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: 15-1307	Period: From 07/01/2017 To 06/30/2018	Worksheet S Parts I-III Date/Time Prepared: 11/26/2018 3:40 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 11/26/2018 Time: 3:40 pm
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by ST. VINCENT WILLIAMSPORT HOSPITAL (15-1307) for the cost reporting period beginning 07/01/2017 and ending 06/30/2018 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

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

_____
Title

_____
Date

	Cost Center Description	Title V	Title XVIII 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	-240,112	-337,872	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	-146,606	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
10.00	RURAL HEALTH CLINIC I	0		128,029		0	10.00
10.01	RURAL HEALTH CLINIC II	0		128,507		0	10.01
200.00	Total	0	-386,718	-81,336	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: 15-1307 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-2 Part I | Date/Time Prepared: 11/26/2018 3:30 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 412 NORTH MONROE	PO Box:			1.00
2.00	City: WILLIAMSPORT	State: IN	Zip Code: 47993	County: WARREN	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	ST. VINCENT WILLIAMSPORT HOSPITAL	151307	99915	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	ST. VINCENT WILLIAMSPORT SWING BEDS	15Z307	99915		02/01/1988	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	NORTH CLINIC	153993	99915		05/06/2001	N	O	N	15.00
15.01	Hospital-Based Health Clinic - RHC II	SOUTH CLINIC	153994	99915		08/01/2001	N	O	N	15.01
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	07/01/2017	06/30/2018	20.00
21.00	Type of Control (see instructions)	6		21.00
	Inpatient PPS Information			
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	N	N	22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	N	N	22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N	22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.	N	N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	2	N	23.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1307 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-2 Part I Date/Time Prepared: 11/26/2018 3:30 pm

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
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)	N		37.01
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.			38.00

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

		V	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: 15-1307 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-2 Part I | Date/Time Prepared: 11/26/2018 3:30 pm

		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)				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: 15-1307 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-2 Part I | Date/Time Prepared: 11/26/2018 3:30 pm

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

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

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

		1.00	2.00	3.00	
	Inpatient Psychiatric Facility PPS				
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1307 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-2 Part I Date/Time Prepared: 11/26/2018 3:30 pm

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

		V	XIX	
		1.00	2.00	
	Title V and XIX Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		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.	N	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.	N	Y	98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	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: 15-1307	Period: From 07/01/2017 To 06/30/2018	Worksheet S-2 Part I Date/Time Prepared: 11/26/2018 3:30 pm

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

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

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	161,564	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.	Y	5.00	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	15H046	140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1307 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-2 Part I | Date/Time Prepared: 11/26/2018 3:30 pm

	1.00	2.00	3.00	
	If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.			
141.00	Name: ST. VINCENT HEALTH	Contractor's Name: WPS	Contractor's Number: 08101	141.00
142.00	Street: 250 W. 96TH ST. SUITE 215	PO Box:		142.00
143.00	City: INDIANAPOLIS	State: IN	Zip Code: 46290	143.00

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

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

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

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

		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.	N	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)	Y	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)			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: 15-1307 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-2 Part II Date/Time Prepared: 11/26/2018 3:30 pm

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

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

		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	N			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	10/10/2018	Y	10/10/2018	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-1307 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-2 Part II Date/Time Prepared: 11/26/2018 3:30 pm

		Description		Y/N	Y/N	
		0		1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
	Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions				N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				N	27.00
	Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				N	31.00
	Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				N	33.00
	Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				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.	JILL		HILL		41.00
42.00	Enter the employer/company name of the cost report preparer.	ST. VINCENT HEALTH				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	3175833519		JILL.HILL1@ASCENSION.ORG		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-1307	Period: From 07/01/2017 To 06/30/2018	Worksheet S-2 Part II Date/Time Prepared: 11/26/2018 3:30 pm

		3.00		
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	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: 15-1307 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-3 Part I Date/Time Prepared: 11/26/2018 3:30 pm

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	16	5,840	37,224.00	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)		16	5,840	37,224.00	0	7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		16	5,840	37,224.00	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
26.01	RURAL HEALTH CLINIC II	88.01				0	26.01
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		16				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: 15-1307 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-3 Part I | Date/Time Prepared: 11/26/2018 3:30 pm

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	1,156	8	1,551			1.00
2.00	HMO and other (see instructions)	236	65				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	615	0	687			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	2			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,771	8	2,240			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		0	0			13.00
14.00	Total (see instructions)	1,771	8	2,240	0.00	79.43	14.00
15.00	CAH visits	25,221	1,048	66,290			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	0	0	0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	2,990	205	15,581	0.00	19.19	26.00
26.01	RURAL HEALTH CLINIC II	5,616	162	16,042	0.00	16.96	26.01
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	115.58	27.00
28.00	Observation Bed Days		0	717			28.00
29.00	Ambulance Trips	469					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: 15-1307 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-3 Part I | Date/Time Prepared: 11/26/2018 3:30 pm

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	354	3	477	1.00
2.00	HMO and other (see instructions)			63	22		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	354	3	477	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
26.01	RURAL HEALTH CLINIC II	0.00					26.01
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: 15-1307 | Component CCN: 15-3993 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-8 | Date/Time Prepared: 11/26/2018 3:30 pm

