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: 15-1334	Period: From 01/01/2018 To 12/31/2018	Worksheet S Parts I-III Date/Time Prepared: 5/30/2019 11:32 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 5/30/2019 Time: 11:32 am
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 SCOTT MEMORIAL HOSPITAL (15-1334) 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	284,081	-13,353	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	38,015	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
10.00	RURAL HEALTH CLINIC I	0		64,376		0	10.00
200.00	Total	0	322,096	51,023	0	0	200.00

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

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0050. The time required to complete and review the information collection is estimated 673 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving the form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.
Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents , please contact 1-800-MEDICARE.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1334 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part I Date/Time Prepared: 5/30/2019 11:32 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 1451 NORTH GARDNER	PO Box:			1.00
2.00	City: SCOTTSBURG	State: IN	Zip Code: 47170-	County: SCOTT	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	SCOTT MEMORIAL HOSPITAL	151334	31140	1	07/01/1966	N	O	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	SCOTT MEMORIAL SWING BEDS	15Z334	31140		03/21/2013	N	O	N	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC	SCOTTSBURG FAMILY PRACTICE	158523	31140		08/09/2017	N	O	O	15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	01/01/2018	12/31/2018	20.00
21.00	Type of Control (see instructions)	4		21.00

		1.00	2.00	3.00	
	Inpatient PPS Information				
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	N			22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	N	N		22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N		22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or “N” for no.	N	N	N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	0			23.00

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	0	0	0	0	0	0	24.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1334 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part I Date/Time Prepared: 5/30/2019 11:32 am

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0		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)	N	N	39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	N	N	40.00

		V	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.				57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.	N			58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1334 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part I | Date/Time Prepared: 5/30/2019 11:32 am

		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: 15-1334 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part I | Date/Time Prepared: 5/30/2019 11:32 am

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	65.00

		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
		1.00	2.00	3.00	
	Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010				
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000	66.00

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	67.00

		1.00	2.00	3.00	
	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.	N			70.00
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0	71.00
	Inpatient Rehabilitation Facility PPS				
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	N			75.00
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0	76.00

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		1.00	
	Long Term Care Hospital PPS		
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.	N	80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.	N	81.00
	TEFRA Providers		
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.	N	85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.		86.00
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	N	87.00

		V	XIX	
		1.00	2.00	
	Title V and XIX Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	Y	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.	Y	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.		Y	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?	Y		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N		106.00
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II.	N		107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00

		Physical	Occupational	Speech	Respiratory	
		1.00	2.00	3.00	4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	Y	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: 15-1334 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part I | Date/Time Prepared: 5/30/2019 11:32 am

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

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

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	113,909	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	44H097	140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1334 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part I | Date/Time Prepared: 5/30/2019 11:32 am

	1.00	2.00	3.00	
	If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.			
141.00	Name: LIFEPOINT HEALTH INC.	Contractor's Name: PALMETTO GBA	Contractor's Number: 10001	141.00
142.00	Street: PO BOX 100307	PO Box:		142.00
143.00	City: COLUMBIA	State: SC	Zip Code: 29202	143.00

		1.00	
144.00	Are provider based physicians' costs included in Worksheet A?	Y	144.00

		1.00	2.00	
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.			145.00
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N		146.00

		1.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.	N	147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.	N	148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.	N	149.00

		Part A	Part B	Title V	Title XIX	
		1.00	2.00	3.00	4.00	
	Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)					
155.00	Hospital	Y	Y	N	N	155.00
156.00	Subprovider - IPF	N	N	N	N	156.00
157.00	Subprovider - IRF	N	N	N	N	157.00
158.00	SUBPROVIDER					158.00
159.00	SNF	N	N	N	N	159.00
160.00	HOME HEALTH AGENCY	N	N	N	N	160.00
161.00	CMHC		N	N	N	161.00

		1.00	
	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)	0.00	169.00

		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	01/01/2018	03/31/2018	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: 15-1334 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part II | Date/Time Prepared: 5/30/2019 11:32 am

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

		Y/N	Date	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	12/31/2018	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)	Y	04/25/2019	Y	04/25/2019	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-1334 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part II Date/Time Prepared: 5/30/2019 11:32 am

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

		1.00	
	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	N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.	N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions	N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.	N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.	N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.	N	27.00
	Interest Expense		
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.	N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions	N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.	N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.	N	31.00
	Purchased Services		
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.	N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.		33.00
	Provider-Based Physicians		
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.	Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.	N	35.00

		Y/N	Date	
		1.00	2.00	
	Home Office Costs			
36.00	Were home office costs claimed on the cost report?	Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.	Y		37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.	N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.	N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.	N		40.00

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	CLINTON	BALLEW	41.00
42.00	Enter the employer/company name of the cost report preparer.	LIFEPOINT HEALTH, INC.		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	6159207569	CLINTON.BALLEW@LPNT.NET	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-1334	Period: From 01/01/2018 To 12/31/2018	Worksheet S-2 Part II Date/Time Prepared: 5/30/2019 11:32 am

		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.	REIMBURSEMENT MANAGER		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: 15-1334 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-3 Part I | Date/Time Prepared: 5/30/2019 11:32 am

	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	21	7,665	70,541.00	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)		21	7,665	70,541.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	4	1,460	2,713.00	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)		25	9,125	73,254.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	88.00				0	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		25				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00
33.01	LTCH site neutral days and discharges						33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-1334 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-3 Part I | Date/Time Prepared: 5/30/2019 11:32 am

	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)	1,203	372	2,274			1.00
2.00	HMO and other (see instructions)	325	0				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	416	0	462			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		11	26			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,619	383	2,762			7.00
8.00	INTENSIVE CARE UNIT	71	30	145			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		98	104			13.00
14.00	Total (see instructions)	1,690	511	3,011	0.00	148.90	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	1,437	0	6,067	0.00	6.60	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	155.50	27.00
28.00	Observation Bed Days		303	1,016			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-1334 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-3 Part I | Date/Time Prepared: 5/30/2019 11:32 am

	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	411	169	807	1.00
2.00	HMO and other (see instructions)			82	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	411	169	807	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	0.00					26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 15-1334 | Component CCN: 15-8523 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-8 | Date/Time Prepared: 5/30/2019 11:32 am

RHC I | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			1465 NORTH GARDNER STREET		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	SCOTTSBURG		IN	47170	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			08:30	17:00	08:30	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		SCOTT				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	16:30	08:30	16:30	08:30	16:30	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 15-1334
Component CCN: 15-8523

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

Worksheet S-8
Date/Time Prepared:
5/30/2019 11:32 am

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	08:30	16:30				11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 15-1334 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-10 | Date/Time Prepared: 5/30/2019 11:32 am

		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)	0.275022	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	3,613,898	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	N	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?		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	16,591,933	6.00
7.00	Medicaid cost (line 1 times line 6)	4,563,147	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)	949,249	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)	949,249	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)	0	0	0	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	0	0	0	21.00
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	0	0	0	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)	4,186,548	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	428,396	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	659,071	27.01
28.00	Non-Medicare bad debt expense (see instructions)	3,527,477	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	1,200,809	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	1,200,809	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	2,150,058	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1334 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A | Date/Time Prepared: 5/30/2019 11:32 am

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		726,920	726,920	213,889	940,809	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		22,241	22,241	140,948	163,189	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	45,449	1,496,269	1,541,718	-60,325	1,481,393	4.00
5.01	00550	INFORMATION TECH	165,661	575,578	741,239	0	741,239	5.01
5.02	00570	ADMITTING	376,938	206,874	583,812	-3,090	580,722	5.02
5.03	00560	PURCHASING RECEIVING AND STORES	0	58,719	58,719	0	58,719	5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	401,210	401,210	0	401,210	5.04
5.05	00590	OTHER ADMIN AND GENERAL	766,897	2,546,185	3,313,082	-276,344	3,036,738	5.05
7.00	00700	OPERATION OF PLANT	235,019	719,217	954,236	-3,338	950,898	7.00
9.00	00900	HOUSEKEEPING	218,900	155,048	373,948	0	373,948	9.00
10.00	01000	DIETARY	196,219	186,668	382,887	-289,948	92,939	10.00
11.00	01100	CAFETERIA	0	0	0	289,450	289,450	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	168,120	168,120	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	65,616	178,141	243,757	-114,097	129,660	14.00
15.00	01500	PHARMACY	188,927	531,866	720,793	-403,145	317,648	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	485,672	132,325	617,997	-5,252	612,745	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,535,100	656,752	2,191,852	-158,205	2,033,647	30.00
31.00	03100	INTENSIVE CARE UNIT	371,097	30,724	401,821	9,051	410,872	31.00
43.00	04300	NURSERY	0	0	0	103,731	103,731	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	474,619	1,085,214	1,559,833	-109,432	1,450,401	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	39,616	39,616	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	729,339	573,890	1,303,229	-63,386	1,239,843	54.00
60.00	06000	LABORATORY	445,810	605,037	1,050,847	-154,286	896,561	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	75,100	75,100	0	75,100	63.00
65.00	06500	RESPIRATORY THERAPY	442,789	120,894	563,683	-175,049	388,634	65.00
66.00	06600	PHYSICAL THERAPY	57,100	577,042	634,142	-62,034	572,108	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	21,837	21,837	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	34,735	34,735	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	165,000	165,000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	114,743	114,743	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	218,054	218,054	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	402,762	402,762	73.00
75.00	03610	SLEEP LAB	350	8,869	9,219	-9,219	0	75.00
76.00	03020	CARDIAC REHAB	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	74,911	9,680	84,591	9,254	93,845	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	390,063	165,213	555,276	-42,984	512,292	88.00
91.00	09100	EMERGENCY	874,426	565,270	1,439,696	37,657	1,477,353	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		326,309	326,309	0	326,309	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	8,140,902	12,737,255	20,878,157	38,713	20,916,870	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	MARKETING	0	89,560	89,560	0	89,560	190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,457	112	1,569	0	1,569	192.00
192.01	19201	SCOTT PHYSICIAN GROUP	0	0	0	0	0	192.01
194.00	07950	BUHSE CAMPUS	155,874	67,258	223,132	-11,987	211,145	194.00
194.01	07951	MEDICAL SPECIALTY	21,292	125,162	146,454	-1,861	144,593	194.01
194.02	07952	MEDICAL OFFICE	0	0	0	0	0	194.02
194.03	07953	VA PROPERTY	0	0	0	0	0	194.03
194.04	07954	ALREFAI CAMPUS	0	0	0	0	0	194.04
194.05	07955	ORTHO CAMPUS	237,727	104,535	342,262	-24,632	317,630	194.05
194.06	07956	DR. CRAIG CLINIC	0	0	0	0	0	194.06
194.07	07957	DR. OLABIGE CLINIC	0	412	412	-233	179	194.07
194.08	07958	URGENT CARE CLINIC	0	0	0	0	0	194.08
194.09	07959	DR. PACE	0	6,363	6,363	0	6,363	194.09
194.10	07960	SCOTTSBURG FAMILY PRACTICE (RHC)	0	0	0	0	0	194.10
200.00		TOTAL (SUM OF LINES 118 through 199)	8,557,252	13,130,657	21,687,909	0	21,687,909	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1334 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A | Date/Time Prepared: 5/30/2019 11:32 am

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	-439,754	501,055		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	514,094	677,283		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	1,481,393		4.00
5.01	00550	INFORMATION TECH	0	741,239		5.01
5.02	00570	ADMITTING	0	580,722		5.02
5.03	00560	PURCHASING RECEIVING AND STORES	0	58,719		5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	401,210		5.04
5.05	00590	OTHER ADMIN AND GENERAL	-1,194,212	1,842,526		5.05
7.00	00700	OPERATION OF PLANT	0	950,898		7.00
9.00	00900	HOUSEKEEPING	0	373,948		9.00
10.00	01000	DIETARY	0	92,939		10.00
11.00	01100	CAFETERIA	-96,944	192,506		11.00
13.00	01300	NURSING ADMINISTRATION	0	168,120		13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	-9,522	120,138		14.00
15.00	01500	PHARMACY	0	317,648		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-24	612,721		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-237,194	1,796,453		30.00
31.00	03100	INTENSIVE CARE UNIT	0	410,872		31.00
43.00	04300	NURSERY	0	103,731		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-435,114	1,015,287		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	39,616		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-235	1,239,608		54.00
60.00	06000	LABORATORY	0	896,561		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	75,100		63.00
65.00	06500	RESPIRATORY THERAPY	0	388,634		65.00
66.00	06600	PHYSICAL THERAPY	0	572,108		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	21,837		67.00
68.00	06800	SPEECH PATHOLOGY	0	34,735		68.00
69.00	06900	ELECTROCARDIOLOGY	0	165,000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	114,743		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	218,054		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	402,762		73.00
75.00	03610	SLEEP LAB	0	0		75.00
76.00	03020	CARDIAC REHAB	0	0		76.00
76.97	07697	CARDIAC REHABILITATION	0	93,845		76.97
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	512,292		88.00
91.00	09100	EMERGENCY	-2,791	1,474,562		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	-326,309	0		113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-2,228,005	18,688,865		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
190.01	19001	MARKETING	0	89,560		190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	1,569		192.00
192.01	19201	SCOTT PHYSICIAN GROUP	0	0		192.01
194.00	07950	BUHSE CAMPUS	0	211,145		194.00
194.01	07951	MEDICAL SPECIALTY	0	144,593		194.01
194.02	07952	MEDICAL OFFICE	0	0		194.02
194.03	07953	VA PROPERTY	0	0		194.03
194.04	07954	ALREFAI CAMPUS	0	0		194.04
194.05	07955	ORTHO CAMPUS	0	317,630		194.05
194.06	07956	DR. CRAIG CLINIC	0	0		194.06
194.07	07957	DR. OLABIGE CLINIC	0	179		194.07
194.08	07958	URGENT CARE CLINIC	0	0		194.08
194.09	07959	DR. PACE	0	6,363		194.09
194.10	07960	SCOTTSBURG FAMILY PRACTICE (RHC)	0	0		194.10
200.00		TOTAL (SUM OF LINES 118 through 199)	-2,228,005	19,459,904		200.00

