443	0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	218,651	0		73.00
76.00 03610 SLEEP LAB	29,274	0		76.00
76.01 03950 SENIOR ENRICHMENT CENTER	627,090	0		76.01
76.97 07697 CARDIAC REHABILITATION	8,676	0		76.97
OUTPATIENT SERVICE COST CENTERS				
88.00 08800 RHC I - HAMILTON MEMORIAL FAM CLINIC	0	0		88.00
88.01 08801 RHC II - CARMIC FAMILY CLINIC	0	0		88.01
88.02 08802 RHC III - DOWNTOWN FAMILY CLINIC	0	0		88.02
90.00 09000 CLINIC	0	0		90.00
91.00 09100 EMERGENCY	756,853	0		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	190,408	0		92.00
200.00 Subtotal (see instructions)	4,220,009	0		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00 Net Charges (line 200 - line 201)	4,220,009	0		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1326

Period: From 07/01/2017

Worksheet D

Component CCN: 14-Z326

To 06/30/2018

Part V

Date/Time Prepared: 11/20/2018 12:36 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	5.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	1.281372	0	0	0	0	50.00
53.00 05300 ANESTHESIOLOGY	1.432882	0	0	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.162625	0	0	0	0	54.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0.149577	0	0	0	0	58.00
60.00 06000 LABORATORY	0.201698	0	0	0	0	60.00
64.00 06400 INTRAVENOUS THERAPY	0.139620	0	0	0	0	64.00
65.00 06500 RESPIRATORY THERAPY	0.884143	0	0	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0.490053	0	0	0	0	66.00
69.00 06900 ELECTROCARDIOLOGY	0.044125	0	0	0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.146775	0	0	0	0	71.00
72.00 07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.184974	0	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0.293991	0	0	0	0	73.00
76.00 03610 SLEEP LAB	0.196270	0	0	0	0	76.00
76.01 03950 SENIOR ENRICHMENT CENTER	0.477837	0	0	0	0	76.01
76.97 07697 CARDIAC REHABILITATION	0.417597	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RHC I - HAMILTON MEMORIAL FAM CLINIC	0.000000					88.00
88.01 08801 RHC II - CARMIC FAMILY CLINIC	0.000000					88.01
88.02 08802 RHC III - DOWNTOWN FAMILY CLINIC	0.000000					88.02
90.00 09000 CLINIC	0.000000					90.00
91.00 09100 EMERGENCY	0.460918	0	0	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.782263	0	0	0	0	92.00
200.00 Subtotal (see instructions)		0	0	0	0	200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges				0	0	201.00
202.00 Net Charges (line 200 - line 201)		0	0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1326

Period:

Worksheet D

Component CCN: 14-Z326

From 07/01/2017

Part V

To 06/30/2018

Date/Time Prepared:

11/20/2018 12:36 pm

Title XVIII

Swing Beds - SNF

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	0	0		50.00
53.00 05300 ANESTHESIOLOGY	0	0		53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0		54.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
60.00 06000 LABORATORY	0	0		60.00
64.00 06400 INTRAVENOUS THERAPY	0	0		64.00
65.00 06500 RESPIRATORY THERAPY	0	0		65.00
66.00 06600 PHYSICAL THERAPY	0	0		66.00
69.00 06900 ELECTROCARDIOLOGY	0	0		69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00 07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		73.00
76.00 03610 SLEEP LAB	0	0		76.00
76.01 03950 SENIOR ENRICHMENT CENTER	0	0		76.01
76.97 07697 CARDIAC REHABILITATION	0	0		76.97
OUTPATIENT SERVICE COST CENTERS				
88.00 08800 RHC I - HAMILTON MEMORIAL FAM CLINIC	0	0		88.00
88.01 08801 RHC II - CARMIC FAMILY CLINIC	0	0		88.01
88.02 08802 RHC III - DOWNTOWN FAMILY CLINIC	0	0		88.02
90.00 09000 CLINIC	0	0		90.00
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 OTHER PASS THROUGH COSTS			Provider CCN: 14-1326		Period: From 07/01/2017 To 06/30/2018		Worksheet D Part III Date/Time Prepared: 11/20/2018 12:36 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	1,542	0.00	91	30.00	
200.00		Total (lines 30 through 199)		0	1,542		91	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: 14-1326