		RHC I	Cost
		1.00	
	Clinic Address and Identification		
1.00	Street	1731 RINGER LANE	1.00
	City	State	ZIP Code
	1.00	2.00	3.00
2.00	City, State, ZIP Code, County	WILLIAMSPORT IN	47993 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
9.01				9.01
9.02				9.02
9.03				9.03
9.04				9.04
9.05				9.05
9.06				9.06
9.07				9.07
9.08				9.08
9.09				9.09
9.10				9.10

		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			07:00	19:00	07:00	11.00

		1.00	2.00	
12.00	Have you received an approval for an exception to the productivity standard?	N		12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.	N	0	13.00

		Provider name	CCN number	
		1.00	2.00	
14.00	RHC/FQHC name, CCN number			14.00

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

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA	Provider CCN: 15-1307 Component CCN: 15-3993	Period: From 07/01/2017 To 06/30/2018	Worksheet S-8 Date/Time Prepared: 11/26/2018 3:30 pm
		RHC I	Cost

			County				
			4.00				
2.00	City, State, ZIP Code, County		WARREN				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	19:00	07:00	19:00	07:00	19:00	11.00
		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	CLINIC	07:00	19:00				11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 15-1307 | Component CCN: 15-3994 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-8 | Date/Time Prepared: 11/26/2018 3:30 pm

RHC II | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			440 W. SONGER LANE		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	VEEDERSBURG		IN	47987	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
9.01						9.01
9.02						9.02
9.03						9.03
9.04						9.04
9.05						9.05
9.06						9.06
9.07						9.07
9.08						9.08
9.09						9.09
9.10						9.10
				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			07:00	17:50	07:00	11.00

	1.00	2.00	
12.00	Have you received an approval for an exception to the productivity standard?	N	12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.	N	0 13.00

		Provider name	CCN number	
		1.00	2.00	
14.00	RHC/FQHC name, CCN number			14.00

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

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA	Provider CCN: 15-1307 Component CCN: 15-3994	Period: From 07/01/2017 To 06/30/2018	Worksheet S-8 Date/Time Prepared: 11/26/2018 3:30 pm
		RHC II	Cost

			County				
			4.00				
2.00	City, State, ZIP Code, County		FOUNTAIN				2.00
		Tuesday	Wednesday		Thursday		
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)						
11.00	CLINIC	17:50	07:00	17:50	07:00	17:50	11.00
		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	CLINIC	07:00	17:50				11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 15-1307 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-10 | Date/Time Prepared: 11/26/2018 3:30 pm

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.265348	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	-1,124,453	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	13,996,744	6.00
7.00	Medicaid cost (line 1 times line 6)	3,714,008	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)	4,838,461	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)	4,838,461	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)	3,887,148	916,981	4,804,129	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	1,031,447	916,981	1,948,428	21.00
22.00	Payments received from patients for amounts previously written off as charity care	67,361	0	67,361	22.00
23.00	Cost of charity care (line 21 minus line 22)	964,086	916,981	1,881,067	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)	929,850	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	336,857	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	518,241	27.01
28.00	Non-Medicare bad debt expense (see instructions)	411,609	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	290,604	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	2,171,671	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	7,010,132	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1307 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A | Date/Time Prepared: 11/26/2018 3:30 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		186,228	186,228	-1,750	184,478	1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		560,536	560,536	0	560,536	2.00
3.00	00300	OTHER CAPITAL RELATED COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	11,980	2,450,013	2,461,993	0	2,461,993	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	873,398	4,314,160	5,187,558	1,750	5,189,308	5.00
7.00	00700	OPERATION OF PLANT	0	339,631	339,631	0	339,631	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	0	258,566	258,566	0	258,566	9.00
10.00	01000	DIETARY	0	25,730	25,730	0	25,730	10.00
13.00	01300	NURSING ADMINISTRATION	172,768	7,891	180,659	0	180,659	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	688	7,967	8,655	0	8,655	14.00
15.00	01500	PHARMACY	166,882	373,998	540,880	0	540,880	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	577	577	0	577	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	998,891	239,224	1,238,115	-4,009	1,234,106	30.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	520,876	293,551	814,427	-22,880	791,547	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	549,659	385,425	935,084	0	935,084	54.00
60.00	06000	LABORATORY	34,591	1,212,519	1,247,110	0	1,247,110	60.00
65.00	06500	RESPIRATORY THERAPY	21,081	48,322	69,403	0	69,403	65.00
66.00	06600	PHYSICAL THERAPY	214,064	66,920	280,984	0	280,984	66.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	10,484	10,484	36,620	47,104	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	36,613	36,613	0	36,613	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	792	792	0	792	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,195,519	372,083	1,567,602	-12,519	1,555,083	88.00
88.01	08801	RURAL HEALTH CLINIC II	1,306,530	363,315	1,669,845	12,519	1,682,364	88.01
91.00	09100	EMERGENCY	963,584	1,322,114	2,285,698	-9,731	2,275,967	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	413,178	46,275	459,453	0	459,453	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	7,443,689	12,922,934	20,366,623	0	20,366,623	118.00
		NONREIMBURSABLE COST CENTERS						
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	ORTHO CLINIC	307,692	21,750	329,442	0	329,442	193.01
193.02	19303	COMMUNITY MED CLINIC	0	0	0	0	0	193.02
194.00	07950	MARKETING	0	2,313	2,313	0	2,313	194.00
200.00		TOTAL (SUM OF LINES 118 through 199)	7,751,381	12,946,997	20,698,378	0	20,698,378	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1307 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A | Date/Time Prepared: 11/26/2018 3:30 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	-139,745	44,733		1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	0	560,536		2.00
3.00	00300	OTHER CAPITAL RELATED COSTS	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-26,241	2,435,752		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	537,803	5,727,111		5.00
7.00	00700	OPERATION OF PLANT	0	339,631		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0		8.00
9.00	00900	HOUSEKEEPING	0	258,566		9.00
10.00	01000	DIETARY	-16,810	8,920		10.00
13.00	01300	NURSING ADMINISTRATION	0	180,659		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	-25	8,630		14.00
15.00	01500	PHARMACY	0	540,880		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	577		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	1,234,106		30.00
43.00	04300	NURSERY	0	0		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-554,291	237,256		50.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-103,299	831,785		54.00
60.00	06000	LABORATORY	0	1,247,110		60.00
65.00	06500	RESPIRATORY THERAPY	0	69,403		65.00
66.00	06600	PHYSICAL THERAPY	-1,564	279,420		66.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	47,104		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	36,613		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-93	699		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	-29,114	1,525,969		88.00
88.01	08801	RURAL HEALTH CLINIC II	-58,558	1,623,806		88.01
91.00	09100	EMERGENCY	-22,137	2,253,830		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	-741	458,712		95.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-414,815	19,951,808		118.00
		NONREIMBURSABLE COST CENTERS				
193.00	19300	NONPAID WORKERS	0	0		193.00
193.01	19301	ORTHO CLINIC	0	329,442		193.01
193.02	19303	COMMUNITY MED CLINIC	0	0		193.02
194.00	07950	MARKETING	94,674	96,987		194.00
200.00		TOTAL (SUM OF LINES 118 through 199)	-320,141	20,378,237		200.00

