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: 15-0061	Period: From 01/01/2018 To 12/31/2018	Worksheet S Parts I-III Date/Time Prepared: 5/29/2019 4:30 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 5/29/2019 Time: 4:30 pm
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by DAVIESS COMMUNITY HOSPITAL (15-0061) for the cost reporting period beginning 01/01/2018 and ending 12/31/2018 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

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

_____
Title

_____
Date

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	69,412	36,204	0	0	1.00
2.00	Subprovider - IPF	0	22,947	0		0	2.00
3.00	Subprovider - IRF	0	-1,053	0		0	3.00
5.00	Swing bed - SNF	0	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
10.00	RURAL HEALTH CLINIC I	0		-15,296		0	10.00
10.01	RURAL HEALTH CLINIC II	0		41,416		0	10.01
10.02	RURAL HEALTH CLINIC III	0		-22,381		0	10.02
10.04	RURAL HEALTH CLINIC V	0		266		0	10.04
10.05	RURAL HEALTH CLINIC VI	0		33,009		0	10.05
200.00	Total	0	91,306	73,218	0	0	200.00

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0061 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part I Date/Time Prepared: 5/29/2019 4:30 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 1314 E. WALNUT STREET	PO Box: 760			1.00
2.00	City: WASHINGTON	State: IN	Zip Code: 47501	County: DAVIESS	2.00

		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)			
							V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
	Hospital and Hospital-Based Component Identification:									
3.00	Hospital	DAVIESS COMMUNITY HOSPITAL	150061	99915	1	07/01/1966	N	P	O	3.00
4.00	Subprovider - IPF	DCH - PSYCH	15S061	99915	4	01/01/2003	N	P	O	4.00
5.00	Subprovider - IRF	DCH - REHAB	15T061	99915	5	01/01/2000	N	P	O	5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	DAVIESS COMMUNITY HOSPITAL	15U061	99915		11/10/1999	N	P	N	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice	HELPING HEART HOSPICE	151553	99915		07/11/1996				14.00
15.00	Hospital-Based Health Clinic - RHC	DAVIESS COMMUNITY HOSPITAL MC	158500	99915		12/17/2003	N	O	N	15.00
15.01	Hospital-Based Health Clinic - RHC II	NORTH DAVIESS MEDICAL CENTER	153999	99915		12/17/2003	N	O	N	15.01
15.02	Hospital-Based Health Clinic - RHC III	DCH HEALTH PAVILION	158501	99915		03/30/2004	N	O	N	15.02
15.04	Hospital-Based Health Clinic - RHC V	GRAND AVENUE PEDIATRICS	158503	99915		01/27/2005	N	O	N	15.04
15.05	Hospital-Based Health Clinic - RHC VI	MARTIN MEDICAL CLINIC	158506	99915		10/31/2006	N	O	N	15.05
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
17.10	Hospital-Based (CORF) I									17.10
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)	01/01/2018	12/31/2018	20.00
21.00	Type of Control (see instructions)	8		21.00

		1.00	2.00	3.00	
	Inpatient PPS Information				
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	Y	N		22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	Y	Y		22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N		22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.	N	N	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.	2	N		23.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0061 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part I | Date/Time Prepared: 5/29/2019 4:30 pm

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
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.	166	40	0	0	1,174	71	24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	45		25.00

		Urban/Rural S	Date of Geogr	
		1.00	2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	2		26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	2		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0		35.00

		Beginning:	Ending:	
		1.00	2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.			36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.	0		37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)			37.01
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.			38.00

		Y/N	Y/N	
		1.00	2.00	
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 “Y” for yes or “N” for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	Y	Y	39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	N	N	40.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0061 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part I Date/Time Prepared: 5/29/2019 4:30 pm

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0061 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part I | Date/Time Prepared: 5/29/2019 4:30 pm

		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	
	Inpatient Psychiatric Facility PPS				
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	Y			70.00
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)	N	N	0	71.00
	Inpatient Rehabilitation Facility PPS				
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	Y			75.00
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)	N	N	0	76.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-0061	Period: From 01/01/2018 To 12/31/2018	Worksheet S-2 Part I Date/Time Prepared: 5/29/2019 4:30 pm

		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	Y	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.06
	Rural Providers			
105.00	Does this hospital qualify as a CAH?	N		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N		106.00
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II.	N		107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00

		Physical	Occupational	Speech	Respiratory	
		1.00	2.00	3.00	4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N	109.00

		1.00	
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration)for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.	N	110.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0061 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part I | Date/Time Prepared: 5/29/2019 4:30 pm

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

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

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	103,807	0	0	118.01

		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N		122.00
	Transplant Center Information			
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y		140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0061 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part I Date/Time Prepared: 5/29/2019 4:30 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	N	N	N	N	155.00
156.00	Subprovider - IPF	N	N	N	N	156.00
157.00	Subprovider - IRF	N	N	N	N	157.00
158.00	SUBPROVIDER					158.00
159.00	SNF	N	N	N	N	159.00
160.00	HOME HEALTH AGENCY	N	N	N	N	160.00
161.00	CMHC		N	N	N	161.00
161.10	CORF		N	N	N	161.10

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

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

		1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act		
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.	Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)	0	168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)		168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	9.99	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)	01/01/2018	12/31/2018	170.00

		1.00	2.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)	N	0	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-0061 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part II | Date/Time Prepared: 5/29/2019 4:30 pm

		Y/N	Date	
		1.00	2.00	
	General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.			
	COMPLETED BY ALL HOSPITALS			
	Provider Organization and Operation			
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N		1.00

		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N			3.00

		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00

		Y/N	Legal Oper.	
		1.00	2.00	
	Approved Educational Activities			
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00

		Y/N	
		1.00	
	Bad Debts		
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.	N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.	N	14.00
	Bed Complement		
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.	N	15.00

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	N		N		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	04/23/2019	Y	04/23/2019	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.	Y		N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-0061 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part II Date/Time Prepared: 5/29/2019 4:30 pm

		Description		Y/N	Y/N	
		0		1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00

		1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)		
	Capital Related Cost		
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions		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.		23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions		24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.		25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.		26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.		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.		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		29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.		30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.		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.		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.		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.		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.		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.	NICHOLAS	EICHELMAN	41.00
42.00	Enter the employer/company name of the cost report preparer.	BKD, LLP		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317-383-4000	NEICHELMAN@BKD.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-0061 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part II Date/Time Prepared: 5/29/2019 4:30 pm

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-0061 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-3 Part I Date/Time Prepared: 5/29/2019 4:30 pm

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	37	13,505	0.00	0	1.00
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		37	13,505	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	5	1,825	0.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		42	15,330	0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF	40.00	20	7,300		0	16.00
17.00	SUBPROVIDER - IRF	41.00	12	4,380		0	17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	101.00				0	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	116.00	0	0			24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
25.10	CMHC - CORF	99.10				0	25.10
26.00	RURAL HEALTH CLINIC	88.00				0	26.00
26.01	RURAL HEALTH CLINIC II	88.01				0	26.01
26.02	RURAL HEALTH CLINIC III	88.02				0	26.02
26.04	RURAL HEALTH CLINIC V	88.04				0	26.04
26.05	RURAL HEALTH CLINIC VI	88.05				0	26.05
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		74				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: 15-0061 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-3 Part I | Date/Time Prepared: 5/29/2019 4:30 pm

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	1,822	113	3,419			1.00
2.00	HMO and other (see instructions)	144	1,214				2.00
3.00	HMO IPF Subprovider	130	1,825				3.00
4.00	HMO IRF Subprovider	16	45				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,822	113	3,419			7.00
8.00	INTENSIVE CARE UNIT	436	25	726			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		28	815			13.00
14.00	Total (see instructions)	2,258	166	4,960	0.00	269.70	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF	5,090	254	6,030	0.00	36.92	16.00
17.00	SUBPROVIDER - IRF	1,265	0	1,519	0.00	12.30	17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0	0	0	0.00	0.00	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	4,620	247	5,043	0.00	5.55	24.00
24.10	HOSPICE (non-distinct part)			28			24.10
25.00	CMHC - CMHC						25.00
25.10	CMHC - CORF	0	0	0	0.00	0.00	25.10
26.00	RURAL HEALTH CLINIC	1,927	1,406	5,810	0.00	7.85	26.00
26.01	RURAL HEALTH CLINIC II	2,295	1,291	7,116	0.00	10.83	26.01
26.02	RURAL HEALTH CLINIC III	1,994	4,695	14,024	0.00	15.24	26.02
26.04	RURAL HEALTH CLINIC V	6	4,002	7,530	0.00	8.66	26.04
26.05	RURAL HEALTH CLINIC VI	1,842	438	4,379	0.00	7.52	26.05
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	374.57	27.00
28.00	Observation Bed Days		380	1,731			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			141			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	71	125			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: 15-0061 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-3 Part I | Date/Time Prepared: 5/29/2019 4:30 pm

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	658	327	1,455	1.00
2.00	HMO and other (see instructions)			46	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	658	327	1,455	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF	0.00	0	255	33	319	16.00
17.00	SUBPROVIDER - IRF	0.00	0	100	3	121	17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0.00					22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	0.00					24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
25.10	CMHC - CORF	0.00					25.10
26.00	RURAL HEALTH CLINIC	0.00					26.00
26.01	RURAL HEALTH CLINIC II	0.00					26.01
26.02	RURAL HEALTH CLINIC III	0.00					26.02
26.04	RURAL HEALTH CLINIC V	0.00					26.04
26.05	RURAL HEALTH CLINIC VI	0.00					26.05
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0061 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-3 Part II Date/Time Prepared: 5/29/2019 4:30 pm

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA							
	SALARIES							
1.00	Total salaries (see instructions)	200.00	25,710,605	0	25,710,605	962,876.00	26.70	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician and Non Physician-Part B		0	0	0	0.00	0.00	5.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		5,967,479	14,161	5,981,640	196,384.00	30.46	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		0	0	0	0.00	0.00	11.00
12.00	Contract labor: Top level management and other management and administrative services		493,553	0	493,553	4,160.00	118.64	12.00
13.00	Contract labor: Physician-Part A - Administrative		0	0	0	0.00	0.00	13.00
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00	14.00
14.01	Home office salaries		0	0	0	0.00	0.00	14.01
14.02	Related organization salaries		0	0	0	0.00	0.00	14.02
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
	WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		4,308,044	0	4,308,044			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		1,189,757	0	1,189,757			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		0	0	0			21.00
22.00	Physician Part A - Administrative		0	0	0			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		0	0	0			23.00
24.00	Wage-related costs (RHC/FQHC)		0	0	0			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
25.50	Home office wage-related (core)		0	0	0			25.50
25.51	Related organization wage-related (core)		0	0	0			25.51
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0			25.52
25.53	Home office & Contract Physicians Part A - Teaching - wage-related (core)		0	0	0			25.53
	OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	140,120	0	140,120	5,726.00	24.47	26.00
27.00	Administrative & General	5.00	2,297,999	-50,374	2,247,625	100,908.00	22.27	27.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0061 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-3 Part II Date/Time Prepared: 5/29/2019 4:30 pm

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
28.00	Administrative & General under contract (see inst.)		193,465	0	193,465	1,086.00	178.14	28.00
29.00	Maintenance & Repairs	6.00	243,192	0	243,192	10,800.00	22.52	29.00
30.00	Operation of Plant	7.00	0	0	0	0.00	0.00	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	468,817	0	468,817	37,632.00	12.46	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	522,490	-437,156	85,334	5,631.00	15.15	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	349,211	349,211	23,041.00	15.16	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	808,421	0	808,421	23,525.00	34.36	38.00
39.00	Central Services and Supply	14.00	275,789	0	275,789	13,427.00	20.54	39.00
40.00	Pharmacy	15.00	458,304	0	458,304	13,939.00	32.88	40.00
41.00	Medical Records & Medical Records Library	16.00	450,385	0	450,385	22,474.00	20.04	41.00
42.00	Social Service	17.00	0	91,009	91,009	5,581.00	16.31	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0061 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-3 Part III Date/Time Prepared: 5/29/2019 4:30 pm

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)		25,904,070	0	25,904,070	963,962.00	26.87	1.00
2.00	Excluded area salaries (see instructions)		5,967,479	14,161	5,981,640	196,384.00	30.46	2.00
3.00	Subtotal salaries (line 1 minus line 2)		19,936,591	-14,161	19,922,430	767,578.00	25.95	3.00
4.00	Subtotal other wages & related costs (see inst.)		493,553	0	493,553	4,160.00	118.64	4.00
5.00	Subtotal wage-related costs (see inst.)		4,308,044	0	4,308,044	0.00	21.62	5.00
6.00	Total (sum of lines 3 thru 5)		24,738,188	-14,161	24,724,027	771,738.00	32.04	6.00
7.00	Total overhead cost (see instructions)		5,858,982	-47,310	5,811,672	263,770.00	22.03	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 15-0061 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-3 Part IV Date/Time Prepared: 5/29/2019 4:30 pm

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	0	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	366,593	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	37,067	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	0	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)	0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	3,066,642	8.02
8.03	Health Insurance (Purchased)	0	8.03
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	0	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	26,522	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	36,421	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	162,633	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	0	16.00
	TAXES		
17.00	FICA-Employers Portion Only	0	17.00
18.00	Medicare Taxes - Employers Portion Only	1,753,319	18.00
19.00	Unemployment Insurance	0	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
	OTHER		
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	48,604	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	5,497,801	24.00
	Part B - Other than Core Related Cost		
25.00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST | Provider CCN: 15-0061 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-3 Part V Date/Time Prepared: 5/29/2019 4:30 pm

	Cost Center Description	Contract Labor	Benefit Cost	
		1.00	2.00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	0	0	1.00
2.00	Hospital	0	0	2.00
3.00	Subprovider - IPF	0	0	3.00
4.00	Subprovider - IRF	0	0	4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA	0	0	11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice	0	0	13.00
14.00	Hospital-Based Health Clinic RHC	0	0	14.00
14.01	Hospital-Based Health Clinic RHC 1	0	0	14.01
14.02	Hospital-Based Health Clinic RHC 2	0	0	14.02
14.04	Hospital-Based Health Clinic RHC 4	0	0	14.04
14.05	Hospital-Based Health Clinic RHC 5	0	0	14.05
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
16.10	Hospital-Based-CMHC 10	0	0	16.10
17.00	Renal Dialysis			17.00
18.00	Other	0	0	18.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 15-0061 | Component CCN: 15-8500 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-8 | Date/Time Prepared: 5/29/2019 4:30 pm

		RHC I	Cost
		1.00	
	Clinic Address and Identification		
1.00	Street	1402 GRAND AVENUE	1.00

		City	State	ZIP Code	
		1.00	2.00	3.00	
2.00	City, State, ZIP Code, County	WASHINGTON	IN	47501	2.00

		1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban	0	3.00

		Grant Award	Date	
		1.00	2.00	
	Source of Federal Funds			
4.00	Community Health Center (Section 330(d), PHS Act)			4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)			5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)			6.00
7.00	Appalachian Regional Commission			7.00
8.00	Look-Alikes			8.00
9.00	OTHER (SPECIFY)			9.00

		1.00	2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)	N	0	10.00

		Sunday		Monday		Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
	Facility hours of operations (1)						
11.00	CLINIC			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			14.00

		Y/N	V	XVIII	XIX	Total Visits	
		1.00	2.00	3.00	4.00	5.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)						15.00

			County				
			4.00				
2.00	City, State, ZIP Code, County		DAVIESS				2.00

		Tuesday	Wednesday		Thursday		
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)						
11.00	CLINIC	17:00	08:00	17:00	08:00	17:00	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 15-0061 | Component CCN: 15-8500 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-8 | Date/Time Prepared: 5/29/2019 4:30 pm

RHC I | Cost

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	CLINIC	08:00	17:00				11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 15-0061 | Component CCN: 15-3999 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-8 | Date/Time Prepared: 5/29/2019 4:30 pm

RHC II | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			202 NORTH WEST STREET		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	ODON		IN	47562	2.00
					1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0	3.00
			Grant Award		Date	
			1.00		2.00	
	Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)					4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)					5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)					6.00
7.00	Appalachian Regional Commission					7.00
8.00	Look-Alikes					8.00
9.00	OTHER (SPECIFY)					9.00
				1.00	2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N	0	10.00

		Sunday		Monday		Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
	Facility hours of operations (1)						
11.00	CLINIC			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						14.00

		Y/N	V	XVIII	XIX	Total Visits	
		1.00	2.00	3.00	4.00	5.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)						15.00

			County				
			4.00				
2.00	City, State, ZIP Code, County		DAVIESS				2.00

		Tuesday	Wednesday		Thursday		
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)						
11.00	CLINIC	17:00	08:00	17:00	08:00	17:00	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 15-0061 | Component CCN: 15-3999 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-8 | Date/Time Prepared: 5/29/2019 4:30 pm

RHC II | Cost

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	CLINIC	08:00	17:00				11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 15-0061 | Component CCN: 15-8501 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-8 | Date/Time Prepared: 5/29/2019 4:30 pm

RHC III | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			1805 S. STATE RD. 57		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	WASHINGTON		IN	47501	2.00
					1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0	3.00
			Grant Award		Date	
			1.00		2.00	
	Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)					4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)					5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)					6.00
7.00	Appalachian Regional Commission					7.00
8.00	Look-Alikes					8.00
9.00	OTHER (SPECIFY)					9.00
				1.00	2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N	0	10.00

		Sunday		Monday		Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
	Facility hours of operations (1)						
11.00	CLINIC			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					14.00

		Y/N	V	XVIII	XIX	Total Visits	
		1.00	2.00	3.00	4.00	5.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)						15.00

			County				
			4.00				
2.00	City, State, ZIP Code, County		DAVIESS				2.00
		Tuesday	Wednesday		Thursday		
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)						
11.00	CLINIC	17:00	08:00	17:00	08:00	17:00	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 15-0061
Component CCN: 15-8501

Period:
From 01/01/2018
To 12/31/2018

Worksheet S-8
Date/Time Prepared:
5/29/2019 4:30 pm

RHC III | Cost

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	CLINIC	08:00	17:00				11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 15-0061 | Component CCN: 15-8503 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-8 | Date/Time Prepared: 5/29/2019 4:30 pm

RHC V | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			1402 GRAND AVE		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	WASHINGTON		IN	47501	2.00
					1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0	3.00
			Grant Award		Date	
			1.00		2.00	
	Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)					4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)					5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)					6.00
7.00	Appalachian Regional Commission					7.00
8.00	Look-Alikes					8.00
9.00	OTHER (SPECIFY)					9.00
				1.00	2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N	0	10.00

		Sunday		Monday		Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
	Facility hours of operations (1)						
11.00	CLINIC			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					14.00

		Y/N	V	XVIII	XIX	Total Visits	
		1.00	2.00	3.00	4.00	5.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)						15.00

			County				
			4.00				
2.00	City, State, ZIP Code, County		DAVIESS				2.00

		Tuesday	Wednesday		Thursday		
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)						
11.00	CLINIC	17:00	08:00	17:00	08:00	17:00	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 15-0061
Component CCN: 15-8503

Period:
From 01/01/2018
To 12/31/2018

Worksheet S-8
Date/Time Prepared:
5/29/2019 4:30 pm

RHC V

Cost

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	CLINIC	08:00	17:00				11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 15-0061 | Component CCN: 15-8506 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-8 | Date/Time Prepared: 5/29/2019 4:30 pm

RHC VI | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			12546 E US HWY 50		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	LOOGOOTEE		IN	47553	2.00
					1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0	3.00
			Grant Award		Date	
			1.00		2.00	
	Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)					4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)					5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)					6.00
7.00	Appalachian Regional Commission					7.00
8.00	Look-Alikes					8.00
9.00	OTHER (SPECIFY)					9.00
				1.00	2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N	0	10.00

		Sunday		Monday		Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
	Facility hours of operations (1)						
11.00	CLINIC			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					14.00

		Y/N	V	XVIII	XIX	Total Visits	
		1.00	2.00	3.00	4.00	5.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)						15.00

			County				
			4.00				
2.00	City, State, ZIP Code, County		DAVIESS				2.00

		Tuesday	Wednesday		Thursday		
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)						
11.00	CLINIC	17:00	08:00	17:00	08:00	17:00	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 15-0061
Component CCN: 15-8506

Period:
From 01/01/2018
To 12/31/2018

Worksheet S-8
Date/Time Prepared:
5/29/2019 4:30 pm

RHC VI

Cost

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	CLINIC	08:00	17:00				11.00

HOSPITAL-BASED HOSPICE IDENTIFICATION DATA

Provider CCN: 15-0061
Hospice CCN: 15-1553

Period:
From 01/01/2018
To 12/31/2018

Worksheet S-9
PARTS I THROUGH IV
Date/Time Prepared:
5/29/2019 4:30 pm

Hospice I

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

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

		Title XVIII	Title XIX	Other	Total (sum of cols. 1 through 3)	
		1.00	2.00	3.00	4.00	
	PART III - ENROLLMENT DAYS FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2015					
10.00	Hospice Continuous Home Care	0	0	0	0	10.00
11.00	Hospice Routine Home Care	4,620	0	717	5,337	11.00
12.00	Hospice Inpatient Respite Care	0	0	0	0	12.00
13.00	Hospice General Inpatient Care	0	0	0	0	13.00
14.00	Total Hospice Days	4,620	0	717	5,337	14.00
	PART IV - CONTRACTED STATISTICAL DATA FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2015					
15.00	Hospice Inpatient Respite Care	0	0	0	0	15.00
16.00	Hospice General Inpatient Care	0	0	0	0	16.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 15-0061 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-10 | Date/Time Prepared: 5/29/2019 4:30 pm

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.332532	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	4,950,081	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	25,038,549	6.00
7.00	Medicaid cost (line 1 times line 6)	8,326,119	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)	3,376,038	8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone CHIP	0	9.00
10.00	Stand-alone CHIP charges	0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	3,376,038	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)	382,690	147,824	530,514	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	127,257	147,824	275,081	21.00
22.00	Payments received from patients for amounts previously written off as charity care	7,758	21,698	29,456	22.00
23.00	Cost of charity care (line 21 minus line 22)	119,499	126,126	245,625	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)	4,000,100	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	250,186	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	384,901	27.01
28.00	Non-Medicare bad debt expense (see instructions)	3,615,199	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	1,336,884	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	1,582,509	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	4,958,547	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0061 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A | Date/Time Prepared: 5/29/2019 4:30 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		2,206,361	2,206,361	697,134	2,903,495	1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		1,351,839	1,351,839	38,949	1,390,788	2.00
3.00	00300	OTHER CAPITAL RELATED COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	140,120	5,576,408	5,716,528	-78,607	5,637,921	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,297,999	9,688,885	11,986,884	-613,433	11,373,451	5.00
6.00	00600	MAINTENANCE & REPAIRS	243,192	1,731,871	1,975,063	0	1,975,063	6.00
7.00	00700	OPERATION OF PLANT	0	799,208	799,208	0	799,208	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	364,388	364,388	0	364,388	8.00
9.00	00900	HOUSEKEEPING	468,817	87,905	556,722	0	556,722	9.00
10.00	01000	DIETARY	522,490	457,220	979,710	-819,701	160,009	10.00
11.00	01100	CAFETERIA	0	0	0	654,798	654,798	11.00
13.00	01300	NURSING ADMINISTRATION	808,421	37,170	845,591	0	845,591	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	275,789	269,092	544,881	0	544,881	14.00
15.00	01500	PHARMACY	458,304	349,009	807,313	0	807,313	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	450,385	116,741	567,126	0	567,126	16.00
17.00	01700	SOCIAL SERVICE	0	389	389	91,009	91,398	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,343,973	281,972	2,625,945	-126,284	2,499,661	30.00
31.00	03100	INTENSIVE CARE UNIT	691,452	24,860	716,312	-70,573	645,739	31.00
40.00	04000	SUBPROVIDER - IPF	1,880,208	320,448	2,200,656	-29,915	2,170,741	40.00
41.00	04100	SUBPROVIDER - IRF	729,912	53,595	783,507	6,004	789,511	41.00
43.00	04300	NURSERY	0	9,795	9,795	291,195	300,990	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,133,180	1,733,155	2,866,335	0	2,866,335	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	287,275	287,275	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	696,271	448,396	1,144,667	35,192	1,179,859	54.00
56.00	05600	RADIOISOTOPE	226,343	71,237	297,580	0	297,580	56.00
60.00	06000	LABORATORY	974,288	1,374,633	2,348,921	37,217	2,386,138	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	199,120	199,120	0	199,120	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	524,936	97,278	622,214	0	622,214	65.00
66.00	06600	PHYSICAL THERAPY	1,066,665	106,772	1,173,437	0	1,173,437	66.00
67.00	06700	OCCUPATIONAL THERAPY	289,006	235	289,241	0	289,241	67.00
68.00	06800	SPEECH PATHOLOGY	124,798	13,036	137,834	0	137,834	68.00
69.00	06900	ELECTROCARDIOLOGY	71,908	20,236	92,144	0	92,144	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,578,748	1,578,748	-120,318	1,458,430	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	120,318	120,318	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,683,636	2,683,636	0	2,683,636	73.00
76.00	03020	CARDIAC REHAB	100,727	4,422	105,149	0	105,149	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	588,849	127,296	716,145	0	716,145	88.00
88.01	08801	RURAL HEALTH CLINIC II	722,690	83,291	805,981	0	805,981	88.01
88.02	08802	RURAL HEALTH CLINIC III	866,331	429,502	1,295,833	0	1,295,833	88.02
88.04	08803	RURAL HEALTH CLINIC V	882,873	144,688	1,027,561	0	1,027,561	88.04
88.05	08804	RURAL HEALTH CLINIC VI	455,005	49,102	504,107	0	504,107	88.05
90.00	09000	CLINIC	410,127	26,139	436,266	0	436,266	90.00
90.01	09001	ONCOLOGY	162,946	241,462	404,408	0	404,408	90.01
90.02	09002	PAIN MANAGEMENT	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	1,168,981	1,114,220	2,283,201	-15,478	2,267,723	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	576,260	167,526	743,786	-2,706	741,080	93.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		1,299,099	1,299,099	-631,376	667,723	113.00
116.00	11600	HOSPICE	267,933	306,043	573,976	3,470	577,446	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	22,621,179	36,046,428	58,667,607	-245,830	58,421,777	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07951	OTHER NONREIMBURSABLE AND PHYSICIAN	3,089,426	1,098,032	4,187,458	245,830	4,433,288	194.00
200.00		TOTAL (SUM OF LINES 118 through 199)	25,710,605	37,144,460	62,855,065	0	62,855,065	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0061 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A | Date/Time Prepared: 5/29/2019 4:30 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	0	2,903,495		1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	0	1,390,788		2.00
3.00	00300	OTHER CAPITAL RELATED COSTS	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-224,317	5,413,604		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-4,252,303	7,121,148		5.00
6.00	00600	MAINTENANCE & REPAIRS	0	1,975,063		6.00
7.00	00700	OPERATION OF PLANT	0	799,208		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	364,388		8.00
9.00	00900	HOUSEKEEPING	0	556,722		9.00
10.00	01000	DIETARY	0	160,009		10.00
11.00	01100	CAFETERIA	-276,724	378,074		11.00
13.00	01300	NURSING ADMINISTRATION	0	845,591		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	-6,055	538,826		14.00
15.00	01500	PHARMACY	0	807,313		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-13,208	553,918		16.00
17.00	01700	SOCIAL SERVICE	0	91,398		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-520,417	1,979,244		30.00
31.00	03100	INTENSIVE CARE UNIT	-1,500	644,239		31.00
40.00	04000	SUBPROVIDER - IPF	-551,799	1,618,942		40.00
41.00	04100	SUBPROVIDER - IRF	-162,761	626,750		41.00
43.00	04300	NURSERY	0	300,990		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-1,448,319	1,418,016		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	287,275		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-225,000	954,859		54.00
56.00	05600	RADIOISOTOPE	-1,800	295,780		56.00
60.00	06000	LABORATORY	-2,500	2,383,638		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	199,120		63.00
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	-44,272	577,942		65.00
66.00	06600	PHYSICAL THERAPY	0	1,173,437		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	289,241		67.00
68.00	06800	SPEECH PATHOLOGY	0	137,834		68.00
69.00	06900	ELECTROCARDIOLOGY	-13,950	78,194		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,458,430		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	120,318		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,683,636		73.00
76.00	03020	CARDIAC REHAB	0	105,149		76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	716,145		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	805,981		88.01
88.02	08802	RURAL HEALTH CLINIC III	0	1,295,833		88.02
88.04	08803	RURAL HEALTH CLINIC V	0	1,027,561		88.04
88.05	08804	RURAL HEALTH CLINIC VI	0	504,107		88.05
90.00	09000	CLINIC	-221,995	214,271		90.00
90.01	09001	ONCOLOGY	-228,102	176,306		90.01
90.02	09002	PAIN MANAGEMENT	238,442	238,442		90.02
91.00	09100	EMERGENCY	-5,646	2,262,077		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	-479,046	262,034		93.00
		OTHER REIMBURSABLE COST CENTERS				
99.10	09910	CORF	0	0		99.10
101.00	10100	HOME HEALTH AGENCY	0	0		101.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	-667,723	0		113.00
116.00	11600	HOSPICE	0	577,446		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-9,108,995	49,312,782		118.00
		NONREIMBURSABLE COST CENTERS				
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0		192.00
194.00	07951	OTHER NONREIMBURSABLE AND PHYSICIAN	0	4,433,288		194.00
200.00		TOTAL (SUM OF LINES 118 through 199)	-9,108,995	53,746,070		200.00