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

Worksheet D
Part IV
Date/Time Prepared:
11/20/2018 12:36 pm

Cost Center Description		Title XIX				Hospital		
		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	208,937	0	0	0	0	53.00	
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00	
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00	
60.00	06000 LABORATORY	0	0	0	0	0	60.00	
64.00	06400 INTRAVENOUS THERAPY	0	0	0	0	0	64.00	
65.00	06500 RESPIRATORY THERAPY	0	0	0	0	0	65.00	
66.00	06600 PHYSICAL THERAPY	0	0	0	0	0	66.00	
69.00	06900 ELECTROCARDIOLOGY	0	0	0	0	0	69.00	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00	
72.00	07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0	72.00	
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00	
76.00	03610 SLEEP LAB	0	0	0	0	0	76.00	
76.01	03950 SENIOR ENRICHMENT CENTER	0	0	0	0	0	76.01	
76.97	07697 CARDIAC REHABILITATION	0	0	0	0	0	76.97	
OUTPATIENT SERVICE COST CENTERS								
88.00	08800 RHC I - HAMILTON MEMORIAL FAM CLINIC	0	0	0	0	0	88.00	
88.01	08801 RHC II - CARMEL FAMILY CLINIC	0	0	0	0	0	88.01	
88.02	08802 RHC III - DOWNTOWN FAMILY CLINIC	0	0	0	0	0	88.02	
90.00	09000 CLINIC	0	0	0	0	0	90.00	
91.00	09100 EMERGENCY	0	0	0	0	0	91.00	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00	
200.00	Total (lines 50 through 199)	208,937	0	0	0	0	200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1326

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

Worksheet D
Part IV
Date/Time Prepared:
11/20/2018 12:36 pm

Cost Center Description		Title XIX			Hospital		Ratio of Cost to Charges (col. 5 ÷ col. 7)	
		All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)			
		4.00	5.00	6.00	7.00	8.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	552,691	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	208,937	0	176,480	1.183913	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	7,565,986	0.000000	54.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	622,250	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	8,704,250	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	110,514	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	263,412	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	2,055,074	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	407,302	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	559,903	0.000000	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	208,375	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	2,988,937	0.000000	73.00
76.00	03610	SLEEP LAB	0	0	0	285,922	0.000000	76.00
76.01	03950	SENIOR ENRICHMENT CENTER	0	0	0	1,351,621	0.000000	76.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	87,381	0.000000	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RHC I - HAMILTON MEMORIAL FAM CLINIC	0	0	0	1,023,912	0.000000	88.00
88.01	08801	RHC II - CARMEL FAMILY CLINIC	0	0	0	1,151,259	0.000000	88.01
88.02	08802	RHC III - DOWNTOWN FAMILY CLINIC	0	0	0	157,068	0.000000	88.02
90.00	09000	CLINIC	0	0	0	0	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	4,051,346	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	367,443	0.000000	92.00
200.00		Total (lines 50 through 199)	0	208,937	0	32,691,126		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1326