RECLASSIFICATIONS | Provider CCN: 15-1307 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-6 | Date/Time Prepared: 11/26/2018 3:30 pm

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - ADMINISTRATIVE & GENERAL				
1.00	ADMINISTRATIVE & GENERAL	5.00	0	1,750	1.00
	TOTALS		0	1,750	
	B - RHC RECLASS				
1.00	RURAL HEALTH CLINIC II	88.01	12,519	0	1.00
	TOTALS		12,519	0	
	C - Medical Supplies				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00		36,620	1.00
2.00					2.00
3.00					3.00
			0	36,620	
500.00	Grand Total: Increases		12,519	38,370	500.00

RECLASSIFICATIONS | Provider CCN: 15-1307 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-6 | Date/Time Prepared: 11/26/2018 3:30 pm

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - ADMINISTRATIVE & GENERAL						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1,750	9		1.00
	TOTALS		0	1,750			
	B - RHC RECLASS						
1.00	RURAL HEALTH CLINIC	88.00	12,519	0	0		1.00
	TOTALS		12,519	0			
	C - Medical Supplies						
1.00	ADULTS & PEDIATRICS	30.00		4,009			1.00
2.00	OPERATING ROOM	50.00		22,880			2.00
3.00	EMERGENCY	91.00		9,731			3.00
			0	36,620			
500.00	Grand Total: Decreases		12,519	38,370			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1307 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-7 Part I | Date/Time Prepared: 11/26/2018 3:30 pm

		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	174,050	0	0	0	0	1.00
2.00	Land Improvements	159,079	0	0	0	0	2.00
3.00	Buildings and Fixtures	8,291,636	128,890	0	128,890	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	1,649,197	27,593	0	27,593	0	5.00
6.00	Movable Equipment	3,875,221	0	0	0	47,224	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	14,149,183	156,483	0	156,483	47,224	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	14,149,183	156,483	0	156,483	47,224	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	174,050	0	1.00
2.00	Land Improvements	159,079	0	2.00
3.00	Buildings and Fixtures	8,420,526	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	1,676,790	0	5.00
6.00	Movable Equipment	3,827,997	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	14,258,442	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	14,258,442	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1307 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-7 Part II | Date/Time Prepared: 11/26/2018 3:30 pm

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	NEW CAP REL COSTS-BLDG & FIXT	21,990	0	141,494	9,927	12,817	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	473,463	86,469	0	604	0	2.00
3.00	Total (sum of lines 1-2)	495,453	86,469	141,494	10,531	12,817	3.00

	Cost Center Description	SUMMARY OF CAPITAL		
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
		14.00	15.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2			
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	186,228	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	560,536	2.00
3.00	Total (sum of lines 1-2)	0	746,764	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1307 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-7 Part III Date/Time Prepared: 11/26/2018 3:30 pm

	Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	10,430,445	0	10,430,445	0.731528	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	3,827,997	0	3,827,997	0.268472	0	2.00
3.00	Total (sum of lines 1-2)	14,258,442	0	14,258,442	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	20,240	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	473,463	86,469	2.00
3.00	Total (sum of lines 1-2)	0	0	0	493,703	86,469	3.00