RECLASSIFICATIONS | Provider CCN: 15-1334 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-6 | Date/Time Prepared: 5/30/2019 11:32 am

		Increases				
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - LEASES					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	75,764		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	118,327		2.00
3.00	CARDIAC REHABILITATION	76.97	0	35		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
16.00		0.00	0	0		16.00
17.00		0.00	0	0		17.00
18.00		0.00	0	0		18.00
19.00		0.00	0	0		19.00
20.00		0.00	0	0		20.00
21.00		0.00	0	0		21.00
	0		0	194,126		
	B - DIRECTOR OF NURSING					
1.00	NURSING ADMINISTRATION	13.00	138,464	10,306		1.00
	0		138,464	10,306		
	C - CORPORATE PAID BENEFITS					
1.00	OTHER ADMIN AND GENERAL	5.05	0	38,699		1.00
2.00	NURSING ADMINISTRATION	13.00	0	19,350		2.00
	0		0	58,049		
	D - GENERAL LIABLILITY INSURANCE					
1.00		0.00	0	0		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	22,621		2.00
	0		0	22,621		
	E - CAFETERIA					
1.00	CAFETERIA	11.00	148,335	141,115		1.00
	0		148,335	141,115		
	F - NURSERY, L&D					
1.00	NURSERY	43.00	83,383	20,348		1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	14,235	3,474		2.00
	0		97,618	23,822		
	G - RESP THERAPY TO EKG					
1.00	ELECTROCARDIOLOGY	69.00	104,811	28,616		1.00
	0		104,811	28,616		
	H - MED SUPPLIES, DRUGS, COGS					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	114,743		1.00
2.00	CENTRAL SERVICE & SUPPLY	14.00	0	101,306		2.00
3.00		0.00	0	0		3.00
	0		0	216,049		
	I - COST TO CHARGE					
1.00	INTENSIVE CARE UNIT	31.00	2,714	6,337		1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	14,676	7,231		2.00
3.00	LABORATORY	60.00	11,772	4,972		3.00
4.00	ELECTROCARDIOLOGY	69.00	17,913	13,660		4.00
5.00		0.00	0	0		5.00
6.00	EMERGENCY	91.00	16,323	22,962		6.00
	0		63,398	55,162		
	J - PROPERTY TAX					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	138,125		1.00
	0		0	138,125		
	L - IMPLANTS RECLASS					
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	218,054		1.00
2.00		0.00	0	0		2.00
	0		0	218,054		
	M - DRUGS RECLASS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	402,762		1.00
2.00		0.00	0	0		2.00
	0		0	402,762		
	N - RECLASS SLEEP LAB COST TO CARD REHAB					
1.00	CARDIAC REHABILITATION	76.97	350	8,869		1.00
	0		350	8,869		

RECLASSIFICATIONS | Provider CCN: 15-1334 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-6 | Date/Time Prepared: 5/30/2019 11:32 am

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	O - RECLASS ST COSTS FROM PT TO OT, ST					
1.00	OCCUPATIONAL THERAPY	67.00	1	1		1.00
2.00	SPEECH PATHOLOGY	68.00	1	1		2.00
	0		2	2		
	P - PT TO ST					
1.00	SPEECH PATHOLOGY	68.00	34,733	0		1.00
2.00	OCCUPATIONAL THERAPY	67.00	21,835	0		2.00
	TOTALS		56,568	0		
500.00	Grand Total: Increases		609,546	1,517,678		500.00

RECLASSIFICATIONS | Provider CCN: 15-1334 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-6 | Date/Time Prepared: 5/30/2019 11:32 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - LEASES						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	2,276	10		1.00
2.00	ADMITTING	5.02	0	3,090	10		2.00
3.00	OTHER ADMIN AND GENERAL	5.05	0	5,527	0		3.00
4.00	OPERATION OF PLANT	7.00	0	3,338	0		4.00
5.00	DIETARY	10.00	0	498	0		5.00
6.00	CENTRAL SERVICE & SUPPLY	14.00	0	2,881	0		6.00
7.00	PHARMACY	15.00	0	719	0		7.00
8.00	MEDICAL RECORDS & LIBRARY	16.00	0	5,252	0		8.00
9.00	ADULTS & PEDIATRICS	30.00	0	8,531	0		9.00
10.00	OPERATING ROOM	50.00	0	58,637	0		10.00
11.00	RADIOLOGY-DIAGNOSTIC	54.00	0	1,396	0		11.00
12.00	LABORATORY	60.00	0	1,396	0		12.00
13.00	RESPIRATORY THERAPY	65.00	0	15,468	0		13.00
14.00	PHYSICAL THERAPY	66.00	0	1,792	0		14.00
16.00	RURAL HEALTH CLINIC	88.00	0	42,984	0		16.00
17.00	EMERGENCY	91.00	0	1,628	0		17.00
18.00	BUHSE CAMPUS	194.00	0	11,987	0		18.00
19.00	MEDICAL SPECIALTY	194.01	0	1,861	0		19.00
20.00	ORTHO CAMPUS	194.05	0	24,632	0		20.00
21.00	DR. OLABIGE CLINIC	194.07	0	233	0		21.00
	0		0	194,126			
	B - DIRECTOR OF NURSING						
1.00	OTHER ADMIN AND GENERAL	5.05	138,464	10,306	0		1.00
	0		138,464	10,306			
	C - CORPORATE PAID BENEFITS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	58,049	0		1.00
2.00		0.00	0	0	0		2.00
	0		0	58,049			
	D - GENERAL LIABLILITY INSURANCE						
1.00		0.00	0	0	0		1.00
2.00	OTHER ADMIN AND GENERAL	5.05	0	22,621	12		2.00
	0		0	22,621			
	E - CAFETERIA						
1.00	DIETARY	10.00	148,335	141,115	0		1.00
	0		148,335	141,115			
	F - NURSERY, L&D						
1.00	ADULTS & PEDIATRICS	30.00	97,618	23,822	0		1.00
2.00		0.00	0	0	0		2.00
	0		97,618	23,822			
	G - RESP THERAPY TO EKG						
1.00	RESPIRATORY THERAPY	65.00	104,811	28,616	0		1.00
	0		104,811	28,616			
	H - MED SUPPLIES, DRUGS, COGS						
1.00	RADIOLOGY-DIAGNOSTIC	54.00	0	30,417	0		1.00
2.00	LABORATORY	60.00	0	169,634	0		2.00
3.00	RESPIRATORY THERAPY	65.00	0	15,998	0		3.00
	0		0	216,049			
	I - COST TO CHARGE						
1.00	ADULTS & PEDIATRICS	30.00	23,943	4,291	0		1.00
2.00	OPERATING ROOM	50.00	13,306	31,957	0		2.00
3.00	RADIOLOGY-DIAGNOSTIC	54.00	17,913	13,660	0		3.00
4.00		0.00	0	0	0		4.00
5.00	RESPIRATORY THERAPY	65.00	7,706	2,450	0		5.00
6.00	PHYSICAL THERAPY	66.00	530	2,804	0		6.00
	0		63,398	55,162			
	J - PROPERTY TAX						
1.00	OTHER ADMIN AND GENERAL	5.05	0	138,125	13		1.00
	0		0	138,125			
	L - IMPLANTS RECLASS						
1.00	CENTRAL SERVICE & SUPPLY	14.00	0	212,522	0		1.00
2.00	OPERATING ROOM	50.00	0	5,532	0		2.00
	0		0	218,054			
	M - DRUGS RECLASS						
1.00	PHARMACY	15.00	0	402,426	0		1.00
2.00	PHYSICAL THERAPY	66.00	0	336	0		2.00
	0		0	402,762			
	N - RECLASS SLEEP LAB COST TO CARD REHAB						
1.00	SLEEP LAB	75.00	350	8,869	0		1.00
	0		350	8,869			
	O - RECLASS ST COSTS FROM PT TO OT, ST						
1.00	PHYSICAL THERAPY	66.00	2	2	0		1.00
2.00		0.00	0	0	0		2.00
	0		2	2			

RECLASSIFICATIONS | Provider CCN: 15-1334 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-6 | Date/Time Prepared: 5/30/2019 11:32 am

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	P - PT TO ST						
1.00	PHYSICAL THERAPY	66.00	56,568	0	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		56,568	0			
500.00	Grand Total: Decreases		609,546	1,517,678			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1334 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-7 Part I | Date/Time Prepared: 5/30/2019 11:32 am

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	840,000	0	0	0	0	1.00
2.00	Land Improvements	444,683	0	0	0	0	2.00
3.00	Buildings and Fixtures	3,056,164	0	0	0	0	3.00
4.00	Building Improvements	290,433	21,516	0	21,516	0	4.00
5.00	Fixed Equipment	1,454,071	54,047	0	54,047	0	5.00
6.00	Movable Equipment	2,624,504	1,132,771	0	1,132,771	0	6.00
7.00	HIT designated Assets	1,345,381	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	10,055,236	1,208,334	0	1,208,334	0	8.00
9.00	Reconciling Items	11,674	-102,069	0	-102,069	0	9.00
10.00	Total (line 8 minus line 9)	10,043,562	1,310,403	0	1,310,403	0	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	840,000	0	1.00
2.00	Land Improvements	444,683	0	2.00
3.00	Buildings and Fixtures	3,056,164	0	3.00
4.00	Building Improvements	311,949	0	4.00
5.00	Fixed Equipment	1,508,118	0	5.00
6.00	Movable Equipment	3,757,275	0	6.00
7.00	HIT designated Assets	1,345,381	0	7.00
8.00	Subtotal (sum of lines 1-7)	11,263,570	0	8.00
9.00	Reconciling Items	-90,395	0	9.00
10.00	Total (line 8 minus line 9)	11,353,965	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1334 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-7 Part II | Date/Time Prepared: 5/30/2019 11:32 am

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	726,920	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	22,241	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	749,161	0	0	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL			
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)		
		14.00	15.00		
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2				
1.00	CAP REL COSTS-BLDG & FIXT	0	726,920		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	22,241		2.00
3.00	Total (sum of lines 1-2)	0	749,161		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1334 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-7 Part III Date/Time Prepared: 5/30/2019 11:32 am

	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	CAP REL COSTS-BLDG & FIXT	0	0	0	1.000000	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0.000000	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	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	CAP REL COSTS-BLDG & FIXT	0	0	0	287,166	75,764	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	536,335	118,327	2.00
3.00	Total (sum of lines 1-2)	0	0	0	823,501	194,091	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	CAP REL COSTS-BLDG & FIXT	0	0	138,125	0	501,055	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	22,621	0	0	677,283	2.00
3.00	Total (sum of lines 1-2)	0	22,621	138,125	0	1,178,338	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1334 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-8 | Date/Time Prepared: 5/30/2019 11:32 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-670,864			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	-314,062			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-96,944	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	-24	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines	B	-1,129	OTHER ADMIN AND GENERAL	5.05	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT	A	-439,754	CAP REL COSTS-BLDG & FIXT	1.00	9	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP	A	528,359	CAP REL COSTS-MVBLE EQUIP	2.00	9	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	MISC INCOME	B	-10,181	OTHER ADMIN AND GENERAL	5.05	0	33.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1334 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-8 | Date/Time Prepared: 5/30/2019 11:32 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.01	INDIANA PROVIDER TAX	A	-1,202,162	OTHER ADMIN AND GENERAL	5.05	0	33.01
33.02	OTHER ADJUSTMENTS (SPECIFY) (3)	A	0		0.00	0	33.02
33.03	DEPRECIATION ON HITECH ASSETS	A	-14,265	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.03
33.04	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.04
34.00	PHYSICIAN RECRUITING	A	-20	OTHER ADMIN AND GENERAL	5.05	0	34.00
34.01	CONTRIBUTIONS	A	-390	OTHER ADMIN AND GENERAL	5.05	0	34.01
36.00	LOBBYING EXP IN ASSOC DUES	A	-2,088	OTHER ADMIN AND GENERAL	5.05	0	36.00
37.00	LOST CHARGES	A	-11	CENTRAL SERVICE & SUPPLY	14.00	0	37.00
37.01	LOST CHARGES	A	-1,444	ADULTS & PEDIATRICS	30.00	0	37.01
37.02	LOST CHARGES	A	-235	RADIOLOGY-DIAGNOSTIC	54.00	0	37.02
37.03	LOST CHARGES	A	-2,791	EMERGENCY	91.00	0	37.03
37.04	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	37.04
37.05	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	37.05
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-2,228,005				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: 15-1334 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-8-1 | Date/Time Prepared: 5/30/2019 11:32 am

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	113.00	INTEREST EXPENSE	HOME OFFICE INTEREST	0	326,309	1.00
2.00	5.05	OTHER ADMIN AND GENERAL	MALPRACTICE INS EXPENSE	17,591	113,909	2.00
3.00	5.05	OTHER ADMIN AND GENERAL	MANAGEMENT FEES	762,638	612,860	3.00
4.00	5.05	OTHER ADMIN AND GENERAL	HOME OFFICE PAYROLL TAXES	-31,702	0	4.00
4.01	14.00	CENTRAL SERVICE & SUPPLY	HPG COST	7,169	16,680	4.01
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			755,696	1,069,758	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:					
6.00	B		0.00	LIFEPOINT HOSP	100.00	6.00
7.00			0.00		0.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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.