RECLASSIFICATIONS | Provider CCN: 15-0061 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-6 | Date/Time Prepared: 5/29/2019 4:30 pm

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - DIETARY					
1.00	CAFETERIA	11.00	349,211	305,587		1.00
2.00	OTHER NONREIMBURSABLE AND PHYSICIAN	194.00	87,945	76,958		2.00
	0		437,156	382,545		
	B - INTEREST EXPENSE					
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	596,174		1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	35,202		2.00
	0		0	631,376		
	C - BILLING COSTS					
1.00	OTHER NONREIMBURSABLE AND PHYSICIAN	194.00	20,222	29,307		1.00
	0		20,222	29,307		
	D - LAB/XRAY					
1.00	LABORATORY	60.00	36,028	1,189		1.00
2.00	RADIOLOGY-DIAGNOSTIC	54.00	34,067	1,125		2.00
	0		70,095	2,314		
	F - OBSTETRICS					
1.00	NURSERY	43.00	268,592	22,603		1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	264,976	22,299		2.00
	0		533,568	44,902		
	G - INSURANCE					
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	100,960		1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	3,747		2.00
3.00	OTHER NONREIMBURSABLE AND PHYSICIAN	194.00	0	103,807		3.00
	0		0	208,514		
	H - IMPLANTABLE DEVICES					
1.00	IMPL. DEV. CHARGED TO PATIENT	72.00	0	120,318		1.00
	0		0	120,318		
	I - SOCIAL SERVICES					
1.00	SOCIAL SERVICE	17.00	91,009	0		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
	0		91,009	0		
	J - OTHER					
1.00	HOSPICE	116.00	0	3,470		1.00
2.00	ADULTS & PEDIATRICS	30.00	55,044	0		2.00
3.00	SUBPROVIDER - IPF	40.00	6,116	0		3.00
4.00	SUBPROVIDER - IRF	41.00	6,116	0		4.00
	0		67,276	3,470		
	K - HOSPITALIST RECLASS					
1.00	ADULTS & PEDIATRICS	30.00	0	400,375		1.00
	0		0	400,375		
	L - ADMIN RECRUITING AND ADVERTISING					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	78,607		1.00
	0		0	78,607		
500.00	Grand Total: Increases		1,219,326	1,901,728		500.00

RECLASSIFICATIONS | Provider CCN: 15-0061 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-6 | Date/Time Prepared: 5/29/2019 4:30 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - DIETARY						
1.00	DIETARY	10.00	437,156	382,545	0		1.00
2.00		0.00	0	0	0		2.00
	0		437,156	382,545			
	B - INTEREST EXPENSE						
1.00	INTEREST EXPENSE	113.00	0	631,376	11		1.00
2.00		0.00	0	0	11		2.00
	0		0	631,376			
	C - BILLING COSTS						
1.00	ADMINISTRATIVE & GENERAL	5.00	20,222	29,307	0		1.00
	0		20,222	29,307			
	D - LAB/XRAY						
1.00	OTHER NONREIMBURSABLE AND PHYSICIAN	194.00	70,095	2,314	0		1.00
2.00		0.00	0	0	0		2.00
	0		70,095	2,314			
	F - OBSTETRICS						
1.00	ADULTS & PEDIATRICS	30.00	533,568	44,902	0		1.00
2.00		0.00	0	0	0		2.00
	0		533,568	44,902			
	G - INSURANCE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	208,514	12		1.00
2.00		0.00	0	0	12		2.00
3.00		0.00	0	0	12		3.00
	0		0	208,514			
	H - IMPLANTABLE DEVICES						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	120,318	0		1.00
	0		0	120,318			
	I - SOCIAL SERVICES						
1.00	ADMINISTRATIVE & GENERAL	5.00	30,152	0	0		1.00
2.00	ADULTS & PEDIATRICS	30.00	3,233	0	0		2.00
3.00	INTENSIVE CARE UNIT	31.00	3,297	0	0		3.00
4.00	SUBPROVIDER - IPF	40.00	36,031	0	0		4.00
5.00	SUBPROVIDER - IRF	41.00	112	0	0		5.00
6.00	EMERGENCY	91.00	15,478	0	0		6.00
7.00	OTHER OUTPATIENT SERVICE COST CENTER	93.00	2,706	0	0		7.00
	0		91,009	0			
	J - OTHER						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	3,470	0		1.00
2.00	INTENSIVE CARE UNIT	31.00	67,276	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
	0		67,276	3,470			
	K - HOSPITALIST RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	400,375	0		1.00
	0		0	400,375			
	L - ADMIN RECRUITING AND ADVERTISING						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	78,607	0		1.00
	0		0	78,607			
500.00	Grand Total: Decreases		1,219,326	1,901,728			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0061 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-7 Part I | Date/Time Prepared: 5/29/2019 4:30 pm

			Acquisitions				
		Beginning Balances	Purchases	Donation	Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	1,280,955	0	0	0	0	1.00
2.00	Land Improvements	687,865	0	0	0	0	2.00
3.00	Buildings and Fixtures	42,857,849	0	0	0	0	3.00
4.00	Building Improvements	39,119	0	0	0	0	4.00
5.00	Fixed Equipment	6,303,153	579,987	0	579,987	4,990	5.00
6.00	Movable Equipment	29,438,774	583,410	0	583,410	135,670	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	80,607,715	1,163,397	0	1,163,397	140,660	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	80,607,715	1,163,397	0	1,163,397	140,660	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	1,280,955	0	1.00
2.00	Land Improvements	687,865	0	2.00
3.00	Buildings and Fixtures	42,857,849	0	3.00
4.00	Building Improvements	39,119	0	4.00
5.00	Fixed Equipment	6,878,150	0	5.00
6.00	Movable Equipment	29,886,514	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	81,630,452	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	81,630,452	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0061 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-7 Part II | Date/Time Prepared: 5/29/2019 4:30 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	NEW CAP REL COSTS-BLDG & FIXT	1,991,496	0	214,865	0	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	1,021,403	279,877	0	0	50,559	2.00
3.00	Total (sum of lines 1-2)	3,012,899	279,877	214,865	0	50,559	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	NEW CAP REL COSTS-BLDG & FIXT	0	2,206,361		1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	1,351,839		2.00
3.00	Total (sum of lines 1-2)	0	3,558,200		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0061 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-7 Part III Date/Time Prepared: 5/29/2019 4:30 pm

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	COMPUTATION OF RATIOS: Capitalized Leases	COMPUTATION OF RATIOS: Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	ALLOCATION OF OTHER CAPITAL: Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	51,743,938	4,373,934	47,370,004	0.634587	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	29,886,514	2,609,501	27,277,013	0.365413	0	2.00
3.00	Total (sum of lines 1-2)	81,630,452	6,983,435	74,647,017	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	ALLOCATION OF OTHER CAPITAL: Other Capital-Related Costs	ALLOCATION OF OTHER CAPITAL: Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	SUMMARY OF CAPITAL: Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	1,991,496	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	1,021,403	279,877	2.00
3.00	Total (sum of lines 1-2)	0	0	0	3,012,899	279,877	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	SUMMARY OF CAPITAL: Insurance (see instructions)	SUMMARY OF CAPITAL: Taxes (see instructions)	SUMMARY OF CAPITAL: Other Capital-Related Costs (see instructions)	SUMMARY OF CAPITAL: Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	811,039	100,960	0	0	2,903,495	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	35,202	3,747	50,559	0	1,390,788	2.00
3.00	Total (sum of lines 1-2)	846,241	104,707	50,559	0	4,294,283	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0061 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-8 | Date/Time Prepared: 5/29/2019 4:30 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	NEW 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	-6,055	CENTRAL SERVICES & SUPPLY	14.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-5,027	ADMINISTRATIVE & GENERAL	5.00	0	7.00
8.00	Television and radio service (chapter 21)	A	-11,701	ADMINISTRATIVE & GENERAL	5.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-3,901,461			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	238,442			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-276,724	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-13,208	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)	A	-222	ADMINISTRATIVE & GENERAL	5.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - NEW CAP REL COSTS-BLDG & FIXT		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - NEW CAP REL COSTS-MVBLE EQUIP		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0061 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-8 | Date/Time Prepared: 5/29/2019 4:30 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	ADVERTISING EXPENSES	A	-293,002	ADMINISTRATIVE & GENERAL	5.00	0	33.00
34.00	PHYSICIAN RECRUITMENT EXPENSES	A	-455,864	ADMINISTRATIVE & GENERAL	5.00	0	34.00
35.01	NON-ALLOWABLE COSTS	A	-20,092	ADMINISTRATIVE & GENERAL	5.00	0	35.01
35.04	PHYSICIAN BENEFITS	A	-224,317	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	35.04
36.00	CPR CLASS INCOME	B	-5,646	EMERGENCY	91.00	0	36.00
36.01	MISC. INCOME	B	-31,036	ADMINISTRATIVE & GENERAL	5.00	0	36.01
36.02	INTEREST EXPENSE OFFSET	A	-667,723	INTEREST EXPENSE	113.00	0	36.02
38.00	LOBBYING EXPENSE	A	-6,315	ADMINISTRATIVE & GENERAL	5.00	0	38.00
39.00	DEBT ISSUANCE COST AMORTIZATION	A	21,425	ADMINISTRATIVE & GENERAL	5.00	0	39.00
40.00	HAF	A	-3,450,469	ADMINISTRATIVE & GENERAL	5.00	0	40.00
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-9,108,995				50.00

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1.
(2) Basis for adjustment (see instructions).
A. Costs - if cost, including applicable overhead, can be determined.
B. Amount Received - if cost cannot be determined.
(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.
Note: See instructions for column 5 referencing to Worksheet A-7.

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 15-0061 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-8-1 | Date/Time Prepared: 5/29/2019 4:30 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	90.02	PAIN MANAGEMENT	SALARIES AND OTHER	238,442	0	1.00
2.00	0.00			0	0	2.00
3.00	0.00			0	0	3.00
4.00	0.00			0	0	4.00
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			238,442	0	5.00

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

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

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

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

6.00	C		0.00	JV PAIN CLINIC	0.00	6.00
7.00			0.00		0.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	Provider CCN: 15-0061	Period: From 01/01/2018 To 12/31/2018	Worksheet A-8-1 Date/Time Prepared: 5/29/2019 4:30 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	238,442	0		1.00
2.00	0	0		2.00
3.00	0	0		3.00
4.00	0	0		4.00
5.00	238,442			5.00

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

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

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

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

6.00			6.00
7.00			7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 15-0061 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-8-2 | Date/Time Prepared: 5/29/2019 4:30 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	520,417	520,417	0	0	0	1.00
2.00	31.00	INTENSIVE CARE UNIT	1,500	1,500	0	0	0	2.00
3.00	40.00	SUBPROVIDER - IPF	551,799	551,799	0	0	0	3.00
4.00	41.00	SUBPROVIDER - IRF	183,225	162,761	20,464	211,500	277	4.00
5.00	50.00	OPERATING ROOM	1,448,319	1,448,319	0	0	0	5.00
6.00	54.00	RADIOLOGY-DIAGNOSTIC	225,000	225,000	0	0	0	6.00
7.00	56.00	RADIOISOTOPE	1,800	1,800	0	0	0	7.00
8.00	60.00	LABORATORY	32,500	2,500	30,000	260,300	960	8.00
9.00	65.00	RESPIRATORY THERAPY	44,272	44,272	0	0	0	9.00
10.00	69.00	ELECTROCARDIOLOGY	13,950	13,950	0	0	0	10.00
11.00	90.00	CLINIC	232,265	214,265	18,000	211,500	101	11.00
12.00	90.01	ONCOLOGY	228,102	228,102	0	0	0	12.00
13.00	93.00	OTHER OUTPATIENT SERVICE COST CENTER	494,298	470,298	24,000	211,500	150	13.00
200.00			3,977,447	3,884,983	92,464		1,488	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	31.00	INTENSIVE CARE UNIT	0	0	0	0	0	2.00
3.00	40.00	SUBPROVIDER - IPF	0	0	0	0	0	3.00
4.00	41.00	SUBPROVIDER - IRF	28,166	1,408	0	0	0	4.00
5.00	50.00	OPERATING ROOM	0	0	0	0	0	5.00
6.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	6.00
7.00	56.00	RADIOISOTOPE	0	0	0	0	0	7.00
8.00	60.00	LABORATORY	120,138	6,007	0	0	0	8.00
9.00	65.00	RESPIRATORY THERAPY	0	0	0	0	0	9.00
10.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	10.00
11.00	90.00	CLINIC	10,270	514	0	0	0	11.00
12.00	90.01	ONCOLOGY	0	0	0	0	0	12.00
13.00	93.00	OTHER OUTPATIENT SERVICE COST CENTER	15,252	763	0	0	0	13.00
200.00			173,826	8,692	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	520,417		1.00
2.00	31.00	INTENSIVE CARE UNIT	0	0	0	1,500		2.00
3.00	40.00	SUBPROVIDER - IPF	0	0	0	551,799		3.00
4.00	41.00	SUBPROVIDER - IRF	0	28,166	0	162,761		4.00
5.00	50.00	OPERATING ROOM	0	0	0	1,448,319		5.00
6.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	225,000		6.00
7.00	56.00	RADIOISOTOPE	0	0	0	1,800		7.00
8.00	60.00	LABORATORY	0	120,138	0	2,500		8.00
9.00	65.00	RESPIRATORY THERAPY	0	0	0	44,272		9.00
10.00	69.00	ELECTROCARDIOLOGY	0	0	0	13,950		10.00
11.00	90.00	CLINIC	0	10,270	7,730	221,995		11.00
12.00	90.01	ONCOLOGY	0	0	0	228,102		12.00
13.00	93.00	OTHER OUTPATIENT SERVICE COST CENTER	0	15,252	8,748	479,046		13.00
200.00			0	173,826	16,478	3,901,461		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0061 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part I Date/Time Prepared: 5/29/2019 4:30 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS NEW BLDG & FIXT	CAPITAL RELATED COSTS NEW MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	2,903,495	2,903,495				1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	1,390,788		1,390,788			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	5,413,604	7,056	4,965	5,425,625		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	7,121,148	158,211	96,875	476,908	7,853,142	5.00
6.00	00600	MAINTENANCE & REPAIRS	1,975,063	86,721	29,056	51,601	2,142,441	6.00
7.00	00700	OPERATION OF PLANT	799,208	557,651	0	0	1,356,859	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	364,388	6,002	0	0	370,390	8.00
9.00	00900	HOUSEKEEPING	556,722	19,871	4,193	99,475	680,261	9.00
10.00	01000	DIETARY	160,009	52,107	14,974	18,106	245,196	10.00
11.00	01100	CAFETERIA	378,074	19,087	0	74,097	471,258	11.00
13.00	01300	NURSING ADMINISTRATION	845,591	38,341	5,581	171,533	1,061,046	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	538,826	57,647	8,548	58,518	663,539	14.00
15.00	01500	PHARMACY	807,313	23,329	61,816	97,244	989,702	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	553,918	127,221	2,571	95,564	779,274	16.00
17.00	01700	SOCIAL SERVICE	91,398	0	66	19,311	110,775	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,979,244	121,759	136,001	395,131	2,632,135	30.00
31.00	03100	INTENSIVE CARE UNIT	644,239	30,732	14,751	131,740	821,462	31.00
40.00	04000	SUBPROVIDER - IPF	1,618,942	126,502	17,055	392,601	2,155,100	40.00
41.00	04100	SUBPROVIDER - IRF	626,750	111,489	11,756	156,149	906,144	41.00
43.00	04300	NURSERY	300,990	12,236	0	56,991	370,217	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,418,016	174,264	229,952	240,442	2,062,674	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	287,275	126,682	5,013	56,223	475,193	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	954,859	156,372	540,125	154,965	1,806,321	54.00
56.00	05600	RADIOISOTOPE	295,780	14,627	14,940	48,026	373,373	56.00
60.00	06000	LABORATORY	2,383,638	43,778	15,434	214,372	2,657,222	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	199,120	2,558	0	0	201,678	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	577,942	33,637	40,505	111,382	763,466	65.00
66.00	06600	PHYSICAL THERAPY	1,173,437	86,695	3,160	226,328	1,489,620	66.00
67.00	06700	OCCUPATIONAL THERAPY	289,241	18,470	0	61,322	369,033	67.00
68.00	06800	SPEECH PATHOLOGY	137,834	13,085	799	26,480	178,198	68.00
69.00	06900	ELECTROCARDIOLOGY	78,194	7,969	7,713	15,258	109,134	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,458,430	0	15,482	0	1,473,912	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	120,318	0	0	0	120,318	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,683,636	4,126	8,479	0	2,696,241	73.00
76.00	03020	CARDIAC REHAB	105,149	72,325	0	21,373	198,847	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	716,145	62,531	3,829	124,944	907,449	88.00
88.01	08801	RURAL HEALTH CLINIC II	805,981	44,781	1,666	153,343	1,005,771	88.01
88.02	08802	RURAL HEALTH CLINIC III	1,295,833	88,160	3,142	183,821	1,570,956	88.02
88.04	08803	RURAL HEALTH CLINIC V	1,027,561	24,961	3,509	187,331	1,243,362	88.04
88.05	08804	RURAL HEALTH CLINIC VI	504,107	32,789	1,652	96,544	635,092	88.05
90.00	09000	CLINIC	214,271	48,315	2,986	87,022	352,594	90.00
90.01	09001	ONCOLOGY	176,306	0	0	34,574	210,880	90.01
90.02	09002	PAIN MANAGEMENT	238,442	22,030	0	0	260,472	90.02
91.00	09100	EMERGENCY	2,262,077	82,903	18,361	244,754	2,608,095	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	262,034	74,986	621	121,698	459,339	93.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	577,446	7,519	0	56,851	641,816	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	49,312,782	2,799,525	1,325,576	4,762,022	48,479,997	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	474	0	474	192.00
194.00	07951	OTHER NONREIMBURSABLE AND PHYSICIAN	4,433,288	103,970	64,738	663,603	5,265,599	194.00
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	53,746,070	2,903,495	1,390,788	5,425,625	53,746,070	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0061 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part I Date/Time Prepared: 5/29/2019 4:30 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	7,853,142					5.00
6.00	00600	MAINTENANCE & REPAIRS	366,612	2,509,053				6.00
7.00	00700	OPERATION OF PLANT	232,184	527,691	2,116,734			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	63,381	5,680	6,068	445,519		8.00
9.00	00900	HOUSEKEEPING	116,406	18,804	20,088	35,371	870,930	9.00
10.00	01000	DIETARY	41,958	49,308	52,676	3,100	21,945	10.00
11.00	01100	CAFETERIA	80,641	18,062	19,296	0	8,039	11.00
13.00	01300	NURSING ADMINISTRATION	181,565	36,281	38,760	0	16,147	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	113,544	54,550	58,277	0	24,278	14.00
15.00	01500	PHARMACY	169,357	22,075	23,584	0	9,825	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	133,349	120,386	128,611	0	53,579	16.00
17.00	01700	SOCIAL SERVICE	18,956	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	450,408	115,217	123,089	104,246	51,279	30.00
31.00	03100	INTENSIVE CARE UNIT	140,568	29,081	31,068	15,501	12,943	31.00
40.00	04000	SUBPROVIDER - IPF	368,779	119,705	127,884	58,902	53,276	40.00
41.00	04100	SUBPROVIDER - IRF	155,058	105,499	112,707	18,601	46,954	41.00
43.00	04300	NURSERY	63,351	11,579	12,370	0	5,153	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	352,963	164,902	176,168	52,702	73,389	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	81,315	119,875	128,066	0	53,352	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	309,096	147,971	158,081	103,525	65,856	54.00
56.00	05600	RADIOISOTOPE	63,891	13,841	14,787	0	6,160	56.00
60.00	06000	LABORATORY	454,701	41,426	44,256	0	18,437	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	34,511	2,420	2,586	0	1,077	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	130,644	31,830	34,004	6,200	14,166	65.00
66.00	06600	PHYSICAL THERAPY	254,902	82,037	87,642	0	36,512	66.00
67.00	06700	OCCUPATIONAL THERAPY	63,149	17,478	18,672	0	7,779	67.00
68.00	06800	SPEECH PATHOLOGY	30,493	12,382	13,228	0	5,511	68.00
69.00	06900	ELECTROCARDIOLOGY	18,675	7,541	8,056	0	3,356	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	252,214	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	20,589	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	461,378	3,904	4,171	0	1,738	73.00
76.00	03020	CARDIAC REHAB	34,026	68,439	73,115	0	30,460	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	155,282	59,171	63,214	0	26,335	88.00
88.01	08801	RURAL HEALTH CLINIC II	172,107	42,375	45,270	2,464	18,859	88.01
88.02	08802	RURAL HEALTH CLINIC III	268,820	83,424	89,124	0	37,129	88.02
88.04	08803	RURAL HEALTH CLINIC V	212,763	23,620	25,234	1,252	10,512	88.04
88.05	08804	RURAL HEALTH CLINIC VI	108,676	31,027	33,147	0	13,809	88.05
90.00	09000	CLINIC	60,336	45,720	48,843	3,354	20,348	90.00
90.01	09001	ONCOLOGY	36,086	0	0	0	0	90.01
90.02	09002	PAIN MANAGEMENT	44,572	20,847	22,271	0	9,278	90.02
91.00	09100	EMERGENCY	446,295	78,449	83,809	40,301	34,915	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	78,602	70,957	75,805	0	31,580	93.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	109,827	7,115	7,601	0	3,167	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	6,952,030	2,410,669	2,011,628	445,519	827,143	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	81	0	0	0	0	192.00
194.00	07951	OTHER NONREIMBURSABLE AND PHYSICIAN	901,031	98,384	105,106	0	43,787	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	7,853,142	2,509,053	2,116,734	445,519	870,930	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0061 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part I | Date/Time Prepared: 5/29/2019 4:30 pm

		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	414,183					10.00
11.00	01100	CAFETERIA	0	597,296				11.00
13.00	01300	NURSING ADMINISTRATION	0	18,035	1,351,834			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	10,293	0	924,481		14.00
15.00	01500	PHARMACY	0	10,686	0	1,922	1,227,151	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	17,229	0	13	0	16.00
17.00	01700	SOCIAL SERVICE	0	4,278	0	103	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	138,166	61,743	264,271	23,802	0	30.00
31.00	03100	INTENSIVE CARE UNIT	37,689	17,446	74,671	4,779	0	31.00
40.00	04000	SUBPROVIDER - IPF	192,086	58,878	252,009	8,883	0	40.00
41.00	04100	SUBPROVIDER - IRF	46,242	19,619	83,973	3,148	0	41.00
43.00	04300	NURSERY	0	7,326	31,356	2,762	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	33,777	144,571	32,209	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	7,227	30,932	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	22,274	95,336	18,597	0	54.00
56.00	05600	RADIOISOTOPE	0	4,595	19,668	7,048	0	56.00
60.00	06000	LABORATORY	0	37,624	161,037	268,926	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	51,651	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	14,441	0	10,066	0	65.00
66.00	06600	PHYSICAL THERAPY	0	26,889	0	1,376	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	7,750	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	2,853	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	2,354	0	1,489	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	439,470	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	1,227,151	73.00
76.00	03020	CARDIAC REHAB	0	2,947	12,613	432	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	12,520	0	676	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	17,270	0	2,204	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	24,300	0	1,908	0	88.02
88.04	08803	RURAL HEALTH CLINIC V	0	13,810	0	2,659	0	88.04
88.05	08804	RURAL HEALTH CLINIC VI	0	11,988	0	521	0	88.05
90.00	09000	CLINIC	0	6,717	0	11,936	0	90.00
90.01	09001	ONCOLOGY	0	3,818	0	826	0	90.01
90.02	09002	PAIN MANAGEMENT	0	4,884	0	0	0	90.02
91.00	09100	EMERGENCY	0	33,527	143,502	10,732	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	8,147	0	45	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	8,854	37,895	13,648	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	414,183	534,099	1,351,834	921,831	1,227,151	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07951	OTHER NONREIMBURSABLE AND PHYSICIAN	0	63,197	0	2,650	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	414,183	597,296	1,351,834	924,481	1,227,151	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0061 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part I | Date/Time Prepared: 5/29/2019 4:30 pm