	Cost Center Description	SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1,749	9,927	12,817	0	44,733	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	604	0	0	560,536	2.00
3.00	Total (sum of lines 1-2)	1,749	10,531	12,817	0	605,269	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1307 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-8 | Date/Time Prepared: 11/26/2018 3:30 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-139,745	NEW CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00	Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)	B	-1,750	ADMINISTRATIVE & GENERAL	5.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		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	-322,440			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	1,836,212			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests		0		0.00	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		0		0.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		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	-1,564	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - NEW CAP REL COSTS-BLDG & FIXT		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - NEW CAP REL COSTS-MVBLE EQUIP		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1307 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-8 | Date/Time Prepared: 11/26/2018 3:30 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	MISSION POINT SAVINGS	B	-16,753	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.00
33.01	REV OFFSET - ADMIN	B	-478,100	ADMINISTRATIVE & GENERAL	5.00	0	33.01
33.02	REV OFFSET - FOOD SERVICES	B	-16,810	DIETARY	10.00	0	33.02
33.04	REV OFFSET - OR	B	-334,961	OPERATING ROOM	50.00	0	33.04
33.05	REV OFFSET - RADIOLOGY	B	-189	RADIOLOGY-DIAGNOSTIC	54.00	0	33.05
33.06	REV OFFSET - DRUGS	B	-93	DRUGS CHARGED TO PATIENTS	73.00	0	33.06
33.07	LOBBYING	A	-312	ADMINISTRATIVE & GENERAL	5.00	0	33.07
33.08	PROVIDER TAX	A	-721,230	ADMINISTRATIVE & GENERAL	5.00	0	33.08
33.09	CHARITABLE CONTRIBUTIONS	A	-590	ADMINISTRATIVE & GENERAL	5.00	0	33.09
33.10	INCENTIVE ACCRUAL ADJUSTMENT	A	-9,488	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.10
33.11	NON-RHC SALARIES	A	-29,114	RURAL HEALTH CLINIC	88.00	0	33.11
33.12	NON-RHC SALARIES	A	-58,558	RURAL HEALTH CLINIC II	88.01	0	33.12
33.13	PROMOTIONAL	A	-1,753	ADMINISTRATIVE & GENERAL	5.00	0	33.13
33.14	LATE PENALTY FEE	A	-25	CENTRAL SERVICES & SUPPLY	14.00	0	33.14
33.15	LOSS ON SALE DISPOSAL	A	-22,137	EMERGENCY	91.00	0	33.15
33.16	LOSS ON SALE DISPOSAL	A	-741	AMBULANCE SERVICES	95.00	0	33.16
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-320,141				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: 15-1307	Period: From 07/01/2017 To 06/30/2018	Worksheet A-8-1 Date/Time Prepared: 11/26/2018 3:30 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE - CAPITAL	333,418	0	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE - OTHER	4,904,038	3,495,918	2.00
3.00	194.00	MARKETING	HOME OFFICE - MARKETING	94,674	0	3.00
3.01	4.00	EMPLOYEE BENEFITS DEPARTMENT	SVH CHARGEBACKS	157,761	157,761	3.01
3.02	15.00	PHARMACY	SVH CHARGEBACKS	31,571	31,571	3.02
3.03	30.00	ADULTS & PEDIATRICS	SVH CHARGEBACKS	1,250	1,250	3.03
3.04	54.00	RADIOLOGY-DIAGNOSTIC	SVH CHARGEBACKS	27,192	27,192	3.04
3.05	65.00	RESPIRATORY THERAPY	SVH CHARGEBACKS	37,360	37,360	3.05
3.06	91.00	EMERGENCY	SVH CHARGEBACKS	1,853	1,853	3.06
3.08	1.00	NEW CAP REL COSTS-BLDG & FIX	INTEREST EXPENSE	141,494	141,494	3.08
4.00	0.00			0	0	4.00
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			5,730,611	3,894,399	5.00

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

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

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

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

6.00	G	SVH	100.00	ST. VINCENT HEALTH	100.00	6.00
7.00	G	ASCENSION	100.00	ASCENSION	100.00	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:	HOME OFFICE				100.00

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 15-1307 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-8-1 | Date/Time Prepared: 11/26/2018 3:30 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	333,418	0		1.00
2.00	1,408,120	0		2.00
3.00	94,674	0		3.00
3.01	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
3.06	0	0		3.06
3.08	0	11		3.08
4.00	0	0		4.00
5.00	1,836,212			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	ADMINISTRATION		6.00
7.00	ADMINISTRATION		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: 15-1307 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-8-2 | Date/Time Prepared: 11/26/2018 3:30 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	50.00	OPERATING ROOM	219,330	219,330	0	0	0	1.00
2.00	54.00	RADIOLOGY-DIAGNOSTIC	103,110	103,110	0	0	0	2.00
3.00	91.00	EMERGENCY	1,155,296	0	1,155,296	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			1,477,736	322,440	1,155,296		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	OPERATING ROOM	0	0	0	0	0	1.00
2.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	2.00
3.00	91.00	EMERGENCY	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	OPERATING ROOM	0	0	0	219,330		1.00
2.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	103,110		2.00
3.00	91.00	EMERGENCY	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	322,440		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 15-1307 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 11/26/2018 3:30 pm