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

Worksheet D
Part IV
Date/Time Prepared:
11/20/2018 12:36 pm

Cost Center Description		Title XIX			Hospital		
		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	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	0	0	0	54.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	58.00
60.00	06000	LABORATORY	0.000000	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.000000	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	0	0	0	73.00
76.00	03610	SLEEP LAB	0.000000	0	0	0	76.00
76.01	03950	SENIOR ENRICHMENT CENTER	0.000000	0	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RHC I - HAMILTON MEMORIAL FAM CLINIC	0.000000	0	0	0	88.00
88.01	08801	RHC II - CARMEL FAMILY CLINIC	0.000000	0	0	0	88.01
88.02	08802	RHC III - DOWNTOWN FAMILY CLINIC	0.000000	0	0	0	88.02
90.00	09000	CLINIC	0.000000	0	0	0	90.00
91.00	09100	EMERGENCY	0.000000	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	92.00
200.00		Total (lines 50 through 199)		0	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-1326	Period: From 07/01/2017 To 06/30/2018	Worksheet D-1 Date/Time Prepared: 11/20/2018 12:36 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)			3,444 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			1,542 2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.			0 3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)			1,216 4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period			794 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)			793 6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period			158 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)			157 8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)			966 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)			767 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)			766 11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period			0 12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)			0 14.00
15.00	Total nursery days (title V or XIX only)			0 15.00
16.00	Nursery days (title V or XIX only)			0 16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period			155.41 19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period			155.41 20.00
21.00	Total general inpatient routine service cost (see instructions)			2,807,818 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)			24,555 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)			24,399 25.00
26.00	Total swing-bed cost (see instructions)			1,448,228 26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)			1,359,590 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)			1,359,590 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)			881.71 38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			851,732 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)			851,732 41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-1326		Period: From 07/01/2017 To 06/30/2018		Worksheet D-1	
Date/Time Prepared: 11/20/2018 12:36 pm		Title XVIII		Hospital		Cost	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
	1.00	2.00	3.00	4.00	5.00		
42.00 NURSERY (title V & XIX only)							42.00
Intensive Care Type Inpatient Hospital Units							
43.00 INTENSIVE CARE UNIT							43.00
44.00 CORONARY CARE UNIT							44.00
45.00 BURN INTENSIVE CARE UNIT							45.00
46.00 SURGICAL INTENSIVE CARE UNIT							46.00
47.00 OTHER SPECIAL CARE (SPECIFY)							47.00
Cost Center Description							
					1.00		
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					439,150		48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					1,290,882		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)					676,272		64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					675,390		65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					1,351,662		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)						326	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)						881.71	88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)						287,437	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-1326		Period: From 07/01/2017 To 06/30/2018		Worksheet D-1 Date/Time Prepared: 11/20/2018 12:36 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	524,039	2,807,818	0.186636	287,437	53,646	90.00
91.00	Nursing School cost	0	2,807,818	0.000000	287,437	0	91.00
92.00	Allied health cost	0	2,807,818	0.000000	287,437	0	92.00
93.00	All other Medical Education	0	2,807,818	0.000000	287,437	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-1326	Period: From 07/01/2017 To 06/30/2018	Worksheet D-3 Date/Time Prepared: 11/20/2018 12:36 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		629,020		30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	1.281372	0	0	50.00
53.00	05300 ANESTHESIOLOGY	1.432882	21,935	31,430	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.162625	135,755	22,077	54.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.149577	10,052	1,504	58.00
60.00	06000 LABORATORY	0.201698	451,073	90,981	60.00
64.00	06400 INTRAVENOUS THERAPY	0.139620	1,128	157	64.00
65.00	06500 RESPIRATORY THERAPY	0.884143	56,453	49,913	65.00
66.00	06600 PHYSICAL THERAPY	0.490053	69,678	34,146	66.00
69.00	06900 ELECTROCARDIOLOGY	0.044125	13,032	575	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.146775	133,510	19,596	71.00
72.00	07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.184974	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.293991	628,764	184,851	73.00
76.00	03610 SLEEP LAB	0.196270	0	0	76.00
76.01	03950 SENIOR ENRICHMENT CENTER	0.477837	0	0	76.01
76.97	07697 CARDIAC REHABILITATION	0.417597	0	0	76.97
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RHC I - HAMILTON MEMORIAL FAM CLINIC	0.000000		0	88.00
88.01	08801 RHC II - CARMEL FAMILY CLINIC	0.000000		0	88.01
88.02	08802 RHC III - DOWNTOWN FAMILY CLINIC	0.000000		0	88.02
90.00	09000 CLINIC	0.000000	0	0	90.00
91.00	09100 EMERGENCY	0.460918	1,813	836	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.782263	3,942	3,084	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		1,527,135	439,150	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00	Net charges (line 200 minus line 201)		1,527,135		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-1326 Component CCN: 14-Z326	Period: From 07/01/2017 To 06/30/2018	Worksheet D-3 Date/Time Prepared: 11/20/2018 12:36 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	1.281372	0	0	50.00
53.00	05300 ANESTHESIOLOGY	1.432882	1,318	1,889	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.162625	71,987	11,707	54.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.149577	0	0	58.00
60.00	06000 LABORATORY	0.201698	161,882	32,651	60.00
64.00	06400 INTRAVENOUS THERAPY	0.139620	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0.884143	38,104	33,689	65.00
66.00	06600 PHYSICAL THERAPY	0.490053	511,405	250,616	66.00
69.00	06900 ELECTROCARDIOLOGY	0.044125	2,534	112	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.146775	97,910	14,371	71.00
72.00	07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.184974	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.293991	726,175	213,489	73.00
76.00	03610 SLEEP LAB	0.196270	0	0	76.00
76.01	03950 SENIOR ENRICHMENT CENTER	0.477837	0	0	76.01
76.97	07697 CARDIAC REHABILITATION	0.417597	0	0	76.97
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RHC I - HAMILTON MEMORIAL FAM CLINIC	0.000000		0	88.00
88.01	08801 RHC II - CARMEL FAMILY CLINIC	0.000000		0	88.01
88.02	08802 RHC III - DOWNTOWN FAMILY CLINIC	0.000000		0	88.02
90.00	09000 CLINIC	0.000000	0	0	90.00
91.00	09100 EMERGENCY	0.460918	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.782263	0	0	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		1,611,315	558,524	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)		1,611,315		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-1326	Period: From 07/01/2017 To 06/30/2018	Worksheet E Part B Date/Time Prepared: 11/20/2018 12:36 pm
		Title XVIII	Hospital	Cost
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)			4,220,009 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)			4,220,009 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)			4,262,209 21.00
22.00	Interns and residents (see instructions)			0 22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)			0 23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)			0 24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance (for CAH, see instructions)			32,951 25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)			1,838,659 26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)			2,390,599 27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)			0 28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)			0 29.00
30.00	Subtotal (sum of lines 27 through 29)			2,390,599 30.00
31.00	Primary payer payments			424 31.00
32.00	Subtotal (line 30 minus line 31)			2,390,175 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)			283,471 34.00
35.00	Adjusted reimbursable bad debts (see instructions)			184,256 35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			283,471 36.00
37.00	Subtotal (see instructions)			2,574,431 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)			2,574,431 40.00
40.01	Sequestration adjustment (see instructions)			51,489 40.01
40.02	Demonstration payment adjustment amount after sequestration			0 40.02
41.00	Interim payments			2,541,036 41.00
42.00	Tentative settlement (for contractors use only)			0 42.00
43.00	Balance due provider/program (see instructions)			-18,094 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: 14-1326