(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: 15-1334	Period: From 01/01/2018 To 12/31/2018	Worksheet A-8-1 Date/Time Prepared: 5/30/2019 11:32 am

	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	-326,309	11		1.00
2.00	-96,318	12		2.00
3.00	149,778	0		3.00
4.00	-31,702	0		4.00
4.01	-9,511	0		4.01
5.00	-314,062			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	HOSP MANAGEMENT		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: 15-1334 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-8-2 | Date/Time Prepared: 5/30/2019 11:32 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	50.00	DR. A	544,466	435,114	109,352	0	0	1.00
2.00	30.00	DR. B	235,750	235,750	0	0	0	2.00
3.00	0.00		0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			780,216	670,864	109,352		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	50.00	DR. A	0	0	0	0	0	1.00
2.00	30.00	DR. B	0	0	0	0	0	2.00
3.00	0.00		0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	50.00	DR. A	0	0	0	435,114		1.00
2.00	30.00	DR. B	0	0	0	235,750		2.00
3.00	0.00		0	0	0	0		3.00
4.00	0.00		0	0	0	0		4.00
5.00	0.00		0	0	0	0		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	670,864		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 15-1334 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 5/30/2019 11:32 am

Physical Therapy | Cost

						1.00	
	PART I - GENERAL INFORMATION						
1.00	Total number of weeks worked (excluding aides) (see instructions)					0	1.00
2.00	Line 1 multiplied by 15 hours per week					0	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					0	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00
7.00	Standard travel expense rate					0.00	7.00
8.00	Optional travel expense rate per mile					0.00	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	1,766.00	6,318.00	910.00	2,106.00	0.00	9.00
10.00	AHSEA (see instructions)	84.74	82.61	27.64	41.45	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	41.31	41.31	13.82			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01
						1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION						
14.00	Supervisors (column 1, line 9 times column 1, line 10)					149,651	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					521,930	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)					25,152	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					696,733	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)					87,294	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)					0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)					784,027	20.00
	If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.						
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)					0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					0	22.00
23.00	Total salary equivalency (see instructions)					784,027	23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE						
	Standard Travel Allowance						
24.00	Therapists (line 3 times column 2, line 11)					0	24.00
25.00	Assistants (line 4 times column 3, line 11)					0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					0	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					0	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					0	28.00
	Optional Travel Allowance and Optional Travel Expense						
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)					0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)					0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)					0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)					0	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE						
	Standard Travel Expense						
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00
	Optional Travel Allowance and Optional Travel Expense						
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.						
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 15-1334 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 5/30/2019 11:32 am

Physical Therapy | Cost

						1.00	
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00
		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	82.61	27.64	41.45	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00

		1.00		
	Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT			
57.00	Salary equivalency amount (from line 23)	784,027		57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	0		58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)	0		59.00
60.00	Overtime allowance (from column 5, line 56)	0		60.00
61.00	Equipment cost (see instructions)	0		61.00
62.00	Supplies (see instructions)	0		62.00
63.00	Total allowance (sum of lines 57-62)	784,027		63.00
64.00	Total cost of outside supplier services (from your records)	546,414		64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)	0		65.00
	LINE 33 CALCULATION			
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others	0		100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	0		100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	0		100.02
	LINE 34 CALCULATION			
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	0		101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0		101.01
101.02	Line 34 = sum of lines 27 and 31	0		101.02
	LINE 35 CALCULATION			
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0		102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others	0		102.01
102.02	Line 35 = sum of lines 31 and 32	0		102.02

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1334 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part I Date/Time Prepared: 5/30/2019 11:32 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	INFORMATION TECH	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	4.00	5.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	501,055	501,055				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	677,283		677,283			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,481,393	0	0	1,481,393		4.00
5.01	00550	INFORMATION TECH	741,239	2,905	4,918	28,832	777,894	5.01
5.02	00570	ADMITTING	580,722	4,526	7,663	65,602	44,091	5.02
5.03	00560	PURCHASING RECEIVING AND STORES	58,719	6,835	11,571	0	50,390	5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE	401,210	638	1,080	0	0	5.04
5.05	00590	OTHER ADMIN AND GENERAL	1,842,526	50,732	85,889	109,372	0	5.05
7.00	00700	OPERATION OF PLANT	950,898	8,323	14,091	40,903	12,597	7.00
9.00	00900	HOUSEKEEPING	373,948	3,706	6,274	38,097	3,149	9.00
10.00	01000	DIETARY	92,939	8,156	13,808	8,334	12,597	10.00
11.00	01100	CAFETERIA	192,506	8,718	14,759	25,816	0	11.00
13.00	01300	NURSING ADMINISTRATION	168,120	0	0	24,098	0	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	120,138	0	0	11,420	151,170	14.00
15.00	01500	PHARMACY	317,648	0	0	32,881	22,046	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	612,721	6,299	10,665	84,526	37,792	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,796,453	68,381	115,768	246,010	116,527	30.00
31.00	03100	INTENSIVE CARE UNIT	410,872	3,083	5,220	65,058	9,448	31.00
43.00	04300	NURSERY	103,731	854	1,446	14,512	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,015,287	85,721	145,126	80,287	50,390	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	39,616	2,802	4,744	5,032	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,239,608	27,924	47,274	123,817	0	54.00
60.00	06000	LABORATORY	896,561	9,800	16,592	79,638	28,344	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	75,100	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	388,634	13,066	22,120	57,481	22,046	65.00
66.00	06600	PHYSICAL THERAPY	572,108	12,952	21,927	0	31,494	66.00
67.00	06700	OCCUPATIONAL THERAPY	21,837	0	0	3,800	0	67.00
68.00	06800	SPEECH PATHOLOGY	34,735	338	572	6,045	0	68.00
69.00	06900	ELECTROCARDIOLOGY	165,000	0	0	21,359	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	114,743	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	218,054	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	402,762	1,823	3,086	0	0	73.00
75.00	03610	SLEEP LAB	0	0	0	0	0	75.00
76.00	03020	CARDIAC REHAB	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	93,845	6,015	10,182	13,098	40,942	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	512,292	2,715	4,596	67,887	0	88.00
91.00	09100	EMERGENCY	1,474,562	28,432	48,135	155,026	47,241	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	18,688,865	364,744	617,506	1,408,931	680,264	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	2,521	4,268	0	0	190.00
190.01	19001	MARKETING	89,560	0	0	0	0	190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,569	0	0	254	97,630	192.00
192.01	19201	SCOTT PHYSICIAN GROUP	0	0	0	0	0	192.01
194.00	07950	BUHSE CAMPUS	211,145	4,746	8,035	27,128	0	194.00
194.01	07951	MEDICAL SPECIALTY	144,593	9,493	16,071	3,706	0	194.01
194.02	07952	MEDICAL OFFICE	0	63,031	0	0	0	194.02
194.03	07953	VA PROPERTY	0	37,971	0	0	0	194.03
194.04	07954	ALREFAI CAMPUS	0	0	0	0	0	194.04
194.05	07955	ORTHO CAMPUS	317,630	7,594	12,857	41,374	0	194.05
194.06	07956	DR. CRAIG CLINIC	0	0	0	0	0	194.06
194.07	07957	DR. OLABIGE CLINIC	179	0	0	0	0	194.07
194.08	07958	URGENT CARE CLINIC	0	0	0	0	0	194.08
194.09	07959	DR. PACE	6,363	6,835	11,571	0	0	194.09
194.10	07960	SCOTTSBURG FAMILY PRACTICE (RHC)	0	4,120	6,975	0	0	194.10
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	19,459,904	501,055	677,283	1,481,393	777,894	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1334 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part I | Date/Time Prepared: 5/30/2019 11:32 am

		Cost Center Description	ADMITTING	PURCHASING RECEIVING AND STORES	CASHIERING/ACCOUNTS RECEIVABLE	Subtotal	OTHER ADMIN AND GENERAL	
			5.02	5.03	5.04	5A.04	5.05	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	INFORMATION TECH						5.01
5.02	00570	ADMITTING	702,604					5.02
5.03	00560	PURCHASING RECEIVING AND STORES	0	127,515				5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	0	402,928			5.04
5.05	00590	OTHER ADMIN AND GENERAL	0	0	0	2,088,519	2,088,519	5.05
7.00	00700	OPERATION OF PLANT	0	0	0	1,026,812	123,452	7.00
9.00	00900	HOUSEKEEPING	0	0	0	425,174	51,118	9.00
10.00	01000	DIETARY	0	0	0	135,834	16,331	10.00
11.00	01100	CAFETERIA	0	0	0	241,799	29,071	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	192,218	23,110	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	0	0	282,728	33,992	14.00
15.00	01500	PHARMACY	0	182	0	372,757	44,816	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	585	0	752,588	90,482	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	117,363	16,481	15,121	2,492,104	299,612	30.00
31.00	03100	INTENSIVE CARE UNIT	10,955	0	1,173	505,809	60,812	31.00
43.00	04300	NURSERY	10,092	0	1,080	131,715	15,836	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	31,126	16,700	15,207	1,439,844	173,110	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,204	0	361	55,759	6,704	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	59,070	5,173	103,875	1,606,741	193,175	54.00
60.00	06000	LABORATORY	115,313	12,074	80,383	1,238,705	148,927	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	2,226	9,095	567	86,988	10,458	63.00
65.00	06500	RESPIRATORY THERAPY	48,004	2,917	14,263	568,531	68,353	65.00
66.00	06600	PHYSICAL THERAPY	13,935	1,331	15,295	669,042	80,438	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,335	0	560	27,532	3,310	67.00
68.00	06800	SPEECH PATHOLOGY	1,171	0	378	43,239	5,199	68.00
69.00	06900	ELECTROCARDIOLOGY	11,535	0	10,765	208,659	25,087	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	99,039	13,895	13,249	240,926	28,966	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	14,485	26,404	3,716	262,659	31,579	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	127,195	0	46,540	581,406	69,901	73.00
75.00	03610	SLEEP LAB	0	0	0	0	0	75.00
76.00	03020	CARDIAC REHAB	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	114	4,448	168,644	20,276	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	7,754	595,244	71,565	88.00
91.00	09100	EMERGENCY	36,556	22,409	68,193	1,880,554	226,095	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	702,604	127,360	402,928	18,322,530	1,951,775	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	6,789	816	190.00
190.01	19001	MARKETING	0	14	0	89,574	10,769	190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	99,453	11,957	192.00
192.01	19201	SCOTT PHYSICIAN GROUP	0	0	0	0	0	192.01
194.00	07950	BUHSE CAMPUS	0	0	0	251,054	30,184	194.00
194.01	07951	MEDICAL SPECIALTY	0	141	0	174,004	20,920	194.01
194.02	07952	MEDICAL OFFICE	0	0	0	63,031	7,578	194.02
194.03	07953	VA PROPERTY	0	0	0	37,971	4,565	194.03
194.04	07954	ALREFAI CAMPUS	0	0	0	0	0	194.04
194.05	07955	ORTHO CAMPUS	0	0	0	379,455	45,621	194.05
194.06	07956	DR. CRAIG CLINIC	0	0	0	0	0	194.06
194.07	07957	DR. OLABIGE CLINIC	0	0	0	179	22	194.07
194.08	07958	URGENT CARE CLINIC	0	0	0	0	0	194.08
194.09	07959	DR. PACE	0	0	0	24,769	2,978	194.09
194.10	07960	SCOTTSBURG FAMILY PRACTICE (RHC)	0	0	0	11,095	1,334	194.10
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	702,604	127,515	402,928	19,459,904	2,088,519	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1334 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part I | Date/Time Prepared: 5/30/2019 11:32 am

		Cost Center Description	OPERATION OF PLANT	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
			7.00	9.00	10.00	11.00	13.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	INFORMATION TECH						5.01
5.02	00570	ADMITTING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.04
5.05	00590	OTHER ADMIN AND GENERAL						5.05
7.00	00700	OPERATION OF PLANT	1,150,264					7.00
9.00	00900	HOUSEKEEPING	9,981	486,273				9.00
10.00	01000	DIETARY	21,966	0	174,131			10.00
11.00	01100	CAFETERIA	23,480	2,765	0	297,115		11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	2,850	218,178	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	0	0	5,850	0	14.00
15.00	01500	PHARMACY	0	0	0	7,426	5,245	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16,965	5,529	0	25,804	41,328	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	184,165	124,717	167,781	67,302	73,425	30.00
31.00	03100	INTENSIVE CARE UNIT	8,304	17,202	6,350	14,820	9,545	31.00
43.00	04300	NURSERY	2,301	8,601	0	3,285	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	230,867	86,012	0	18,699	29,055	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	7,547	25,803	0	1,139	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	75,204	31,947	0	33,159	0	54.00
60.00	06000	LABORATORY	26,394	34,405	0	28,721	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	215	0	63.00
65.00	06500	RESPIRATORY THERAPY	35,189	17,202	0	17,384	0	65.00
66.00	06600	PHYSICAL THERAPY	34,882	9,830	0	16,877	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	910	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	8,601	0	5,486	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,909	6,144	0	0	0	73.00
75.00	03610	SLEEP LAB	0	0	0	0	0	75.00
76.00	03020	CARDIAC REHAB	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	16,198	11,059	0	4,251	5,245	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	7,312	0	0	43,525	0	88.00
91.00	09100	EMERGENCY	76,575	94,613	0	0	54,335	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	783,149	484,430	174,131	296,793	218,178	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	6,790	1,843	0	0	0	190.00
190.01	19001	MARKETING	0	0	0	322	0	190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	SCOTT PHYSICIAN GROUP	0	0	0	0	0	192.01
194.00	07950	BUHSE CAMPUS	12,783	0	0	0	0	194.00
194.01	07951	MEDICAL SPECIALTY	25,566	0	0	0	0	194.01
194.02	07952	MEDICAL OFFICE	169,757	0	0	0	0	194.02
194.03	07953	VA PROPERTY	102,263	0	0	0	0	194.03
194.04	07954	ALREFAI CAMPUS	0	0	0	0	0	194.04
194.05	07955	ORTHO CAMPUS	20,453	0	0	0	0	194.05
194.06	07956	DR. CRAIG CLINIC	0	0	0	0	0	194.06
194.07	07957	DR. OLABIGE CLINIC	0	0	0	0	0	194.07
194.08	07958	URGENT CARE CLINIC	0	0	0	0	0	194.08
194.09	07959	DR. PACE	18,407	0	0	0	0	194.09
194.10	07960	SCOTTSBURG FAMILY PRACTICE (RHC)	11,096	0	0	0	0	194.10
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,150,264	486,273	174,131	297,115	218,178	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1334 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part I | Date/Time Prepared: 5/30/2019 11:32 am