Physical Therapy | Cost

						1.00	
	PART I - GENERAL INFORMATION						
1.00	Total number of weeks worked (excluding aides) (see instructions)					26	1.00
2.00	Line 1 multiplied by 15 hours per week					390	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)					128	6.00
7.00	Standard travel expense rate					9.57	7.00
8.00	Optional travel expense rate per mile					0.00	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	0.00	858.59	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	0.00	53.21	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	0.00	0.00	26.61			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01
						1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION						
14.00	Supervisors (column 1, line 9 times column 1, line 10)					0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					0	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)					45,686	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					45,686	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)					0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)					0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)					45,686	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)					45,686	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)					3,406	37.00
38.00	Subtotal (sum of lines 36 and 37)					3,406	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					1,225	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: 15-1307 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 11/26/2018 3:30 pm

Physical Therapy | Cost

						1.00	
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00
		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	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)	0.00	53.21	0.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00

		1.00	
	Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT		
57.00	Salary equivalency amount (from line 23)	45,686	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)	45,686	63.00
64.00	Total cost of outside supplier services (from your records)	47,250	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)	1,564	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: 15-1307 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B Part I Date/Time Prepared: 11/26/2018 3:30 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
				NEW BLDG & FIXT	NEW MVBLE EQUIP			
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	44,733	44,733				1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	560,536		560,536			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,435,752	0	0	2,435,752		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5,727,111	3,652	45,759	274,877	6,051,399	5.00
7.00	00700	OPERATION OF PLANT	339,631	6,393	80,095	0	426,119	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	179	2,248	0	2,427	8.00
9.00	00900	HOUSEKEEPING	258,566	44	557	0	259,167	9.00
10.00	01000	DIETARY	8,920	0	0	0	8,920	10.00
13.00	01300	NURSING ADMINISTRATION	180,659	476	5,962	54,374	241,471	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	8,630	0	0	217	8,847	14.00
15.00	01500	PHARMACY	540,880	0	0	52,521	593,401	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	577	1,529	19,160	0	21,266	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,234,106	5,446	68,237	314,372	1,622,161	30.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	237,256	3,735	46,808	163,931	451,730	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	831,785	2,968	37,185	172,989	1,044,927	54.00
60.00	06000	LABORATORY	1,247,110	1,274	15,970	10,887	1,275,241	60.00
65.00	06500	RESPIRATORY THERAPY	69,403	772	9,676	6,635	86,486	65.00
66.00	06600	PHYSICAL THERAPY	279,420	1,686	21,129	67,370	369,605	66.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	47,104	479	6,005	0	53,588	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	36,613	0	0	0	36,613	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	699	406	5,084	0	6,189	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,525,969	3,905	48,938	372,315	1,951,127	88.00
88.01	08801	RURAL HEALTH CLINIC II	1,623,806	5,545	69,489	415,131	2,113,971	88.01
91.00	09100	EMERGENCY	2,253,830	3,315	41,541	303,260	2,601,946	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	458,712	2,505	31,384	130,036	622,637	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	19,951,808	44,309	555,227	2,338,915	19,849,238	118.00
		NONREIMBURSABLE COST CENTERS						
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	ORTHO CLINIC	329,442	424	5,309	96,837	432,012	193.01
193.02	19303	COMMUNITY MED CLINIC	0	0	0	0	0	193.02
194.00	07950	MARKETING	96,987	0	0	0	96,987	194.00
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	20,378,237	44,733	560,536	2,435,752	20,378,237	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1307 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B Part I Date/Time Prepared: 11/26/2018 3:30 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	6,051,399					5.00
7.00	00700	OPERATION OF PLANT	179,985	606,104				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,025	4,308	7,760			8.00
9.00	00900	HOUSEKEEPING	109,467	1,067	0	369,701		9.00
10.00	01000	DIETARY	3,768	0	0	0	12,688	10.00
13.00	01300	NURSING ADMINISTRATION	101,993	11,426	0	5,104	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3,737	0	0	0	0	14.00
15.00	01500	PHARMACY	250,642	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	8,982	36,720	0	16,401	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	685,172	130,777	3,349	58,413	12,688	30.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	190,803	89,707	1,584	40,069	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	441,358	71,265	372	31,832	0	54.00
60.00	06000	LABORATORY	538,639	30,607	0	13,671	0	60.00
65.00	06500	RESPIRATORY THERAPY	36,530	18,545	0	8,283	0	65.00
66.00	06600	PHYSICAL THERAPY	156,114	40,494	744	18,087	0	66.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	22,635	11,508	0	5,140	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	15,465	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,614	9,744	0	4,352	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	824,121	0	203	41,892	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	892,903	0	169	59,486	0	88.01
91.00	09100	EMERGENCY	1,099,015	79,614	1,116	35,561	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	262,991	60,147	223	26,865	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	5,827,959	595,929	7,760	365,156	12,688	118.00
		NONREIMBURSABLE COST CENTERS						
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	ORTHO CLINIC	182,474	10,175	0	4,545	0	193.01
193.02	19303	COMMUNITY MED CLINIC	0	0	0	0	0	193.02
194.00	07950	MARKETING	40,966	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	6,051,399	606,104	7,760	369,701	12,688	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1307 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B Part I Date/Time Prepared: 11/26/2018 3:30 pm