		Cost Center Description	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			16.00	17.00	24.00	25.00	26.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,232,441					16.00
17.00	01700	SOCIAL SERVICE	0	134,112				17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	22,265	2,572	3,989,193	0	3,989,193	30.00
31.00	03100	INTENSIVE CARE UNIT	25,680	2,980	1,213,868	0	1,213,868	31.00
40.00	04000	SUBPROVIDER - IPF	80,590	52,275	3,528,367	0	3,528,367	40.00
41.00	04100	SUBPROVIDER - IRF	18,310	120	1,516,375	0	1,516,375	41.00
43.00	04300	NURSERY	6,671	0	510,785	0	510,785	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	89,970	0	3,183,325	0	3,183,325	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	6,581	0	902,541	0	902,541	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	203,680	0	2,930,737	0	2,930,737	54.00
56.00	05600	RADIOISOTOPE	49,767	0	553,130	0	553,130	56.00
60.00	06000	LABORATORY	217,677	0	3,901,306	0	3,901,306	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	7,691	0	301,614	0	301,614	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	20,536	0	1,025,353	0	1,025,353	65.00
66.00	06600	PHYSICAL THERAPY	33,265	0	2,012,243	0	2,012,243	66.00
67.00	06700	OCCUPATIONAL THERAPY	13,244	0	497,105	0	497,105	67.00
68.00	06800	SPEECH PATHOLOGY	3,229	0	245,894	0	245,894	68.00
69.00	06900	ELECTROCARDIOLOGY	10,106	0	160,711	0	160,711	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	51,860	0	2,217,456	0	2,217,456	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	4,726	0	145,633	0	145,633	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	114,576	0	4,509,159	0	4,509,159	73.00
76.00	03020	CARDIAC REHAB	1,931	0	422,810	0	422,810	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	9,527	0	1,234,174	0	1,234,174	88.00
88.01	08801	RURAL HEALTH CLINIC II	11,029	0	1,317,349	0	1,317,349	88.01
88.02	08802	RURAL HEALTH CLINIC III	20,919	0	2,096,580	0	2,096,580	88.02
88.04	08803	RURAL HEALTH CLINIC V	12,663	0	1,545,875	0	1,545,875	88.04
88.05	08804	RURAL HEALTH CLINIC VI	6,319	0	840,579	0	840,579	88.05
90.00	09000	CLINIC	11,901	0	561,749	0	561,749	90.00
90.01	09001	ONCOLOGY	18,042	0	269,652	0	269,652	90.01
90.02	09002	PAIN MANAGEMENT	4,634	0	366,958	0	366,958	90.02
91.00	09100	EMERGENCY	85,114	12,931	3,577,670	0	3,577,670	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	5,289	2,932	732,696	0	732,696	93.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	10,941	60,302	901,166	0	901,166	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,178,733	134,112	47,212,053	0	47,212,053	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	555	0	555	192.00
194.00	07951	OTHER NONREIMBURSABLE AND PHYSICIAN	53,708	0	6,533,462	0	6,533,462	194.00
200.00		Cross Foot Adjustments			0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,232,441	134,112	53,746,070	0	53,746,070	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0061 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part II | Date/Time Prepared: 5/29/2019 4:30 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS NEW BLDG & FIXT	CAPITAL RELATED COSTS NEW MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	7,056	4,965	12,021	12,021	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	158,211	96,875	255,086	1,056	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	86,721	29,056	115,777	114	6.00
7.00	00700	OPERATION OF PLANT	0	557,651	0	557,651	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	6,002	0	6,002	0	8.00
9.00	00900	HOUSEKEEPING	0	19,871	4,193	24,064	220	9.00
10.00	01000	DIETARY	0	52,107	14,974	67,081	40	10.00
11.00	01100	CAFETERIA	0	19,087	0	19,087	164	11.00
13.00	01300	NURSING ADMINISTRATION	0	38,341	5,581	43,922	380	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	57,647	8,548	66,195	130	14.00
15.00	01500	PHARMACY	0	23,329	61,816	85,145	215	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	127,221	2,571	129,792	212	16.00
17.00	01700	SOCIAL SERVICE	0	0	66	66	43	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	121,759	136,001	257,760	875	30.00
31.00	03100	INTENSIVE CARE UNIT	0	30,732	14,751	45,483	292	31.00
40.00	04000	SUBPROVIDER - IPF	0	126,502	17,055	143,557	870	40.00
41.00	04100	SUBPROVIDER - IRF	0	111,489	11,756	123,245	346	41.00
43.00	04300	NURSERY	0	12,236	0	12,236	126	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	174,264	229,952	404,216	533	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	126,682	5,013	131,695	125	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	156,372	540,125	696,497	343	54.00
56.00	05600	RADIOISOTOPE	0	14,627	14,940	29,567	106	56.00
60.00	06000	LABORATORY	0	43,778	15,434	59,212	475	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	2,558	0	2,558	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	33,637	40,505	74,142	247	65.00
66.00	06600	PHYSICAL THERAPY	0	86,695	3,160	89,855	501	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	18,470	0	18,470	136	67.00
68.00	06800	SPEECH PATHOLOGY	0	13,085	799	13,884	59	68.00
69.00	06900	ELECTROCARDIOLOGY	0	7,969	7,713	15,682	34	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	15,482	15,482	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	4,126	8,479	12,605	0	73.00
76.00	03020	CARDIAC REHAB	0	72,325	0	72,325	47	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	62,531	3,829	66,360	277	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	44,781	1,666	46,447	340	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	88,160	3,142	91,302	407	88.02
88.04	08803	RURAL HEALTH CLINIC V	0	24,961	3,509	28,470	415	88.04
88.05	08804	RURAL HEALTH CLINIC VI	0	32,789	1,652	34,441	214	88.05
90.00	09000	CLINIC	0	48,315	2,986	51,301	193	90.00
90.01	09001	ONCOLOGY	0	0	0	0	77	90.01
90.02	09002	PAIN MANAGEMENT	0	22,030	0	22,030	0	90.02
91.00	09100	EMERGENCY	0	82,903	18,361	101,264	542	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	74,986	621	75,607	270	93.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	7,519	0	7,519	126	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	2,799,525	1,325,576	4,125,101	10,550	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	474	474	0	192.00
194.00	07951	OTHER NONREIMBURSABLE AND PHYSICIAN	0	103,970	64,738	168,708	1,471	194.00
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	2,903,495	1,390,788	4,294,283	12,021	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0061 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part II | Date/Time Prepared: 5/29/2019 4:30 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	256,142					5.00
6.00	00600	MAINTENANCE & REPAIRS	11,957	127,848				6.00
7.00	00700	OPERATION OF PLANT	7,573	26,887	592,111			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,067	289	1,697	10,055		8.00
9.00	00900	HOUSEKEEPING	3,797	958	5,619	798	35,456	9.00
10.00	01000	DIETARY	1,368	2,512	14,735	70	893	10.00
11.00	01100	CAFETERIA	2,630	920	5,398	0	327	11.00
13.00	01300	NURSING ADMINISTRATION	5,922	1,849	10,842	0	657	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3,703	2,780	16,302	0	988	14.00
15.00	01500	PHARMACY	5,524	1,125	6,597	0	400	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,349	6,134	35,976	0	2,181	16.00
17.00	01700	SOCIAL SERVICE	618	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	14,690	5,871	34,432	2,352	2,088	30.00
31.00	03100	INTENSIVE CARE UNIT	4,585	1,482	8,691	350	527	31.00
40.00	04000	SUBPROVIDER - IPF	12,028	6,100	35,773	1,329	2,169	40.00
41.00	04100	SUBPROVIDER - IRF	5,057	5,376	31,527	420	1,911	41.00
43.00	04300	NURSERY	2,066	590	3,460	0	210	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	11,512	8,403	49,279	1,189	2,987	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,652	6,108	35,824	0	2,172	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	10,081	7,540	44,220	2,337	2,681	54.00
56.00	05600	RADIOISOTOPE	2,084	705	4,136	0	251	56.00
60.00	06000	LABORATORY	14,830	2,111	12,380	0	751	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	1,126	123	723	0	44	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	4,261	1,622	9,512	140	577	65.00
66.00	06600	PHYSICAL THERAPY	8,314	4,180	24,516	0	1,486	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,060	891	5,223	0	317	67.00
68.00	06800	SPEECH PATHOLOGY	995	631	3,700	0	224	68.00
69.00	06900	ELECTROCARDIOLOGY	609	384	2,254	0	137	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	8,226	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	671	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	15,048	199	1,167	0	71	73.00
76.00	03020	CARDIAC REHAB	1,110	3,487	20,452	0	1,240	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	5,064	3,015	17,683	0	1,072	88.00
88.01	08801	RURAL HEALTH CLINIC II	5,613	2,159	12,663	56	768	88.01
88.02	08802	RURAL HEALTH CLINIC III	8,768	4,251	24,930	0	1,512	88.02
88.04	08803	RURAL HEALTH CLINIC V	6,939	1,204	7,059	28	428	88.04
88.05	08804	RURAL HEALTH CLINIC VI	3,544	1,581	9,272	0	562	88.05
90.00	09000	CLINIC	1,968	2,330	13,663	76	828	90.00
90.01	09001	ONCOLOGY	1,177	0	0	0	0	90.01
90.02	09002	PAIN MANAGEMENT	1,454	1,062	6,230	0	378	90.02
91.00	09100	EMERGENCY	14,556	3,997	23,444	910	1,421	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	2,564	3,616	21,205	0	1,286	93.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	3,582	363	2,126	0	129	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	226,742	122,835	562,710	10,055	33,673	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	3	0	0	0	0	192.00
194.00	07951	OTHER NONREIMBURSABLE AND PHYSICIAN	29,397	5,013	29,401	0	1,783	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	256,142	127,848	592,111	10,055	35,456	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0061 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part II | Date/Time Prepared: 5/29/2019 4:30 pm

		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	86,699					10.00
11.00	01100	CAFETERIA	0	28,526				11.00
13.00	01300	NURSING ADMINISTRATION	0	861	64,433			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	492	0	90,590		14.00
15.00	01500	PHARMACY	0	510	0	188	99,704	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	823	0	1	0	16.00
17.00	01700	SOCIAL SERVICE	0	204	0	10	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	28,922	2,949	12,596	2,332	0	30.00
31.00	03100	INTENSIVE CARE UNIT	7,889	833	3,559	468	0	31.00
40.00	04000	SUBPROVIDER - IPF	40,208	2,812	12,012	870	0	40.00
41.00	04100	SUBPROVIDER - IRF	9,680	937	4,002	308	0	41.00
43.00	04300	NURSERY	0	350	1,495	271	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	1,613	6,891	3,156	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	345	1,474	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,064	4,544	1,822	0	54.00
56.00	05600	RADIOISOTOPE	0	219	937	691	0	56.00
60.00	06000	LABORATORY	0	1,797	7,676	26,352	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	5,061	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	690	0	986	0	65.00
66.00	06600	PHYSICAL THERAPY	0	1,284	0	135	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	370	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	136	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	112	0	146	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	43,066	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	99,704	73.00
76.00	03020	CARDIAC REHAB	0	141	601	42	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	598	0	66	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	825	0	216	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	1,161	0	187	0	88.02
88.04	08803	RURAL HEALTH CLINIC V	0	660	0	261	0	88.04
88.05	08804	RURAL HEALTH CLINIC VI	0	573	0	51	0	88.05
90.00	09000	CLINIC	0	321	0	1,170	0	90.00
90.01	09001	ONCOLOGY	0	182	0	81	0	90.01
90.02	09002	PAIN MANAGEMENT	0	233	0	0	0	90.02
91.00	09100	EMERGENCY	0	1,601	6,840	1,052	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	389	0	4	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	423	1,806	1,337	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	86,699	25,508	64,433	90,330	99,704	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07951	OTHER NONREIMBURSABLE AND PHYSICIAN	0	3,018	0	260	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	86,699	28,526	64,433	90,590	99,704	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0061 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part II Date/Time Prepared: 5/29/2019 4:30 pm

		Cost Center Description	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			16.00	17.00	24.00	25.00	26.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	179,468					16.00
17.00	01700	SOCIAL SERVICE	0	941				17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,242	18	368,127	0	368,127	30.00
31.00	03100	INTENSIVE CARE UNIT	3,740	21	77,920	0	77,920	31.00
40.00	04000	SUBPROVIDER - IPF	11,736	367	269,831	0	269,831	40.00
41.00	04100	SUBPROVIDER - IRF	2,667	1	185,477	0	185,477	41.00
43.00	04300	NURSERY	971	0	21,775	0	21,775	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	13,102	0	502,881	0	502,881	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	958	0	181,353	0	181,353	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	29,662	0	800,791	0	800,791	54.00
56.00	05600	RADIOISOTOPE	7,248	0	45,944	0	45,944	56.00
60.00	06000	LABORATORY	31,691	0	157,275	0	157,275	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	1,120	0	10,755	0	10,755	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	2,991	0	95,168	0	95,168	65.00
66.00	06600	PHYSICAL THERAPY	4,844	0	135,115	0	135,115	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,929	0	29,396	0	29,396	67.00
68.00	06800	SPEECH PATHOLOGY	470	0	20,099	0	20,099	68.00
69.00	06900	ELECTROCARDIOLOGY	1,472	0	20,830	0	20,830	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	7,552	0	74,326	0	74,326	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	688	0	1,359	0	1,359	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	16,686	0	145,480	0	145,480	73.00
76.00	03020	CARDIAC REHAB	281	0	99,726	0	99,726	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,387	0	95,522	0	95,522	88.00
88.01	08801	RURAL HEALTH CLINIC II	1,606	0	70,693	0	70,693	88.01
88.02	08802	RURAL HEALTH CLINIC III	3,046	0	135,564	0	135,564	88.02
88.04	08803	RURAL HEALTH CLINIC V	1,844	0	47,308	0	47,308	88.04
88.05	08804	RURAL HEALTH CLINIC VI	920	0	51,158	0	51,158	88.05
90.00	09000	CLINIC	1,733	0	73,583	0	73,583	90.00
90.01	09001	ONCOLOGY	2,627	0	4,144	0	4,144	90.01
90.02	09002	PAIN MANAGEMENT	675	0	32,062	0	32,062	90.02
91.00	09100	EMERGENCY	12,395	91	168,113	0	168,113	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	770	21	105,732	0	105,732	93.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	1,593	422	19,426	0	19,426	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	171,646	941	4,046,933	0	4,046,933	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	477	0	477	192.00
194.00	07951	OTHER NONREIMBURSABLE AND PHYSICIAN	7,822	0	246,873	0	246,873	194.00
200.00		Cross Foot Adjustments			0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	179,468	941	4,294,283	0	4,294,283	202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0061 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B-1 | Date/Time Prepared: 5/29/2019 4:30 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	225,896					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		1,012,679				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	549	3,615	25,570,485			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	12,309	70,538	2,247,625	-7,853,142	45,892,928	5.00
6.00	00600	MAINTENANCE & REPAIRS	6,747	21,157	243,192	0	2,142,441	6.00
7.00	00700	OPERATION OF PLANT	43,386	0	0	0	1,356,859	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	467	0	0	0	370,390	8.00
9.00	00900	HOUSEKEEPING	1,546	3,053	468,817	0	680,261	9.00
10.00	01000	DIETARY	4,054	10,903	85,334	0	245,196	10.00
11.00	01100	CAFETERIA	1,485	0	349,211	0	471,258	11.00
13.00	01300	NURSING ADMINISTRATION	2,983	4,064	808,421	0	1,061,046	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	4,485	6,224	275,789	0	663,539	14.00
15.00	01500	PHARMACY	1,815	45,010	458,304	0	989,702	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	9,898	1,872	450,385	0	779,274	16.00
17.00	01700	SOCIAL SERVICE	0	48	91,009	0	110,775	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	9,473	99,027	1,862,216	0	2,632,135	30.00
31.00	03100	INTENSIVE CARE UNIT	2,391	10,741	620,879	0	821,462	31.00
40.00	04000	SUBPROVIDER - IPF	9,842	12,418	1,850,293	0	2,155,100	40.00
41.00	04100	SUBPROVIDER - IRF	8,674	8,560	735,916	0	906,144	41.00
43.00	04300	NURSERY	952	0	268,592	0	370,217	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	13,558	167,436	1,133,180	0	2,062,674	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	9,856	3,650	264,976	0	475,193	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	12,166	393,283	730,338	0	1,806,321	54.00
56.00	05600	RADIOISOTOPE	1,138	10,878	226,343	0	373,373	56.00
60.00	06000	LABORATORY	3,406	11,238	1,010,316	0	2,657,222	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	199	0	0	0	201,678	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	2,617	29,493	524,936	0	763,466	65.00
66.00	06600	PHYSICAL THERAPY	6,745	2,301	1,066,665	0	1,489,620	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,437	0	289,006	0	369,033	67.00
68.00	06800	SPEECH PATHOLOGY	1,018	582	124,798	0	178,198	68.00
69.00	06900	ELECTROCARDIOLOGY	620	5,616	71,908	0	109,134	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	11,273	0	0	1,473,912	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	120,318	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	321	6,174	0	0	2,696,241	73.00
76.00	03020	CARDIAC REHAB	5,627	0	100,727	0	198,847	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	4,865	2,788	588,849	0	907,449	88.00
88.01	08801	RURAL HEALTH CLINIC II	3,484	1,213	722,690	0	1,005,771	88.01
88.02	08802	RURAL HEALTH CLINIC III	6,859	2,288	866,331	0	1,570,956	88.02
88.04	08803	RURAL HEALTH CLINIC V	1,942	2,555	882,873	0	1,243,362	88.04
88.05	08804	RURAL HEALTH CLINIC VI	2,551	1,203	455,005	0	635,092	88.05
90.00	09000	CLINIC	3,759	2,174	410,127	0	352,594	90.00
90.01	09001	ONCOLOGY	0	0	162,946	0	210,880	90.01
90.02	09002	PAIN MANAGEMENT	1,714	0	0	0	260,472	90.02
91.00	09100	EMERGENCY	6,450	13,369	1,153,503	0	2,608,095	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	5,834	452	573,554	0	459,339	93.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	585	0	267,933	0	641,816	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	217,807	965,196	22,442,987	-7,853,142	40,626,855	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	345	0	0	474	192.00
194.00	07951	OTHER NONREIMBURSABLE AND PHYSICIAN	8,089	47,138	3,127,498	0	5,265,599	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)	2,903,495	1,390,788	5,425,625		7,853,142	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	12.853238	1.373375	0.212183		0.171119	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			12,021		256,142	204.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0061 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B-1 | Date/Time Prepared: 5/29/2019 4:30 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000470		0.005581	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: 15-0061 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B-1 | Date/Time Prepared: 5/29/2019 4:30 pm

		Cost Center Description	MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	
			6.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS	206,291					6.00
7.00	00700	OPERATION OF PLANT	43,386	162,905				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	467	467	341,744			8.00
9.00	00900	HOUSEKEEPING	1,546	1,546	27,132	160,892		9.00
10.00	01000	DIETARY	4,054	4,054	2,378	4,054	40,628	10.00
11.00	01100	CAFETERIA	1,485	1,485	0	1,485	0	11.00
13.00	01300	NURSING ADMINISTRATION	2,983	2,983	0	2,983	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	4,485	4,485	0	4,485	0	14.00
15.00	01500	PHARMACY	1,815	1,815	0	1,815	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	9,898	9,898	0	9,898	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	9,473	9,473	79,964	9,473	13,553	30.00
31.00	03100	INTENSIVE CARE UNIT	2,391	2,391	11,890	2,391	3,697	31.00
40.00	04000	SUBPROVIDER - IPF	9,842	9,842	45,182	9,842	18,842	40.00
41.00	04100	SUBPROVIDER - IRF	8,674	8,674	14,268	8,674	4,536	41.00
43.00	04300	NURSERY	952	952	0	952	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	13,558	13,558	40,426	13,558	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	9,856	9,856	0	9,856	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	12,166	12,166	79,411	12,166	0	54.00
56.00	05600	RADIOISOTOPE	1,138	1,138	0	1,138	0	56.00
60.00	06000	LABORATORY	3,406	3,406	0	3,406	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	199	199	0	199	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	2,617	2,617	4,756	2,617	0	65.00
66.00	06600	PHYSICAL THERAPY	6,745	6,745	0	6,745	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,437	1,437	0	1,437	0	67.00
68.00	06800	SPEECH PATHOLOGY	1,018	1,018	0	1,018	0	68.00
69.00	06900	ELECTROCARDIOLOGY	620	620	0	620	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	321	321	0	321	0	73.00
76.00	03020	CARDIAC REHAB	5,627	5,627	0	5,627	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	4,865	4,865	0	4,865	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	3,484	3,484	1,890	3,484	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	6,859	6,859	0	6,859	0	88.02
88.04	08803	RURAL HEALTH CLINIC V	1,942	1,942	960	1,942	0	88.04
88.05	08804	RURAL HEALTH CLINIC VI	2,551	2,551	0	2,551	0	88.05
90.00	09000	CLINIC	3,759	3,759	2,573	3,759	0	90.00
90.01	09001	ONCOLOGY	0	0	0	0	0	90.01
90.02	09002	PAIN MANAGEMENT	1,714	1,714	0	1,714	0	90.02
91.00	09100	EMERGENCY	6,450	6,450	30,914	6,450	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	5,834	5,834	0	5,834	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	585	585	0	585	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	198,202	154,816	341,744	152,803	40,628	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07951	OTHER NONREIMBURSABLE AND PHYSICIAN	8,089	8,089	0	8,089	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)	2,509,053	2,116,734	445,519	870,930	414,183	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	12.162688	12.993671	1.303663	5.413134	10.194521	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	127,848	592,111	10,055	35,456	86,699	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.619746	3.634701	0.029423	0.220371	2.133972	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0061 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B-1 | Date/Time Prepared: 5/29/2019 4:30 pm

		Cost Center Description	MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	
			6.00	7.00	8.00	9.00	10.00	
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: 15-0061 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B-1 | Date/Time Prepared: 5/29/2019 4:30 pm

		Cost Center Description	CAFETERIA (HOURS PAID)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	779,139					11.00
13.00	01300	NURSING ADMINISTRATION	23,525	411,989				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	13,427	0	3,223,922			14.00
15.00	01500	PHARMACY	13,939	0	6,702	100		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	22,474	0	45	0	146,759,845	16.00
17.00	01700	SOCIAL SERVICE	5,581	0	359	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	80,540	80,540	83,004	0	2,651,214	30.00
31.00	03100	INTENSIVE CARE UNIT	22,757	22,757	16,665	0	3,057,878	31.00
40.00	04000	SUBPROVIDER - IPF	76,803	76,803	30,976	0	9,596,328	40.00
41.00	04100	SUBPROVIDER - IRF	25,592	25,592	10,977	0	2,180,321	41.00
43.00	04300	NURSERY	9,556	9,556	9,631	0	794,329	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	44,060	44,060	112,322	0	10,713,215	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	9,427	9,427	0	0	783,635	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	29,055	29,055	64,853	0	24,253,352	54.00
56.00	05600	RADIOISOTOPE	5,994	5,994	24,580	0	5,926,006	56.00
60.00	06000	LABORATORY	49,078	49,078	937,820	0	25,925,850	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	180,120	0	915,867	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	18,838	0	35,104	0	2,445,339	65.00
66.00	06600	PHYSICAL THERAPY	35,075	0	4,800	0	3,961,015	66.00
67.00	06700	OCCUPATIONAL THERAPY	10,109	0	0	0	1,577,068	67.00
68.00	06800	SPEECH PATHOLOGY	3,721	0	0	0	384,437	68.00
69.00	06900	ELECTROCARDIOLOGY	3,071	0	5,193	0	1,203,364	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	1,532,551	0	6,175,294	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	562,748	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	100	13,643,191	73.00
76.00	03020	CARDIAC REHAB	3,844	3,844	1,507	0	229,980	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	16,331	0	2,358	0	1,134,490	88.00
88.01	08801	RURAL HEALTH CLINIC II	22,528	0	7,687	0	1,313,326	88.01
88.02	08802	RURAL HEALTH CLINIC III	31,698	0	6,653	0	2,490,952	88.02
88.04	08803	RURAL HEALTH CLINIC V	18,015	0	9,271	0	1,507,818	88.04
88.05	08804	RURAL HEALTH CLINIC VI	15,638	0	1,817	0	752,444	88.05
90.00	09000	CLINIC	8,762	0	41,625	0	1,417,159	90.00
90.01	09001	ONCOLOGY	4,981	0	2,879	0	2,148,353	90.01
90.02	09002	PAIN MANAGEMENT	6,371	0	0	0	551,806	90.02
91.00	09100	EMERGENCY	43,734	43,734	37,426	0	10,135,041	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	10,627	0	158	0	629,813	93.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	11,549	11,549	47,596	0	1,302,840	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	696,700	411,989	3,214,679	100	140,364,473	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07951	OTHER NONREIMBURSABLE AND PHYSICIAN	82,439	0	9,243	0	6,395,372	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)	597,296	1,351,834	924,481	1,227,151	1,232,441	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.766610	3.281238	0.286757	12,271.510000	0.008398	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	28,526	64,433	90,590	99,704	179,468	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.036612	0.156395	0.028099	997.040000	0.001223	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0061 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B-1 | Date/Time Prepared: 5/29/2019 4:30 pm

		Cost Center Description	CAFETERIA (HOURS PAID)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	
			11.00	13.00	14.00	15.00	16.00	
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: 15-0061 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B-1 | Date/Time Prepared: 5/29/2019 4:30 pm

		Cost Center Description	SOCIAL SERVICE (TIME SPENT)		
			17.00		
		GENERAL SERVICE COST CENTERS			
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.00	00500	ADMINISTRATIVE & GENERAL			5.00
6.00	00600	MAINTENANCE & REPAIRS			6.00
7.00	00700	OPERATION OF PLANT			7.00
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
13.00	01300	NURSING ADMINISTRATION			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY			14.00
15.00	01500	PHARMACY			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
17.00	01700	SOCIAL SERVICE	5,580		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	107		30.00
31.00	03100	INTENSIVE CARE UNIT	124		31.00
40.00	04000	SUBPROVIDER - IPF	2,175		40.00
41.00	04100	SUBPROVIDER - IRF	5		41.00
43.00	04300	NURSERY	0		43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0		50.00
51.00	05100	RECOVERY ROOM	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0		54.00
56.00	05600	RADIOISOTOPE	0		56.00
60.00	06000	LABORATORY	0		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0		63.00
64.00	06400	INTRAVENOUS THERAPY	0		64.00
65.00	06500	RESPIRATORY THERAPY	0		65.00
66.00	06600	PHYSICAL THERAPY	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0		67.00
68.00	06800	SPEECH PATHOLOGY	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0		73.00
76.00	03020	CARDIAC REHAB	0		76.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	0		88.00
88.01	08801	RURAL HEALTH CLINIC II	0		88.01
88.02	08802	RURAL HEALTH CLINIC III	0		88.02
88.04	08803	RURAL HEALTH CLINIC V	0		88.04
88.05	08804	RURAL HEALTH CLINIC VI	0		88.05
90.00	09000	CLINIC	0		90.00
90.01	09001	ONCOLOGY	0		90.01
90.02	09002	PAIN MANAGEMENT	0		90.02
91.00	09100	EMERGENCY	538		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	122		93.00
		OTHER REIMBURSABLE COST CENTERS			
99.10	09910	CORF	0		99.10
101.00	10100	HOME HEALTH AGENCY	0		101.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
116.00	11600	HOSPICE	2,509		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	5,580		118.00
		NONREIMBURSABLE COST CENTERS			
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0		192.00
194.00	07951	OTHER NONREIMBURSABLE AND PHYSICIAN	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)	134,112		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	24.034409		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	941		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.168638		205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0061 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B-1 | Date/Time Prepared: 5/29/2019 4:30 pm