		Cost Center Description	CENTRAL SERVICE & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			14.00	15.00	16.00	24.00	25.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	INFORMATION TECH						5.01
5.02	00570	ADMITTING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.04
5.05	00590	OTHER ADMIN AND GENERAL						5.05
7.00	00700	OPERATION OF PLANT						7.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	322,570					14.00
15.00	01500	PHARMACY	460	430,704				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,479	0	934,175			16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	41,691	0	35,058	3,485,855	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	2,719	625,561	0	31.00
43.00	04300	NURSERY	0	0	2,505	164,243	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	42,244	0	35,258	2,055,089	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	836	97,788	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	13,087	0	240,826	2,194,139	0	54.00
60.00	06000	LABORATORY	30,542	0	186,366	1,694,060	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	23,006	0	1,314	121,981	0	63.00
65.00	06500	RESPIRATORY THERAPY	7,378	0	33,068	747,105	0	65.00
66.00	06600	PHYSICAL THERAPY	3,368	0	35,461	849,898	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	1,299	32,141	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	877	50,225	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	24,959	272,792	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	35,150	0	30,718	335,760	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	66,799	0	8,615	369,652	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	430,704	107,903	1,200,967	0	73.00
75.00	03610	SLEEP LAB	0	0	0	0	0	75.00
76.00	03020	CARDIAC REHAB	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	289	0	10,312	236,274	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	17,977	735,623	0	88.00
91.00	09100	EMERGENCY	56,686	0	158,104	2,546,962	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	322,179	430,704	934,175	17,816,115	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	16,238	0	190.00
190.01	19001	MARKETING	35	0	0	100,700	0	190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	111,410	0	192.00
192.01	19201	SCOTT PHYSICIAN GROUP	0	0	0	0	0	192.01
194.00	07950	BUHSE CAMPUS	0	0	0	294,021	0	194.00
194.01	07951	MEDICAL SPECIALTY	356	0	0	220,846	0	194.01
194.02	07952	MEDICAL OFFICE	0	0	0	240,366	0	194.02
194.03	07953	VA PROPERTY	0	0	0	144,799	0	194.03
194.04	07954	ALREFAI CAMPUS	0	0	0	0	0	194.04
194.05	07955	ORTHO CAMPUS	0	0	0	445,529	0	194.05
194.06	07956	DR. CRAIG CLINIC	0	0	0	0	0	194.06
194.07	07957	DR. OLABIGE CLINIC	0	0	0	201	0	194.07
194.08	07958	URGENT CARE CLINIC	0	0	0	0	0	194.08
194.09	07959	DR. PACE	0	0	0	46,154	0	194.09
194.10	07960	SCOTTSBURG FAMILY PRACTICE (RHC)	0	0	0	23,525	0	194.10
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	322,570	430,704	934,175	19,459,904	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1334 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part I | Date/Time Prepared: 5/30/2019 11:32 am

		Cost Center Description	Total		
			26.00		
		GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.01	00550	INFORMATION TECH			5.01
5.02	00570	ADMITTING			5.02
5.03	00560	PURCHASING RECEIVING AND STORES			5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE			5.04
5.05	00590	OTHER ADMIN AND GENERAL			5.05
7.00	00700	OPERATION OF PLANT			7.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
13.00	01300	NURSING ADMINISTRATION			13.00
14.00	01400	CENTRAL SERVICE & SUPPLY			14.00
15.00	01500	PHARMACY			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	3,485,855		30.00
31.00	03100	INTENSIVE CARE UNIT	625,561		31.00
43.00	04300	NURSERY	164,243		43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	2,055,089		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	97,788		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,194,139		54.00
60.00	06000	LABORATORY	1,694,060		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	121,981		63.00
65.00	06500	RESPIRATORY THERAPY	747,105		65.00
66.00	06600	PHYSICAL THERAPY	849,898		66.00
67.00	06700	OCCUPATIONAL THERAPY	32,141		67.00
68.00	06800	SPEECH PATHOLOGY	50,225		68.00
69.00	06900	ELECTROCARDIOLOGY	272,792		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	335,760		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	369,652		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,200,967		73.00
75.00	03610	SLEEP LAB	0		75.00
76.00	03020	CARDIAC REHAB	0		76.00
76.97	07697	CARDIAC REHABILITATION	236,274		76.97
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	735,623		88.00
91.00	09100	EMERGENCY	2,546,962		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	17,816,115		118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	16,238		190.00
190.01	19001	MARKETING	100,700		190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	111,410		192.00
192.01	19201	SCOTT PHYSICIAN GROUP	0		192.01
194.00	07950	BUHSE CAMPUS	294,021		194.00
194.01	07951	MEDICAL SPECIALTY	220,846		194.01
194.02	07952	MEDICAL OFFICE	240,366		194.02
194.03	07953	VA PROPERTY	144,799		194.03
194.04	07954	ALREFAI CAMPUS	0		194.04
194.05	07955	ORTHO CAMPUS	445,529		194.05
194.06	07956	DR. CRAIG CLINIC	0		194.06
194.07	07957	DR. OLABIGE CLINIC	201		194.07
194.08	07958	URGENT CARE CLINIC	0		194.08
194.09	07959	DR. PACE	46,154		194.09
194.10	07960	SCOTTSBURG FAMILY PRACTICE (RHC)	23,525		194.10
200.00		Cross Foot Adjustments	0		200.00
201.00		Negative Cost Centers	0		201.00
202.00		TOTAL (sum lines 118 through 201)	19,459,904		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1334 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part II | Date/Time Prepared: 5/30/2019 11:32 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	4.00
5.01	00550	INFORMATION TECH	0	2,905	4,918	7,823	0	5.01
5.02	00570	ADMITTING	0	4,526	7,663	12,189	0	5.02
5.03	00560	PURCHASING RECEIVING AND STORES	0	6,835	11,571	18,406	0	5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	638	1,080	1,718	0	5.04
5.05	00590	OTHER ADMIN AND GENERAL	133,817	50,732	85,889	270,438	0	5.05
7.00	00700	OPERATION OF PLANT	0	8,323	14,091	22,414	0	7.00
9.00	00900	HOUSEKEEPING	0	3,706	6,274	9,980	0	9.00
10.00	01000	DIETARY	0	8,156	13,808	21,964	0	10.00
11.00	01100	CAFETERIA	0	8,718	14,759	23,477	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	7,169	0	0	7,169	0	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	6,299	10,665	16,964	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	68,381	115,768	184,149	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	3,083	5,220	8,303	0	31.00
43.00	04300	NURSERY	0	854	1,446	2,300	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	85,721	145,126	230,847	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	2,802	4,744	7,546	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	27,924	47,274	75,198	0	54.00
60.00	06000	LABORATORY	0	9,800	16,592	26,392	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	13,066	22,120	35,186	0	65.00
66.00	06600	PHYSICAL THERAPY	0	12,952	21,927	34,879	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	338	572	910	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,823	3,086	4,909	0	73.00
75.00	03610	SLEEP LAB	0	0	0	0	0	75.00
76.00	03020	CARDIAC REHAB	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	6,015	10,182	16,197	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	2,715	4,596	7,311	0	88.00
91.00	09100	EMERGENCY	0	28,432	48,135	76,567	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	140,986	364,744	617,506	1,123,236	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	2,521	4,268	6,789	0	190.00
190.01	19001	MARKETING	0	0	0	0	0	190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	SCOTT PHYSICIAN GROUP	0	0	0	0	0	192.01
194.00	07950	BUHSE CAMPUS	0	4,746	8,035	12,781	0	194.00
194.01	07951	MEDICAL SPECIALTY	0	9,493	16,071	25,564	0	194.01
194.02	07952	MEDICAL OFFICE	0	63,031	0	63,031	0	194.02
194.03	07953	VA PROPERTY	0	37,971	0	37,971	0	194.03
194.04	07954	ALREFAI CAMPUS	0	0	0	0	0	194.04
194.05	07955	ORTHO CAMPUS	0	7,594	12,857	20,451	0	194.05
194.06	07956	DR. CRAIG CLINIC	0	0	0	0	0	194.06
194.07	07957	DR. OLABIGE CLINIC	0	0	0	0	0	194.07
194.08	07958	URGENT CARE CLINIC	0	0	0	0	0	194.08
194.09	07959	DR. PACE	0	6,835	11,571	18,406	0	194.09
194.10	07960	SCOTTSBURG FAMILY PRACTICE (RHC)	0	4,120	6,975	11,095	0	194.10
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)	140,986	501,055	677,283	1,319,324	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1334 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part II Date/Time Prepared: 5/30/2019 11:32 am

		Cost Center Description	INFORMATION TECH	ADMITTING	PURCHASING RECEIVING AND STORES	CASHIERING/ACCOUNTS RECEIVABLE	OTHER ADMIN AND GENERAL	
			5.01	5.02	5.03	5.04	5.05	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	INFORMATION TECH	7,823					5.01
5.02	00570	ADMITTING	443	12,632				5.02
5.03	00560	PURCHASING RECEIVING AND STORES	507	0	18,913			5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	0	0	1,718		5.04
5.05	00590	OTHER ADMIN AND GENERAL	0	0	0	0	270,438	5.05
7.00	00700	OPERATION OF PLANT	127	0	0	0	15,985	7.00
9.00	00900	HOUSEKEEPING	32	0	0	0	6,619	9.00
10.00	01000	DIETARY	127	0	0	0	2,115	10.00
11.00	01100	CAFETERIA	0	0	0	0	3,764	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	2,992	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	1,518	0	0	0	4,402	14.00
15.00	01500	PHARMACY	222	0	27	0	5,803	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	380	0	87	0	11,716	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,172	2,109	2,444	66	38,800	30.00
31.00	03100	INTENSIVE CARE UNIT	95	197	0	5	7,874	31.00
43.00	04300	NURSERY	0	181	0	5	2,051	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	507	559	2,477	66	22,415	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	58	0	2	868	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,062	767	419	25,014	54.00
60.00	06000	LABORATORY	285	2,072	1,791	349	19,284	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	40	1,349	2	1,354	63.00
65.00	06500	RESPIRATORY THERAPY	222	863	433	62	8,851	65.00
66.00	06600	PHYSICAL THERAPY	317	250	197	66	10,416	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	24	0	2	429	67.00
68.00	06800	SPEECH PATHOLOGY	0	21	0	2	673	68.00
69.00	06900	ELECTROCARDIOLOGY	0	207	0	47	3,248	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	1,780	2,061	58	3,751	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	260	3,916	16	4,089	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,292	0	202	9,051	73.00
75.00	03610	SLEEP LAB	0	0	0	0	0	75.00
76.00	03020	CARDIAC REHAB	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	412	0	17	19	2,625	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	34	9,267	88.00
91.00	09100	EMERGENCY	475	657	3,324	296	29,276	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	6,841	12,632	18,890	1,718	252,732	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	106	190.00
190.01	19001	MARKETING	0	0	2	0	1,394	190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	982	0	0	0	1,548	192.00
192.01	19201	SCOTT PHYSICIAN GROUP	0	0	0	0	0	192.01
194.00	07950	BUHSE CAMPUS	0	0	0	0	3,908	194.00
194.01	07951	MEDICAL SPECIALTY	0	0	21	0	2,709	194.01
194.02	07952	MEDICAL OFFICE	0	0	0	0	981	194.02
194.03	07953	VA PROPERTY	0	0	0	0	591	194.03
194.04	07954	ALREFAI CAMPUS	0	0	0	0	0	194.04
194.05	07955	ORTHO CAMPUS	0	0	0	0	5,907	194.05
194.06	07956	DR. CRAIG CLINIC	0	0	0	0	0	194.06
194.07	07957	DR. OLABIGE CLINIC	0	0	0	0	3	194.07
194.08	07958	URGENT CARE CLINIC	0	0	0	0	0	194.08
194.09	07959	DR. PACE	0	0	0	0	386	194.09
194.10	07960	SCOTTSBURG FAMILY PRACTICE (RHC)	0	0	0	0	173	194.10
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)	7,823	12,632	18,913	1,718	270,438	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1334 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part II Date/Time Prepared: 5/30/2019 11:32 am