		Cost Center Description	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	
			13.00	14.00	15.00	16.00	24.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
13.00	01300	NURSING ADMINISTRATION	359,994					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	12,584				14.00
15.00	01500	PHARMACY	0	0	844,043			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	83,369		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	151,377	0	0	6,950	2,670,887	30.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	49,173	0	0	6,351	829,417	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	20,035	1,609,789	54.00
60.00	06000	LABORATORY	8,838	0	0	15,319	1,882,315	60.00
65.00	06500	RESPIRATORY THERAPY	4,333	0	0	1,929	156,106	65.00
66.00	06600	PHYSICAL THERAPY	28,163	0	0	2,128	615,335	66.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	7,080	0	0	99,951	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	5,504	0	0	57,582	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	844,043	0	866,942	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	3,708	2,821,051	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	3,575	3,070,104	88.01
91.00	09100	EMERGENCY	118,110	0	0	20,412	3,955,774	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	2,962	975,825	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	359,994	12,584	844,043	83,369	19,611,078	118.00
		NONREIMBURSABLE COST CENTERS						
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	ORTHO CLINIC	0	0	0	0	629,206	193.01
193.02	19303	COMMUNITY MED CLINIC	0	0	0	0	0	193.02
194.00	07950	MARKETING	0	0	0	0	137,953	194.00
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	359,994	12,584	844,043	83,369	20,378,237	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1307 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B Part I Date/Time Prepared: 11/26/2018 3:30 pm

		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			25.00	26.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	2,670,887		30.00
43.00	04300	NURSERY	0	0		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	829,417		50.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,609,789		54.00
60.00	06000	LABORATORY	0	1,882,315		60.00
65.00	06500	RESPIRATORY THERAPY	0	156,106		65.00
66.00	06600	PHYSICAL THERAPY	0	615,335		66.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	99,951		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	57,582		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	866,942		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	2,821,051		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	3,070,104		88.01
91.00	09100	EMERGENCY	0	3,955,774		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0			92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0	975,825		95.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	19,611,078		118.00
		NONREIMBURSABLE COST CENTERS				
193.00	19300	NONPAID WORKERS	0	0		193.00
193.01	19301	ORTHO CLINIC	0	629,206		193.01
193.02	19303	COMMUNITY MED CLINIC	0	0		193.02
194.00	07950	MARKETING	0	137,953		194.00
200.00		Cross Foot Adjustments	0	0		200.00
201.00		Negative Cost Centers	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	0	20,378,237		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1307 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B Part II Date/Time Prepared: 11/26/2018 3:30 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS NEW BLDG & FIXT	CAPITAL RELATED COSTS NEW MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	333,418	3,652	45,759	382,829	0	5.00
7.00	00700	OPERATION OF PLANT	0	6,393	80,095	86,488	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	179	2,248	2,427	0	8.00
9.00	00900	HOUSEKEEPING	0	44	557	601	0	9.00
10.00	01000	DIETARY	0	0	0	0	0	10.00
13.00	01300	NURSING ADMINISTRATION	0	476	5,962	6,438	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,529	19,160	20,689	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	5,446	68,237	73,683	0	30.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	3,735	46,808	50,543	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,968	37,185	40,153	0	54.00
60.00	06000	LABORATORY	0	1,274	15,970	17,244	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	772	9,676	10,448	0	65.00
66.00	06600	PHYSICAL THERAPY	0	1,686	21,129	22,815	0	66.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	479	6,005	6,484	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	406	5,084	5,490	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	3,905	48,938	52,843	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	5,545	69,489	75,034	0	88.01
91.00	09100	EMERGENCY	0	3,315	41,541	44,856	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	2,505	31,384	33,889	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	333,418	44,309	555,227	932,954	0	118.00
		NONREIMBURSABLE COST CENTERS						
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	ORTHO CLINIC	0	424	5,309	5,733	0	193.01
193.02	19303	COMMUNITY MED CLINIC	0	0	0	0	0	193.02
194.00	07950	MARKETING	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	333,418	44,733	560,536	938,687	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1307 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B Part II Date/Time Prepared: 11/26/2018 3:30 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	382,829					5.00
7.00	00700	OPERATION OF PLANT	11,386	97,874				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	65	696	3,188			8.00
9.00	00900	HOUSEKEEPING	6,925	172	0	7,698		9.00
10.00	01000	DIETARY	238	0	0	0	238	10.00
13.00	01300	NURSING ADMINISTRATION	6,452	1,845	0	106	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	236	0	0	0	0	14.00
15.00	01500	PHARMACY	15,856	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	568	5,930	0	342	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	43,346	21,118	1,374	1,216	238	30.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	12,071	14,486	651	834	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	27,921	11,508	153	663	0	54.00
60.00	06000	LABORATORY	34,076	4,942	0	285	0	60.00
65.00	06500	RESPIRATORY THERAPY	2,311	2,995	0	172	0	65.00
66.00	06600	PHYSICAL THERAPY	9,876	6,539	306	377	0	66.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,432	1,858	0	107	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	978	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	165	1,573	0	91	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	52,136	0	83	872	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	56,487	0	70	1,239	0	88.01
91.00	09100	EMERGENCY	69,531	12,856	459	740	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	16,637	9,713	92	559	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	368,693	96,231	3,188	7,603	238	118.00
		NONREIMBURSABLE COST CENTERS						
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	ORTHO CLINIC	11,544	1,643	0	95	0	193.01
193.02	19303	COMMUNITY MED CLINIC	0	0	0	0	0	193.02
194.00	07950	MARKETING	2,592	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	382,829	97,874	3,188	7,698	238	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1307 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B Part II Date/Time Prepared: 11/26/2018 3:30 pm