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

Worksheet E-1
Part I
Date/Time Prepared:
11/20/2018 12:36 pm

		Title XVIII		Hospital		Cost	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		1,011,716		2,888,100	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00	
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER		0	06/27/2018	68,390	3.01	
3.02			0		0	3.02	
3.03			0		0	3.03	
3.04			0		0	3.04	
3.05			0		0	3.05	
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM		0	01/25/2018	415,454	3.50	
3.51			0		0	3.51	
3.52			0		0	3.52	
3.53			0		0	3.53	
3.54			0		0	3.54	
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		-347,064	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)		1,011,716		2,541,036	4.00	
TO BE COMPLETED BY CONTRACTOR							
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00	
Program to Provider							
5.01	TENTATIVE TO PROVIDER		0		0	5.01	
5.02			0		0	5.02	
5.03			0		0	5.03	
Provider to Program							
5.50	TENTATIVE TO PROGRAM		0		0	5.50	
5.51			0		0	5.51	
5.52			0		0	5.52	
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99	
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00	
6.01	SETTLEMENT TO PROVIDER		7,848		0	6.01	
6.02	SETTLEMENT TO PROGRAM		0		18,094	6.02	
7.00	Total Medicare program liability (see instructions)		1,019,564		2,522,942	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: 14-1326
Component CCN: 14-Z326

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

Worksheet E-1
Part I
Date/Time Prepared:
11/20/2018 12:36 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		1,864,103		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM	01/25/2018	117,446		0	3.50
3.51		06/27/2018	30,103		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)		-147,549		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)		1,716,554		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		111,152		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,827,706		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: 14-1326	Period: From 07/01/2017 To 06/30/2018	Worksheet E-1 Part II Date/Time Prepared: 11/20/2018 12:36 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: 14-1326	Period: From 07/01/2017 To 06/30/2018	Worksheet E-2
		Component CCN: 14-Z326		Date/Time Prepared: 11/20/2018 12:36 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)	1,365,179	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)	564,109	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	1,533	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)	1,929,288	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	1,929,288	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)	1,929,288	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	64,282	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)	1,865,006	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)	1,865,006	0	19.00
19.01	Sequestration adjustment (see instructions)	37,300	0	19.01
19.02	Demonstration payment adjustment amount after sequestration	0	0	19.02
20.00	Interim payments	1,716,554	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)	111,152	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: 14-1326	Period: From 07/01/2017 To 06/30/2018	Worksheet E-3 Part V Date/Time Prepared: 11/20/2018 12:36 pm
		Title XVIII	Hospital	Cost
				1.00
PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT				
1.00	Inpatient services			1,290,882 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)			1,290,882 4.00
5.00	Primary payer payments			0 5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)			1,303,791 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)			1,303,791 19.00
20.00	Deductibles (exclude professional component)			293,650 20.00
21.00	Excess reasonable cost (from line 16)			0 21.00
22.00	Subtotal (line 19 minus line 20 and 21)			1,010,141 22.00
23.00	Coinsurance			1,974 23.00
24.00	Subtotal (line 22 minus line 23)			1,008,167 24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			49,544 25.00
26.00	Adjusted reimbursable bad debts (see instructions)			32,204 26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			49,544 27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)			1,040,371 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)			1,040,371 30.00
30.01	Sequestration adjustment (see instructions)			20,807 30.01
30.02	Demonstration payment adjustment amount after sequestration			0 30.02
31.00	Interim payments			1,011,716 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)			7,848 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: 14-1326

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

Worksheet G

Date/Time Prepared:
11/20/2018 12:36 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	2,544,315	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	2,272,514	0	0	0	4.00
5.00	Other receivable	53,632	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	341,432	0	0	0	7.00
8.00	Prepaid expenses	87,433	0	0	0	8.00
9.00	Other current assets	0	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)	5,299,326	0	0	0	11.00
FIXED ASSETS						
12.00	Land	69,760	0	0	0	12.00
13.00	Land improvements	499,729	0	0	0	13.00
14.00	Accumulated depreciation	-276,702	0	0	0	14.00
15.00	Buildings	21,731,995	0	0	0	15.00
16.00	Accumulated depreciation	-11,249,730	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	6,564,979	0	0	0	23.00
24.00	Accumulated depreciation	-5,188,794	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	12,151,237	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	3,088,410	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	177,002	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	3,265,412	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	20,715,975	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	305,761	0	0	0	37.00
38.00	Salaries, wages, and fees payable	560,694	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	550,000	0	0	0	40.00
41.00	Deferred income	43,700	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	933,216	0	0	0	43.00
44.00	Other current liabilities	144,724	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	2,538,095	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	18,015,000	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	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	18,015,000	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	20,553,095	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	162,880				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)	162,880	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	20,715,975	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-1326