		Cost Center Description	SOCIAL SERVICE (TIME SPENT)		
			17.00		
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)			206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)			207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0061 | Period: From 01/01/2018 To 12/31/2018 | Worksheet C Part I Date/Time Prepared: 5/29/2019 4:30 pm

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		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	Costs RCE Disallowance	Costs Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,989,193		3,989,193	0	3,989,193	30.00
31.00	03100	INTENSIVE CARE UNIT	1,213,868		1,213,868	0	1,213,868	31.00
40.00	04000	SUBPROVIDER - IPF	3,528,367		3,528,367	0	3,528,367	40.00
41.00	04100	SUBPROVIDER - IRF	1,516,375		1,516,375	0	1,516,375	41.00
43.00	04300	NURSERY	510,785		510,785	0	510,785	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,183,325		3,183,325	0	3,183,325	50.00
51.00	05100	RECOVERY ROOM	0		0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	902,541		902,541	0	902,541	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,930,737		2,930,737	0	2,930,737	54.00
56.00	05600	RADIOISOTOPE	553,130		553,130	0	553,130	56.00
60.00	06000	LABORATORY	3,901,306		3,901,306	0	3,901,306	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	301,614		301,614	0	301,614	63.00
64.00	06400	INTRAVENOUS THERAPY	0		0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	1,025,353	0	1,025,353	0	1,025,353	65.00
66.00	06600	PHYSICAL THERAPY	2,012,243	0	2,012,243	0	2,012,243	66.00
67.00	06700	OCCUPATIONAL THERAPY	497,105	0	497,105	0	497,105	67.00
68.00	06800	SPEECH PATHOLOGY	245,894	0	245,894	0	245,894	68.00
69.00	06900	ELECTROCARDIOLOGY	160,711		160,711	0	160,711	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,217,456		2,217,456	0	2,217,456	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	145,633		145,633	0	145,633	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,509,159		4,509,159	0	4,509,159	73.00
76.00	03020	CARDIAC REHAB	422,810		422,810	0	422,810	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,234,174		1,234,174	0	1,234,174	88.00
88.01	08801	RURAL HEALTH CLINIC II	1,317,349		1,317,349	0	1,317,349	88.01
88.02	08802	RURAL HEALTH CLINIC III	2,096,580		2,096,580	0	2,096,580	88.02
88.04	08803	RURAL HEALTH CLINIC V	1,545,875		1,545,875	0	1,545,875	88.04
88.05	08804	RURAL HEALTH CLINIC VI	840,579		840,579	0	840,579	88.05
90.00	09000	CLINIC	561,749		561,749	7,730	569,479	90.00
90.01	09001	ONCOLOGY	269,652		269,652	0	269,652	90.01
90.02	09002	PAIN MANAGEMENT	366,958		366,958	0	366,958	90.02
91.00	09100	EMERGENCY	3,577,670		3,577,670	0	3,577,670	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,340,833		1,340,833		1,340,833	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	732,696		732,696	8,748	741,444	93.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0		0		0	99.10
101.00	10100	HOME HEALTH AGENCY	0		0		0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	901,166		901,166		901,166	116.00
200.00		Subtotal (see instructions)	48,552,886	0	48,552,886	16,478	48,569,364	200.00
201.00		Less Observation Beds	1,340,833		1,340,833		1,340,833	201.00
202.00		Total (see instructions)	47,212,053	0	47,212,053	16,478	47,228,531	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0061 | Period: From 01/01/2018 To 12/31/2018 | Worksheet C Part I Date/Time Prepared: 5/29/2019 4:30 pm

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		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,651,214		2,651,214			30.00
31.00	03100	INTENSIVE CARE UNIT	3,057,878		3,057,878			31.00
40.00	04000	SUBPROVIDER - IPF	9,596,328		9,596,328			40.00
41.00	04100	SUBPROVIDER - IRF	2,180,321		2,180,321			41.00
43.00	04300	NURSERY	794,329		794,329			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,652,502	8,060,713	10,713,215	0.297140	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0.000000	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	701,997	81,638	783,635	1.151736	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,824,531	20,428,821	24,253,352	0.120838	0.000000	54.00
56.00	05600	RADIOISOTOPE	660,795	5,265,211	5,926,006	0.093339	0.000000	56.00
60.00	06000	LABORATORY	6,801,401	19,124,449	25,925,850	0.150479	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	527,269	388,598	915,867	0.329321	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0.000000	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	1,207,359	1,237,980	2,445,339	0.419309	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	797,212	3,163,803	3,961,015	0.508012	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	552,183	1,024,885	1,577,068	0.315208	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	83,788	300,649	384,437	0.639621	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	324,880	878,484	1,203,364	0.133551	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,654,246	4,521,048	6,175,294	0.359085	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	220,022	342,726	562,748	0.258789	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,497,807	8,145,384	13,643,191	0.330506	0.000000	73.00
76.00	03020	CARDIAC REHAB	138	229,842	229,980	1.838464	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	1,134,490	1,134,490			88.00
88.01	08801	RURAL HEALTH CLINIC II	0	1,313,326	1,313,326			88.01
88.02	08802	RURAL HEALTH CLINIC III	0	2,490,952	2,490,952			88.02
88.04	08803	RURAL HEALTH CLINIC V	0	1,507,818	1,507,818			88.04
88.05	08804	RURAL HEALTH CLINIC VI	0	752,444	752,444			88.05
90.00	09000	CLINIC	56,448	1,360,711	1,417,159	0.396391	0.000000	90.00
90.01	09001	ONCOLOGY	98	2,148,255	2,148,353	0.125516	0.000000	90.01
90.02	09002	PAIN MANAGEMENT	0	551,806	551,806	0.665013	0.000000	90.02
91.00	09100	EMERGENCY	1,446,743	8,688,097	10,134,840	0.353007	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	297,442	1,315,568	1,613,010	0.831261	0.000000	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	3,166	626,848	630,014	1.162984	0.000000	93.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0			99.10
101.00	10100	HOME HEALTH AGENCY	0	0	0			101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	1,302,840	1,302,840			116.00
200.00		Subtotal (see instructions)	45,590,097	96,387,386	141,977,483			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	45,590,097	96,387,386	141,977,483			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0061 | Period: From 01/01/2018 To 12/31/2018 | Worksheet C Part I Date/Time Prepared: 5/29/2019 4:30 pm

Title XVIII | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
40.00	04000	SUBPROVIDER - IPF		40.00
41.00	04100	SUBPROVIDER - IRF		41.00
43.00	04300	NURSERY		43.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.297140	50.00
51.00	05100	RECOVERY ROOM	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.151736	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.120838	54.00
56.00	05600	RADIOISOTOPE	0.093339	56.00
60.00	06000	LABORATORY	0.150479	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.329321	63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0.419309	65.00
66.00	06600	PHYSICAL THERAPY	0.508012	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.315208	67.00
68.00	06800	SPEECH PATHOLOGY	0.639621	68.00
69.00	06900	ELECTROCARDIOLOGY	0.133551	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.359085	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.258789	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.330506	73.00
76.00	03020	CARDIAC REHAB	1.838464	76.00
		OUTPATIENT SERVICE COST CENTERS		
88.00	08800	RURAL HEALTH CLINIC		88.00
88.01	08801	RURAL HEALTH CLINIC II		88.01
88.02	08802	RURAL HEALTH CLINIC III		88.02
88.04	08803	RURAL HEALTH CLINIC V		88.04
88.05	08804	RURAL HEALTH CLINIC VI		88.05
90.00	09000	CLINIC	0.401846	90.00
90.01	09001	ONCOLOGY	0.125516	90.01
90.02	09002	PAIN MANAGEMENT	0.665013	90.02
91.00	09100	EMERGENCY	0.353007	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.831261	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	1.176869	93.00
		OTHER REIMBURSABLE COST CENTERS		
99.10	09910	CORF		99.10
101.00	10100	HOME HEALTH AGENCY		101.00
		SPECIAL PURPOSE COST CENTERS		
113.00	11300	INTEREST EXPENSE		113.00
116.00	11600	HOSPICE		116.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0061 | Period: From 01/01/2018 To 12/31/2018 | Worksheet C Part I Date/Time Prepared: 5/29/2019 4:30 pm

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,989,193		3,989,193	0	3,989,193	30.00
31.00	03100	INTENSIVE CARE UNIT	1,213,868		1,213,868	0	1,213,868	31.00
40.00	04000	SUBPROVIDER - IPF	3,528,367		3,528,367	0	3,528,367	40.00
41.00	04100	SUBPROVIDER - IRF	1,516,375		1,516,375	0	1,516,375	41.00
43.00	04300	NURSERY	510,785		510,785	0	510,785	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,183,325		3,183,325	0	3,183,325	50.00
51.00	05100	RECOVERY ROOM	0		0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	902,541		902,541	0	902,541	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,930,737		2,930,737	0	2,930,737	54.00
56.00	05600	RADIOISOTOPE	553,130		553,130	0	553,130	56.00
60.00	06000	LABORATORY	3,901,306		3,901,306	0	3,901,306	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	301,614		301,614	0	301,614	63.00
64.00	06400	INTRAVENOUS THERAPY	0		0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	1,025,353	0	1,025,353	0	1,025,353	65.00
66.00	06600	PHYSICAL THERAPY	2,012,243	0	2,012,243	0	2,012,243	66.00
67.00	06700	OCCUPATIONAL THERAPY	497,105	0	497,105	0	497,105	67.00
68.00	06800	SPEECH PATHOLOGY	245,894	0	245,894	0	245,894	68.00
69.00	06900	ELECTROCARDIOLOGY	160,711		160,711	0	160,711	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,217,456		2,217,456	0	2,217,456	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	145,633		145,633	0	145,633	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,509,159		4,509,159	0	4,509,159	73.00
76.00	03020	CARDIAC REHAB	422,810		422,810	0	422,810	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,234,174		1,234,174	0	1,234,174	88.00
88.01	08801	RURAL HEALTH CLINIC II	1,317,349		1,317,349	0	1,317,349	88.01
88.02	08802	RURAL HEALTH CLINIC III	2,096,580		2,096,580	0	2,096,580	88.02
88.04	08803	RURAL HEALTH CLINIC V	1,545,875		1,545,875	0	1,545,875	88.04
88.05	08804	RURAL HEALTH CLINIC VI	840,579		840,579	0	840,579	88.05
90.00	09000	CLINIC	561,749		561,749	7,730	569,479	90.00
90.01	09001	ONCOLOGY	269,652		269,652	0	269,652	90.01
90.02	09002	PAIN MANAGEMENT	366,958		366,958	0	366,958	90.02
91.00	09100	EMERGENCY	3,577,670		3,577,670	0	3,577,670	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,340,833		1,340,833		1,340,833	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	732,696		732,696	8,748	741,444	93.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0		0		0	99.10
101.00	10100	HOME HEALTH AGENCY	0		0		0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	901,166		901,166		901,166	116.00
200.00		Subtotal (see instructions)	48,552,886	0	48,552,886	16,478	48,569,364	200.00
201.00		Less Observation Beds	1,340,833		1,340,833		1,340,833	201.00
202.00		Total (see instructions)	47,212,053	0	47,212,053	16,478	47,228,531	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0061 | Period: From 01/01/2018 To 12/31/2018 | Worksheet C Part I Date/Time Prepared: 5/29/2019 4:30 pm

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,651,214		2,651,214			30.00
31.00	03100	INTENSIVE CARE UNIT	3,057,878		3,057,878			31.00
40.00	04000	SUBPROVIDER - IPF	9,596,328		9,596,328			40.00
41.00	04100	SUBPROVIDER - IRF	2,180,321		2,180,321			41.00
43.00	04300	NURSERY	794,329		794,329			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,652,502	8,060,713	10,713,215	0.297140	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0.000000	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	701,997	81,638	783,635	1.151736	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,824,531	20,428,821	24,253,352	0.120838	0.000000	54.00
56.00	05600	RADIOISOTOPE	660,795	5,265,211	5,926,006	0.093339	0.000000	56.00
60.00	06000	LABORATORY	6,801,401	19,124,449	25,925,850	0.150479	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	527,269	388,598	915,867	0.329321	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0.000000	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	1,207,359	1,237,980	2,445,339	0.419309	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	797,212	3,163,803	3,961,015	0.508012	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	552,183	1,024,885	1,577,068	0.315208	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	83,788	300,649	384,437	0.639621	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	324,880	878,484	1,203,364	0.133551	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,654,246	4,521,048	6,175,294	0.359085	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	220,022	342,726	562,748	0.258789	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,497,807	8,145,384	13,643,191	0.330506	0.000000	73.00
76.00	03020	CARDIAC REHAB	138	229,842	229,980	1.838464	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	1,134,490	1,134,490	1.087867	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	1,313,326	1,313,326	1.003063	0.000000	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	2,490,952	2,490,952	0.841678	0.000000	88.02
88.04	08803	RURAL HEALTH CLINIC V	0	1,507,818	1,507,818	1.025240	0.000000	88.04
88.05	08804	RURAL HEALTH CLINIC VI	0	752,444	752,444	1.117132	0.000000	88.05
90.00	09000	CLINIC	56,448	1,360,711	1,417,159	0.396391	0.000000	90.00
90.01	09001	ONCOLOGY	98	2,148,255	2,148,353	0.125516	0.000000	90.01
90.02	09002	PAIN MANAGEMENT	0	551,806	551,806	0.665013	0.000000	90.02
91.00	09100	EMERGENCY	1,446,743	8,688,097	10,134,840	0.353007	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	297,442	1,315,568	1,613,010	0.831261	0.000000	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	3,166	626,848	630,014	1.162984	0.000000	93.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0			99.10
101.00	10100	HOME HEALTH AGENCY	0	0	0			101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	1,302,840	1,302,840			116.00
200.00		Subtotal (see instructions)	45,590,097	96,387,386	141,977,483			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	45,590,097	96,387,386	141,977,483			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0061 | Period: From 01/01/2018 To 12/31/2018 | Worksheet C Part I Date/Time Prepared: 5/29/2019 4:30 pm

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
40.00	04000	SUBPROVIDER - IPF			40.00
41.00	04100	SUBPROVIDER - IRF			41.00
43.00	04300	NURSERY			43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
51.00	05100	RECOVERY ROOM	0.000000		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
56.00	05600	RADIOISOTOPE	0.000000		56.00
60.00	06000	LABORATORY	0.000000		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000		63.00
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
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
76.00	03020	CARDIAC REHAB	0.000000		76.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	0.000000		88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000		88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000		88.02
88.04	08803	RURAL HEALTH CLINIC V	0.000000		88.04
88.05	08804	RURAL HEALTH CLINIC VI	0.000000		88.05
90.00	09000	CLINIC	0.000000		90.00
90.01	09001	ONCOLOGY	0.000000		90.01
90.02	09002	PAIN MANAGEMENT	0.000000		90.02
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0.000000		93.00
		OTHER REIMBURSABLE COST CENTERS			
99.10	09910	CORF			99.10
101.00	10100	HOME HEALTH AGENCY			101.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
116.00	11600	HOSPICE			116.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 15-0061 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part I Date/Time Prepared: 5/29/2019 4:30 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	368,127	0	368,127	5,150	71.48	30.00
31.00	INTENSIVE CARE UNIT	77,920		77,920	726	107.33	31.00
40.00	SUBPROVIDER - IPF	269,831	0	269,831	6,030	44.75	40.00
41.00	SUBPROVIDER - IRF	185,477	0	185,477	1,519	122.10	41.00
43.00	NURSERY	21,775		21,775	815	26.72	43.00
200.00	Total (lines 30 through 199)	923,130		923,130	14,240		200.00

	Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)	
		6.00	7.00	
	INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	ADULTS & PEDIATRICS	1,822	130,237	30.00
31.00	INTENSIVE CARE UNIT	436	46,796	31.00
40.00	SUBPROVIDER - IPF	5,090	227,778	40.00
41.00	SUBPROVIDER - IRF	1,265	154,457	41.00
43.00	NURSERY	0	0	43.00
200.00	Total (lines 30 through 199)	8,613	559,268	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-0061 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part II Date/Time Prepared: 5/29/2019 4:30 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	502,881	10,713,215	0.046940	699,128	32,817	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	181,353	783,635	0.231425	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	800,791	24,253,352	0.033018	2,146,874	70,885	54.00
56.00	05600	RADIOISOTOPE	45,944	5,926,006	0.007753	410,267	3,181	56.00
60.00	06000	LABORATORY	157,275	25,925,850	0.006066	3,343,842	20,284	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	10,755	915,867	0.011743	199,029	2,337	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0.000000	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	95,168	2,445,339	0.038918	638,913	24,865	65.00
66.00	06600	PHYSICAL THERAPY	135,115	3,961,015	0.034111	97,385	3,322	66.00
67.00	06700	OCCUPATIONAL THERAPY	29,396	1,577,068	0.018640	22,175	413	67.00
68.00	06800	SPEECH PATHOLOGY	20,099	384,437	0.052282	9,798	512	68.00
69.00	06900	ELECTROCARDIOLOGY	20,830	1,203,364	0.017310	160,850	2,784	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	74,326	6,175,294	0.012036	1,121,520	13,499	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1,359	562,748	0.002415	91,102	220	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	145,480	13,643,191	0.010663	1,315,276	14,025	73.00
76.00	03020	CARDIAC REHAB	99,726	229,980	0.433629	133	58	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	95,522	1,134,490	0.084198	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	70,693	1,313,326	0.053827	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	135,564	2,490,952	0.054423	0	0	88.02
88.04	08803	RURAL HEALTH CLINIC V	47,308	1,507,818	0.031375	0	0	88.04
88.05	08804	RURAL HEALTH CLINIC VI	51,158	752,444	0.067989	0	0	88.05
90.00	09000	CLINIC	73,583	1,417,159	0.051923	56,448	2,931	90.00
90.01	09001	ONCOLOGY	4,144	2,148,353	0.001929	0	0	90.01
90.02	09002	PAIN MANAGEMENT	32,062	551,806	0.058104	0	0	90.02
91.00	09100	EMERGENCY	168,113	10,134,840	0.016588	833,848	13,832	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	123,733	1,613,010	0.076709	197,790	15,172	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	105,732	630,014	0.167825	0	0	93.00
200.00		Total (lines 50 through 199)	3,228,110	122,394,573		11,344,378	221,137	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0061 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part III Date/Time Prepared: 5/29/2019 4:30 pm

Title XVIII | Hospital | PPS

		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
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
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	5,150	0.00	1,822	30.00
31.00	03100	INTENSIVE CARE UNIT		0	726	0.00	436	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	6,030	0.00	5,090	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	1,519	0.00	1,265	41.00
43.00	04300	NURSERY		0	815	0.00	0	43.00
200.00		Total (lines 30 through 199)		0	14,240		8,613	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
31.00	03100	INTENSIVE CARE UNIT	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	41.00
43.00	04300	NURSERY	0	43.00
200.00		Total (lines 30 through 199)	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0061 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part IV Date/Time Prepared: 5/29/2019 4:30 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
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
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	CARDIAC REHAB	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	0	88.02
88.04	08803	RURAL HEALTH CLINIC V	0	0	0	0	0	88.04
88.05	08804	RURAL HEALTH CLINIC VI	0	0	0	0	0	88.05
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	ONCOLOGY	0	0	0	0	0	90.01
90.02	09002	PAIN MANAGEMENT	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0		0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0061 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part IV Date/Time Prepared: 5/29/2019 4:30 pm

Title XVIII | Hospital | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	10,713,215	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	783,635	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	24,253,352	0.000000	54.00
56.00	05600	RADIOISOTOPE	0	0	0	5,926,006	0.000000	56.00
60.00	06000	LABORATORY	0	0	0	25,925,850	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	915,867	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	2,445,339	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	3,961,015	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,577,068	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	384,437	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	1,203,364	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	6,175,294	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	562,748	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	13,643,191	0.000000	73.00
76.00	03020	CARDIAC REHAB	0	0	0	229,980	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	1,134,490	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	1,313,326	0.000000	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	2,490,952	0.000000	88.02
88.04	08803	RURAL HEALTH CLINIC V	0	0	0	1,507,818	0.000000	88.04
88.05	08804	RURAL HEALTH CLINIC VI	0	0	0	752,444	0.000000	88.05
90.00	09000	CLINIC	0	0	0	1,417,159	0.000000	90.00
90.01	09001	ONCOLOGY	0	0	0	2,148,353	0.000000	90.01
90.02	09002	PAIN MANAGEMENT	0	0	0	551,806	0.000000	90.02
91.00	09100	EMERGENCY	0	0	0	10,134,840	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	1,613,010	0.000000	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	630,014	0.000000	93.00
200.00		Total (lines 50 through 199)	0	0	0	122,394,573		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0061 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part IV | Date/Time Prepared: 5/29/2019 4:30 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	699,128	0	2,613,305	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	2,146,874	0	6,105,094	0	54.00
56.00	05600	RADIOISOTOPE	0.000000	410,267	0	1,974,344	0	56.00
60.00	06000	LABORATORY	0.000000	3,343,842	0	2,560,020	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	199,029	0	126,695	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	638,913	0	611,423	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	97,385	0	12,427	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	22,175	0	3,906	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	9,798	0	395	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	160,850	0	313,569	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	1,121,520	0	1,118,407	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000	91,102	0	72,886	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	1,315,276	0	4,103,023	0	73.00
76.00	03020	CARDIAC REHAB	0.000000	133	0	128,819	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000	0	0	0	0	88.02
88.04	08803	RURAL HEALTH CLINIC V	0.000000	0	0	0	0	88.04
88.05	08804	RURAL HEALTH CLINIC VI	0.000000	0	0	0	0	88.05
90.00	09000	CLINIC	0.000000	56,448	0	590,999	0	90.00
90.01	09001	ONCOLOGY	0.000000	0	0	155,277	0	90.01
90.02	09002	PAIN MANAGEMENT	0.000000	0	0	0	0	90.02
91.00	09100	EMERGENCY	0.000000	833,848	0	1,869,066	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	197,790	0	436,379	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	616,734	0	93.00
200.00		Total (lines 50 through 199)		11,344,378	0	23,412,768	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0061 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part V Date/Time Prepared: 5/29/2019 4:30 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.297140	2,613,305	0	0	776,517	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.151736	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.120838	6,105,094	0	0	737,727	54.00
56.00	05600	RADIOISOTOPE	0.093339	1,974,344	0	0	184,283	56.00
60.00	06000	LABORATORY	0.150479	2,560,020	0	0	385,229	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.329321	126,695	0	0	41,723	63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.419309	611,423	0	0	256,375	65.00
66.00	06600	PHYSICAL THERAPY	0.508012	12,427	0	0	6,313	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.315208	3,906	0	0	1,231	67.00
68.00	06800	SPEECH PATHOLOGY	0.639621	395	0	0	253	68.00
69.00	06900	ELECTROCARDIOLOGY	0.133551	313,569	0	0	41,877	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.359085	1,118,407	0	0	401,603	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.258789	72,886	0	0	18,862	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.330506	4,103,023	0	2,549	1,356,074	73.00
76.00	03020	CARDIAC REHAB	1.838464	128,819	0	0	236,829	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000				0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000				0	88.02
88.04	08803	RURAL HEALTH CLINIC V	0.000000				0	88.04
88.05	08804	RURAL HEALTH CLINIC VI	0.000000				0	88.05
90.00	09000	CLINIC	0.396391	590,999	0	0	234,267	90.00
90.01	09001	ONCOLOGY	0.125516	155,277	0	0	19,490	90.01
90.02	09002	PAIN MANAGEMENT	0.665013	0	0	0	0	90.02
91.00	09100	EMERGENCY	0.353007	1,869,066	0	0	659,793	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.831261	436,379	0	0	362,745	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	1.162984	616,734	0	0	717,252	93.00
200.00		Subtotal (see instructions)		23,412,768	0	2,549	6,438,443	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		23,412,768	0	2,549	6,438,443	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0061 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part V Date/Time Prepared: 5/29/2019 4:30 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
56.00	05600	RADIOISOTOPE	0	0		56.00
60.00	06000	LABORATORY	0	0		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0		63.00
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
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	842		73.00
76.00	03020	CARDIAC REHAB	0	0		76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0		88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0		88.02
88.04	08803	RURAL HEALTH CLINIC V	0	0		88.04
88.05	08804	RURAL HEALTH CLINIC VI	0	0		88.05
90.00	09000	CLINIC	0	0		90.00
90.01	09001	ONCOLOGY	0	0		90.01
90.02	09002	PAIN MANAGEMENT	0	0		90.02
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0		93.00
200.00		Subtotal (see instructions)	0	842		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	842		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 15-0061 | Component CCN: 15-S061 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part II Date/Time Prepared: 5/29/2019 4:30 pm

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	502,881	10,713,215	0.046940	13,404	629	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	181,353	783,635	0.231425	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	800,791	24,253,352	0.033018	272,659	9,003	54.00
56.00	05600	RADIOISOTOPE	45,944	5,926,006	0.007753	12,444	96	56.00
60.00	06000	LABORATORY	157,275	25,925,850	0.006066	920,968	5,587	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	10,755	915,867	0.011743	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0.000000	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	95,168	2,445,339	0.038918	98,198	3,822	65.00
66.00	06600	PHYSICAL THERAPY	135,115	3,961,015	0.034111	78,792	2,688	66.00
67.00	06700	OCCUPATIONAL THERAPY	29,396	1,577,068	0.018640	4,401	82	67.00
68.00	06800	SPEECH PATHOLOGY	20,099	384,437	0.052282	9,963	521	68.00
69.00	06900	ELECTROCARDIOLOGY	20,830	1,203,364	0.017310	43,254	749	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	74,326	6,175,294	0.012036	83,295	1,003	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1,359	562,748	0.002415	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	145,480	13,643,191	0.010663	1,163,763	12,409	73.00
76.00	03020	CARDIAC REHAB	99,726	229,980	0.433629	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	95,522	1,134,490	0.084198	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	70,693	1,313,326	0.053827	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	135,564	2,490,952	0.054423	0	0	88.02
88.04	08803	RURAL HEALTH CLINIC V	47,308	1,507,818	0.031375	0	0	88.04
88.05	08804	RURAL HEALTH CLINIC VI	51,158	752,444	0.067989	0	0	88.05
90.00	09000	CLINIC	73,583	1,417,159	0.051923	0	0	90.00
90.01	09001	ONCOLOGY	4,144	2,148,353	0.001929	0	0	90.01
90.02	09002	PAIN MANAGEMENT	32,062	551,806	0.058104	0	0	90.02
91.00	09100	EMERGENCY	168,113	10,134,840	0.016588	122,444	2,031	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	1,613,010	0.000000	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	105,732	630,014	0.167825	2,965	498	93.00
200.00		Total (lines 50 through 199)	3,104,377	122,394,573		2,826,550	39,118	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0061 | Component CCN: 15-S061 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part IV Date/Time Prepared: 5/29/2019 4:30 pm