		Cost Center Description	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	
			13.00	14.00	15.00	16.00	24.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
13.00	01300	NURSING ADMINISTRATION	14,841					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	236				14.00
15.00	01500	PHARMACY	0	0	15,856			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	27,529		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,241	0	0	2,298	149,514	30.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,027	0	0	2,100	82,712	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	6,623	87,021	54.00
60.00	06000	LABORATORY	364	0	0	5,064	61,975	60.00
65.00	06500	RESPIRATORY THERAPY	179	0	0	638	16,743	65.00
66.00	06600	PHYSICAL THERAPY	1,161	0	0	703	41,777	66.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	133	0	0	10,014	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	103	0	0	1,081	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	15,856	0	23,175	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	1,226	107,160	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	1,182	134,012	88.01
91.00	09100	EMERGENCY	4,869	0	0	6,716	140,027	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	979	61,869	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	14,841	236	15,856	27,529	917,080	118.00
		NONREIMBURSABLE COST CENTERS						
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	ORTHO CLINIC	0	0	0	0	19,015	193.01
193.02	19303	COMMUNITY MED CLINIC	0	0	0	0	0	193.02
194.00	07950	MARKETING	0	0	0	0	2,592	194.00
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	14,841	236	15,856	27,529	938,687	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1307 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B Part II | Date/Time Prepared: 11/26/2018 3:30 pm

		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			25.00	26.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	149,514		30.00
43.00	04300	NURSERY	0	0		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	82,712		50.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	87,021		54.00
60.00	06000	LABORATORY	0	61,975		60.00
65.00	06500	RESPIRATORY THERAPY	0	16,743		65.00
66.00	06600	PHYSICAL THERAPY	0	41,777		66.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	10,014		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	1,081		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	23,175		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	107,160		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	134,012		88.01
91.00	09100	EMERGENCY	0	140,027		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0			92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0	61,869		95.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	917,080		118.00
		NONREIMBURSABLE COST CENTERS				
193.00	19300	NONPAID WORKERS	0	0		193.00
193.01	19301	ORTHO CLINIC	0	19,015		193.01
193.02	19303	COMMUNITY MED CLINIC	0	0		193.02
194.00	07950	MARKETING	0	2,592		194.00
200.00		Cross Foot Adjustments	0	0		200.00
201.00		Negative Cost Centers	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	0	938,687		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1307 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B-1 | Date/Time Prepared: 11/26/2018 3:30 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	52,368					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		52,368				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	7,739,401			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	4,275	4,275	873,398	-6,051,399	14,326,838	5.00
7.00	00700	OPERATION OF PLANT	7,483	7,483	0	0	426,119	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	210	210	0	0	2,427	8.00
9.00	00900	HOUSEKEEPING	52	52	0	0	259,167	9.00
10.00	01000	DIETARY	0	0	0	0	8,920	10.00
13.00	01300	NURSING ADMINISTRATION	557	557	172,768	0	241,471	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	688	0	8,847	14.00
15.00	01500	PHARMACY	0	0	166,882	0	593,401	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,790	1,790	0	0	21,266	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,375	6,375	998,891	0	1,622,161	30.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,373	4,373	520,876	0	451,730	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,474	3,474	549,659	0	1,044,927	54.00
60.00	06000	LABORATORY	1,492	1,492	34,591	0	1,275,241	60.00
65.00	06500	RESPIRATORY THERAPY	904	904	21,081	0	86,486	65.00
66.00	06600	PHYSICAL THERAPY	1,974	1,974	214,064	0	369,605	66.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	561	561	0	0	53,588	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	36,613	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	475	475	0	0	6,189	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	4,572	4,572	1,183,000	0	1,951,127	88.00
88.01	08801	RURAL HEALTH CLINIC II	6,492	6,492	1,319,049	0	2,113,971	88.01
91.00	09100	EMERGENCY	3,881	3,881	963,584	0	2,601,946	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	2,932	2,932	413,178	0	622,637	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	51,872	51,872	7,431,709	-6,051,399	13,797,839	118.00
		NONREIMBURSABLE COST CENTERS						
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	ORTHO CLINIC	496	496	307,692	0	432,012	193.01
193.02	19303	COMMUNITY MED CLINIC	0	0	0	0	0	193.02
194.00	07950	MARKETING	0	0	0	0	96,987	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	44,733	560,536	2,435,752		6,051,399	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.854205	10.703789	0.314721		0.422382	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			0		382,829	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000000		0.026721	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: 15-1307 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B-1 | Date/Time Prepared: 11/26/2018 3:30 pm