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

Worksheet G-1

Date/Time Prepared:
11/20/2018 12:36 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		1,514,283		0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		-701,404			2.00
3.00	Total (sum of line 1 and line 2)		812,879		0	3.00
4.00	ROUNDING	1		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)		1		0	10.00
11.00	Subtotal (line 3 plus line 10)		812,880		0	11.00
12.00	PY RESTATEMENT	650,000		0		12.00
13.00		0		0		13.00
14.00		0		0		14.00
15.00		0		0		15.00
16.00		0		0		16.00
17.00		0		0		17.00
18.00	Total deductions (sum of lines 12-17)		650,000		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		162,880		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	ROUNDING		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	PY RESTATEMENT		0			12.00
13.00			0			13.00
14.00			0			14.00
15.00			0			15.00
16.00			0			16.00
17.00			0			17.00
18.00	Total deductions (sum of lines 12-17)	0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0		19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 14-1326

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

Worksheet G-2
Parts I & II
Date/Time Prepared:
11/20/2018 12:36 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	573,542		573,542	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	590,280		590,280	5.00
6.00	Swing bed - NF	117,163		117,163	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	1,280,985		1,280,985	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	1,280,985		1,280,985	17.00
18.00	Ancillary services	3,970,295	21,942,192	25,912,487	18.00
19.00	Outpatient services	4,857	4,371,705	4,376,562	19.00
20.00	RHC I - HAMILTON MEMORIAL FAM CLINIC	0	944,626	944,626	20.00
20.01	RHC II - CARMEL FAMILY CLINIC	0	1,151,259	1,151,259	20.01
20.02	RHC III - DOWNTOWN FAMILY CLINIC	0	157,068	157,068	20.02
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	210,224	224,618	434,842	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	5,466,361	28,791,468	34,257,829	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		17,525,243		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)		17,525,243		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-1326

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

Worksheet G-3

Date/Time Prepared:
11/20/2018 12:36 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	34,257,829	1.00
2.00	Less contractual allowances and discounts on patients' accounts	19,156,466	2.00
3.00	Net patient revenues (line 1 minus line 2)	15,101,363	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	17,525,243	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-2,423,880	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	80,846	6.00
7.00	Income from investments	73,175	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	1,216	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	1,335	16.00
17.00	Revenue from sale of drugs to other than patients	10,204	17.00
18.00	Revenue from sale of medical records and abstracts	3,150	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	36,620	22.00
23.00	Governmental appropriations	642,524	23.00
24.00	EHR INCENTIVE	48,200	24.00
24.01	340B NET REVENUES	577,732	24.01
24.02	HH CONTRACT SERVICES	108,225	24.02
24.03	WELLNESS PROGRAMS	91,742	24.03
24.04	RHC III SALE PROCEEDS	17,892	24.04
24.05	GAIN ON DISPOSAL OF FIXED ASSETS	16,360	24.05
24.06	MISC INCOME	13,255	24.06
25.00	Total other income (sum of lines 6-24)	1,722,476	25.00
26.00	Total (line 5 plus line 25)	-701,404	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)	-701,404	29.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS		Provider CCN: 14-1326 Component CCN: 14-3477		Period: From 07/01/2017 To 06/30/2018		Worksheet M-1 Date/Time Prepared: 11/20/2018 12:36 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	642,228	0	642,228	0	642,228	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	209,740	0	209,740	0	209,740	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	150,944	0	150,944	0	150,944	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	1,002,912	0	1,002,912	0	1,002,912	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	39,365	39,365	0	39,365	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	39,365	39,365	0	39,365	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	1,002,912	39,365	1,042,277	0	1,042,277	22.00
COSTS OTHER THAN RHC/FQHC SERVICES							
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
25.01	Telehealth	0	0	0	0	0	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs	0	0	0	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0	28.00
FACILITY OVERHEAD							
29.00	Facility Costs	0	530	530	0	530	29.00
30.00	Administrative Costs	121,346	249,605	370,951	-55,608	315,343	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	121,346	250,135	371,481	-55,608	315,873	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	1,124,258	289,500	1,413,758	-55,608	1,358,150	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1326

Period: From 07/01/2017

Worksheet M-1

Component CCN: 14-3477

To 06/30/2018

Date/Time Prepared: 11/20/2018 12:36 pm

RHC I

Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
		6.00	7.00	
FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	-43,850	598,378	1.00
2.00	Physician Assistant	0	0	2.00
3.00	Nurse Practitioner	0	209,740	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	150,944	5.00
6.00	Clinical Psychologist	0	0	6.00
7.00	Clinical Social Worker	0	0	7.00
8.00	Laboratory Technician	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	-43,850	959,062	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	39,365	15.00
16.00	Transportation (Health Care Staff)	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	17.00
18.00	Professional Liability Insurance	0	0	18.00
19.00	Other Health Care Costs	0	0	19.00
20.00	Allowable GME Costs			20.00
21.00	Subtotal (sum of lines 15 through 20)	0	39,365	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-43,850	998,427	22.00
COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0	23.00
24.00	Dental	0	0	24.00
25.00	Optometry	0	0	25.00
25.01	Telehealth	0	0	25.01
25.02	Chronic Care Management	0	0	25.02
26.00	All other nonreimbursable costs	0	0	26.00
27.00	Nonallowable GME costs			27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	28.00
FACILITY OVERHEAD				
29.00	Facility Costs	0	530	29.00
30.00	Administrative Costs	0	315,343	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	315,873	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-43,850	1,314,300	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1326