		Cost Center Description	OPERATION OF PLANT	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
			7.00	9.00	10.00	11.00	13.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	INFORMATION TECH						5.01
5.02	00570	ADMITTING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.04
5.05	00590	OTHER ADMIN AND GENERAL						5.05
7.00	00700	OPERATION OF PLANT	38,526					7.00
9.00	00900	HOUSEKEEPING	334	16,965				9.00
10.00	01000	DIETARY	736	0	24,942			10.00
11.00	01100	CAFETERIA	786	96	0	28,123		11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	270	3,262	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	0	0	554	0	14.00
15.00	01500	PHARMACY	0	0	0	703	78	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	568	193	0	2,442	618	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,168	4,352	24,032	6,371	1,099	30.00
31.00	03100	INTENSIVE CARE UNIT	278	600	910	1,403	143	31.00
43.00	04300	NURSERY	77	300	0	311	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	7,733	3,001	0	1,770	434	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	253	900	0	108	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,519	1,115	0	3,139	0	54.00
60.00	06000	LABORATORY	884	1,200	0	2,719	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	20	0	63.00
65.00	06500	RESPIRATORY THERAPY	1,179	600	0	1,645	0	65.00
66.00	06600	PHYSICAL THERAPY	1,168	343	0	1,597	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	30	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	300	0	519	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	164	214	0	0	0	73.00
75.00	03610	SLEEP LAB	0	0	0	0	0	75.00
76.00	03020	CARDIAC REHAB	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	543	386	0	402	78	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	245	0	0	4,120	0	88.00
91.00	09100	EMERGENCY	2,565	3,301	0	0	812	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	26,230	16,901	24,942	28,093	3,262	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	227	64	0	0	0	190.00
190.01	19001	MARKETING	0	0	0	30	0	190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	SCOTT PHYSICIAN GROUP	0	0	0	0	0	192.01
194.00	07950	BUHSE CAMPUS	428	0	0	0	0	194.00
194.01	07951	MEDICAL SPECIALTY	856	0	0	0	0	194.01
194.02	07952	MEDICAL OFFICE	5,686	0	0	0	0	194.02
194.03	07953	VA PROPERTY	3,425	0	0	0	0	194.03
194.04	07954	ALREFAI CAMPUS	0	0	0	0	0	194.04
194.05	07955	ORTHO CAMPUS	685	0	0	0	0	194.05
194.06	07956	DR. CRAIG CLINIC	0	0	0	0	0	194.06
194.07	07957	DR. OLABIGE CLINIC	0	0	0	0	0	194.07
194.08	07958	URGENT CARE CLINIC	0	0	0	0	0	194.08
194.09	07959	DR. PACE	617	0	0	0	0	194.09
194.10	07960	SCOTTSBURG FAMILY PRACTICE (RHC)	372	0	0	0	0	194.10
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)	38,526	16,965	24,942	28,123	3,262	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1334 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part II Date/Time Prepared: 5/30/2019 11:32 am

		Cost Center Description	CENTRAL SERVICE & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			14.00	15.00	16.00	24.00	25.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	INFORMATION TECH						5.01
5.02	00570	ADMITTING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.04
5.05	00590	OTHER ADMIN AND GENERAL						5.05
7.00	00700	OPERATION OF PLANT						7.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	13,643					14.00
15.00	01500	PHARMACY	19	6,852				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	63	0	33,031			16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,763	0	1,240	273,765	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	96	19,904	0	31.00
43.00	04300	NURSERY	0	0	89	5,314	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,787	0	1,247	272,843	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	30	9,765	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	554	0	8,510	118,297	0	54.00
60.00	06000	LABORATORY	1,292	0	6,591	62,859	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	973	0	46	3,784	0	63.00
65.00	06500	RESPIRATORY THERAPY	312	0	1,169	50,522	0	65.00
66.00	06600	PHYSICAL THERAPY	142	0	1,254	50,629	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	46	501	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	31	1,667	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	883	5,204	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,487	0	1,086	10,223	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,825	0	305	11,411	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	6,852	3,816	27,500	0	73.00
75.00	03610	SLEEP LAB	0	0	0	0	0	75.00
76.00	03020	CARDIAC REHAB	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	12	0	365	21,056	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	636	21,613	0	88.00
91.00	09100	EMERGENCY	2,398	0	5,591	125,262	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	13,627	6,852	33,031	1,092,119	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	7,186	0	190.00
190.01	19001	MARKETING	1	0	0	1,427	0	190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	2,530	0	192.00
192.01	19201	SCOTT PHYSICIAN GROUP	0	0	0	0	0	192.01
194.00	07950	BUHSE CAMPUS	0	0	0	17,117	0	194.00
194.01	07951	MEDICAL SPECIALTY	15	0	0	29,165	0	194.01
194.02	07952	MEDICAL OFFICE	0	0	0	69,698	0	194.02
194.03	07953	VA PROPERTY	0	0	0	41,987	0	194.03
194.04	07954	ALREFAI CAMPUS	0	0	0	0	0	194.04
194.05	07955	ORTHO CAMPUS	0	0	0	27,043	0	194.05
194.06	07956	DR. CRAIG CLINIC	0	0	0	0	0	194.06
194.07	07957	DR. OLABIGE CLINIC	0	0	0	3	0	194.07
194.08	07958	URGENT CARE CLINIC	0	0	0	0	0	194.08
194.09	07959	DR. PACE	0	0	0	19,409	0	194.09
194.10	07960	SCOTTSBURG FAMILY PRACTICE (RHC)	0	0	0	11,640	0	194.10
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	13,643	6,852	33,031	1,319,324	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1334 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part II | Date/Time Prepared: 5/30/2019 11:32 am

		Cost Center Description	Total		
			26.00		
		GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.01	00550	INFORMATION TECH			5.01
5.02	00570	ADMITTING			5.02
5.03	00560	PURCHASING RECEIVING AND STORES			5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE			5.04
5.05	00590	OTHER ADMIN AND GENERAL			5.05
7.00	00700	OPERATION OF PLANT			7.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
13.00	01300	NURSING ADMINISTRATION			13.00
14.00	01400	CENTRAL SERVICE & SUPPLY			14.00
15.00	01500	PHARMACY			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	273,765		30.00
31.00	03100	INTENSIVE CARE UNIT	19,904		31.00
43.00	04300	NURSERY	5,314		43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	272,843		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	9,765		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	118,297		54.00
60.00	06000	LABORATORY	62,859		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	3,784		63.00
65.00	06500	RESPIRATORY THERAPY	50,522		65.00
66.00	06600	PHYSICAL THERAPY	50,629		66.00
67.00	06700	OCCUPATIONAL THERAPY	501		67.00
68.00	06800	SPEECH PATHOLOGY	1,667		68.00
69.00	06900	ELECTROCARDIOLOGY	5,204		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	10,223		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	11,411		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	27,500		73.00
75.00	03610	SLEEP LAB	0		75.00
76.00	03020	CARDIAC REHAB	0		76.00
76.97	07697	CARDIAC REHABILITATION	21,056		76.97
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	21,613		88.00
91.00	09100	EMERGENCY	125,262		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,092,119		118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	7,186		190.00
190.01	19001	MARKETING	1,427		190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2,530		192.00
192.01	19201	SCOTT PHYSICIAN GROUP	0		192.01
194.00	07950	BUHSE CAMPUS	17,117		194.00
194.01	07951	MEDICAL SPECIALTY	29,165		194.01
194.02	07952	MEDICAL OFFICE	69,698		194.02
194.03	07953	VA PROPERTY	41,987		194.03
194.04	07954	ALREFAI CAMPUS	0		194.04
194.05	07955	ORTHO CAMPUS	27,043		194.05
194.06	07956	DR. CRAIG CLINIC	0		194.06
194.07	07957	DR. OLABIGE CLINIC	3		194.07
194.08	07958	URGENT CARE CLINIC	0		194.08
194.09	07959	DR. PACE	19,409		194.09
194.10	07960	SCOTTSBURG FAMILY PRACTICE (RHC)	11,640		194.10
200.00		Cross Foot Adjustments	0		200.00
201.00		Negative Cost Centers	0		201.00
202.00		TOTAL (sum lines 118 through 201)	1,319,324		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1334 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B-1 | Date/Time Prepared: 5/30/2019 11:32 am

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	INFORMATION TECH (# OF COMPUTERS)	ADMITTING (INPATIENT CHARGES)	
			1.00	2.00	4.00	5.01	5.02	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	131,959					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		105,359				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	8,511,803			4.00
5.01	00550	INFORMATION TECH	765	765	165,661	247		5.01
5.02	00570	ADMITTING	1,192	1,192	376,938	14	12,093,898	5.02
5.03	00560	PURCHASING RECEIVING AND STORES	1,800	1,800	0	16	0	5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE	168	168	0	0	0	5.04
5.05	00590	OTHER ADMIN AND GENERAL	13,361	13,361	628,433	0	0	5.05
7.00	00700	OPERATION OF PLANT	2,192	2,192	235,019	4	0	7.00
9.00	00900	HOUSEKEEPING	976	976	218,900	1	0	9.00
10.00	01000	DIETARY	2,148	2,148	47,884	4	0	10.00
11.00	01100	CAFETERIA	2,296	2,296	148,335	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	138,464	0	0	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	0	65,616	48	0	14.00
15.00	01500	PHARMACY	0	0	188,927	7	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,659	1,659	485,672	12	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	18,009	18,009	1,413,539	37	2,020,164	30.00
31.00	03100	INTENSIVE CARE UNIT	812	812	373,811	3	188,564	31.00
43.00	04300	NURSERY	225	225	83,383	0	173,706	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	22,576	22,576	461,313	16	535,773	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	738	738	28,911	0	55,145	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,354	7,354	711,426	0	1,016,768	54.00
60.00	06000	LABORATORY	2,581	2,581	457,582	9	1,984,862	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	38,315	63.00
65.00	06500	RESPIRATORY THERAPY	3,441	3,441	330,272	7	826,287	65.00
66.00	06600	PHYSICAL THERAPY	3,411	3,411	0	10	239,858	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	21,836	0	22,977	67.00
68.00	06800	SPEECH PATHOLOGY	89	89	34,734	0	20,162	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	122,724	0	198,546	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	1,704,751	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	249,322	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	480	480	0	0	2,189,458	73.00
75.00	03610	SLEEP LAB	0	0	0	0	0	75.00
76.00	03020	CARDIAC REHAB	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	1,584	1,584	75,261	13	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	715	715	390,063	0	0	88.00
91.00	09100	EMERGENCY	7,488	7,488	890,749	15	629,240	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	96,060	96,060	8,095,453	216	12,093,898	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	664	664	0	0	0	190.00
190.01	19001	MARKETING	0	0	0	0	0	190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	1,457	31	0	192.00
192.01	19201	SCOTT PHYSICIAN GROUP	0	0	0	0	0	192.01
194.00	07950	BUHSE CAMPUS	1,250	1,250	155,874	0	0	194.00
194.01	07951	MEDICAL SPECIALTY	2,500	2,500	21,292	0	0	194.01
194.02	07952	MEDICAL OFFICE	16,600	0	0	0	0	194.02
194.03	07953	VA PROPERTY	10,000	0	0	0	0	194.03
194.04	07954	ALREFAI CAMPUS	0	0	0	0	0	194.04
194.05	07955	ORTHO CAMPUS	2,000	2,000	237,727	0	0	194.05
194.06	07956	DR. CRAIG CLINIC	0	0	0	0	0	194.06
194.07	07957	DR. OLABIGE CLINIC	0	0	0	0	0	194.07
194.08	07958	URGENT CARE CLINIC	0	0	0	0	0	194.08
194.09	07959	DR. PACE	1,800	1,800	0	0	0	194.09
194.10	07960	SCOTTSBURG FAMILY PRACTICE (RHC)	1,085	1,085	0	0	0	194.10
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)	501,055	677,283	1,481,393	777,894	702,604	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	3.797051	6.428336	0.174040	3,149.368421	0.058096	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			0	7,823	12,632	204.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1334 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B-1 | Date/Time Prepared: 5/30/2019 11:32 am

	Cost Center Description	CAPITAL RELATED COSTS					
		BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	INFORMATION TECH (# OF COMPUTERS)	ADMITTING (INPATIENT CHARGES)	
		1.00	2.00	4.00	5.01	5.02	
205.00	Unit cost multiplier (Wkst. B, Part II)			0.000000	31.672065	0.001044	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: 15-1334 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B-1 | Date/Time Prepared: 5/30/2019 11:32 am

		Cost Center Description	PURCHASING RECEIVING AND STORES (COSTED REQUIS.)	CASHIERING/ACCOUNTS RECEIVABLE (GROSS CHARGES)	Reconciliation	OTHER ADMIN AND GENERAL (ACCUMULATED COST)	OPERATION OF PLANT (SQUARE FEET)	
			5.03	5.04	5A.05	5.05	7.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	INFORMATION TECH						5.01
5.02	00570	ADMITTING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES	1,052,983					5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	64,780,664				5.04
5.05	00590	OTHER ADMIN AND GENERAL	0	0	-2,088,519	17,371,385		5.05
7.00	00700	OPERATION OF PLANT	0	0	0	1,026,812	112,481	7.00
9.00	00900	HOUSEKEEPING	0	0	0	425,174	976	9.00
10.00	01000	DIETARY	0	0	0	135,834	2,148	10.00
11.00	01100	CAFETERIA	0	0	0	241,799	2,296	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	192,218	0	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	0	0	282,728	0	14.00
15.00	01500	PHARMACY	1,500	0	0	372,757	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,829	0	0	752,588	1,659	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	136,093	2,431,052	0	2,492,104	18,009	30.00
31.00	03100	INTENSIVE CARE UNIT	0	188,564	0	505,809	812	31.00
43.00	04300	NURSERY	0	173,706	0	131,715	225	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	137,900	2,444,930	0	1,439,844	22,576	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	57,996	0	55,759	738	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	42,721	16,701,489	0	1,606,741	7,354	54.00
60.00	06000	LABORATORY	99,700	12,923,259	0	1,238,705	2,581	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	75,100	91,107	0	86,988	0	63.00
65.00	06500	RESPIRATORY THERAPY	24,085	2,293,027	0	568,531	3,441	65.00
66.00	06600	PHYSICAL THERAPY	10,993	2,458,980	0	669,042	3,411	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	90,061	0	27,532	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	60,787	0	43,239	89	68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,730,769	0	208,659	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	114,743	2,130,097	0	240,926	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	218,054	597,368	0	262,659	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	7,482,350	0	581,406	480	73.00
75.00	03610	SLEEP LAB	0	0	0	0	0	75.00
76.00	03020	CARDIAC REHAB	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	943	715,051	0	168,644	1,584	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	1,246,597	0	595,244	715	88.00
91.00	09100	EMERGENCY	185,044	10,963,474	0	1,880,554	7,488	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,051,705	64,780,664	-2,088,519	16,234,011	76,582	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	6,789	664	190.00
190.01	19001	MARKETING	115	0	0	89,574	0	190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	99,453	0	192.00
192.01	19201	SCOTT PHYSICIAN GROUP	0	0	0	0	0	192.01
194.00	07950	BUHSE CAMPUS	0	0	0	251,054	1,250	194.00
194.01	07951	MEDICAL SPECIALTY	1,163	0	0	174,004	2,500	194.01
194.02	07952	MEDICAL OFFICE	0	0	0	63,031	16,600	194.02
194.03	07953	VA PROPERTY	0	0	0	37,971	10,000	194.03
194.04	07954	ALREFAI CAMPUS	0	0	0	0	0	194.04
194.05	07955	ORTHO CAMPUS	0	0	0	379,455	2,000	194.05
194.06	07956	DR. CRAIG CLINIC	0	0	0	0	0	194.06
194.07	07957	DR. OLABIGE CLINIC	0	0	0	179	0	194.07
194.08	07958	URGENT CARE CLINIC	0	0	0	0	0	194.08
194.09	07959	DR. PACE	0	0	0	24,769	1,800	194.09
194.10	07960	SCOTTSBURG FAMILY PRACTICE (RHC)	0	0	0	11,095	1,085	194.10
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)	127,515	402,928		2,088,519	1,150,264	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.121099	0.006220		0.120228	10.226296	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	18,913	1,718		270,438	38,526	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.017961	0.000027		0.015568	0.342511	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1334 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B-1 | Date/Time Prepared: 5/30/2019 11:32 am