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
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
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	CARDIAC REHAB	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	0	88.02
88.04	08803	RURAL HEALTH CLINIC V	0	0	0	0	0	88.04
88.05	08804	RURAL HEALTH CLINIC VI	0	0	0	0	0	88.05
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	ONCOLOGY	0	0	0	0	0	90.01
90.02	09002	PAIN MANAGEMENT	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0		0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0061 | Component CCN: 15-S061 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part IV | Date/Time Prepared: 5/29/2019 4:30 pm

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	10,713,215	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	783,635	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	24,253,352	0.000000	54.00
56.00	05600	RADIOISOTOPE	0	0	0	5,926,006	0.000000	56.00
60.00	06000	LABORATORY	0	0	0	25,925,850	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	915,867	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	2,445,339	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	3,961,015	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,577,068	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	384,437	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	1,203,364	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	6,175,294	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	562,748	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	13,643,191	0.000000	73.00
76.00	03020	CARDIAC REHAB	0	0	0	229,980	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	1,134,490	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	1,313,326	0.000000	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	2,490,952	0.000000	88.02
88.04	08803	RURAL HEALTH CLINIC V	0	0	0	1,507,818	0.000000	88.04
88.05	08804	RURAL HEALTH CLINIC VI	0	0	0	752,444	0.000000	88.05
90.00	09000	CLINIC	0	0	0	1,417,159	0.000000	90.00
90.01	09001	ONCOLOGY	0	0	0	2,148,353	0.000000	90.01
90.02	09002	PAIN MANAGEMENT	0	0	0	551,806	0.000000	90.02
91.00	09100	EMERGENCY	0	0	0	10,134,840	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	1,613,010	0.000000	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	630,014	0.000000	93.00
200.00		Total (lines 50 through 199)	0	0	0	122,394,573		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0061 | Component CCN: 15-S061 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part IV Date/Time Prepared: 5/29/2019 4:30 pm

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	13,404	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	272,659	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0.000000	12,444	0	0	0	56.00
60.00	06000	LABORATORY	0.000000	920,968	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	98,198	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	78,792	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	4,401	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	9,963	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	43,254	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	83,295	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	1,163,763	0	0	0	73.00
76.00	03020	CARDIAC REHAB	0.000000	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000	0	0	0	0	88.02
88.04	08803	RURAL HEALTH CLINIC V	0.000000	0	0	0	0	88.04
88.05	08804	RURAL HEALTH CLINIC VI	0.000000	0	0	0	0	88.05
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	ONCOLOGY	0.000000	0	0	0	0	90.01
90.02	09002	PAIN MANAGEMENT	0.000000	0	0	0	0	90.02
91.00	09100	EMERGENCY	0.000000	122,444	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	2,965	0	0	0	93.00
200.00		Total (lines 50 through 199)		2,826,550	0	0	0	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 15-0061 | Component CCN: 15-T061 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part II Date/Time Prepared: 5/29/2019 4:30 pm

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	502,881	10,713,215	0.046940	175	8	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	181,353	783,635	0.231425	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	800,791	24,253,352	0.033018	45,033	1,487	54.00
56.00	05600	RADIOISOTOPE	45,944	5,926,006	0.007753	3,962	31	56.00
60.00	06000	LABORATORY	157,275	25,925,850	0.006066	159,526	968	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	10,755	915,867	0.011743	5,654	66	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0.000000	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	95,168	2,445,339	0.038918	164,754	6,412	65.00
66.00	06600	PHYSICAL THERAPY	135,115	3,961,015	0.034111	474,340	16,180	66.00
67.00	06700	OCCUPATIONAL THERAPY	29,396	1,577,068	0.018640	433,877	8,087	67.00
68.00	06800	SPEECH PATHOLOGY	20,099	384,437	0.052282	25,064	1,310	68.00
69.00	06900	ELECTROCARDIOLOGY	20,830	1,203,364	0.017310	1,720	30	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	74,326	6,175,294	0.012036	125,622	1,512	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1,359	562,748	0.002415	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	145,480	13,643,191	0.010663	228,828	2,440	73.00
76.00	03020	CARDIAC REHAB	99,726	229,980	0.433629	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	95,522	1,134,490	0.084198	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	70,693	1,313,326	0.053827	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	135,564	2,490,952	0.054423	0	0	88.02
88.04	08803	RURAL HEALTH CLINIC V	47,308	1,507,818	0.031375	0	0	88.04
88.05	08804	RURAL HEALTH CLINIC VI	51,158	752,444	0.067989	0	0	88.05
90.00	09000	CLINIC	73,583	1,417,159	0.051923	0	0	90.00
90.01	09001	ONCOLOGY	4,144	2,148,353	0.001929	0	0	90.01
90.02	09002	PAIN MANAGEMENT	32,062	551,806	0.058104	0	0	90.02
91.00	09100	EMERGENCY	168,113	10,134,840	0.016588	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	1,613,010	0.000000	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	105,732	630,014	0.167825	0	0	93.00
200.00		Total (lines 50 through 199)	3,104,377	122,394,573		1,668,555	38,531	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0061 | Component CCN: 15-T061 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part IV Date/Time Prepared: 5/29/2019 4:30 pm

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
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
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	CARDIAC REHAB	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	0	88.02
88.04	08803	RURAL HEALTH CLINIC V	0	0	0	0	0	88.04
88.05	08804	RURAL HEALTH CLINIC VI	0	0	0	0	0	88.05
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	ONCOLOGY	0	0	0	0	0	90.01
90.02	09002	PAIN MANAGEMENT	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0		0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0061 | Component CCN: 15-T061 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part IV | Date/Time Prepared: 5/29/2019 4:30 pm

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	10,713,215	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	783,635	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	24,253,352	0.000000	54.00
56.00	05600	RADIOISOTOPE	0	0	0	5,926,006	0.000000	56.00
60.00	06000	LABORATORY	0	0	0	25,925,850	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	915,867	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	2,445,339	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	3,961,015	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,577,068	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	384,437	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	1,203,364	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	6,175,294	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	562,748	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	13,643,191	0.000000	73.00
76.00	03020	CARDIAC REHAB	0	0	0	229,980	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	1,134,490	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	1,313,326	0.000000	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	2,490,952	0.000000	88.02
88.04	08803	RURAL HEALTH CLINIC V	0	0	0	1,507,818	0.000000	88.04
88.05	08804	RURAL HEALTH CLINIC VI	0	0	0	752,444	0.000000	88.05
90.00	09000	CLINIC	0	0	0	1,417,159	0.000000	90.00
90.01	09001	ONCOLOGY	0	0	0	2,148,353	0.000000	90.01
90.02	09002	PAIN MANAGEMENT	0	0	0	551,806	0.000000	90.02
91.00	09100	EMERGENCY	0	0	0	10,134,840	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	1,613,010	0.000000	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	630,014	0.000000	93.00
200.00		Total (lines 50 through 199)	0	0	0	122,394,573		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0061 | Component CCN: 15-T061 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part IV Date/Time Prepared: 5/29/2019 4:30 pm

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	175	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	45,033	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0.000000	3,962	0	0	0	56.00
60.00	06000	LABORATORY	0.000000	159,526	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	5,654	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	164,754	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	474,340	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	433,877	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	25,064	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	1,720	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	125,622	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	228,828	0	0	0	73.00
76.00	03020	CARDIAC REHAB	0.000000	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000	0	0	0	0	88.02
88.04	08803	RURAL HEALTH CLINIC V	0.000000	0	0	0	0	88.04
88.05	08804	RURAL HEALTH CLINIC VI	0.000000	0	0	0	0	88.05
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	ONCOLOGY	0.000000	0	0	0	0	90.01
90.02	09002	PAIN MANAGEMENT	0.000000	0	0	0	0	90.02
91.00	09100	EMERGENCY	0.000000	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	0	0	93.00
200.00		Total (lines 50 through 199)		1,668,555	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0061 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part V Date/Time Prepared: 5/29/2019 4:30 pm

Title XIX | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.297140	0	146,573	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.151736	0	1,484	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.120838	0	371,471	0	0	54.00
56.00	05600	RADIOISOTOPE	0.093339	0	95,741	0	0	56.00
60.00	06000	LABORATORY	0.150479	0	347,752	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.329321	0	7,066	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.419309	0	22,511	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.508012	0	57,546	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.315208	0	18,645	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.639621	0	5,467	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.133551	0	15,974	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.359085	0	82,209	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.258789	0	6,232	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.330506	0	148,113	0	0	73.00
76.00	03020	CARDIAC REHAB	1.838464	0	4,179	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1.087867				0	88.00
88.01	08801	RURAL HEALTH CLINIC II	1.003063				0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0.841678				0	88.02
88.04	08803	RURAL HEALTH CLINIC V	1.025240				0	88.04
88.05	08804	RURAL HEALTH CLINIC VI	1.117132				0	88.05
90.00	09000	CLINIC	0.396391	0	25,769	0	0	90.00
90.01	09001	ONCOLOGY	0.125516	0	39,063	0	0	90.01
90.02	09002	PAIN MANAGEMENT	0.665013	0	10,034	0	0	90.02
91.00	09100	EMERGENCY	0.353007	0	159,323	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.831261	0	23,922	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	1.162984	0	10,114	0	0	93.00
200.00		Subtotal (see instructions)		0	1,599,188	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	1,599,188	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0061 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part V Date/Time Prepared: 5/29/2019 4:30 pm

Title XIX | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	43,553	0		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,709	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	44,888	0		54.00
56.00	05600	RADIOISOTOPE	8,936	0		56.00
60.00	06000	LABORATORY	52,329	0		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	2,327	0		63.00
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	9,439	0		65.00
66.00	06600	PHYSICAL THERAPY	29,234	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	5,877	0		67.00
68.00	06800	SPEECH PATHOLOGY	3,497	0		68.00
69.00	06900	ELECTROCARDIOLOGY	2,133	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	29,520	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1,613	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	48,952	0		73.00
76.00	03020	CARDIAC REHAB	7,683	0		76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0		88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0		88.02
88.04	08803	RURAL HEALTH CLINIC V	0	0		88.04
88.05	08804	RURAL HEALTH CLINIC VI	0	0		88.05
90.00	09000	CLINIC	10,215	0		90.00
90.01	09001	ONCOLOGY	4,903	0		90.01
90.02	09002	PAIN MANAGEMENT	6,673	0		90.02
91.00	09100	EMERGENCY	56,242	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	19,885	0		92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	11,762	0		93.00
200.00		Subtotal (see instructions)	401,370	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	401,370	0		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0061 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-1 | Date/Time Prepared: 5/29/2019 4:30 pm

Title XVIII | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	5,150	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	5,150	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)	3,419	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	1,822	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	3,989,193	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	3,989,193	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)	3,989,193	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)	774.60	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,411,321	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	1,411,321	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0061 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-1 | Date/Time Prepared: 5/29/2019 4:30 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	1,213,868	726	1,671.99	436	728,988	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)	2,768,994	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	4,909,303	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)	177,033	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	221,137	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	398,170	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	4,511,133	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	1,731	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	774.60	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,340,833	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0061 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-1 | Date/Time Prepared: 5/29/2019 4:30 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	368,127	3,989,193	0.092281	1,340,833	123,733	90.00
91.00	Nursing School cost	0	3,989,193	0.000000	1,340,833	0	91.00
92.00	Allied health cost	0	3,989,193	0.000000	1,340,833	0	92.00
93.00	All other Medical Education	0	3,989,193	0.000000	1,340,833	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0061 Component CCN: 15-S061	Period: From 01/01/2018 To 12/31/2018	Worksheet D-1 Date/Time Prepared: 5/29/2019 4:30 pm
	Title XVIII	Subprovider - IPF	PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	6,030	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	6,030	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	6,030	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	5,090	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	3,528,367	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	3,528,367	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)	3,528,367	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)	585.14	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	2,978,363	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)	2,978,363	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0061 | Component CCN: 15-S061 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-1 | Date/Time Prepared: 5/29/2019 4:30 pm

Title XVIII | Subprovider - IPF | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	732,672	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	3,711,035	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)	227,778	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	39,118	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	266,896	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	3,444,139	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0061 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-1

Component CCN: 15-S061 | Date/Time Prepared: 5/29/2019 4:30 pm

Title XVIII | Subprovider - IPF | PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	269,831	3,528,367	0.076475	0	0	90.00
91.00	Nursing School cost	0	3,528,367	0.000000	0	0	91.00
92.00	Allied health cost	0	3,528,367	0.000000	0	0	92.00
93.00	All other Medical Education	0	3,528,367	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0061 Component CCN: 15-T061	Period: From 01/01/2018 To 12/31/2018	Worksheet D-1 Date/Time Prepared: 5/29/2019 4:30 pm
	Title XVIII	Subprovider - IRF	PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	1,519	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,519	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)	1,519	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	1,265	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	1,516,375	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	1,516,375	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)	1,516,375	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)	998.27	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,262,812	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	1,262,812	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0061 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-1

Component CCN: 15-T061 | Date/Time Prepared: 5/29/2019 4:30 pm

Title XVIII | Subprovider - IRF | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	615,545	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	1,878,357	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	154,457	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	38,531	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	192,988	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	1,685,369	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0061 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-1

Component CCN: 15-T061 | Date/Time Prepared: 5/29/2019 4:30 pm

Title XVIII | Subprovider - IRF | PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	185,477	1,516,375	0.122316	0	0	90.00
91.00	Nursing School cost	0	1,516,375	0.000000	0	0	91.00
92.00	Allied health cost	0	1,516,375	0.000000	0	0	92.00
93.00	All other Medical Education	0	1,516,375	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0061 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-1 | Date/Time Prepared: 5/29/2019 4:30 pm

Title XIX | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	5,150	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	5,150	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)	3,419	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	113	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	815	15.00
16.00	Nursery days (title V or XIX only)	28	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	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	3,989,193	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	3,989,193	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)	3,989,193	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)	774.60	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	87,530	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)	87,530	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0061 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-1 | Date/Time Prepared: 5/29/2019 4:30 pm

Title XIX | 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)	510,785	815	626.73	28	17,548	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	1,213,868	726	1,671.99	25	41,800	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)	314,176	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	461,054	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	1,731	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	774.60	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,340,833	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0061 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-1 | Date/Time Prepared: 5/29/2019 4:30 pm

Title XIX | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	368,127	3,989,193	0.092281	1,340,833	123,733	90.00
91.00	Nursing School cost	0	3,989,193	0.000000	1,340,833	0	91.00
92.00	Allied health cost	0	3,989,193	0.000000	1,340,833	0	92.00
93.00	All other Medical Education	0	3,989,193	0.000000	1,340,833	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0061 Component CCN: 15-S061	Period: From 01/01/2018 To 12/31/2018	Worksheet D-1 Date/Time Prepared: 5/29/2019 4:30 pm
	Title XIX	Subprovider - IPF	Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	6,030	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	6,030	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	6,030	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	254	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	815	15.00
16.00	Nursery days (title V or XIX only)	28	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	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	3,528,367	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	3,528,367	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)	3,528,367	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)	585.14	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	148,626	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)	148,626	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0061 | Component CCN: 15-S061 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-1 | Date/Time Prepared: 5/29/2019 4:30 pm

Title XIX | Subprovider - IPF | 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)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	25,141	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	173,767	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0061 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-1

Component CCN: 15-S061 | Date/Time Prepared: 5/29/2019 4:30 pm

Title XIX | Subprovider - IPF | Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	269,831	3,528,367	0.076475	0	0	90.00
91.00	Nursing School cost	0	3,528,367	0.000000	0	0	91.00
92.00	Allied health cost	0	3,528,367	0.000000	0	0	92.00
93.00	All other Medical Education	0	3,528,367	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0061 Component CCN: 15-T061	Period: From 01/01/2018 To 12/31/2018	Worksheet D-1 Date/Time Prepared: 5/29/2019 4:30 pm
	Title XIX	Subprovider - IRF	Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	1,519	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,519	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)	1,519	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	0	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	815	15.00
16.00	Nursery days (title V or XIX only)	28	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	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	1,516,375	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	1,516,375	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)	1,516,375	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)	998.27	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	0	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)	0	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0061 | Component CCN: 15-T061 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-1 | Date/Time Prepared: 5/29/2019 4:30 pm

Title XIX | Subprovider - IRF | 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)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	15,117	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	15,117	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0061 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-1

Component CCN: 15-T061 | Date/Time Prepared: 5/29/2019 4:30 pm

Title XIX | Subprovider - IRF | Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	185,477	1,516,375	0.122316	0	0	90.00
91.00	Nursing School cost	0	1,516,375	0.000000	0	0	91.00
92.00	Allied health cost	0	1,516,375	0.000000	0	0	92.00
93.00	All other Medical Education	0	1,516,375	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0061 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-3 | Date/Time Prepared: 5/29/2019 4:30 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		835,294		30.00
31.00	03100	INTENSIVE CARE UNIT		2,095,641		31.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.297140	699,128	207,739	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.151736	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.120838	2,146,874	259,424	54.00
56.00	05600	RADIOISOTOPE	0.093339	410,267	38,294	56.00
60.00	06000	LABORATORY	0.150479	3,343,842	503,178	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.329321	199,029	65,544	63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.419309	638,913	267,902	65.00
66.00	06600	PHYSICAL THERAPY	0.508012	97,385	49,473	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.315208	22,175	6,990	67.00
68.00	06800	SPEECH PATHOLOGY	0.639621	9,798	6,267	68.00
69.00	06900	ELECTROCARDIOLOGY	0.133551	160,850	21,482	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.359085	1,121,520	402,721	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.258789	91,102	23,576	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.330506	1,315,276	434,707	73.00
76.00	03020	CARDIAC REHAB	1.838464	133	245	76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000		0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000		0	88.02
88.04	08803	RURAL HEALTH CLINIC V	0.000000		0	88.04
88.05	08804	RURAL HEALTH CLINIC VI	0.000000		0	88.05
90.00	09000	CLINIC	0.401846	56,448	22,683	90.00
90.01	09001	ONCOLOGY	0.125516	0	0	90.01
90.02	09002	PAIN MANAGEMENT	0.665013	0	0	90.02
91.00	09100	EMERGENCY	0.353007	833,848	294,354	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.831261	197,790	164,415	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	1.176869	0	0	93.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		11,344,378	2,768,994	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)		11,344,378		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-0061 | Component CCN: 15-S061 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-3 | Date/Time Prepared: 5/29/2019 4:30 pm

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
40.00	04000	SUBPROVIDER - IPF		8,103,900		40.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.297140	13,404	3,983	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.151736	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.120838	272,659	32,948	54.00
56.00	05600	RADIOISOTOPE	0.093339	12,444	1,162	56.00
60.00	06000	LABORATORY	0.150479	920,968	138,586	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.329321	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.419309	98,198	41,175	65.00
66.00	06600	PHYSICAL THERAPY	0.508012	78,792	40,027	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.315208	4,401	1,387	67.00
68.00	06800	SPEECH PATHOLOGY	0.639621	9,963	6,373	68.00
69.00	06900	ELECTROCARDIOLOGY	0.133551	43,254	5,777	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.359085	83,295	29,910	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.258789	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.330506	1,163,763	384,631	73.00
76.00	03020	CARDIAC REHAB	1.838464	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000		0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000		0	88.02
88.04	08803	RURAL HEALTH CLINIC V	0.000000		0	88.04
88.05	08804	RURAL HEALTH CLINIC VI	0.000000		0	88.05
90.00	09000	CLINIC	0.401846	0	0	90.00
90.01	09001	ONCOLOGY	0.125516	0	0	90.01
90.02	09002	PAIN MANAGEMENT	0.665013	0	0	90.02
91.00	09100	EMERGENCY	0.353007	122,444	43,224	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.831261	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	1.176869	2,965	3,489	93.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		2,826,550	732,672	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)		2,826,550		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-0061 | Component CCN: 15-T061 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-3 | Date/Time Prepared: 5/29/2019 4:30 pm

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
41.00	04100	SUBPROVIDER - IRF		1,800,728		41.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.297140	175	52	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.151736	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.120838	45,033	5,442	54.00
56.00	05600	RADIOISOTOPE	0.093339	3,962	370	56.00
60.00	06000	LABORATORY	0.150479	159,526	24,005	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.329321	5,654	1,862	63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.419309	164,754	69,083	65.00
66.00	06600	PHYSICAL THERAPY	0.508012	474,340	240,970	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.315208	433,877	136,762	67.00
68.00	06800	SPEECH PATHOLOGY	0.639621	25,064	16,031	68.00
69.00	06900	ELECTROCARDIOLOGY	0.133551	1,720	230	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.359085	125,622	45,109	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.258789	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.330506	228,828	75,629	73.00
76.00	03020	CARDIAC REHAB	1.838464	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000		0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000		0	88.02
88.04	08803	RURAL HEALTH CLINIC V	0.000000		0	88.04
88.05	08804	RURAL HEALTH CLINIC VI	0.000000		0	88.05
90.00	09000	CLINIC	0.401846	0	0	90.00
90.01	09001	ONCOLOGY	0.125516	0	0	90.01
90.02	09002	PAIN MANAGEMENT	0.665013	0	0	90.02
91.00	09100	EMERGENCY	0.353007	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.831261	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	1.176869	0	0	93.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		1,668,555	615,545	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)		1,668,555		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0061 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-3 | Date/Time Prepared: 5/29/2019 4:30 pm

Title XIX | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		107,820		30.00
31.00	03100	INTENSIVE CARE UNIT		124,358		31.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
43.00	04300	NURSERY		32,304		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.297140	107,872	32,053	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.151736	28,549	32,881	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.120838	155,536	18,795	54.00
56.00	05600	RADIOISOTOPE	0.093339	26,873	2,508	56.00
60.00	06000	LABORATORY	0.150479	276,599	41,622	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.329321	21,443	7,062	63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.419309	49,101	20,588	65.00
66.00	06600	PHYSICAL THERAPY	0.508012	32,366	16,442	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.315208	22,455	7,078	67.00
68.00	06800	SPEECH PATHOLOGY	0.639621	3,407	2,179	68.00
69.00	06900	ELECTROCARDIOLOGY	0.133551	13,212	1,764	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.359085	67,275	24,157	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.258789	8,948	2,316	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.330506	223,585	73,896	73.00
76.00	03020	CARDIAC REHAB	1.838464	5	9	76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	1.087867	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	1.003063	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0.841678	0	0	88.02
88.04	08803	RURAL HEALTH CLINIC V	1.025240	0	0	88.04
88.05	08804	RURAL HEALTH CLINIC VI	1.117132	0	0	88.05
90.00	09000	CLINIC	0.396391	0	0	90.00
90.01	09001	ONCOLOGY	0.125516	4	1	90.01
90.02	09002	PAIN MANAGEMENT	0.665013	0	0	90.02
91.00	09100	EMERGENCY	0.353007	58,836	20,770	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.831261	12,096	10,055	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	1.162984	0	0	93.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		1,108,162	314,176	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)		1,108,162		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-0061 | Component CCN: 15-S061 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-3 | Date/Time Prepared: 5/29/2019 4:30 pm

Title XIX | Subprovider - IPF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
40.00	04000	SUBPROVIDER - IPF		294,192		40.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
43.00	04300	NURSERY		0		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.297140	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.151736	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.120838	8,884	1,074	54.00
56.00	05600	RADIOISOTOPE	0.093339	480	45	56.00
60.00	06000	LABORATORY	0.150479	31,489	4,738	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.329321	77	25	63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.419309	5,628	2,360	65.00
66.00	06600	PHYSICAL THERAPY	0.508012	2,576	1,309	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.315208	168	53	67.00
68.00	06800	SPEECH PATHOLOGY	0.639621	320	205	68.00
69.00	06900	ELECTROCARDIOLOGY	0.133551	1,631	218	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.359085	1,289	463	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.258789	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.330506	39,051	12,907	73.00
76.00	03020	CARDIAC REHAB	1.838464	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	1.087867	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	1.003063	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0.841678	0	0	88.02
88.04	08803	RURAL HEALTH CLINIC V	1.025240	0	0	88.04
88.05	08804	RURAL HEALTH CLINIC VI	1.117132	0	0	88.05
90.00	09000	CLINIC	0.396391	0	0	90.00
90.01	09001	ONCOLOGY	0.125516	0	0	90.01
90.02	09002	PAIN MANAGEMENT	0.665013	0	0	90.02
91.00	09100	EMERGENCY	0.353007	4,277	1,510	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.831261	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	1.162984	201	234	93.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		96,071	25,141	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)		96,071		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-0061 | Component CCN: 15-T061 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-3 | Date/Time Prepared: 5/29/2019 4:30 pm