Period: From 07/01/2017

Worksheet M-1

Component CCN: 14-8529

To 06/30/2018

Date/Time Prepared: 11/20/2018 12:36 pm

		RHC II		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	424	0	424	0	424	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	387,874	0	387,874	0	387,874	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	97,938	0	97,938	0	97,938	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	1,171	0	1,171	0	1,171	8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	487,407	0	487,407	0	487,407	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	13,344	13,344	0	13,344	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	13,344	13,344	0	13,344	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	487,407	13,344	500,751	0	500,751	22.00
COSTS OTHER THAN RHC/FQHC SERVICES							
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
25.01	Telehealth	0	0	0	0	0	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs	0	0	0	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0	28.00
FACILITY OVERHEAD							
29.00	Facility Costs	0	113,760	113,760	-113,265	495	29.00
30.00	Administrative Costs	75,561	140,491	216,052	-5,360	210,692	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	75,561	254,251	329,812	-118,625	211,187	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	562,968	267,595	830,563	-118,625	711,938	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1326

Period: From 07/01/2017

Worksheet M-1

Component CCN: 14-8529

To 06/30/2018

Date/Time Prepared: 11/20/2018 12:36 pm

RHC II

Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
		6.00	7.00	
FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	424	1.00
2.00	Physician Assistant	0	0	2.00
3.00	Nurse Practitioner	0	387,874	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	97,938	5.00
6.00	Clinical Psychologist	0	0	6.00
7.00	Clinical Social Worker	0	0	7.00
8.00	Laboratory Technician	0	1,171	8.00
9.00	Other Facility Health Care Staff Costs	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	0	487,407	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	13,344	15.00
16.00	Transportation (Health Care Staff)	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	17.00
18.00	Professional Liability Insurance	0	0	18.00
19.00	Other Health Care Costs	0	0	19.00
20.00	Allowable GME Costs	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	13,344	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	500,751	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	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	28.00
FACILITY OVERHEAD				
29.00	Facility Costs	0	495	29.00
30.00	Administrative Costs	0	210,692	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	211,187	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	711,938	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1326

Period: From 07/01/2017

Worksheet M-1

Component CCN: 14-8556

To 06/30/2018

Date/Time Prepared: 11/20/2018 12:36 pm

		RHC III		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	0	0	0	0	0	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	66,019	0	66,019	0	66,019	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	34,206	0	34,206	0	34,206	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	100,225	0	100,225	0	100,225	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	1,559	1,559	0	1,559	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	1,559	1,559	0	1,559	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	100,225	1,559	101,784	0	101,784	22.00
COSTS OTHER THAN RHC/FQHC SERVICES							
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
25.01	Telehealth	0	0	0	0	0	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs	0	0	0	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0	28.00
FACILITY OVERHEAD							
29.00	Facility Costs	0	33,496	33,496	-32,854	642	29.00
30.00	Administrative Costs	26,332	26,329	52,661	-446	52,215	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	26,332	59,825	86,157	-33,300	52,857	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	126,557	61,384	187,941	-33,300	154,641	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1326