		Cost Center Description	PURCHASING RECEIVING AND STORES (COSTED REQUIS.)	CASHIERING/ACCOUNTS RECEIVABLE (GROSS CHARGES)	Reconciliation	OTHER ADMIN AND GENERAL (ACCUMULATED COST)	OPERATION OF PLANT (SQUARE FEET)	
			5.03	5.04	5A.05	5.05	7.00	
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: 15-1334 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B-1 | Date/Time Prepared: 5/30/2019 11:32 am

		Cost Center Description	HOUSEKEEPING (MAN HOURS)	DIETARY (MEALS SERVED)	CAFETERIA (MAN HOURS (CAF))	NURSING ADMINISTRATION (HOURS SUPE RVI)	CENTRAL SERVICE & SUPPLY (COSTED REQUIS.)	
			9.00	10.00	11.00	13.00	14.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	INFORMATION TECH						5.01
5.02	00570	ADMITTING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.04
5.05	00590	OTHER ADMIN AND GENERAL						5.05
7.00	00700	OPERATION OF PLANT						7.00
9.00	00900	HOUSEKEEPING	1,583					9.00
10.00	01000	DIETARY	0	12,176				10.00
11.00	01100	CAFETERIA	9	0	216,858			11.00
13.00	01300	NURSING ADMINISTRATION	0	0	2,080	2,080		13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	0	4,270	0	1,052,983	14.00
15.00	01500	PHARMACY	0	0	5,420	50	1,500	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	18	0	18,834	394	4,829	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	406	11,732	49,122	700	136,093	30.00
31.00	03100	INTENSIVE CARE UNIT	56	444	10,817	91	0	31.00
43.00	04300	NURSERY	28	0	2,398	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	280	0	13,648	277	137,900	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	84	0	831	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	104	0	24,202	0	42,721	54.00
60.00	06000	LABORATORY	112	0	20,963	0	99,700	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	157	0	75,100	63.00
65.00	06500	RESPIRATORY THERAPY	56	0	12,688	0	24,085	65.00
66.00	06600	PHYSICAL THERAPY	32	0	12,318	0	10,993	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	28	0	4,004	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	114,743	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	218,054	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	20	0	0	0	0	73.00
75.00	03610	SLEEP LAB	0	0	0	0	0	75.00
76.00	03020	CARDIAC REHAB	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	36	0	3,103	50	943	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	31,768	0	0	88.00
91.00	09100	EMERGENCY	308	0	0	518	185,044	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,577	12,176	216,623	2,080	1,051,705	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	6	0	0	0	0	190.00
190.01	19001	MARKETING	0	0	235	0	115	190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	SCOTT PHYSICIAN GROUP	0	0	0	0	0	192.01
194.00	07950	BUHSE CAMPUS	0	0	0	0	0	194.00
194.01	07951	MEDICAL SPECIALTY	0	0	0	0	1,163	194.01
194.02	07952	MEDICAL OFFICE	0	0	0	0	0	194.02
194.03	07953	VA PROPERTY	0	0	0	0	0	194.03
194.04	07954	ALREFAI CAMPUS	0	0	0	0	0	194.04
194.05	07955	ORTHO CAMPUS	0	0	0	0	0	194.05
194.06	07956	DR. CRAIG CLINIC	0	0	0	0	0	194.06
194.07	07957	DR. OLABIGE CLINIC	0	0	0	0	0	194.07
194.08	07958	URGENT CARE CLINIC	0	0	0	0	0	194.08
194.09	07959	DR. PACE	0	0	0	0	0	194.09
194.10	07960	SCOTTSBURG FAMILY PRACTICE (RHC)	0	0	0	0	0	194.10
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)	486,273	174,131	297,115	218,178	322,570	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	307.184460	14.301166	1.370090	104.893269	0.306339	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	16,965	24,942	28,123	3,262	13,643	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	10.716993	2.048456	0.129684	1.568269	0.012957	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1334 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B-1 | Date/Time Prepared: 5/30/2019 11:32 am

		Cost Center Description	HOUSEKEEPING (MAN HOURS)	DIETARY (MEALS SERVED)	CAFETERIA (MAN HOURS (CAF))	NURSING ADMINISTRATION (HOURS SUPE RVI)	CENTRAL SERVICE & SUPPLY (COSTED REQUIS.)	
			9.00	10.00	11.00	13.00	14.00	
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: 15-1334 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B-1 | Date/Time Prepared: 5/30/2019 11:32 am

		Cost Center Description	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)		
			15.00	16.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.01	00550	INFORMATION TECH				5.01
5.02	00570	ADMITTING				5.02
5.03	00560	PURCHASING RECEIVING AND STORES				5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE				5.04
5.05	00590	OTHER ADMIN AND GENERAL				5.05
7.00	00700	OPERATION OF PLANT				7.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICE & SUPPLY				14.00
15.00	01500	PHARMACY	402,744			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	64,780,664		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	2,431,052		30.00
31.00	03100	INTENSIVE CARE UNIT	0	188,564		31.00
43.00	04300	NURSERY	0	173,706		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	2,444,930		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	57,996		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	16,701,489		54.00
60.00	06000	LABORATORY	0	12,923,259		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	91,107		63.00
65.00	06500	RESPIRATORY THERAPY	0	2,293,027		65.00
66.00	06600	PHYSICAL THERAPY	0	2,458,980		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	90,061		67.00
68.00	06800	SPEECH PATHOLOGY	0	60,787		68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,730,769		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	2,130,097		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	597,368		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	402,744	7,482,350		73.00
75.00	03610	SLEEP LAB	0	0		75.00
76.00	03020	CARDIAC REHAB	0	0		76.00
76.97	07697	CARDIAC REHABILITATION	0	715,051		76.97
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	1,246,597		88.00
91.00	09100	EMERGENCY	0	10,963,474		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE				113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	402,744	64,780,664		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
190.01	19001	MARKETING	0	0		190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0		192.00
192.01	19201	SCOTT PHYSICIAN GROUP	0	0		192.01
194.00	07950	BUHSE CAMPUS	0	0		194.00
194.01	07951	MEDICAL SPECIALTY	0	0		194.01
194.02	07952	MEDICAL OFFICE	0	0		194.02
194.03	07953	VA PROPERTY	0	0		194.03
194.04	07954	ALREFAI CAMPUS	0	0		194.04
194.05	07955	ORTHO CAMPUS	0	0		194.05
194.06	07956	DR. CRAIG CLINIC	0	0		194.06
194.07	07957	DR. OLABIGE CLINIC	0	0		194.07
194.08	07958	URGENT CARE CLINIC	0	0		194.08
194.09	07959	DR. PACE	0	0		194.09
194.10	07960	SCOTTSBURG FAMILY PRACTICE (RHC)	0	0		194.10
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)	430,704	934,175		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	1.069424	0.014421		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	6,852	33,031		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.017013	0.000510		205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1334 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B-1 | Date/Time Prepared: 5/30/2019 11:32 am

		Cost Center Description	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)				
			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

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1334 | Period: From 01/01/2018 To 12/31/2018 | Worksheet C Part I Date/Time Prepared: 5/30/2019 11:32 am

Title XVIII | Hospital | Cost

		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	3,485,855		3,485,855	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	625,561		625,561	0	0	31.00
43.00	04300	NURSERY	164,243		164,243	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,055,089		2,055,089	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	97,788		97,788	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,194,139		2,194,139	0	0	54.00
60.00	06000	LABORATORY	1,694,060		1,694,060	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	121,981		121,981	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	747,105	0	747,105	0	0	65.00
66.00	06600	PHYSICAL THERAPY	849,898	0	849,898	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	32,141	0	32,141	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	50,225	0	50,225	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	272,792		272,792	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	335,760		335,760	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	369,652		369,652	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,200,967		1,200,967	0	0	73.00
75.00	03610	SLEEP LAB	0		0	0	0	75.00
76.00	03020	CARDIAC REHAB	0		0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	236,274		236,274	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	735,623		735,623	0	0	88.00
91.00	09100	EMERGENCY	2,546,962		2,546,962	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	943,935		943,935		0	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	18,760,050	0	18,760,050	0	0	200.00
201.00		Less Observation Beds	943,935		943,935		0	201.00
202.00		Total (see instructions)	17,816,115	0	17,816,115	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1334 | Period: From 01/01/2018 To 12/31/2018 | Worksheet C Part I Date/Time Prepared: 5/30/2019 11:32 am

Title XVIII | 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	1,964,145		1,964,145			30.00
31.00	03100	INTENSIVE CARE UNIT	188,564		188,564			31.00
43.00	04300	NURSERY	173,706		173,706			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	535,773	1,909,157	2,444,930	0.840551	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	55,145	2,851	57,996	1.686116	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,016,768	15,684,721	16,701,489	0.131374	0.000000	54.00
60.00	06000	LABORATORY	1,984,862	10,938,397	12,923,259	0.131086	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	38,315	52,792	91,107	1.338876	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	826,287	1,466,740	2,293,027	0.325816	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	239,858	2,219,122	2,458,980	0.345630	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	22,977	67,084	90,061	0.356880	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	20,162	40,625	60,787	0.826246	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	198,546	1,532,223	1,730,769	0.157613	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,704,751	425,346	2,130,097	0.157627	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	249,322	348,046	597,368	0.618801	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,189,458	5,292,892	7,482,350	0.160507	0.000000	73.00
75.00	03610	SLEEP LAB	0	0	0	0.000000	0.000000	75.00
76.00	03020	CARDIAC REHAB	0	0	0	0.000000	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0	715,051	715,051	0.330430	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	1,246,597	1,246,597			88.00
91.00	09100	EMERGENCY	629,240	10,334,234	10,963,474	0.232313	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	56,019	410,888	466,907	2.021677	0.000000	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	12,093,898	52,686,766	64,780,664			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	12,093,898	52,686,766	64,780,664			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1334 | Period: From 01/01/2018 To 12/31/2018 | Worksheet C Part I Date/Time Prepared: 5/30/2019 11:32 am

Title XVIII | 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
43.00	04300	NURSERY		43.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	54.00
60.00	06000	LABORATORY	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	63.00
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 PATIENT	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	73.00
75.00	03610	SLEEP LAB	0.000000	75.00
76.00	03020	CARDIAC REHAB	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS		
88.00	08800	RURAL HEALTH CLINIC		88.00
91.00	09100	EMERGENCY	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	92.00
		SPECIAL PURPOSE COST CENTERS		
113.00	11300	INTEREST EXPENSE		113.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1334 | Period: From 01/01/2018 To 12/31/2018 | Worksheet C Part I Date/Time Prepared: 5/30/2019 11:32 am

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,485,855		3,485,855	0	3,485,855	30.00
31.00	03100	INTENSIVE CARE UNIT	625,561		625,561	0	625,561	31.00
43.00	04300	NURSERY	164,243		164,243	0	164,243	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,055,089		2,055,089	0	2,055,089	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	97,788		97,788	0	97,788	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,194,139		2,194,139	0	2,194,139	54.00
60.00	06000	LABORATORY	1,694,060		1,694,060	0	1,694,060	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	121,981		121,981	0	121,981	63.00
65.00	06500	RESPIRATORY THERAPY	747,105	0	747,105	0	747,105	65.00
66.00	06600	PHYSICAL THERAPY	849,898	0	849,898	0	849,898	66.00
67.00	06700	OCCUPATIONAL THERAPY	32,141	0	32,141	0	32,141	67.00
68.00	06800	SPEECH PATHOLOGY	50,225	0	50,225	0	50,225	68.00
69.00	06900	ELECTROCARDIOLOGY	272,792		272,792	0	272,792	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	335,760		335,760	0	335,760	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	369,652		369,652	0	369,652	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,200,967		1,200,967	0	1,200,967	73.00
75.00	03610	SLEEP LAB	0		0	0	0	75.00
76.00	03020	CARDIAC REHAB	0		0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	236,274		236,274	0	236,274	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	735,623		735,623	0	735,623	88.00
91.00	09100	EMERGENCY	2,546,962		2,546,962	0	2,546,962	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	943,935		943,935		943,935	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	18,760,050	0	18,760,050	0	18,760,050	200.00
201.00		Less Observation Beds	943,935		943,935		943,935	201.00
202.00		Total (see instructions)	17,816,115	0	17,816,115	0	17,816,115	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1334 | Period: From 01/01/2018 To 12/31/2018 | Worksheet C Part I Date/Time Prepared: 5/30/2019 11:32 am