Title XIX | Subprovider - IRF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
41.00	04100	SUBPROVIDER - IRF		47,979		41.00
43.00	04300	NURSERY		0		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.297140	11	3	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.151736	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.120838	1,215	147	54.00
56.00	05600	RADIOISOTOPE	0.093339	111	10	56.00
60.00	06000	LABORATORY	0.150479	3,745	564	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.329321	457	150	63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.419309	5,651	2,370	65.00
66.00	06600	PHYSICAL THERAPY	0.508012	11,753	5,971	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.315208	10,617	3,347	67.00
68.00	06800	SPEECH PATHOLOGY	0.639621	614	393	68.00
69.00	06900	ELECTROCARDIOLOGY	0.133551	50	7	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.359085	618	222	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.258789	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.330506	5,848	1,933	73.00
76.00	03020	CARDIAC REHAB	1.838464	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	1.087867	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	1.003063	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0.841678	0	0	88.02
88.04	08803	RURAL HEALTH CLINIC V	1.025240	0	0	88.04
88.05	08804	RURAL HEALTH CLINIC VI	1.117132	0	0	88.05
90.00	09000	CLINIC	0.396391	0	0	90.00
90.01	09001	ONCOLOGY	0.125516	0	0	90.01
90.02	09002	PAIN MANAGEMENT	0.665013	0	0	90.02
91.00	09100	EMERGENCY	0.353007	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.831261	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	1.162984	0	0	93.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		40,690	15,117	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)		40,690		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0061	Period: From 01/01/2018 To 12/31/2018	Worksheet E Part A Date/Time Prepared: 5/29/2019 4:30 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS		
1.00	DRG Amounts Other than Outlier Payments	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)	2,899,502	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	910,642	1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)	0	1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)	0	1.04
2.00	Outlier payments for discharges. (see instructions)	5,965	2.00
2.01	Outlier reconciliation amount	0	2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)	0	2.02
3.00	Managed Care Simulated Payments	308,129	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)	37.18	4.00
	Indirect Medical Education Adjustment		
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)	0.00	5.00
6.00	FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)	0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)	0.00	7.00
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.	0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).	0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.	0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)	0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see instructions)	0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records	0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.	0.00	11.00
12.00	Current year allowable FTE (see instructions)	0.00	12.00
13.00	Total allowable FTE count for the prior year.	0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.	0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.	0.00	15.00
16.00	Adjustment for residents in initial years of the program	0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure	0.00	17.00
18.00	Adjusted rolling average FTE count	0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).	0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)	0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)	0.000000	21.00
22.00	IME payment adjustment (see instructions)	0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)	0	22.01
	Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA		
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C).	0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)	0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)	0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)	0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)	0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)	0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)	0	28.01
29.00	Total IME payment (sum of lines 22 and 28)	0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)	0	29.01
	Disproportionate Share Adjustment		
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	3.33	30.00
31.00	Percentage of Medicaid patient days (see instructions)	27.77	31.00
32.00	Sum of lines 30 and 31	31.10	32.00
33.00	Allowable disproportionate share percentage (see instructions)	12.00	33.00
34.00	Disproportionate share adjustment (see instructions)	114,304	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-0061 | Period: From 01/01/2018 To 12/31/2018 | Worksheet E Part A Date/Time Prepared: 5/29/2019 4:30 pm

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		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	Uncompensated Care Adjustment			
35.00	Total uncompensated care amount (see instructions)	6,766,695,164	8,272,872,447	35.00
35.01	Factor 3 (see instructions)	0.000052342	0.000053319	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	354,184	441,099	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	264,910	111,181	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	376,091		36.00
	Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)			
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)	0		40.00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0		41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0		41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)	0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)	0.00		45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)	0		46.00
47.00	Subtotal (see instructions)	4,306,504		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)	0		48.00

		Amount	
		1.00	
49.00	Total payment for inpatient operating costs (see instructions)	4,306,504	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)	305,063	50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)	0	51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).	0	52.00
53.00	Nursing and Allied Health Managed Care payment	0	53.00
54.00	Special add-on payments for new technologies	0	54.00
54.01	Islet isolation add-on payment	0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)	0	55.00
56.00	Cost of physicians' services in a teaching hospital (see intructions)	0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).	0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)	0	58.00
59.00	Total (sum of amounts on lines 49 through 58)	4,611,567	59.00
60.00	Primary payer payments	0	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)	4,611,567	61.00
62.00	Deductibles billed to program beneficiaries	612,260	62.00
63.00	Coinsurance billed to program beneficiaries	9,715	63.00
64.00	Allowable bad debts (see instructions)	86,627	64.00
65.00	Adjusted reimbursable bad debts (see instructions)	56,308	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	47,187	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	4,045,900	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)	0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96).(For SCH see instructions)	0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	70.00
70.50	Rural Community Hospital Demonstration Project (§410A Demonstration) adjustment (see instructions)	0	70.50
70.87	Demonstration payment adjustment amount before sequestration	0	70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)	0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)		70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)	0	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)	0	70.91
70.92	Bundled Model 1 discount amount (see instructions)	0	70.92
70.93	HVBP payment adjustment amount (see instructions)	-171	70.93
70.94	HRR adjustment amount (see instructions)	-8,605	70.94
70.95	Recovery of accelerated depreciation	0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0061	Period: From 01/01/2018 To 12/31/2018	Worksheet E Part A Date/Time Prepared: 5/29/2019 4:30 pm
	Title XVIII	Hospital	PPS

		FFY (yyyy)	Amount	
		0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	2018	495,340	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	2019	222,746	70.97
70.98	Low Volume Payment-3		0	70.98
70.99	HAC adjustment amount (see instructions)		0	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		4,755,210	71.00
71.01	Sequestration adjustment (see instructions)		95,104	71.01
71.02	Demonstration payment adjustment amount after sequestration		0	71.02
72.00	Interim payments		4,590,694	72.00
73.00	Tentative settlement (for contractor use only)		0	73.00
74.00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 73)		69,412	74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	75.00
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)			
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)		0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00
95.00	Time value of money for operating expenses (see instructions)		0	95.00
96.00	Time value of money for capital related expenses (see instructions)		0	96.00

		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	HSP Bonus Payment Amount			
100.00	HSP bonus amount (see instructions)	0	0	100.00
	HVBP Adjustment for HSP Bonus Payment			
101.00	HVBP adjustment factor (see instructions)	0.0000000000	0.0000000000	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)	0	0	102.00
	HRR Adjustment for HSP Bonus Payment			
103.00	HRR adjustment factor (see instructions)	0.0000	0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)	0	0	104.00
	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 inpatient service costs (from Wkst. D-1, Pt. II, line 49)			201.00
202.00	Medicare discharges (see instructions)			202.00
203.00	Case-mix adjustment factor (see instructions)			203.00
	Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)			
204.00	Medicare target amount			204.00
205.00	Case-mix adjusted target amount (line 203 times line 204)			205.00
206.00	Medicare inpatient routine cost cap (line 202 times line 205)			206.00
	Adjustment to Medicare Part A Inpatient Reimbursement			
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)			208.00
209.00	Adjustment to Medicare IPPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
211.00	Total adjustment to Medicare IPPS payments (see instructions)			211.00
	Comparision of PPS versus Cost Reimbursement			
212.00	Total adjustment to Medicare Part A IPPS payments (from line 211)			212.00
213.00	Low-volume adjustment (see instructions)			213.00
218.00	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)			218.00

LOW VOLUME CALCULATION EXHIBIT 4 | Provider CCN: 15-0061 | Period: From 01/01/2018 To 12/31/2018 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 5/29/2019 4:30 pm

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		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	2,899,502	0	2,899,502		2,899,502	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	910,642	0		910,642	910,642	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00	5,965	0	5,965	0	5,965	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0	2.01
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	308,129	0	308,129	0	308,129	4.00
	Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	0	6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	0	9.01
	Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.1200	0.1200	0.1200	0.1200		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	114,304	0	86,985	27,319	114,304	11.00
11.01	Uncompensated care payments	36.00	376,091	0	264,909	111,182	376,091	11.01
	Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	4,306,504	0	3,257,361	1,049,143	4,306,504	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	4,306,504	0	3,257,361	1,049,143	4,306,504	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	305,063	0	-76,273	381,336	305,063	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	0	17.00
17.01	Net organ aquisition cost							17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0	17.02

LOW VOLUME CALCULATION EXHIBIT 4 | Provider CCN: 15-0061 | Period: From 01/01/2018 To 12/31/2018 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 5/29/2019 4:30 pm

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		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0	18.00
19.00	SUBTOTAL			0	3,181,088	1,430,479	4,611,567	19.00
		W/S L, line	(Amounts from L)					
		0	1.00	2.00	3.00	4.00	5.00	
20.00	Capital DRG other than outlier	1.00	304,234	0	-76,684	380,918	304,234	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	829	0	620	209	829	20.01
21.00	Capital DRG outlier payments	2.00	0	0	-209	209	0	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	305,063	0	-76,273	381,336	305,063	26.00
		W/S E, Part A line	(Amounts to E, Part A)					
		0	1.00	2.00	3.00	4.00	5.00	
27.00	Low volume adjustment factor				0.155714	0.155714		27.00
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			495,340		495,340	28.00
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				222,746	222,746	29.00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 | Provider CCN: 15-0061 | Period: From 01/01/2018 To 12/31/2018 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 5/29/2019 4:30 pm

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		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	1.00	2.00	3.00	4.00	
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	2,899,502	2,899,502		2,899,502	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	910,642		910,642	910,642	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00	5,965	5,965	0	5,965	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	2.01
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	308,129	0	0	0	4.00
	Indirect Medical Education Adjustment						
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA						
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	9.01
	Disproportionate Share Adjustment						
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.1200	0.1200	0.1200		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	114,304	86,985	27,319	114,304	11.00
11.01	Uncompensated care payments	36.00	376,091	264,910	111,181	376,091	11.01
	Additional payment for high percentage of ESRD beneficiary discharges						
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	4,306,504	3,257,362	1,049,142	4,306,504	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	4,306,504	3,257,362	1,049,142	4,306,504	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	305,063	-76,273	381,336	305,063	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	17.00
17.01	Net organ acquisition cost						17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	18.00
19.00	SUBTOTAL			3,181,089	1,430,478	4,611,567	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 | Provider CCN: 15-0061 | Period: From 01/01/2018 To 12/31/2018 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 5/29/2019 4:30 pm

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		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	304,234	-76,684	380,918	304,234	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	829	620	209	829	20.01
21.00	Capital DRG outlier payments	2.00	0	-209	209	0	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	305,063	-76,273	381,336	305,063	26.00
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
		0	1.00	2.00	3.00	4.00	
27.00							27.00
28.00	Low volume adjustment prior to October 1	70.96	495,340	495,340		495,340	28.00
29.00	Low volume adjustment on or after October 1	70.97	222,746		222,746	222,746	29.00
30.00	HVBP payment adjustment (see instructions)	70.93	-171	-128	-43	-171	30.00
30.01	HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	0	0	0	0	30.01
31.00	HRR adjustment (see instructions)	70.94	-8,605	-6,436	-2,169	-8,605	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	0	0	0	0	31.01
						(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3.00	4.00	
32.00	HAC Reduction Program adjustment (see instructions)	70.99		0	0	0	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		N				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0061	Period: From 01/01/2018 To 12/31/2018	Worksheet E Part B Date/Time Prepared: 5/29/2019 4:30 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	842	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	6,438,443	2.00
3.00	OPPS payments	5,219,788	3.00
4.00	Outlier payment (see instructions)	30,164	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)	842	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	2,549	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	2,549	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	2,549	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	1,707	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)	842	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)	5,249,952	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)	0	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	1,037,245	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)	4,213,549	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)	4,213,549	30.00
31.00	Primary payer payments	173	31.00
32.00	Subtotal (line 30 minus line 31)	4,213,376	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)	253,047	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	164,481	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	213,648	36.00
37.00	Subtotal (see instructions)	4,377,857	37.00
38.00	MSP-LCC reconciliation amount from PS&R	1,277	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		39.50
39.97	Demonstration payment adjustment amount before sequestration	0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	4,376,580	40.00
40.01	Sequestration adjustment (see instructions)	87,532	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
41.00	Interim payments	4,252,844	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	36,204	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

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0061 Component CCN: 15-S061	Period: From 01/01/2018 To 12/31/2018	Worksheet E Part B Date/Time Prepared: 5/29/2019 4:30 pm
	Title XVIII	Subprovider - IPF	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	0	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)	0	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	0	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (see instructions)	0	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	0	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)	0	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	0	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	0	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)	0	30.00
31.00	Primary payer payments	0	31.00
32.00	Subtotal (line 30 minus line 31)	0	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)	0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	36.00
37.00	Subtotal (see instructions)	0	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		39.50
39.97	Demonstration payment adjustment amount before sequestration	0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	0	40.00
40.01	Sequestration adjustment (see instructions)	0	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
41.00	Interim payments	0	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	0	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: 15-0061 | Period: From 01/01/2018 To 12/31/2018 | Worksheet E-1 Part I | Date/Time Prepared: 5/29/2019 4:30 pm

Title XVIII | Hospital | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		4,590,694		4,252,844	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		4,590,694		4,252,844	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		69,412		36,204	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		4,660,106		4,289,048	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: 15-0061 | Component CCN: 15-S061 | Period: From 01/01/2018 To 12/31/2018 | Worksheet E-1 Part I | Date/Time Prepared: 5/29/2019 4:30 pm

Title XVIII | Subprovider - IPF | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		4,577,416		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		4,577,416		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		22,947		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		4,600,363		0	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: 15-0061 | Component CCN: 15-T061 | Period: From 01/01/2018 To 12/31/2018 | Worksheet E-1 Part I | Date/Time Prepared: 5/29/2019 4:30 pm

Title XVIII | Subprovider - IRF | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,946,511		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,946,511		0	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		1,053		0	6.02
7.00	Total Medicare program liability (see instructions)		1,945,458		0	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: 15-0061 | Component CCN: 15-U061 | Period: From 01/01/2018 To 12/31/2018 | Worksheet E-1 Part I | Date/Time Prepared: 5/29/2019 4:30 pm

Title XVIII | Swing Beds - SNF | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		0		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		0		0	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		0		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: 15-0061	Period: From 01/01/2018 To 12/31/2018	Worksheet E-1 Part II Date/Time Prepared: 5/29/2019 4:30 pm
	Title XVIII	Hospital	PPS

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

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

Provider CCN: 15-0061 | Component CCN: 15-U061 | Period: From 01/01/2018 To 12/31/2018 | Worksheet E-2 | Date/Time Prepared: 5/29/2019 4:30 pm

Title XVIII | Swing Beds - SNF | PPS

		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)	0	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)			2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202, for Part B) (For CAH, see instructions)			3.00
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)		0.00	4.00
5.00	Program days	0	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)	0	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	0	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)	0	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	0	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)	0	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)	0	0	19.00
19.01	Sequestration adjustment (see instructions)	0	0	19.01
19.02	Demonstration payment adjustment amount after sequestration)	0	0	19.02
20.00	Interim payments	0	0	20.00
21.00	Tentative settlement (for contractor use only)	0	0	21.00
22.00	Balance due provider/program (line 19 minus lines 19.01, 20, and 21)	0	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	23.00
	Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment			
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
	Cost Reimbursement			
201.00	Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital))			201.00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))			202.00
203.00	Total (sum of lines 201 and 202)			203.00
204.00	Medicare swing-bed SNF discharges (see instructions)			204.00
	Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)			
205.00	Medicare swing-bed SNF target amount			205.00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)			206.00
	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement			
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)			208.00
209.00	Adjustment to Medicare swing-bed SNF PPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
	Comparision of PPS versus Cost Reimbursement			
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see instructions)			215.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0061 Component CCN: 15-S061	Period: From 01/01/2018 To 12/31/2018	Worksheet E-3 Part II Date/Time Prepared: 5/29/2019 4:30 pm
	Title XVIII	Subprovider - IPF	PPS

		1.00	
	PART II - MEDICARE PART A SERVICES - IPF PPS		
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)	4,959,422	1.00
2.00	Net IPF PPS Outlier Payments	0	2.00
3.00	Net IPF PPS ECT Payments	3,437	3.00
4.00	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004. (see instructions)	0.00	4.00
4.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)	0.00	4.01
5.00	New Teaching program adjustment. (see instructions)	0.00	5.00
6.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instuctions)	0.00	6.00
7.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instuctions)	0.00	7.00
8.00	Intern and resident count for IPF PPS medical education adjustment (see instructions)	0.00	8.00
9.00	Average Daily Census (see instructions)	16.520548	9.00
10.00	Teaching Adjustment Factor {((1 + (line 8/line 9)) raised to the power of .5150 -1}.	0.000000	10.00
11.00	Teaching Adjustment (line 1 multiplied by line 10).	0	11.00
12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)	4,962,859	12.00
13.00	Nursing and Allied Health Managed Care payment (see instruction)	0	13.00
14.00	Organ acquisition (DO NOT USE THIS LINE)		14.00
15.00	Cost of physicians' services in a teaching hospital (see instructions)	0	15.00
16.00	Subtotal (see instructions)	4,962,859	16.00
17.00	Primary payer payments	0	17.00
18.00	Subtotal (line 16 less line 17).	4,962,859	18.00
19.00	Deductibles	203,464	19.00
20.00	Subtotal (line 18 minus line 19)	4,759,395	20.00
21.00	Coinsurance	88,559	21.00
22.00	Subtotal (line 20 minus line 21)	4,670,836	22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	36,019	23.00
24.00	Adjusted reimbursable bad debts (see instructions)	23,412	24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	26,313	25.00
26.00	Subtotal (sum of lines 22 and 24)	4,694,248	26.00
27.00	Direct graduate medical education payments (from Wkst. E-4, line 49)	0	27.00
28.00	Other pass through costs (see instructions)	0	28.00
29.00	Outlier payments reconciliation	0	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	30.50
30.99	Demonstration payment adjustment amount before sequestration	0	30.99
31.00	Total amount payable to the provider (see instructions)	4,694,248	31.00
31.01	Sequestration adjustment (see instructions)	93,885	31.01
31.02	Demonstration payment adjustment amount after sequestration	0	31.02
32.00	Interim payments	4,577,416	32.00
33.00	Tentative settlement (for contractor use only)	0	33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 31.02, 32 and 33)	22,947	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	35.00
	TO BE COMPLETED BY CONTRACTOR		
50.00	Original outlier amount from Worksheet E-3, Part II, line 2	0	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)	0	51.00
52.00	The rate used to calculate the Time Value of Money	0.00	52.00
53.00	Time Value of Money (see instructions)	0	53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0061 Component CCN: 15-T061	Period: From 01/01/2018 To 12/31/2018	Worksheet E-3 Part III Date/Time Prepared: 5/29/2019 4:30 pm
	Title XVIII	Subprovider - IRF	PPS

		1.00	
	PART III - MEDICARE PART A SERVICES - IRF PPS		
1.00	Net Federal PPS Payment (see instructions)	1,972,513	1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)	0.0195	2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)	30,377	3.00
4.00	Outlier Payments	1,698	4.00
5.00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)	0.00	5.00
5.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)	0.00	5.01
6.00	New Teaching program adjustment. (see instructions)	0.00	6.00
7.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)	0.00	7.00
8.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)	0.00	8.00
9.00	Intern and resident count for IRF PPS medical education adjustment (see instructions)	0.00	9.00
10.00	Average Daily Census (see instructions)	4.161644	10.00
11.00	Teaching Adjustment Factor (see instructions)	0.000000	11.00
12.00	Teaching Adjustment (see instructions)	0	12.00
13.00	Total PPS Payment (see instructions)	2,004,588	13.00
14.00	Nursing and Allied Health Managed Care payments (see instruction)	0	14.00
15.00	Organ acquisition (DO NOT USE THIS LINE)		15.00
16.00	Cost of physicians' services in a teaching hospital (see instructions)	0	16.00
17.00	Subtotal (see instructions)	2,004,588	17.00
18.00	Primary payer payments	0	18.00
19.00	Subtotal (line 17 less line 18).	2,004,588	19.00
20.00	Deductibles	25,412	20.00
21.00	Subtotal (line 19 minus line 20)	1,979,176	21.00
22.00	Coinsurance	0	22.00
23.00	Subtotal (line 21 minus line 22)	1,979,176	23.00
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	9,208	24.00
25.00	Adjusted reimbursable bad debts (see instructions)	5,985	25.00
26.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	6,604	26.00
27.00	Subtotal (sum of lines 23 and 25)	1,985,161	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 49)	0	28.00
29.00	Other pass through costs (see instructions)	0	29.00
30.00	Outlier payments reconciliation	0	30.00
31.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	31.00
31.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	31.50
31.99	Demonstration payment adjustment amount before sequestration	0	31.99
32.00	Total amount payable to the provider (see instructions)	1,985,161	32.00
32.01	Sequestration adjustment (see instructions)	39,703	32.01
32.02	Demonstration payment adjustment amount after sequestration	0	32.02
33.00	Interim payments	1,946,511	33.00
34.00	Tentative settlement (for contractor use only)	0	34.00
35.00	Balance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34)	-1,053	35.00
36.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	36.00
	TO BE COMPLETED BY CONTRACTOR		
50.00	Original outlier amount from Wkst. E-3, Pt. III, line 4	1,698	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)	0	51.00
52.00	The rate used to calculate the Time Value of Money	0.00	52.00
53.00	Time Value of Money (see instructions)	0	53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-0061 | Period: From 01/01/2018 To 12/31/2018 | Worksheet E-3 Part VII Date/Time Prepared: 5/29/2019 4:30 pm

Title XIX | Hospital | Cost

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	461,054		1.00
2.00	Medical and other services		401,370	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	461,054	401,370	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	461,054	401,370	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	0		8.00
9.00	Ancillary service charges	1,108,162	1,599,188	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	1,108,162	1,599,188	12.00
	CUSTOMARY CHARGES			
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	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	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	1,108,162	1,599,188	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	647,108	1,197,818	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	461,054	401,370	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.			
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0		24.00
25.00	Capital exception payments (see instructions)	0		25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	461,054	401,370	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30.00	Excess of reasonable cost (from line 18)	0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	461,054	401,370	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	461,054	401,370	36.00
37.00	OTHER ADJUSTMENTS	-461,054	-401,370	37.00
38.00	Subtotal (line 36 ± line 37)	0	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	0	0	40.00
41.00	Interim payments	0	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0061 Component CCN: 15-S061	Period: From 01/01/2018 To 12/31/2018	Worksheet E-3 Part VII Date/Time Prepared: 5/29/2019 4:30 pm
	Title XIX	Subprovider - IPF	Cost

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	173,767		1.00
2.00	Medical and other services		0	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	173,767	0	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	173,767	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	0		8.00
9.00	Ancillary service charges	96,071	0	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	96,071	0	12.00
	CUSTOMARY CHARGES			
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	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	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	96,071	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	0	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	77,696	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	96,071	0	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.			
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0		24.00
25.00	Capital exception payments (see instructions)	0		25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	96,071	0	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30.00	Excess of reasonable cost (from line 18)	77,696	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	96,071	0	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	96,071	0	36.00
37.00	OTHER ADJUSTMENTS	-96,071	0	37.00
38.00	Subtotal (line 36 ± line 37)	0	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	0	0	40.00
41.00	Interim payments	0	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0061 Component CCN: 15-T061	Period: From 01/01/2018 To 12/31/2018	Worksheet E-3 Part VII Date/Time Prepared: 5/29/2019 4:30 pm
	Title XIX	Subprovider - IRF	Cost

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	15,117		1.00
2.00	Medical and other services		0	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	15,117	0	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	15,117	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	0		8.00
9.00	Ancillary service charges	40,690	0	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	40,690	0	12.00
	CUSTOMARY CHARGES			
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	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	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	40,690	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	25,573	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	15,117	0	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.			
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0		24.00
25.00	Capital exception payments (see instructions)	0		25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	15,117	0	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30.00	Excess of reasonable cost (from line 18)	0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	15,117	0	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	15,117	0	36.00
37.00	OTHER ADJUSTMENTS	-15,117	0	37.00
38.00	Subtotal (line 36 ± line 37)	0	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	0	0	40.00
41.00	Interim payments	0	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 15-0061 | Period: From 01/01/2018 To 12/31/2018 | Worksheet G | Date/Time Prepared: 5/29/2019 4:30 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	1,119,794	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	18,654,265	0	0	0	4.00
5.00	Other receivable	541,816	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-10,953,493	0	0	0	6.00
7.00	Inventory	1,380,441	0	0	0	7.00
8.00	Prepaid expenses	538,775	0	0	0	8.00
9.00	Other current assets	524,000	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)	11,805,598	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	1,280,955	0	0	0	12.00
13.00	Land improvements	687,865	0	0	0	13.00
14.00	Accumulated depreciation	-683,509	0	0	0	14.00
15.00	Buildings	64,509,458	0	0	0	15.00
16.00	Accumulated depreciation	-43,968,796	0	0	0	16.00
17.00	Leasehold improvements	39,119	0	0	0	17.00
18.00	Accumulated depreciation	-35,528	0	0	0	18.00
19.00	Fixed equipment	7,765,420	0	0	0	19.00
20.00	Accumulated depreciation	-4,857,078	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	29,886,514	0	0	0	23.00
24.00	Accumulated depreciation	-27,044,089	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)	27,580,331	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	3,367,670	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	2,540,970	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	5,908,640	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	45,294,569	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	2,397,010	0	0	0	37.00
38.00	Salaries, wages, and fees payable	713,090	0	0	0	38.00
39.00	Payroll taxes payable	203,836	0	0	0	39.00
40.00	Notes and loans payable (short term)	24,940,654	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	2,395,318	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	30,649,908	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	16,824,270	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	16,824,270	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	47,474,178	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	-2,179,609				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)	-2,179,609	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	45,294,569	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-0061 | Period: From 01/01/2018 To 12/31/2018 | Worksheet G-1 | Date/Time Prepared: 5/29/2019 4:30 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		12,318,796		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-2,637,385				2.00
3.00	Total (sum of line 1 and line 2)		9,681,411		0		3.00
4.00	TRANSFER TO LTC OPERATIONS	-11,861,018		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		-11,861,018		0		10.00
11.00	Subtotal (line 3 plus line 10)		-2,179,607		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		-2,179,607		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	TRANSFER TO LTC OPERATIONS		0			4.00
5.00			0			5.00
6.00			0			6.00
7.00			0			7.00
8.00			0			8.00
9.00			0			9.00
10.00	Total additions (sum of line 4-9)	0		0		10.00
11.00	Subtotal (line 3 plus line 10)	0		0		11.00
12.00	Deductions (debit adjustments) (specify)		0			12.00
13.00			0			13.00
14.00			0			14.00
15.00			0			15.00
16.00			0			16.00
17.00			0			17.00
18.00	Total deductions (sum of lines 12-17)	0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0		19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 15-0061 | Period: From 01/01/2018 To 12/31/2018 | Worksheet G-2 Parts I & II Date/Time Prepared: 5/29/2019 4:30 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	6,547,390		6,547,390	1.00
2.00	SUBPROVIDER - IPF	10,609,134		10,609,134	2.00
3.00	SUBPROVIDER - IRF	2,326,924		2,326,924	3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	19,483,448		19,483,448	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	3,512,422		3,512,422	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)	3,512,422		3,512,422	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	22,995,870		22,995,870	17.00
18.00	Ancillary services	26,784,926	86,256,658	113,041,584	18.00
19.00	Outpatient services	0	947,770	947,770	19.00
20.00	RURAL HEALTH CLINIC	0	1,134,490	1,134,490	20.00
20.01	RURAL HEALTH CLINIC II	0	1,313,326	1,313,326	20.01
20.02	RURAL HEALTH CLINIC III	0	2,375,673	2,375,673	20.02
20.04	RURAL HEALTH CLINIC V	0	1,403,909	1,403,909	20.04
20.05	RURAL HEALTH CLINIC VI	0	752,444	752,444	20.05
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		0	0	22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
24.10	CORF	0	0	0	24.10
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE	0	1,302,840	1,302,840	26.00
27.00	OTHER	0	6,625,456	6,625,456	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	49,780,796	102,112,566	151,893,362	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		62,855,065		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)		62,855,065		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 15-0061 | Period: From 01/01/2018 To 12/31/2018 | Worksheet G-3 | Date/Time Prepared: 5/29/2019 4:30 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	151,893,362	1.00
2.00	Less contractual allowances and discounts on patients' accounts	92,998,213	2.00
3.00	Net patient revenues (line 1 minus line 2)	58,895,149	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	62,855,065	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-3,959,916	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	-902	6.00
7.00	Income from investments	59,745	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	1,965	10.00
11.00	Rebates and refunds of expenses	4,090	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	277,512	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	520,012	17.00
18.00	Revenue from sale of medical records and abstracts	13,208	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	143,622	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER REVENUE	303,279	24.00
25.00	Total other income (sum of lines 6-24)	1,322,531	25.00
26.00	Total (line 5 plus line 25)	-2,637,385	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)	-2,637,385	29.00