Period: From 07/01/2017

Worksheet M-1

Component CCN: 14-8556

To 06/30/2018

Date/Time Prepared: 11/20/2018 12:36 pm

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	RHC III	Cost
		6.00	7.00		
FACILITY HEALTH CARE STAFF COSTS					
1.00	Physician	0	0		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	66,019		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	34,206		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	0		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	100,225		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	1,559		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs	0	0		20.00
21.00	Subtotal (sum of lines 15 through 20)	0	1,559		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	101,784		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	0	0		27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0		28.00
FACILITY OVERHEAD					
29.00	Facility Costs	0	642		29.00
30.00	Administrative Costs	0	52,215		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	52,857		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	154,641		32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 14-1326 Component CCN: 14-3477	Period: From 07/01/2017 To 06/30/2018	Worksheet M-2 Date/Time Prepared: 11/20/2018 12:36 pm
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		RHC I		Cost		
	Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
	1.00	2.00	3.00	4.00	5.00	
VISITS AND PRODUCTIVITY						
Positions						
1.00	Physician	1.78	3,971	4,200	7,476	1.00
2.00	Physician Assistant	0.00	0	2,100	0	2.00
3.00	Nurse Practitioner	1.46	5,112	2,100	3,066	3.00
4.00	Subtotal (sum of lines 1 through 3)	3.24	9,083		10,542	4.00
5.00	Visiting Nurse	0.00	0		0	5.00
6.00	Clinical Psychologist	0.00	0		0	6.00
7.00	Clinical Social Worker	0.00	0		0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0		0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0		0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	3.24	9,083		10,542	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)				998,427	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)				998,427	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)				315,873	14.00
15.00	Parent provider overhead allocated to facility (see instructions)				775,084	15.00
16.00	Total overhead (sum of lines 14 and 15)				1,090,957	16.00
17.00	Allowable GME overhead (see instructions)				0	17.00
18.00	Enter the amount from line 16				1,090,957	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)				1,090,957	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)				2,089,384	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 14-1326 Component CCN: 14-8529	Period: From 07/01/2017 To 06/30/2018	Worksheet M-2 Date/Time Prepared: 11/20/2018 12:36 pm
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		RHC II		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	0.00	13	4,200	0
2.00	Physician Assistant	0.00	0	2,100	0
3.00	Nurse Practitioner	2.28	8,759	2,100	4,788
4.00	Subtotal (sum of lines 1 through 3)	2.28	8,772		8,772
5.00	Visiting Nurse	0.00	0		0
6.00	Clinical Psychologist	0.00	0		0
7.00	Clinical Social Worker	0.00	0		0
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0		0
7.02	Diabetes Self Management Training (FQHC only)	0.00	0		0
8.00	Total FTEs and Visits (sum of lines 4 through 7)	2.28	8,772		8,772
9.00	Physician Services Under Agreements		0		0
					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)				500,751
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)				0
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)				500,751
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)				1.000000
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)				211,187
15.00	Parent provider overhead allocated to facility (see instructions)				346,468
16.00	Total overhead (sum of lines 14 and 15)				557,655
17.00	Allowable GME overhead (see instructions)				0
18.00	Enter the amount from line 16				557,655
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)				557,655
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)				1,058,406