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	1,964,145		1,964,145			30.00
31.00	03100	INTENSIVE CARE UNIT	188,564		188,564			31.00
43.00	04300	NURSERY	173,706		173,706			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	535,773	1,909,157	2,444,930	0.840551	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	55,145	2,851	57,996	1.686116	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,016,768	15,684,721	16,701,489	0.131374	0.000000	54.00
60.00	06000	LABORATORY	1,984,862	10,938,397	12,923,259	0.131086	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	38,315	52,792	91,107	1.338876	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	826,287	1,466,740	2,293,027	0.325816	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	239,858	2,219,122	2,458,980	0.345630	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	22,977	67,084	90,061	0.356880	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	20,162	40,625	60,787	0.826246	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	198,546	1,532,223	1,730,769	0.157613	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,704,751	425,346	2,130,097	0.157627	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	249,322	348,046	597,368	0.618801	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,189,458	5,292,892	7,482,350	0.160507	0.000000	73.00
75.00	03610	SLEEP LAB	0	0	0	0.000000	0.000000	75.00
76.00	03020	CARDIAC REHAB	0	0	0	0.000000	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0	715,051	715,051	0.330430	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	1,246,597	1,246,597	0.590105	0.000000	88.00
91.00	09100	EMERGENCY	629,240	10,334,234	10,963,474	0.232313	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	56,019	410,888	466,907	2.021677	0.000000	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	12,093,898	52,686,766	64,780,664			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	12,093,898	52,686,766	64,780,664			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1334 | Period: From 01/01/2018 To 12/31/2018 | Worksheet C Part I Date/Time Prepared: 5/30/2019 11:32 am

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
43.00	04300	NURSERY			43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	06000	LABORATORY	0.000000		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000		63.00
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 PATIENT	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
75.00	03610	SLEEP LAB	0.000000		75.00
76.00	03020	CARDIAC REHAB	0.000000		76.00
76.97	07697	CARDIAC REHABILITATION	0.000000		76.97
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	0.000000		88.00
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-1334 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part II Date/Time Prepared: 5/30/2019 11:32 am

Title XVIII | Hospital | Cost

		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	272,843	2,444,930	0.111595	214,137	23,897	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	9,765	57,996	0.168374	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	118,297	16,701,489	0.007083	450,176	3,189	54.00
60.00	06000	LABORATORY	62,859	12,923,259	0.004864	954,038	4,640	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	3,784	91,107	0.041534	23,871	991	63.00
65.00	06500	RESPIRATORY THERAPY	50,522	2,293,027	0.022033	334,324	7,366	65.00
66.00	06600	PHYSICAL THERAPY	50,629	2,458,980	0.020589	76,628	1,578	66.00
67.00	06700	OCCUPATIONAL THERAPY	501	90,061	0.005563	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	1,667	60,787	0.027424	7,493	205	68.00
69.00	06900	ELECTROCARDIOLOGY	5,204	1,730,769	0.003007	109,179	328	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	10,223	2,130,097	0.004799	851,404	4,086	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	11,411	597,368	0.019102	179,917	3,437	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	27,500	7,482,350	0.003675	858,692	3,156	73.00
75.00	03610	SLEEP LAB	0	0	0.000000	0	0	75.00
76.00	03020	CARDIAC REHAB	0	0	0.000000	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	21,056	715,051	0.029447	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	21,613	1,246,597	0.017338	0	0	88.00
91.00	09100	EMERGENCY	125,262	10,963,474	0.011425	292,620	3,343	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	74,133	466,907	0.158775	26,221	4,163	92.00
200.00		Total (lines 50 through 199)	867,269	62,454,249		4,378,700	60,379	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-1334 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part IV Date/Time Prepared: 5/30/2019 11:32 am

Title XVIII | Hospital | Cost

		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
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
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
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
75.00	03610	SLEEP LAB	0	0	0	0	0	75.00
76.00	03020	CARDIAC REHAB	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1334 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part IV | Date/Time Prepared: 5/30/2019 11:32 am

Title XVIII | Hospital | Cost

		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	2,444,930	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	57,996	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	16,701,489	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	12,923,259	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	91,107	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	2,293,027	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	2,458,980	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	90,061	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	60,787	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	1,730,769	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	2,130,097	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	597,368	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	7,482,350	0.000000	73.00
75.00	03610	SLEEP LAB	0	0	0	0	0.000000	75.00
76.00	03020	CARDIAC REHAB	0	0	0	0	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	715,051	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	1,246,597	0.000000	88.00
91.00	09100	EMERGENCY	0	0	0	10,963,474	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	466,907	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	62,454,249		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1334 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part IV | Date/Time Prepared: 5/30/2019 11:32 am

Title XVIII | Hospital | Cost

		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	214,137	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	450,176	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	954,038	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	23,871	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.000000	334,324	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	76,628	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	7,493	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	109,179	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	851,404	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	179,917	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	858,692	0	0	0	73.00
75.00	03610	SLEEP LAB	0.000000	0	0	0	0	75.00
76.00	03020	CARDIAC REHAB	0.000000	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
91.00	09100	EMERGENCY	0.000000	292,620	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	26,221	0	0	0	92.00
200.00		Total (lines 50 through 199)		4,378,700	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1334 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part V Date/Time Prepared: 5/30/2019 11:32 am

Title XVIII | 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	0.840551	0	570,084	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.686116	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.131374	0	4,766,635	0	0	54.00
60.00	06000	LABORATORY	0.131086	0	3,476,900	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	1.338876	0	26,649	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.325816	0	554,602	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.345630	0	816,106	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.356880	0	37,333	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.826246	0	9,244	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.157613	0	568,581	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.157627	0	161,620	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.618801	0	48,505	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.160507	0	1,423,696	3,062	0	73.00
75.00	03610	SLEEP LAB	0.000000	0	0	0	0	75.00
76.00	03020	CARDIAC REHAB	0.000000	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.330430	0	240,794	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
91.00	09100	EMERGENCY	0.232313	0	2,496,987	2,513	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2.021677	0	141,242	0	0	92.00
200.00		Subtotal (see instructions)		0	15,338,978	5,575	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	15,338,978	5,575	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1334 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part V Date/Time Prepared: 5/30/2019 11:32 am

Title XVIII | 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	479,185	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	626,212	0		54.00
60.00	06000	LABORATORY	455,773	0		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	35,680	0		63.00
65.00	06500	RESPIRATORY THERAPY	180,698	0		65.00
66.00	06600	PHYSICAL THERAPY	282,071	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	13,323	0		67.00
68.00	06800	SPEECH PATHOLOGY	7,638	0		68.00
69.00	06900	ELECTROCARDIOLOGY	89,616	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	25,476	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	30,015	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	228,513	491		73.00
75.00	03610	SLEEP LAB	0	0		75.00
76.00	03020	CARDIAC REHAB	0	0		76.00
76.97	07697	CARDIAC REHABILITATION	79,566	0		76.97
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
91.00	09100	EMERGENCY	580,083	584		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	285,546	0		92.00
200.00		Subtotal (see instructions)	3,399,395	1,075		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	3,399,395	1,075		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-1334 | Component CCN: 15-Z334 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part V | Date/Time Prepared: 5/30/2019 11:32 am

Title XVIII | Swing Beds - SNF | 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	0.840551	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.686116	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.131374	0	0	0	0	54.00
60.00	06000	LABORATORY	0.131086	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	1.338876	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.325816	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.345630	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.356880	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.826246	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.157613	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.157627	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.618801	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.160507	0	0	0	0	73.00
75.00	03610	SLEEP LAB	0.000000	0	0	0	0	75.00
76.00	03020	CARDIAC REHAB	0.000000	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.330430	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
91.00	09100	EMERGENCY	0.232313	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2.021677	0	0	0	0	92.00
200.00		Subtotal (see instructions)		0	0	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-1334 | Component CCN: 15-Z334 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part V | Date/Time Prepared: 5/30/2019 11:32 am

Title XVIII | Swing Beds - SNF | 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	0	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
60.00	06000	LABORATORY	0	0		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0		63.00
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 PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
75.00	03610	SLEEP LAB	0	0		75.00
76.00	03020	CARDIAC REHAB	0	0		76.00
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
200.00		Subtotal (see instructions)	0	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	0		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1334 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part V Date/Time Prepared: 5/30/2019 11:32 am

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	0.840551	0	37,007	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.686116	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.131374	0	300,009	0	0	54.00
60.00	06000	LABORATORY	0.131086	0	271,421	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	1.338876	0	2,060	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.325816	0	7,981	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.345630	0	19,889	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.356880	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.826246	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.157613	0	24,994	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.157627	0	4,674	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.618801	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.160507	0	64,074	0	0	73.00
75.00	03610	SLEEP LAB	0.000000	0	0	0	0	75.00
76.00	03020	CARDIAC REHAB	0.000000	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.330430	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.590105				0	88.00
91.00	09100	EMERGENCY	0.232313	0	354,013	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2.021677	0	5,341	0	0	92.00
200.00		Subtotal (see instructions)		0	1,091,463	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	1,091,463	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1334 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part V Date/Time Prepared: 5/30/2019 11:32 am

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	31,106	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	39,413	0		54.00
60.00	06000	LABORATORY	35,579	0		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	2,758	0		63.00
65.00	06500	RESPIRATORY THERAPY	2,600	0		65.00
66.00	06600	PHYSICAL THERAPY	6,874	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	3,939	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	737	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	10,284	0		73.00
75.00	03610	SLEEP LAB	0	0		75.00
76.00	03020	CARDIAC REHAB	0	0		76.00
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
91.00	09100	EMERGENCY	82,242	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	10,798	0		92.00
200.00		Subtotal (see instructions)	226,330	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	226,330	0		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1334 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-1 | Date/Time Prepared: 5/30/2019 11:32 am

Title XVIII | 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)	3,778	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	3,290	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	2,274	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	462	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	26	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)	1,203	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)	416	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	3,485,855	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)	429,230	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	3,056,625	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)	3,056,625	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)	929.07	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,117,671	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)	1,117,671	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1334 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-1 | Date/Time Prepared: 5/30/2019 11:32 am

Title XVIII | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	625,561	145	4,314.21	71	306,309	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)	1,059,319	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	2,483,299	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)	386,493	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)	386,493	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)	1,016	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	929.07	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	943,935	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1334 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-1 | Date/Time Prepared: 5/30/2019 11:32 am

Title XVIII | 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	273,765	3,485,855	0.078536	943,935	74,133	90.00
91.00	Nursing School cost	0	3,485,855	0.000000	943,935	0	91.00
92.00	Allied health cost	0	3,485,855	0.000000	943,935	0	92.00
93.00	All other Medical Education	0	3,485,855	0.000000	943,935	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1334 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-1 | Date/Time Prepared: 5/30/2019 11:32 am

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)	3,778	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	3,290	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	2,274	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	462	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	26	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)	372	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)	416	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)	104	15.00
16.00	Nursery days (title V or XIX only)	98	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	3,485,855	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)	429,230	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	3,056,625	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)	3,056,625	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)	929.07	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	345,614	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)	345,614	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1334 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-1 | Date/Time Prepared: 5/30/2019 11:32 am

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)	164,243	104	1,579.26	98	154,767	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	625,561	145	4,314.21	30	129,426	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)	65,799	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	695,606	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)	386,493	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)	386,493	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)	1,016	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	929.07	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	943,935	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1334 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-1 | Date/Time Prepared: 5/30/2019 11:32 am

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	273,765	3,485,855	0.078536	943,935	74,133	90.00
91.00	Nursing School cost	0	3,485,855	0.000000	943,935	0	91.00
92.00	Allied health cost	0	3,485,855	0.000000	943,935	0	92.00
93.00	All other Medical Education	0	3,485,855	0.000000	943,935	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1334 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-3 | Date/Time Prepared: 5/30/2019 11:32 am

Title XVIII | 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		836,758		30.00
31.00	03100	INTENSIVE CARE UNIT		84,290		31.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.840551	214,137	179,993	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.686116	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.131374	450,176	59,141	54.00
60.00	06000	LABORATORY	0.131086	954,038	125,061	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	1.338876	23,871	31,960	63.00
65.00	06500	RESPIRATORY THERAPY	0.325816	334,324	108,928	65.00
66.00	06600	PHYSICAL THERAPY	0.345630	76,628	26,485	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.356880	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.826246	7,493	6,191	68.00
69.00	06900	ELECTROCARDIOLOGY	0.157613	109,179	17,208	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.157627	851,404	134,204	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.618801	179,917	111,333	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.160507	858,692	137,826	73.00
75.00	03610	SLEEP LAB	0.000000	0	0	75.00
76.00	03020	CARDIAC REHAB	0.000000	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.330430	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
91.00	09100	EMERGENCY	0.232313	292,620	67,979	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2.021677	26,221	53,010	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		4,378,700	1,059,319	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)		4,378,700		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-1334 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-3

Component CCN: 15-Z334 | Date/Time Prepared: 5/30/2019 11:32 am

Title XVIII | Swing Beds - SNF | 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
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.840551	15	13	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.686116	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.131374	15,912	2,090	54.00
60.00	06000	LABORATORY	0.131086	65,633	8,604	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	1.338876	2,510	3,361	63.00
65.00	06500	RESPIRATORY THERAPY	0.325816	80,273	26,154	65.00
66.00	06600	PHYSICAL THERAPY	0.345630	132,760	45,886	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.356880	22,977	8,200	67.00
68.00	06800	SPEECH PATHOLOGY	0.826246	6,150	5,081	68.00
69.00	06900	ELECTROCARDIOLOGY	0.157613	8,063	1,271	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.157627	275,505	43,427	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.618801	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.160507	137,957	22,143	73.00
75.00	03610	SLEEP LAB	0.000000	0	0	75.00
76.00	03020	CARDIAC REHAB	0.000000	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.330430	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
91.00	09100	EMERGENCY	0.232313	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2.021677	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		747,755	166,230	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)		747,755		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1334 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-3 | Date/Time Prepared: 5/30/2019 11:32 am