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS

Provider CCN: 15-0061 | Hospice CCN: 15-1553 | Period: From 01/01/2018 To 12/31/2018 | Worksheet O | Date/Time Prepared: 5/29/2019 4:30 pm

Hospice I

		SALARIES	OTHER	SUBTOTAL (col. 1 plus col. 2)	RECLASSIFI-CATIONS	SUBTOTAL	
		1.00	2.00	3.00	4.00	5.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT*		0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP*		0	0	0	0	2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT*	0	0	0	0	0	3.00
4.00	ADMINISTRATIVE & GENERAL*	114,115	77,626	191,741	0	191,741	4.00
5.00	PLANT OPERATION & MAINTENANCE*	0	0	0	0	0	5.00
6.00	LAUNDRY & LINEN SERVICE*	0	0	0	0	0	6.00
7.00	HOUSEKEEPING*	0	0	0	0	0	7.00
8.00	DIETARY*	0	0	0	0	0	8.00
9.00	NURSING ADMINISTRATION*	0	0	0	0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES*	0	0	0	0	0	10.00
11.00	MEDICAL RECORDS*	0	0	0	0	0	11.00
12.00	STAFF TRANSPORTATION*	0	13,689	13,689	0	13,689	12.00
13.00	VOLUNTEER SERVICE COORDINATION*	0	0	0	0	0	13.00
14.00	PHARMACY*	0	0	0	0	0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES*	0	0	0	0	0	15.00
16.00	OTHER GENERAL SERVICE*	0	0	0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES						17.00
	DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED**		0	0	0	0	25.00
26.00	PHYSICIAN SERVICES**	0	12,000	12,000	3,470	15,470	26.00
27.00	NURSE PRACTITIONER**	0	0	0	0	0	27.00
28.00	REGISTERED NURSE**	88,598	202,728	291,326	0	291,326	28.00
29.00	LPN/LVN**	0	0	0	0	0	29.00
30.00	PHYSICAL THERAPY**	0	0	0	0	0	30.00
31.00	OCCUPATIONAL THERAPY**	0	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY**	0	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES**	0	0	0	0	0	33.00
34.00	SPIRITUAL COUNSELING**	0	0	0	0	0	34.00
35.00	DIETARY COUNSELING**	0	0	0	0	0	35.00
36.00	COUNSELING - OTHER**	0	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES**	55,264	0	55,264	0	55,264	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN**	0	0	0	0	0	38.00
39.00	PATIENT TRANSPORTATION**	0	0	0	0	0	39.00
40.00	IMAGING SERVICES**	0	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS**	0	0	0	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE**	0	0	0	0	0	42.00
42.50	DRUGS CHARGED TO PATIENTS**	0	0	0	0	0	42.50
43.00	OUTPATIENT SERVICES**	0	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY**	0	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY**	0	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)**	9,956	0	9,956	0	9,956	46.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM *	0	0	0	0	0	60.00
61.00	VOLUNTEER PROGRAM *	0	0	0	0	0	61.00
62.00	FUNDRAISING*	0	0	0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS*	0	0	0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM*	0	0	0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES*	0	0	0	0	0	65.00
66.00	RESIDENTIAL CARE*	0	0	0	0	0	66.00
67.00	ADVERTISING*	0	0	0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING*	0	0	0	0	0	68.00
69.00	THRIFT STORE*	0	0	0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD*	0	0	0	0	0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)*	0	0	0	0	0	71.00
100.00	TOTAL	267,933	306,043	573,976	3,470	577,446	100.00

* Transfer the amounts in column 7 to Wkst. O-5, column 1, line as appropriate.
** See instructions. Do not transfer the amounts in column 7 to Wkst. O-5.

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS

Provider CCN: 15-0061 | Hospice CCN: 15-1553 | Period: From 01/01/2018 To 12/31/2018 | Worksheet O | Date/Time Prepared: 5/29/2019 4:30 pm

Hospice I

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)		
		6.00	7.00		
	GENERAL SERVICE COST CENTERS				
1.00	CAP REL COSTS-BLDG & FIXT*	0	0		1.00
2.00	CAP REL COSTS-MVBLE EQUIP*	0	0		2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT*	0	0		3.00
4.00	ADMINISTRATIVE & GENERAL*	0	191,741		4.00
5.00	PLANT OPERATION & MAINTENANCE*	0	0		5.00
6.00	LAUNDRY & LINEN SERVICE*	0	0		6.00
7.00	HOUSEKEEPING*	0	0		7.00
8.00	DIETARY*	0	0		8.00
9.00	NURSING ADMINISTRATION*	0	0		9.00
10.00	ROUTINE MEDICAL SUPPLIES*	0	0		10.00
11.00	MEDICAL RECORDS*	0	0		11.00
12.00	STAFF TRANSPORTATION*	0	13,689		12.00
13.00	VOLUNTEER SERVICE COORDINATION*	0	0		13.00
14.00	PHARMACY*	0	0		14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES*	0	0		15.00
16.00	OTHER GENERAL SERVICE*	0	0		16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES				17.00
	DIRECT PATIENT CARE SERVICE COST CENTERS				
25.00	INPATIENT CARE-CONTRACTED**	0	0		25.00
26.00	PHYSICIAN SERVICES**	0	15,470		26.00
27.00	NURSE PRACTITIONER**	0	0		27.00
28.00	REGISTERED NURSE**	0	291,326		28.00
29.00	LPN/LVN**	0	0		29.00
30.00	PHYSICAL THERAPY**	0	0		30.00
31.00	OCCUPATIONAL THERAPY**	0	0		31.00
32.00	SPEECH/LANGUAGE PATHOLOGY**	0	0		32.00
33.00	MEDICAL SOCIAL SERVICES**	0	0		33.00
34.00	SPIRITUAL COUNSELING**	0	0		34.00
35.00	DIETARY COUNSELING**	0	0		35.00
36.00	COUNSELING - OTHER**	0	0		36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES**	0	55,264		37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN**	0	0		38.00
39.00	PATIENT TRANSPORTATION**	0	0		39.00
40.00	IMAGING SERVICES**	0	0		40.00
41.00	LABS & DIAGNOSTICS**	0	0		41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE**	0	0		42.00
42.50	DRUGS CHARGED TO PATIENTS**	0	0		42.50
43.00	OUTPATIENT SERVICES**	0	0		43.00
44.00	PALLIATIVE RADIATION THERAPY**	0	0		44.00
45.00	PALLIATIVE CHEMOTHERAPY**	0	0		45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)**	0	9,956		46.00
	NONREIMBURSABLE COST CENTERS				
60.00	BEREAVEMENT PROGRAM *	0	0		60.00
61.00	VOLUNTEER PROGRAM *	0	0		61.00
62.00	FUNDRAISING*	0	0		62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS*	0	0		63.00
64.00	PALLIATIVE CARE PROGRAM*	0	0		64.00
65.00	OTHER PHYSICIAN SERVICES*	0	0		65.00
66.00	RESIDENTIAL CARE*	0	0		66.00
67.00	ADVERTISING*	0	0		67.00
68.00	TELEHEALTH/TELEMONITORING*	0	0		68.00
69.00	THRIFT STORE*	0	0		69.00
70.00	NURSING FACILITY ROOM & BOARD*	0	0		70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)*	0	0		71.00
100.00	TOTAL	0	577,446		100.00

* Transfer the amounts in column 7 to Wkst. O-5, column 1, line as appropriate.
** See instructions. Do not transfer the amounts in column 7 to Wkst. O-5.

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS FOR HOSPICE ROUTINE HOME CARE

Provider CCN: 15-0061 | Hospice CCN: 15-1553 | Period: From 01/01/2018 To 12/31/2018 | Worksheet O-2 | Date/Time Prepared: 5/29/2019 4:30 pm

Hospice I

		SALARIES	OTHER	SUBTOTAL (col. 1 + col. 2)	RECLASSIFI-CATIONS	SUBTOTAL	
		1.00	2.00	3.00	4.00	5.00	
	DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED						25.00
26.00	PHYSICIAN SERVICES	0	12,000	12,000	3,470	15,470	26.00
27.00	NURSE PRACTITIONER	0	0	0	0	0	27.00
28.00	REGISTERED NURSE	88,598	202,728	291,326	0	291,326	28.00
29.00	LPN/LVN	0	0	0	0	0	29.00
30.00	PHYSICAL THERAPY	0	0	0	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0	0	0	0	0	33.00
34.00	SPIRITUAL COUNSELING	0	0	0	0	0	34.00
35.00	DIETARY COUNSELING	0	0	0	0	0	35.00
36.00	COUNSELING - OTHER	0	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	55,264	0	55,264	0	55,264	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	0	0	0	38.00
39.00	PATIENT TRANSPORTATION	0	0	0	0	0	39.00
40.00	IMAGING SERVICES	0	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	0	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	0	0	0	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	42.50
43.00	OUTPATIENT SERVICES	0	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	9,956	0	9,956	0	9,956	46.00
100.00	TOTAL *	153,818	214,728	368,546	3,470	372,016	100.00

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

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)		
		6.00	7.00		
	DIRECT PATIENT CARE SERVICE COST CENTERS				
25.00	INPATIENT CARE-CONTRACTED				25.00
26.00	PHYSICIAN SERVICES	0	15,470		26.00
27.00	NURSE PRACTITIONER	0	0		27.00
28.00	REGISTERED NURSE	0	291,326		28.00
29.00	LPN/LVN	0	0		29.00
30.00	PHYSICAL THERAPY	0	0		30.00
31.00	OCCUPATIONAL THERAPY	0	0		31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0		32.00
33.00	MEDICAL SOCIAL SERVICES	0	0		33.00
34.00	SPIRITUAL COUNSELING	0	0		34.00
35.00	DIETARY COUNSELING	0	0		35.00
36.00	COUNSELING - OTHER	0	0		36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	55,264		37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0		38.00
39.00	PATIENT TRANSPORTATION	0	0		39.00
40.00	IMAGING SERVICES	0	0		40.00
41.00	LABS & DIAGNOSTICS	0	0		41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0		42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0		42.50
43.00	OUTPATIENT SERVICES	0	0		43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0		44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0		45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	9,956		46.00
100.00	TOTAL *	0	372,016		100.00

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

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

Provider CCN: 15-0061 Hospice CCN: 15-1553

Period: From 01/01/2018 To 12/31/2018

Worksheet O-5

Date/Time Prepared: 5/29/2019 4:30 pm

Hospice I

	Descriptions	HOSPICE DIRECT EXPENSES (see instructions)	GENERAL SERVICE EXPENSES FROM WKST B PART I (see instructions)	TOTAL EXPENSES (sum of cols. 1 + 2)	
		1.00	2.00	3.00	
	GENERAL SERVICE COST CENTERS				
1.00	CAP REL COSTS-BLDG & FIXT	0	7,519	7,519	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	0	56,851	56,851	3.00
4.00	ADMINISTRATIVE & GENERAL	191,741	133,397	325,138	4.00
5.00	PLANT OPERATION & MAINTENANCE	0	0	0	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0	6.00
7.00	HOUSEKEEPING	0	3,167	3,167	7.00
8.00	DIETARY	0	0	0	8.00
9.00	NURSING ADMINISTRATION	0	37,895	37,895	9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	13,648	13,648	10.00
11.00	MEDICAL RECORDS	0	10,941	10,941	11.00
12.00	STAFF TRANSPORTATION	13,689		13,689	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0		0	13.00
14.00	PHARMACY	0	0	0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0		0	15.00
16.00	OTHER GENERAL SERVICE	0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES		60,302	60,302	17.00
	LEVEL OF CARE				
50.00	HOSPICE CONTINUOUS HOME CARE	0		0	50.00
51.00	HOSPICE ROUTINE HOME CARE	372,016		372,016	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0		0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0		0	53.00
	NONREIMBURSABLE COST CENTERS				
60.00	BEREAVEMENT PROGRAM	0		0	60.00
61.00	VOLUNTEER PROGRAM	0		0	61.00
62.00	FUNDRAISING	0		0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0		0	63.00
64.00	PALLIATIVE CARE PROGRAM	0		0	64.00
65.00	OTHER PHYSICIAN SERVICES	0		0	65.00
66.00	RESIDENTIAL CARE	0		0	66.00
67.00	ADVERTISING	0		0	67.00
68.00	TELEHEALTH/TELEMONITORING	0		0	68.00
69.00	THRIFT STORE	0		0	69.00
70.00	NURSING FACILITY ROOM & BOARD	0		0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0		0	71.00
99.00	NEGATIVE COST CENTER	0		0	99.00
100.00	TOTAL	577,446	323,720	901,166	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN: 15-0061
Hospice CCN: 15-1553

Period: From 01/01/2018 To 12/31/2018

Worksheet O-6
Part I
Date/Time Prepared: 5/29/2019 4:30 pm

Hospice I

	Descriptions	TOTAL EXPENSES	CAP REL BLDG & FIX	CAP REL MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	SUBTOTAL	
		0	1.00	2.00	3.00	3A	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	7,519	7,519				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0		0			2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	56,851	0	0	56,851		3.00
4.00	ADMINISTRATIVE & GENERAL	325,138	0	0	33,835	358,973	4.00
5.00	PLANT OPERATION & MAINTENANCE	0	0	0	0	0	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0	0	0	6.00
7.00	HOUSEKEEPING	3,167	0	0	0	3,167	7.00
8.00	DIETARY	0	0	0	0	0	8.00
9.00	NURSING ADMINISTRATION	37,895	0	0	0	37,895	9.00
10.00	ROUTINE MEDICAL SUPPLIES	13,648	0	0	0	13,648	10.00
11.00	MEDICAL RECORDS	10,941	0	0	0	10,941	11.00
12.00	STAFF TRANSPORTATION	13,689	0	0	0	13,689	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0	0	0	0	0	13.00
14.00	PHARMACY	0	0	0	0	0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0	0	0	0	15.00
16.00	OTHER GENERAL SERVICE	0	0	0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES		0	0		60,302	17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0			0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	372,016			23,016	395,032	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0	0	0	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	0	0	0	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0	0	0	0	0	60.00
61.00	VOLUNTEER PROGRAM	0	0	0	0	0	61.00
62.00	FUNDRAISING	0	0	0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0	0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0	0	0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES	0	0	0	0	0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0	0	0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING	0	0	0	0	0	68.00
69.00	THRIFT STORE	0	0	0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD	0				0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	7,519	0	0	7,519	71.00
99.00	NEGATIVE COST CENTER	0	0	0	0		99.00
100.00	TOTAL	901,166	7,519	0	56,851	901,166	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN: 15-0061
Hospice CCN: 15-1553

Period: From 01/01/2018 To 12/31/2018

Worksheet O-6 Part I
Date/Time Prepared: 5/29/2019 4:30 pm

Hospice I

	Descriptions	ADMINISTRATIVE & GENERAL	PLANT OPERATION & MAINTENANCE	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		4.00	5.00	6.00	7.00	8.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL	358,973					4.00
5.00	PLANT OPERATION & MAINTENANCE	0	0				5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0			6.00
7.00	HOUSEKEEPING	2,097	0		5,264		7.00
8.00	DIETARY	0	0		0	0	8.00
9.00	NURSING ADMINISTRATION	25,089	0		0		9.00
10.00	ROUTINE MEDICAL SUPPLIES	9,036	0		0		10.00
11.00	MEDICAL RECORDS	7,244	0		0		11.00
12.00	STAFF TRANSPORTATION	9,063	0		0		12.00
13.00	VOLUNTEER SERVICE COORDINATION	0	0		0		13.00
14.00	PHARMACY	0	0		0		14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0		0		15.00
16.00	OTHER GENERAL SERVICE	0	0		0		16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	39,925	0		0		17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0					50.00
51.00	HOSPICE ROUTINE HOME CARE	261,541					51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0	0	0	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	0	0	0	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0	0		0		60.00
61.00	VOLUNTEER PROGRAM	0	0		0		61.00
62.00	FUNDRAISING	0	0		0		62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0		0		63.00
64.00	PALLIATIVE CARE PROGRAM	0	0		0		64.00
65.00	OTHER PHYSICIAN SERVICES	0	0		0		65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0	0		0		67.00
68.00	TELEHEALTH/TELEMONITORING	0	0		0		68.00
69.00	THRIFT STORE	0	0		0		69.00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	4,978	0	0	5,264	0	71.00
99.00	NEGATIVE COST CENTER	0	0	0	0	0	99.00
100.00	TOTAL	358,973	0	0	5,264	0	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN: 15-0061
Hospice CCN: 15-1553

Period: From 01/01/2018 To 12/31/2018

Worksheet O-6 Part I
Date/Time Prepared: 5/29/2019 4:30 pm

Hospice I

	Descriptions	NURSING ADMINISTRATION	ROUTINE MEDICAL SUPPLIES	MEDICAL RECORDS	STAFF TRANSPORTATION	VOLUNTEER SERVICE COORDINATION	
		9.00	10.00	11.00	12.00	13.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5.00
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPING						7.00
8.00	DIETARY						8.00
9.00	NURSING ADMINISTRATION	62,984					9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	22,684				10.00
11.00	MEDICAL RECORDS	0		18,185			11.00
12.00	STAFF TRANSPORTATION	0			22,752		12.00
13.00	VOLUNTEER SERVICE COORDINATION	0			0	0	13.00
14.00	PHARMACY	0			0	0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0			0	0	15.00
16.00	OTHER GENERAL SERVICE	0			0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES						17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0	0	0	0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	62,984	22,684	18,185	22,752	0	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0	0	0	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	0	0	0	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0			0	0	60.00
61.00	VOLUNTEER PROGRAM	0			0	0	61.00
62.00	FUNDRAISING	0			0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0			0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0			0	0	64.00
65.00	OTHER PHYSICIAN SERVICES	0			0	0	65.00
66.00	RESIDENTIAL CARE	0			0	0	66.00
67.00	ADVERTISING	0			0	0	67.00
68.00	TELEHEALTH/TELEMONITORING	0			0	0	68.00
69.00	THRIFT STORE	0			0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0			0	0	71.00
99.00	NEGATIVE COST CENTER	0	0	0	0	0	99.00
100.00	TOTAL	62,984	22,684	18,185	22,752	0	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN: 15-0061
Hospice CCN: 15-1553

Period: From 01/01/2018 To 12/31/2018

Worksheet O-6 Part I
Date/Time Prepared: 5/29/2019 4:30 pm

Hospice I

	Descriptions	PHARMACY	PHYSICIAN ADMINISTRATIVE SERVICES	OTHER GENERAL SERVICE	PATIENT/ RESIDENTIAL CARE SERVICES	TOTAL	
		14.00	15.00	16.00	17.00	18.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5.00
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPING						7.00
8.00	DIETARY						8.00
9.00	NURSING ADMINISTRATION						9.00
10.00	ROUTINE MEDICAL SUPPLIES						10.00
11.00	MEDICAL RECORDS						11.00
12.00	STAFF TRANSPORTATION						12.00
13.00	VOLUNTEER SERVICE COORDINATION						13.00
14.00	PHARMACY	0					14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0				15.00
16.00	OTHER GENERAL SERVICE	0		0			16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES				100,227		17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0	0	0		0	50.00
51.00	HOSPICE ROUTINE HOME CARE	0	0	0		783,178	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0	0	0	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	0	0	0	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0		0		0	60.00
61.00	VOLUNTEER PROGRAM	0		0		0	61.00
62.00	FUNDRAISING	0		0		0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0		0		0	63.00
64.00	PALLIATIVE CARE PROGRAM	0		0		0	64.00
65.00	OTHER PHYSICIAN SERVICES	0		0		0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0		0		0	67.00
68.00	TELEHEALTH/TELEMONITORING	0		0		0	68.00
69.00	THRIFT STORE	0		0		0	69.00
70.00	NURSING FACILITY ROOM & BOARD					0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	100,227	117,988	71.00
99.00	NEGATIVE COST CENTER	0	0	0	0	0	99.00
100.00	TOTAL	0	0	0	100,227	901,166	100.00

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

Provider CCN: 15-0061
Hospice CCN: 15-1553

Period: From 01/01/2018 To 12/31/2018

Worksheet O-6
Part II
Date/Time Prepared: 5/29/2019 4:30 pm

Hospice I

	Cost Center Descriptions	CAP REL BLDG & FIX (SQUARE FEET)	CAP REL MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	RECONCILIATION	ADMINISTRATIVE & GENERAL (ACCUMULATED COSTS)	
		1.00	2.00	3.00	4A	4.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	585					1.00
2.00	CAP REL COSTS-MVBLE EQUIP		0				2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	0	0	191,741			3.00
4.00	ADMINISTRATIVE & GENERAL	0	0	114,115	-358,973	542,193	4.00
5.00	PLANT OPERATION & MAINTENANCE	0	0	0	0	0	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0	0	0	6.00
7.00	HOUSEKEEPING	0	0	0	0	3,167	7.00
8.00	DIETARY	0	0	0	0	0	8.00
9.00	NURSING ADMINISTRATION	0	0	0	0	37,895	9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	0	0	0	13,648	10.00
11.00	MEDICAL RECORDS	0	0	0	0	10,941	11.00
12.00	STAFF TRANSPORTATION	0	0	0	0	13,689	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0	0	0	0	0	13.00
14.00	PHARMACY	0	0	0	0	0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0	0	0	0	15.00
16.00	OTHER GENERAL SERVICE	0	0	0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0	0		0	60,302	17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE			0	0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE			77,626	0	395,032	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0	0	0	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	0	0	0	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0	0	0	0	0	60.00
61.00	VOLUNTEER PROGRAM	0	0	0	0	0	61.00
62.00	FUNDRAISING	0	0	0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0	0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0	0	0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES	0	0	0	0	0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0	0	0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING	0	0	0	0	0	68.00
69.00	THRIFT STORE	0	0	0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD				0		70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	585	0	0	0	7,519	71.00
99.00	NEGATIVE COST CENTER						99.00
100.00	COST TO BE ALLOCATED (per Wkst. O-6, Part I)	7,519	0	56,851		358,973	100.00
101.00	UNIT COST MULTIPLIER	12.852991	0.000000	0.296499		0.662076	101.00

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

Provider CCN: 15-0061
Hospice CCN: 15-1553

Period:
From 01/01/2018
To 12/31/2018

Worksheet O-6
Part II
Date/Time Prepared:
5/29/2019 4:30 pm

Hospice I

	Cost Center Descriptions	PLANT OPERATION & MAINTENANCE (SQUARE FEET)	LAUNDRY & LINEN SERVICE (IN-FACILITY DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (IN-FACILITY DAYS)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	
		5.00	6.00	7.00	8.00	9.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE	0					5.00
6.00	LAUNDRY & LINEN SERVICE	0	0				6.00
7.00	HOUSEKEEPING	0		585			7.00
8.00	DIETARY	0		0	0		8.00
9.00	NURSING ADMINISTRATION	0		0		11,549	9.00
10.00	ROUTINE MEDICAL SUPPLIES	0		0		0	10.00
11.00	MEDICAL RECORDS	0		0		0	11.00
12.00	STAFF TRANSPORTATION	0		0		0	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0		0		0	13.00
14.00	PHARMACY	0		0		0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0		0		0	15.00
16.00	OTHER GENERAL SERVICE	0		0		0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0		0			17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE					0	50.00
51.00	HOSPICE ROUTINE HOME CARE					11,549	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0	0	0	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	0	0	0	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0		0		0	60.00
61.00	VOLUNTEER PROGRAM	0		0		0	61.00
62.00	FUNDRAISING	0		0		0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0		0		0	63.00
64.00	PALLIATIVE CARE PROGRAM	0		0		0	64.00
65.00	OTHER PHYSICIAN SERVICES	0		0		0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0		0		0	67.00
68.00	TELEHEALTH/TELEMONITORING	0		0		0	68.00
69.00	THRIFT STORE	0		0		0	69.00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	585	0	0	71.00
99.00	NEGATIVE COST CENTER						99.00
100.00	COST TO BE ALLOCATED (per Wkst. O-6, Part I)	0	0	5,264	0	62,984	100.00
101.00	UNIT COST MULTIPLIER	0.000000	0.000000	8.998291	0.000000	5.453632	101.00

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

Provider CCN: 15-0061
Hospice CCN: 15-1553

Period:
From 01/01/2018
To 12/31/2018

Worksheet O-6
Part II
Date/Time Prepared:
5/29/2019 4:30 pm

Hospice I

	Cost Center Descriptions	ROUTINE MEDICAL SUPPLIES (PATIENT DAYS)	MEDICAL RECORDS (PATIENT DAYS)	STAFF TRANSPORTATION (MILEAGE)	VOLUNTEER SERVICE COORDINATION (HOURS OF SERVICE)	PHARMACY (CHARGES)	
		10.00	11.00	12.00	13.00	14.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5.00
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPING						7.00
8.00	DIETARY						8.00
9.00	NURSING ADMINISTRATION						9.00
10.00	ROUTINE MEDICAL SUPPLIES	5,337					10.00
11.00	MEDICAL RECORDS		5,337				11.00
12.00	STAFF TRANSPORTATION			13,689			12.00
13.00	VOLUNTEER SERVICE COORDINATION			0	0		13.00
14.00	PHARMACY			0	0	0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES			0	0	0	15.00
16.00	OTHER GENERAL SERVICE			0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES						17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0	0	0	0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	5,337	5,337	13,689	0	0	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0	0	0	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	0	0	0	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM			0	0	0	60.00
61.00	VOLUNTEER PROGRAM			0	0	0	61.00
62.00	FUNDRAISING			0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS			0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM			0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES			0	0	0	65.00
66.00	RESIDENTIAL CARE			0	0	0	66.00
67.00	ADVERTISING			0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING			0	0	0	68.00
69.00	THRIFT STORE			0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)			0	0	0	71.00
99.00	NEGATIVE COST CENTER						99.00
100.00	COST TO BE ALLOCATED (per Wkst. O-6, Part I)	22,684	18,185	22,752	0	0	100.00
101.00	UNIT COST MULTIPLIER	4.250328	3.407345	1.662064	0.000000	0.000000	101.00