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 14-1326 Component CCN: 14-8556	Period: From 07/01/2017 To 06/30/2018	Worksheet M-2 Date/Time Prepared: 11/20/2018 12:36 pm
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		RHC III		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	0.00	0	4,200	0	1.00
2.00	Physician Assistant	0.00	0	2,100	0	2.00
3.00	Nurse Practitioner	0.43	1,575	2,100	903	3.00
4.00	Subtotal (sum of lines 1 through 3)	0.43	1,575		903	4.00
5.00	Visiting Nurse	0.00	0		0	5.00
6.00	Clinical Psychologist	0.00	0		0	6.00
7.00	Clinical Social Worker	0.00	0		0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0		0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0		0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	0.43	1,575		1,575	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)				101,784	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)				101,784	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)				52,857	14.00
15.00	Parent provider overhead allocated to facility (see instructions)				150,064	15.00
16.00	Total overhead (sum of lines 14 and 15)				202,921	16.00
17.00	Allowable GME overhead (see instructions)				0	17.00
18.00	Enter the amount from line 16				202,921	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)				202,921	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)				304,705	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 14-1326 Component CCN: 14-3477	Period: From 07/01/2017 To 06/30/2018	Worksheet M-3 Date/Time Prepared: 11/20/2018 12:36 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)			2,089,384	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			30,492	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			2,058,892	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			10,542	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)			10,542	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			195.30	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)	195.30	195.30		9.00
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)	0	2,740		10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	535,122		11.00
12.00	Program covered visits for mental health services (from contractor records)	0	375		12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	73,238		13.00
14.00	Limit adjustment for mental health services (see instructions)	0	73,238		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	608,360		16.00
16.01	Total program charges (see instructions)(from contractor's records)		298,841		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		2,246		16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		4,572		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.)		451,280		16.04
16.05	Total program cost (see instructions)	0	455,852		16.05
17.00	Primary payer amounts		0		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		39,688		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		51,381		19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		455,852		20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		16,190		21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		472,042		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)		472,042		26.00
26.01	Sequestration adjustment (see instructions)		9,441		26.01
26.02	Demonstration payment adjustment amount after sequestration		0		26.02
27.00	Interim payments		509,218		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)		-46,617		29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0		30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 14-1326 Component CCN: 14-8529	Period: From 07/01/2017 To 06/30/2018	Worksheet M-3 Date/Time Prepared: 11/20/2018 12:36 pm	
		Title XVIII	RHC II	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)			1,058,406	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			18,021	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			1,040,385	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			8,772	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)			8,772	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			118.60	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)		118.60	118.60	9.00
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)		0	967	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)		0	114,686	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	114,686	16.00
16.01	Total program charges (see instructions)(from contractor's records)			106,798	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)			1,806	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)			1,939	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.)			86,075	16.04
16.05	Total program cost (see instructions)		0	88,014	16.05
17.00	Primary payer amounts			0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)			5,153	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)			19,968	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)			88,014	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)			7,116	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)			95,130	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)			95,130	26.00
26.01	Sequestration adjustment (see instructions)			1,903	26.01
26.02	Demonstration payment adjustment amount after sequestration			0	26.02
27.00	Interim payments			99,232	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)			-6,005	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2			0	30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 14-1326 Component CCN: 14-8556	Period: From 07/01/2017 To 06/30/2018	Worksheet M-3 Date/Time Prepared: 11/20/2018 12:36 pm	
		Title XVIII	RHC III	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)			304,705	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			2,233	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			302,472	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			1,575	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)			1,575	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			192.05	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)	192.05	192.05		9.00
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)	0	303		10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	58,191		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	58,191		16.00
16.01	Total program charges (see instructions)(from contractor's records)		25,844		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		0		16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		0		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.)		45,125		16.04
16.05	Total program cost (see instructions)	0	45,125		16.05
17.00	Primary payer amounts		0		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		1,785		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		4,812		19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		45,125		20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		1,148		21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		46,273		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)		46,273		26.00
26.01	Sequestration adjustment (see instructions)		925		26.01
26.02	Demonstration payment adjustment amount after sequestration		0		26.02
27.00	Interim payments		42,602		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)		2,746		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: 14-1326 Component CCN: 14-3477	Period: From 07/01/2017 To 06/30/2018	Worksheet M-4 Date/Time Prepared: 11/20/2018 12:36 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)		959,062	959,062	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time		0.000385	0.003933	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)		369	3,772	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)		3,475	6,955	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)		3,844	10,727	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)		998,427	998,427	6.00
7.00	Total overhead (from Wkst. M-2, line 19)		1,090,957	1,090,957	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)		0.003850	0.010744	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)		4,200	11,721	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)		8,044	22,448	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)		41	419	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)		196.20	53.58	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries		35	174	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)		6,867	9,323	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)			30,492	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)			16,190	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA VACCINE COST		Provider CCN: 14-1326 Component CCN: 14-8529	Period: From 07/01/2017 To 06/30/2018	Worksheet M-4 Date/Time Prepared: 11/20/2018 12:36 pm	
		Title XVIII	RHC II	Cost	
			Pneumococcal	Influenza	
			1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)		487,407	487,407	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time		0.000277	0.004171	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)		135	2,033	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)		1,610	4,748	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)		1,745	6,781	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)		500,751	500,751	6.00
7.00	Total overhead (from Wkst. M-2, line 19)		557,655	557,655	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)		0.003485	0.013542	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)		1,943	7,552	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)		3,688	14,333	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)		19	286	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)		194.11	50.12	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries		16	80	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)		3,106	4,010	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)			18,021	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)			7,116	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA VACCINE COST		Provider CCN: 14-1326 Component CCN: 14-8556	Period: From 07/01/2017 To 06/30/2018	Worksheet M-4 Date/Time Prepared: 11/20/2018 12:36 pm	
		Title XVIII	RHC III	Cost	
			Pneumococcal	Influenza	
			1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)		100,225	100,225	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time		0.000000	0.001647	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)		0	165	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)		0	581	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)		0	746	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)		101,784	101,784	6.00
7.00	Total overhead (from Wkst. M-2, line 19)		202,921	202,921	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)		0.000000	0.007329	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)		0	1,487	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)		0	2,233	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)		0	35	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)		0.00	63.80	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries		0	18	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)		0	1,148	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)			2,233	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)			1,148	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 14-1326 Component CCN: 14-3477	Period: From 07/01/2017 To 06/30/2018	Worksheet M-5 Date/Time Prepared: 11/20/2018 12:36 pm
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		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		509,218	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00
Program to Provider				
3.01			0	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
Provider to Program				
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		509,218	4.00
TO BE COMPLETED BY CONTRACTOR				
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			5.00
Program to Provider				
5.01			0	5.01
5.02			0	5.02
5.03			0	5.03
Provider to Program				
5.50			0	5.50
5.51			0	5.51
5.52			0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00
6.01	SETTLEMENT TO PROVIDER		0	6.01
6.02	SETTLEMENT TO PROGRAM		46,617	6.02
7.00	Total Medicare program liability (see instructions)		462,601	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 HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 14-1326 Component CCN: 14-8529	Period: From 07/01/2017 To 06/30/2018	Worksheet M-5 Date/Time Prepared: 11/20/2018 12:36 pm
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		RHC II	Cost	
		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		99,232	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00
Program to Provider				
3.01			0	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
Provider to Program				
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		99,232	4.00
TO BE COMPLETED BY CONTRACTOR				
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			5.00
Program to Provider				
5.01			0	5.01
5.02			0	5.02
5.03			0	5.03
Provider to Program				
5.50			0	5.50
5.51			0	5.51
5.52			0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00
6.01	SETTLEMENT TO PROVIDER		0	6.01
6.02	SETTLEMENT TO PROGRAM		6,005	6.02
7.00	Total Medicare program liability (see instructions)		93,227	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 HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 14-1326 Component CCN: 14-8556	Period: From 07/01/2017 To 06/30/2018	Worksheet M-5 Date/Time Prepared: 11/20/2018 12:36 pm
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		RHC III	Cost	
		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		42,602	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00
Program to Provider				
3.01			0	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
Provider to Program				
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		42,602	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		2,746	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		45,348	7.00
		Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00 2.00	
8.00	Name of Contractor			8.00