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		24,302		30.00
31.00	03100	INTENSIVE CARE UNIT		7,164		31.00
43.00	04300	NURSERY		2,315		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.840551	28,095	23,615	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.686116	1,532	2,583	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.131374	35,088	4,610	54.00
60.00	06000	LABORATORY	0.131086	46,164	6,051	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	1.338876	515	690	63.00
65.00	06500	RESPIRATORY THERAPY	0.325816	11,941	3,891	65.00
66.00	06600	PHYSICAL THERAPY	0.345630	8,163	2,821	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.356880	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.826246	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.157613	3,900	615	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.157627	19,185	3,024	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.618801	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.160507	52,101	8,363	73.00
75.00	03610	SLEEP LAB	0.000000	0	0	75.00
76.00	03020	CARDIAC REHAB	0.000000	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.330430	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.590105	0	0	88.00
91.00	09100	EMERGENCY	0.232313	18,788	4,365	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2.021677	2,558	5,171	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		228,030	65,799	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)		228,030		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1334	Period: From 01/01/2018 To 12/31/2018	Worksheet E Part B Date/Time Prepared: 5/30/2019 11:32 am
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	3,400,470	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)	3,400,470	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)	3,434,475	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)	54,165	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	2,359,885	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	1,020,425	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	1,020,425	30.00
31.00	Primary payer payments	621	31.00
32.00	Subtotal (line 30 minus line 31)	1,019,804	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)	574,589	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	373,483	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	352,614	36.00
37.00	Subtotal (see instructions)	1,393,287	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)	1,393,287	40.00
40.01	Sequestration adjustment (see instructions)	27,866	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
41.00	Interim payments	1,378,774	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	-13,353	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: 15-1334 | Period: From 01/01/2018 To 12/31/2018 | Worksheet E-1 Part I Date/Time Prepared: 5/30/2019 11:32 am

Title XVIII | Hospital | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,822,578		1,292,574	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	08/15/2018	86,200	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		86,200	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)		1,822,578		1,378,774	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		284,081		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		13,353	6.02
7.00	Total Medicare program liability (see instructions)		2,106,659		1,365,421	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: 15-1334 | Component CCN: 15-Z334 | Period: From 01/01/2018 To 12/31/2018 | Worksheet E-1 Part I | Date/Time Prepared: 5/30/2019 11:32 am

Title XVIII | Swing Beds - SNF | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		498,071		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)		498,071		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		38,015		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		536,086		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: 15-1334	Period: From 01/01/2018 To 12/31/2018	Worksheet E-1 Part II Date/Time Prepared: 5/30/2019 11:32 am
	Title XVIII	Hospital	Cost

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

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

Provider CCN: 15-1334 | Component CCN: 15-Z334 | Period: From 01/01/2018 To 12/31/2018 | Worksheet E-2 | Date/Time Prepared: 5/30/2019 11:32 am

Title XVIII | Swing Beds - SNF | Cost

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	390,358	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)	167,892	0	3.00
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)		0.00	4.00
5.00	Program days	416	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)	558,250	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	558,250	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)	558,250	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	11,223	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)	547,027	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)	547,027	0	19.00
19.01	Sequestration adjustment (see instructions)	10,941	0	19.01
19.02	Demonstration payment adjustment amount after sequestration)	0	0	19.02
20.00	Interim payments	498,071	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)	38,015	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: 15-1334	Period: From 01/01/2018 To 12/31/2018	Worksheet E-3 Part V Date/Time Prepared: 5/30/2019 11:32 am
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	2,483,299	1.00
2.00	Nursing and Allied Health Managed Care payment (see instructions)	0	2.00
3.00	Organ acquisition	0	3.00
4.00	Subtotal (sum of lines 1 through 3)	2,483,299	4.00
5.00	Primary payer payments	8,331	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	2,499,801	6.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
7.00	Routine service charges	0	7.00
8.00	Ancillary service charges	0	8.00
9.00	Organ acquisition charges, net of revenue	0	9.00
10.00	Total reasonable charges	0	10.00
	Customary charges		
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)	0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)	0.000000	13.00
14.00	Total customary charges (see instructions)	0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)	0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)	0	16.00
17.00	Cost of physicians' services in a teaching hospital (see instructions)	0	17.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)	0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)	2,499,801	19.00
20.00	Deductibles (exclude professional component)	390,992	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	2,108,809	22.00
23.00	Coinsurance	14,070	23.00
24.00	Subtotal (line 22 minus line 23)	2,094,739	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	84,482	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	54,913	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	39,928	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	2,149,652	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	29.50
29.99	Demonstration payment adjustment amount before sequestration	0	29.99
30.00	Subtotal (see instructions)	2,149,652	30.00
30.01	Sequestration adjustment (see instructions)	42,993	30.01
30.02	Demonstration payment adjustment amount after sequestration	0	30.02
31.00	Interim payments	1,822,578	31.00
32.00	Tentative settlement (for contractor use only)	0	32.00
33.00	Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32)	284,081	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-1334 | Period: From 01/01/2018 To 12/31/2018 | Worksheet E-3 Part VII Date/Time Prepared: 5/30/2019 11:32 am

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	695,606		1.00
2.00	Medical and other services		226,330	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	695,606	226,330	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)	695,606	226,330	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	33,781		8.00
9.00	Ancillary service charges	228,030	1,091,463	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)	261,811	1,091,463	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)	261,811	1,091,463	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	0	865,133	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	433,795	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)	695,606	226,330	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)	695,606	226,330	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30.00	Excess of reasonable cost (from line 18)	433,795	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	695,606	226,330	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)	695,606	226,330	36.00
37.00	ADJUSTMENT TO FORCE 0 SETTLEMENT	-589,151	-1,746	37.00
38.00	Subtotal (line 36 ± line 37)	106,455	224,584	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)	106,455	224,584	40.00
41.00	Interim payments	106,455	224,584	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: 15-1334 | Period: From 01/01/2018 To 12/31/2018 | Worksheet G | Date/Time Prepared: 5/30/2019 11:32 am

		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	25,958	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	3,737,759	0	0	0	4.00
5.00	Other receivable	2,903,495	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	603,299	0	0	0	7.00
8.00	Prepaid expenses	249,993	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	7,520,504	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	840,000	0	0	0	12.00
13.00	Land improvements	466,199	0	0	0	13.00
14.00	Accumulated depreciation	-167,071	0	0	0	14.00
15.00	Buildings	3,056,163	0	0	0	15.00
16.00	Accumulated depreciation	-1,341,729	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	756,517	0	0	0	19.00
20.00	Accumulated depreciation	-121,030	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	2,292,896	0	0	0	23.00
24.00	Accumulated depreciation	-1,208,705	0	0	0	24.00
25.00	Minor equipment depreciable	3,942,189	0	0	0	25.00
26.00	Accumulated depreciation	-2,380,455	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)	6,134,974	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	380,203	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	380,203	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	14,035,681	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	577,744	0	0	0	37.00
38.00	Salaries, wages, and fees payable	640,602	0	0	0	38.00
39.00	Payroll taxes payable	176,743	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	75,930	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	1,471,019	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	8,249,829	0	0	0	46.00
47.00	Notes payable	118,269	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	8,368,098	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	9,839,117	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	4,196,564				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)	4,196,564	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	14,035,681	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-1334 | Period: From 01/01/2018 To 12/31/2018 | Worksheet G-1 | Date/Time Prepared: 5/30/2019 11:32 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		5,566,010		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-856,823				2.00
3.00	Total (sum of line 1 and line 2)		4,709,187		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		4,709,187		0		11.00
12.00	INCOME TAX	392,190		0		0	12.00
13.00	ADJUSTMENTS TO RETAINED EARNINGS	120,433		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)		512,623		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		4,196,564		0		19.00

		Endowment Fund	Plant Fund		
		6.00	7.00	8.00	
1.00	Fund balances at beginning of period	0		0	1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)				2.00
3.00	Total (sum of line 1 and line 2)	0		0	3.00
4.00	Additions (credit adjustments) (specify)		0		4.00
5.00			0		5.00
6.00			0		6.00
7.00			0		7.00
8.00			0		8.00
9.00			0		9.00
10.00	Total additions (sum of line 4-9)	0		0	10.00
11.00	Subtotal (line 3 plus line 10)	0		0	11.00
12.00	INCOME TAX		0		12.00
13.00	ADJUSTMENTS TO RETAINED EARNINGS		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: 15-1334 | Period: From 01/01/2018 To 12/31/2018 | Worksheet G-2 Parts I & II Date/Time Prepared: 5/30/2019 11:32 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	1,808,165		1,808,165	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	155,980		155,980	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)	1,964,145		1,964,145	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	188,564		188,564	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)	188,564		188,564	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	2,152,709		2,152,709	17.00
18.00	Ancillary services	8,987,522	40,661,286	49,648,808	18.00
19.00	Outpatient services	685,259	10,745,122	11,430,381	19.00
20.00	RURAL HEALTH CLINIC	0	1,246,597	1,246,597	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	NURSERY	173,706	0	173,706	27.00
27.01	PRIVATE PHYSICIAN OFFICES	0	660,519	660,519	27.01
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	11,999,196	53,313,524	65,312,720	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		21,687,909		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	IMPUTED INCOME TAX	392,190			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)		392,190		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		21,295,719		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 15-1334 | Period: From 01/01/2018 To 12/31/2018 | Worksheet G-3 | Date/Time Prepared: 5/30/2019 11:32 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	65,312,720	1.00
2.00	Less contractual allowances and discounts on patients' accounts	45,548,070	2.00
3.00	Net patient revenues (line 1 minus line 2)	19,764,650	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	21,295,719	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-1,531,069	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	1,484	6.00
7.00	Income from investments	10,181	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	96,944	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	24	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	1,129	21.00
22.00	Rental of hospital space	564,484	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER (SPECIFY)	0	24.00
25.00	Total other income (sum of lines 6-24)	674,246	25.00
26.00	Total (line 5 plus line 25)	-856,823	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)	-856,823	29.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1334 | Component CCN: 15-8523 | Period: From 01/01/2018 To 12/31/2018 | Worksheet M-1 | Date/Time Prepared: 5/30/2019 11:32 am

RHC I | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	146,059	0	146,059	0	146,059	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	103,940	0	103,940	0	103,940	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	92,853	0	92,853	0	92,853	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	342,852	0	342,852	0	342,852	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	39,350	39,350	0	39,350	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	39,350	39,350	0	39,350	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	342,852	39,350	382,202	0	382,202	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	52,891	52,891	0	52,891	29.00
30.00	Administrative Costs	0	77,199	77,199	0	77,199	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	130,090	130,090	0	130,090	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	342,852	169,440	512,292	0	512,292	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1334 | Component CCN: 15-8523 | Period: From 01/01/2018 To 12/31/2018 | Worksheet M-1 | Date/Time Prepared: 5/30/2019 11:32 am

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	146,059		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	103,940		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	92,853		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	0		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	342,852		10.00
11.00	Physician Services Under Agreement	0	0		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	0		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0		14.00
15.00	Medical Supplies	0	39,350		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	39,350		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	382,202		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	52,891		29.00
30.00	Administrative Costs	0	77,199		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	130,090		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	512,292		32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 15-1334 | Component CCN: 15-8523 | Period: From 01/01/2018 To 12/31/2018 | Worksheet M-2 | Date/Time Prepared: 5/30/2019 11:32 am

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	0.80	2,920	4,200	3,360		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	1.00	3,147	2,100	2,100		3.00
4.00	Subtotal (sum of lines 1 through 3)	1.80	6,067		5,460	6,067	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)	1.80	6,067			6,067	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)					382,202	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)					382,202	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)					130,090	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					223,331	15.00
16.00	Total overhead (sum of lines 14 and 15)					353,421	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					353,421	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					353,421	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					735,623	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 15-1334 Component CCN: 15-8523	Period: From 01/01/2018 To 12/31/2018	Worksheet M-3 Date/Time Prepared: 5/30/2019 11:32 am
	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)		735,623	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)		35,883	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		699,740	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		6,067	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)		6,067	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		115.34	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)	0.00	83.45	8.00
9.00	Rate for Program covered visits (see instructions)	115.34	115.34	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	1,437	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	165,744	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	165,744	16.00
16.01	Total program charges (see instructions)(from contractor's records)		291,425	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		2,384	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		1,356	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.)		115,151	16.04
16.05	Total program cost (see instructions)	0	116,507	16.05
17.00	Primary payer amounts		297	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		20,449	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		53,718	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		116,210	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		19,030	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		135,240	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)		135,240	26.00
26.01	Sequestration adjustment (see instructions)		2,705	26.01
26.02	Demonstration payment adjustment amount after sequestration		0	26.02
27.00	Interim payments		68,159	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)		64,376	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: 15-1334 Component CCN: 15-8523	Period: From 01/01/2018 To 12/31/2018	Worksheet M-4 Date/Time Prepared: 5/30/2019 11:32 am
	Title XVIII	RHC I	Cost

		Pneumococcal	Influenza	
		1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	342,852	342,852	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000681	0.004915	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	233	1,685	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	6,958	9,767	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	7,191	11,452	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	382,202	382,202	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	353,421	353,421	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.018815	0.029963	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	6,650	10,590	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	13,841	22,042	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	51	368	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	271.39	59.90	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	39	141	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	10,584	8,446	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)		35,883	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)		19,030	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 15-1334 Component CCN: 15-8523	Period: From 01/01/2018 To 12/31/2018	Worksheet M-5 Date/Time Prepared: 5/30/2019 11:32 am
		RHC I	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		68,159	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)		68,159	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		64,376	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		132,535	7.00

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