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

Provider CCN: 15-0061
Hospice CCN: 15-1553

Period:
From 01/01/2018
To 12/31/2018

Worksheet O-6
Part II
Date/Time Prepared:
5/29/2019 4:30 pm

Hospice I

	Cost Center Descriptions	PHYSICIAN ADMINISTRATIVE SERVICES (PATIENT DAYS)	OTHER GENERAL SERVICE (SPECIFY BASIS)	PATIENT/ RESIDENTIAL CARE SERVICES (IN-FACILITY DAYS)		
		15.00	16.00	17.00		
	GENERAL SERVICE COST CENTERS					
1.00	CAP REL COSTS-BLDG & FIXT					1.00
2.00	CAP REL COSTS-MVBLE EQUIP					2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT					3.00
4.00	ADMINISTRATIVE & GENERAL					4.00
5.00	PLANT OPERATION & MAINTENANCE					5.00
6.00	LAUNDRY & LINEN SERVICE					6.00
7.00	HOUSEKEEPING					7.00
8.00	DIETARY					8.00
9.00	NURSING ADMINISTRATION					9.00
10.00	ROUTINE MEDICAL SUPPLIES					10.00
11.00	MEDICAL RECORDS					11.00
12.00	STAFF TRANSPORTATION					12.00
13.00	VOLUNTEER SERVICE COORDINATION					13.00
14.00	PHARMACY					14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0				15.00
16.00	OTHER GENERAL SERVICE		0			16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES			1		17.00
	LEVEL OF CARE					
50.00	HOSPICE CONTINUOUS HOME CARE	0	0			50.00
51.00	HOSPICE ROUTINE HOME CARE	0	0			51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0	0		52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	0		53.00
	NONREIMBURSABLE COST CENTERS					
60.00	BEREAVEMENT PROGRAM		0			60.00
61.00	VOLUNTEER PROGRAM		0			61.00
62.00	FUNDRAISING		0			62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS		0			63.00
64.00	PALLIATIVE CARE PROGRAM		0			64.00
65.00	OTHER PHYSICIAN SERVICES		0			65.00
66.00	RESIDENTIAL CARE	0	0	0		66.00
67.00	ADVERTISING		0			67.00
68.00	TELEHEALTH/TELEMONITORING		0			68.00
69.00	THRIFT STORE		0			69.00
70.00	NURSING FACILITY ROOM & BOARD					70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	1		71.00
99.00	NEGATIVE COST CENTER					99.00
100.00	COST TO BE ALLOCATED (per Wkst. O-6, Part I)	0	0	100,227		100.00
101.00	UNIT COST MULTIPLIER	0.000000	0.000000	100,227.000000		101.00

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

Provider CCN: 15-0061 Hospice CCN: 15-1553

Period: From 01/01/2018 To 12/31/2018

Worksheet O-7

Date/Time Prepared: 5/29/2019 4:30 pm

Hospice I

	Cost Center Descriptions	From Wkst. C, Part I, Col. 9 line	Cost to Charge Ratio	Charges by LOC (from Provider Records) HCHC	HRHC	HIRC	
		0	1.00	2.00	3.00	4.00	
	ANCILLARY SERVICE COST CENTERS						
1.00	PHYSICAL THERAPY	66.00	0.508012	0	0	0	1.00
2.00	OCCUPATIONAL THERAPY	67.00	0.315208	0	0	0	2.00
3.00	SPEECH PATHOLOGY	68.00	0.639621	0	0	0	3.00
4.00	DRUGS CHARGED TO PATIENTS	73.00	0.330506	0	0	0	4.00
5.00	DURABLE MEDICAL EQUIP-RENTED	96.00					5.00
6.00	LABORATORY	60.00	0.150479	0	0	0	6.00
7.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0.359085	0	0	0	7.00
8.00	OTHER OUTPATIENT SERVICE COST CENTER	93.00	1.162984	0	0	0	8.00
9.00	RADIOLOGY-THERAPEUTIC	55.00					9.00
10.00	CARDIAC REHAB	76.00	1.838464	0	0	0	10.00
11.00	Totals (sum of lines 1-11)						11.00

	Cost Center Descriptions	Charges by LOC (from Provider Records) HGIP	Shared Service Costs by LOC HCHC (col. 1 x col. 2)	HRHC (col. 1 x col. 3)	HIRC (col. 1 x col. 4)	HGIP (col. 1 x col. 5)	
		5.00	6.00	7.00	8.00	9.00	
	ANCILLARY SERVICE COST CENTERS						
1.00	PHYSICAL THERAPY	0	0	0	0	0	1.00
2.00	OCCUPATIONAL THERAPY	0	0	0	0	0	2.00
3.00	SPEECH PATHOLOGY	0	0	0	0	0	3.00
4.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	4.00
5.00	DURABLE MEDICAL EQUIP-RENTED						5.00
6.00	LABORATORY	0	0	0	0	0	6.00
7.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	7.00
8.00	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	8.00
9.00	RADIOLOGY-THERAPEUTIC						9.00
10.00	CARDIAC REHAB	0	0	0	0	0	10.00
11.00	Totals (sum of lines 1-11)		0	0	0	0	11.00

CALCULATION OF HOSPITAL-BASED HOSPICE PER DIEM COST

Provider CCN: 15-0061 | Hospice CCN: 15-1553 | Period: From 01/01/2018 To 12/31/2018 | Worksheet O-8 | Date/Time Prepared: 5/29/2019 4:30 pm

Hospice I

		TITLE XVIII MEDICARE	TITLE XIX MEDICAID	TOTAL	
		1.00	2.00	3.00	
	HOSPICE CONTINUOUS HOME CARE				
1.00	Total cost (Wkst. O-6, Part I, col. 18, line 50 plus Wkst. O-7, col. 6, line 11)			0	1.00
2.00	Total unduplicated days (Wkst. S-9, col. 4, line 10)			0	2.00
3.00	Total average cost per diem (line 1 divided by line 2)			0.00	3.00
4.00	Unduplicated program days (Wkst. S-9 col. as appropriate, line 10)	0	0		4.00
5.00	Program cost (line 3 times line 4)	0	0		5.00
	HOSPICE ROUTINE HOME CARE				
6.00	Total cost (Wkst. O-6, Part I, col. 18, line 51 plus Wkst. O-7, col. 7, line 11)			783,178	6.00
7.00	Total unduplicated days (Wkst. S-9, col. 4, line 11)			5,337	7.00
8.00	Total average cost per diem (line 6 divided by line 7)			146.74	8.00
9.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 11)	4,620	0		9.00
10.00	Program cost (line 8 times line 9)	677,939	0		10.00
	HOSPICE INPATIENT RESPITE CARE				
11.00	Total cost (Wkst. O-6, Part I, col. 18, line 52 plus Wkst. O-7, col. 8, line 11)			0	11.00
12.00	Total unduplicated days (Wkst. S-9, col. 4, line 12)			0	12.00
13.00	Total average cost per diem (line 11 divided by line 12)			0.00	13.00
14.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 12)	0	0		14.00
15.00	Program cost (line 13 times line 14)	0	0		15.00
	HOSPICE GENERAL INPATIENT CARE				
16.00	Total cost (Wkst. O-6, Part I, col. 18, line 53 plus Wkst. O-7, col. 9, line 11)			0	16.00
17.00	Total unduplicated days (Wkst. S-9, col. 4, line 13)			0	17.00
18.00	Total average cost per diem (line 16 divided by line 17)			0.00	18.00
19.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 13)	0	0		19.00
20.00	Program cost (line 18 times line 19)	0	0		20.00
	TOTAL HOSPICE CARE				
21.00	Total cost (sum of line 1 + line 6 + line 11 + line 16)			783,178	21.00
22.00	Total unduplicated days (Wkst. S-9, col. 4, line 14)			5,337	22.00
23.00	Average cost per diem (line 21 divided by line 22)			146.74	23.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 15-0061	Period: From 01/01/2018 To 12/31/2018	Worksheet L Parts I-III Date/Time Prepared: 5/29/2019 4:30 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	304,234	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	829	1.01
2.00	Capital DRG outlier payments	0	2.00
2.01	Model 4 BPCI Capital DRG outlier payments	0	2.01
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)	12.08	3.00
4.00	Number of interns & residents (see instructions)	0.00	4.00
5.00	Indirect medical education percentage (see instructions)	0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)	0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)	0.00	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)	0.00	8.00
9.00	Sum of lines 7 and 8	0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)	0.00	10.00
11.00	Disproportionate share adjustment (see instructions)	0	11.00
12.00	Total prospective capital payments (see instructions)	305,063	12.00
		1.00	
	PART II - PAYMENT UNDER REASONABLE COST		
1.00	Program inpatient routine capital cost (see instructions)	0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)	0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)	0	3.00
4.00	Capital cost payment factor (see instructions)	0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)	0	5.00
		1.00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS		
1.00	Program inpatient capital costs (see instructions)	0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)	0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)	0	3.00
4.00	Applicable exception percentage (see instructions)	0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)	0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)	0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)	0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)	0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)	0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)	0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)	0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)	0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)	0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)	0	14.00
15.00	Current year allowable operating and capital payment (see instructions)	0	15.00
16.00	Current year operating and capital costs (see instructions)	0	16.00
17.00	Current year exception offset amount (see instructions)	0	17.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-0061 | Component CCN: 15-8500 | Period: From 01/01/2018 To 12/31/2018 | Worksheet M-1 | Date/Time Prepared: 5/29/2019 4:30 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	238,888	0	238,888	0	238,888	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	158,611	0	158,611	0	158,611	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	0	0	0	0	0	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	114,680	0	114,680	0	114,680	9.00
10.00	Subtotal (sum of lines 1 through 9)	512,179	0	512,179	0	512,179	10.00
11.00	Physician Services Under Agreement	0	78,589	78,589	0	78,589	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	78,589	78,589	0	78,589	14.00
15.00	Medical Supplies	0	12,772	12,772	0	12,772	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						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	12,772	12,772	0	12,772	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	512,179	91,361	603,540	0	603,540	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
25.01	Telehealth	0	0	0	0	0	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	35,935	35,935	0	35,935	29.00
30.00	Administrative Costs	76,670	0	76,670	0	76,670	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	76,670	35,935	112,605	0	112,605	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	588,849	127,296	716,145	0	716,145	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-0061 | Period: From 01/01/2018 To 12/31/2018 | Worksheet M-1

Component CCN: 15-8500 | Date/Time Prepared: 5/29/2019 4:30 pm

RHC I | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	238,888		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	158,611		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	0		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	114,680		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	512,179		10.00
11.00	Physician Services Under Agreement	0	78,589		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	78,589		14.00
15.00	Medical Supplies	0	12,772		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	12,772		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	603,540		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	35,935		29.00
30.00	Administrative Costs	0	76,670		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	112,605		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	716,145		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-0061 | Component CCN: 15-3999 | Period: From 01/01/2018 To 12/31/2018 | Worksheet M-1 | Date/Time Prepared: 5/29/2019 4:30 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	231,060	0	231,060	0	231,060	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	190,740	0	190,740	0	190,740	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	0	0	0	0	0	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	180,925	0	180,925	0	180,925	9.00
10.00	Subtotal (sum of lines 1 through 9)	602,725	0	602,725	0	602,725	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	44,528	44,528	0	44,528	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						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	44,528	44,528	0	44,528	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	602,725	44,528	647,253	0	647,253	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
25.01	Telehealth	0	0	0	0	0	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	38,763	38,763	0	38,763	29.00
30.00	Administrative Costs	119,965	0	119,965	0	119,965	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	119,965	38,763	158,728	0	158,728	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	722,690	83,291	805,981	0	805,981	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-0061 | Period: From 01/01/2018 To 12/31/2018 | Worksheet M-1

Component CCN: 15-3999 | Date/Time Prepared: 5/29/2019 4:30 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	231,060		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	190,740		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	0		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	180,925		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	602,725		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	44,528		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	44,528		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	647,253		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	38,763		29.00
30.00	Administrative Costs	0	119,965		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	158,728		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	805,981		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-0061 | Component CCN: 15-8501 | Period: From 01/01/2018 To 12/31/2018 | Worksheet M-1 | Date/Time Prepared: 5/29/2019 4:30 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	33,103	0	33,103	0	33,103	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	477,806	0	477,806	0	477,806	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	0	0	0	0	0	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	264,038	0	264,038	0	264,038	9.00
10.00	Subtotal (sum of lines 1 through 9)	774,947	0	774,947	0	774,947	10.00
11.00	Physician Services Under Agreement	0	127,955	127,955	0	127,955	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	203,423	203,423	0	203,423	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	331,378	331,378	0	331,378	14.00
15.00	Medical Supplies	0	23,774	23,774	0	23,774	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						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	23,774	23,774	0	23,774	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	774,947	355,152	1,130,099	0	1,130,099	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
25.01	Telehealth	0	0	0	0	0	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	74,350	74,350	0	74,350	29.00
30.00	Administrative Costs	91,384	0	91,384	0	91,384	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	91,384	74,350	165,734	0	165,734	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	866,331	429,502	1,295,833	0	1,295,833	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-0061 | Period: From 01/01/2018 To 12/31/2018 | Worksheet M-1

Component CCN: 15-8501 | Date/Time Prepared: 5/29/2019 4:30 pm

RHC III | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	33,103		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	477,806		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	0		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	264,038		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	774,947		10.00
11.00	Physician Services Under Agreement	0	127,955		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	203,423		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	331,378		14.00
15.00	Medical Supplies	0	23,774		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	23,774		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	1,130,099		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	74,350		29.00
30.00	Administrative Costs	0	91,384		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	165,734		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	1,295,833		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-0061 | Component CCN: 15-8503 | Period: From 01/01/2018 To 12/31/2018 | Worksheet M-1 | Date/Time Prepared: 5/29/2019 4:30 pm

RHC V | 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	535,153	0	535,153	0	535,153	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	166,145	0	166,145	0	166,145	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	0	0	0	0	0	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	118,188	0	118,188	0	118,188	9.00
10.00	Subtotal (sum of lines 1 through 9)	819,486	0	819,486	0	819,486	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	100,865	100,865	0	100,865	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						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	100,865	100,865	0	100,865	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	819,486	100,865	920,351	0	920,351	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
25.01	Telehealth	0	0	0	0	0	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	43,823	43,823	0	43,823	29.00
30.00	Administrative Costs	63,387	0	63,387	0	63,387	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	63,387	43,823	107,210	0	107,210	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	882,873	144,688	1,027,561	0	1,027,561	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-0061 | Period: From 01/01/2018 To 12/31/2018 | Worksheet M-1

Component CCN: 15-8503 | Date/Time Prepared: 5/29/2019 4:30 pm

RHC V | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	535,153		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	166,145		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	0		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	118,188		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	819,486		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	100,865		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	100,865		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	920,351		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	43,823		29.00
30.00	Administrative Costs	0	63,387		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	107,210		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	1,027,561		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-0061 | Component CCN: 15-8506 | Period: From 01/01/2018 To 12/31/2018 | Worksheet M-1 | Date/Time Prepared: 5/29/2019 4:30 pm

RHC VI | 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	64,140	0	64,140	0	64,140	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	175,613	0	175,613	0	175,613	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	0	0	0	0	0	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	171,412	0	171,412	0	171,412	9.00
10.00	Subtotal (sum of lines 1 through 9)	411,165	0	411,165	0	411,165	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	23,227	23,227	0	23,227	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						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	23,227	23,227	0	23,227	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	411,165	23,227	434,392	0	434,392	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
25.01	Telehealth	0	0	0	0	0	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	25,875	25,875	0	25,875	29.00
30.00	Administrative Costs	43,840	0	43,840	0	43,840	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	43,840	25,875	69,715	0	69,715	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	455,005	49,102	504,107	0	504,107	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-0061 | Period: From 01/01/2018 To 12/31/2018 | Worksheet M-1

Component CCN: 15-8506 | Date/Time Prepared: 5/29/2019 4:30 pm

RHC VI | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	64,140		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	175,613		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	0		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	171,412		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	411,165		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	23,227		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	23,227		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	434,392		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	25,875		29.00
30.00	Administrative Costs	0	43,840		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	69,715		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	504,107		32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 15-0061 Component CCN: 15-8500 | Period: From 01/01/2018 To 12/31/2018 | Worksheet M-2 Date/Time Prepared: 5/29/2019 4:30 pm

RHC I | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	0.96	2,680	4,200	4,032		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	0.97	3,130	2,100	2,037		3.00
4.00	Subtotal (sum of lines 1 through 3)	1.93	5,810		6,069	6,069	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)	1.93	5,810			6,069	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)					603,540	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)					603,540	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)					112,605	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					518,029	15.00
16.00	Total overhead (sum of lines 14 and 15)					630,634	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					630,634	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					630,634	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					1,234,174	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 15-0061 Component CCN: 15-3999 | Period: From 01/01/2018 To 12/31/2018 | Worksheet M-2 Date/Time Prepared: 5/29/2019 4:30 pm

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	RHC II Minimum Visits (col. 1 x col. 3)	Cost Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	1.02	4,091	4,200	4,284		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	1.67	3,025	2,100	3,507		3.00
4.00	Subtotal (sum of lines 1 through 3)	2.69	7,116		7,791	7,791	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)	2.69	7,116			7,791	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)					647,253	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)					647,253	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)					158,728	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					511,368	15.00
16.00	Total overhead (sum of lines 14 and 15)					670,096	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					670,096	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					670,096	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					1,317,349	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 15-0061 Component CCN: 15-8501 | Period: From 01/01/2018 To 12/31/2018 | Worksheet M-2 | Date/Time Prepared: 5/29/2019 4:30 pm

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	0.55	1,839	4,200	2,310		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	4.78	12,185	2,100	10,038		3.00
4.00	Subtotal (sum of lines 1 through 3)	5.33	14,024		12,348	14,024	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)	5.33	14,024			14,024	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)					1,130,099	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)					1,130,099	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)					165,734	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					800,747	15.00
16.00	Total overhead (sum of lines 14 and 15)					966,481	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					966,481	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					966,481	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					2,096,580	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 15-0061 Component CCN: 15-8503 | Period: From 01/01/2018 To 12/31/2018 | Worksheet M-2 Date/Time Prepared: 5/29/2019 4:30 pm

RHC V | 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	0.92	3,683	4,200	3,864		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	1.30	3,847	2,100	2,730		3.00
4.00	Subtotal (sum of lines 1 through 3)	2.22	7,530		6,594	7,530	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)	2.22	7,530			7,530	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)					920,351	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)					920,351	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)					107,210	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					518,314	15.00
16.00	Total overhead (sum of lines 14 and 15)					625,524	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					625,524	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					625,524	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					1,545,875	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 15-0061 Component CCN: 15-8506 | Period: From 01/01/2018 To 12/31/2018 | Worksheet M-2 Date/Time Prepared: 5/29/2019 4:30 pm

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	RHC VI Minimum Visits (col. 1 x col. 3)	Cost Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	0.10	400	4,200	420		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	1.49	3,979	2,100	3,129		3.00
4.00	Subtotal (sum of lines 1 through 3)	1.59	4,379		3,549	4,379	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)	1.59	4,379			4,379	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)					434,392	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)					434,392	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)					69,715	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					336,472	15.00
16.00	Total overhead (sum of lines 14 and 15)					406,187	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					406,187	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					406,187	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					840,579	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 15-0061 Component CCN: 15-8500	Period: From 01/01/2018 To 12/31/2018	Worksheet M-3 Date/Time Prepared: 5/29/2019 4:30 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)		1,234,174	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)		1,904	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		1,232,270	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		6,069	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)		6,069	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		203.04	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)	203.04	203.04	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	1,927	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	391,258	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	391,258	16.00
16.01	Total program charges (see instructions)(from contractor's records)		379,807	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		41,506	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		42,757	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.)		254,440	16.04
16.05	Total program cost (see instructions)	0	297,197	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		30,451	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		61,573	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		297,197	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		819	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		298,016	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)		298,016	26.00
26.01	Sequestration adjustment (see instructions)		5,960	26.01
26.02	Demonstration payment adjustment amount after sequestration		0	26.02
27.00	Interim payments		307,352	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)		-15,296	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: 15-0061 Component CCN: 15-3999	Period: From 01/01/2018 To 12/31/2018	Worksheet M-3 Date/Time Prepared: 5/29/2019 4:30 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)		1,317,349	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)		3,525	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		1,313,824	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		7,791	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)		0	5.00
6.00	Total adjusted visits (line 4 plus line 5)		7,791	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		168.63	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)	168.63	168.63	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	2,295	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	387,006	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	387,006	16.00
16.01	Total program charges (see instructions)(from contractor's records)		462,560	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.)		272,681	16.04
16.05	Total program cost (see instructions)	0	272,681	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		46,155	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		83,284	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		272,681	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		1,884	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		274,565	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)		274,565	26.00
26.01	Sequestration adjustment (see instructions)		5,491	26.01
26.02	Demonstration payment adjustment amount after sequestration		0	26.02
27.00	Interim payments		227,658	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)		41,416	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: 15-0061 Component CCN: 15-8501	Period: From 01/01/2018 To 12/31/2018	Worksheet M-3 Date/Time Prepared: 5/29/2019 4:30 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)		2,096,580	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)		939	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		2,095,641	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		14,024	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)		14,024	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		149.43	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)	149.43	149.43	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	1,994	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	297,963	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	297,963	16.00
16.01	Total program charges (see instructions)(from contractor's records)		382,564	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		16,243	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		12,651	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.)		196,611	16.04
16.05	Total program cost (see instructions)	0	209,262	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		39,548	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		65,356	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		209,262	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		606	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		209,868	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)		209,868	26.00
26.01	Sequestration adjustment (see instructions)		4,197	26.01
26.02	Demonstration payment adjustment amount after sequestration		0	26.02
27.00	Interim payments		228,052	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)		-22,381	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: 15-0061 Component CCN: 15-8503	Period: From 01/01/2018 To 12/31/2018	Worksheet M-3 Date/Time Prepared: 5/29/2019 4:30 pm
	Title XVIII	RHC V	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)	1,545,875	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)	0	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)	1,545,875	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)	7,530	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)	0	5.00
6.00	Total adjusted visits (line 4 plus line 5)	7,530	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)	205.30	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)	205.30	205.30	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	6	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	1,232	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)			15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *	0	1,232	16.00
16.01	Total program charges (see instructions)(from contractor's records)		954	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.)		622	16.04
16.05	Total program cost (see instructions)	0	622	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		454	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		100	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		622	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		0	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		622	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)		622	26.00
26.01	Sequestration adjustment (see instructions)		12	26.01
26.02	Demonstration payment adjustment amount after sequestration		0	26.02
27.00	Interim payments		344	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)		266	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: 15-0061 Component CCN: 15-8506	Period: From 01/01/2018 To 12/31/2018	Worksheet M-3 Date/Time Prepared: 5/29/2019 4:30 pm
	Title XVIII	RHC VI	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)		840,579	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)		1,618	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		838,961	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		4,379	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)		4,379	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		191.59	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)	191.59	191.59	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	1,842	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	352,909	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	352,909	16.00
16.01	Total program charges (see instructions)(from contractor's records)		344,072	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		202	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		207	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.)		248,970	16.04
16.05	Total program cost (see instructions)	0	249,177	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		41,490	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		60,479	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		249,177	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		872	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		250,049	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)		250,049	26.00
26.01	Sequestration adjustment (see instructions)		5,001	26.01
26.02	Demonstration payment adjustment amount after sequestration		0	26.02
27.00	Interim payments		212,039	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)		33,009	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: 15-0061 Component CCN: 15-8500	Period: From 01/01/2018 To 12/31/2018	Worksheet M-4 Date/Time Prepared: 5/29/2019 4:30 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)	512,179	512,179	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000122	0.001424	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	62	729	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	93	47	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	155	776	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	603,540	603,540	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	630,634	630,634	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.000257	0.001286	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	162	811	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	317	1,587	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	15	227	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	21.13	6.99	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	8	93	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	169	650	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)		1,904	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)		819	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA VACCINE COST	Provider CCN: 15-0061 Component CCN: 15-3999	Period: From 01/01/2018 To 12/31/2018	Worksheet M-4 Date/Time Prepared: 5/29/2019 4:30 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)	602,725	602,725	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.002208	0.000433	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	1,331	261	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	93	47	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	1,424	308	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	647,253	647,253	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	670,096	670,096	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.002200	0.000476	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	1,474	319	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	2,898	627	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	73	372	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	39.70	1.69	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	39	199	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	1,548	336	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)		3,525	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)		1,884	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA VACCINE COST	Provider CCN: 15-0061 Component CCN: 15-8501	Period: From 01/01/2018 To 12/31/2018	Worksheet M-4 Date/Time Prepared: 5/29/2019 4:30 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)	774,947	774,947	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000016	0.000457	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	12	354	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	93	47	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	105	401	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	1,130,099	1,130,099	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	966,481	966,481	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.000093	0.000355	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	90	343	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	195	744	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	2	105	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	97.50	7.09	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	2	58	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	195	411	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)		939	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)		606	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA VACCINE COST	Provider CCN: 15-0061 Component CCN: 15-8506	Period: From 01/01/2018 To 12/31/2018	Worksheet M-4 Date/Time Prepared: 5/29/2019 4:30 pm
	Title XVIII	RHC VI	Cost

		Pneumococcal	Influenza	
		1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	411,165	411,165	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000488	0.001204	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	201	495	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	93	47	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	294	542	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	434,392	434,392	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	406,187	406,187	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.000677	0.001248	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	275	507	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	569	1,049	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	34	210	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	16.74	5.00	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	30	74	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	502	370	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)		1,618	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)		872	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 15-0061 Component CCN: 15-8500	Period: From 01/01/2018 To 12/31/2018	Worksheet M-5 Date/Time Prepared: 5/29/2019 4:30 pm
		RHC I	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		307,352	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)		307,352	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		15,296	6.02
7.00	Total Medicare program liability (see instructions)		292,056	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: 15-0061 Component CCN: 15-3999	Period: From 01/01/2018 To 12/31/2018	Worksheet M-5 Date/Time Prepared: 5/29/2019 4:30 pm
		RHC II	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		227,658	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)		227,658	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		41,416	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		269,074	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: 15-0061 Component CCN: 15-8501	Period: From 01/01/2018 To 12/31/2018	Worksheet M-5 Date/Time Prepared: 5/29/2019 4:30 pm
		RHC III	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		200,052	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		08/09/2018	28,000	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)		28,000	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		228,052	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		22,381	6.02
7.00	Total Medicare program liability (see instructions)		205,671	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: 15-0061 Component CCN: 15-8503	Period: From 01/01/2018 To 12/31/2018	Worksheet M-5 Date/Time Prepared: 5/29/2019 4:30 pm
		RHC V	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		344	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)		344	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		266	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		610	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: 15-0061 Component CCN: 15-8506	Period: From 01/01/2018 To 12/31/2018	Worksheet M-5 Date/Time Prepared: 5/29/2019 4:30 pm
		RHC VI	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		212,039	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)		212,039	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		33,009	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		245,048	7.00

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