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	
			7.00	8.00	9.00	10.00	13.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	29,546					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	210	84,892				8.00
9.00	00900	HOUSEKEEPING	52	0	40,348			9.00
10.00	01000	DIETARY	0	0	0	100		10.00
13.00	01300	NURSING ADMINISTRATION	557	0	557	0	87,574	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,790	0	1,790	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,375	36,633	6,375	100	36,825	30.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,373	17,325	4,373	0	11,962	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,474	4,070	3,474	0	0	54.00
60.00	06000	LABORATORY	1,492	0	1,492	0	2,150	60.00
65.00	06500	RESPIRATORY THERAPY	904	0	904	0	1,054	65.00
66.00	06600	PHYSICAL THERAPY	1,974	8,141	1,974	0	6,851	66.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	561	0	561	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	475	0	475	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	2,218	4,572	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	1,852	6,492	0	0	88.01
91.00	09100	EMERGENCY	3,881	12,211	3,881	0	28,732	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	2,932	2,442	2,932	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	29,050	84,892	39,852	100	87,574	118.00
		NONREIMBURSABLE COST CENTERS						
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	ORTHO CLINIC	496	0	496	0	0	193.01
193.02	19303	COMMUNITY MED CLINIC	0	0	0	0	0	193.02
194.00	07950	MARKETING	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	606,104	7,760	369,701	12,688	359,994	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	20.513911	0.091410	9.162809	126.880000	4.110741	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	97,874	3,188	7,698	238	14,841	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	3.312597	0.037554	0.190790	2.380000	0.169468	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: 15-1307 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B-1 | Date/Time Prepared: 11/26/2018 3:30 pm

		Cost Center Description	CENTRAL SERVICES & SUPPLY (DIRECT COSTS)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)		
			14.00	15.00	16.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	83,717				14.00
15.00	01500	PHARMACY	0	100			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	68,540,794		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	0	0	5,715,303		30.00
43.00	04300	NURSERY	0	0	0		43.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	5,222,707		50.00
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	16,476,067		54.00
60.00	06000	LABORATORY	0	0	12,597,985		60.00
65.00	06500	RESPIRATORY THERAPY	0	0	1,586,246		65.00
66.00	06600	PHYSICAL THERAPY	0	0	1,749,776		66.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	47,104	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	36,613	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	100	0		73.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	3,049,081		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	2,940,085		88.01
91.00	09100	EMERGENCY	0	0	16,767,587		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0	0	2,435,957		95.00
		SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	83,717	100	68,540,794		118.00
		NONREIMBURSABLE COST CENTERS					
193.00	19300	NONPAID WORKERS	0	0	0		193.00
193.01	19301	ORTHO CLINIC	0	0	0		193.01
193.02	19303	COMMUNITY MED CLINIC	0	0	0		193.02
194.00	07950	MARKETING	0	0	0		194.00
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	12,584	844,043	83,369		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.150316	8,440.430000	0.001216		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	236	15,856	27,529		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.002819	158.560000	0.000402		205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)					206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)					207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1307 | Period: From 07/01/2017 To 06/30/2018 | Worksheet C Part I Date/Time Prepared: 11/26/2018 3:30 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,670,887		2,670,887	0	0	30.00
43.00	04300	NURSERY	0		0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	829,417		829,417	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0		0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,609,789		1,609,789	0	0	54.00
60.00	06000	LABORATORY	1,882,315		1,882,315	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	156,106	0	156,106	0	0	65.00
66.00	06600	PHYSICAL THERAPY	615,335	0	615,335	0	0	66.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	99,951		99,951	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	57,582		57,582	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	866,942		866,942	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	2,821,051		2,821,051	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	3,070,104		3,070,104	0	0	88.01
91.00	09100	EMERGENCY	3,955,774		3,955,774	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	647,996		647,996		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	975,825		975,825	0	0	95.00
200.00		Subtotal (see instructions)	20,259,074	0	20,259,074	0	0	200.00
201.00		Less Observation Beds	647,996		647,996		0	201.00
202.00		Total (see instructions)	19,611,078	0	19,611,078	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1307 | Period: From 07/01/2017 To 06/30/2018 | Worksheet C Part I Date/Time Prepared: 11/26/2018 3:30 pm

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	4,481,140		4,481,140			30.00
43.00	04300	NURSERY	0		0			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	151,088	5,071,619	5,222,707	0.158810	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	734,196	15,741,871	16,476,067	0.097705	0.000000	54.00
60.00	06000	LABORATORY	996,557	11,601,428	12,597,985	0.149414	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	84,836	1,501,410	1,586,246	0.098412	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	309,201	1,440,575	1,749,776	0.351665	0.000000	66.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	692,721	882,892	1,575,613	0.063436	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	37,352	190,977	228,329	0.252189	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,030,078	2,532,168	3,562,246	0.243369	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	3,049,081	3,049,081			88.00
88.01	08801	RURAL HEALTH CLINIC II	0	2,940,085	2,940,085			88.01
91.00	09100	EMERGENCY	200,660	16,566,927	16,767,587	0.235918	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	79,037	1,155,126	1,234,163	0.525049	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	2,435,957	2,435,957	0.400592	0.000000	95.00
200.00		Subtotal (see instructions)	8,796,866	65,110,116	73,906,982			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	8,796,866	65,110,116	73,906,982			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1307 | Period: From 07/01/2017 To 06/30/2018 | Worksheet C Part I Date/Time Prepared: 11/26/2018 3:30 pm

Title XVIII | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
43.00	04300	NURSERY			43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	06000	LABORATORY	0.000000		60.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC			88.00
88.01	08801	RURAL HEALTH CLINIC II			88.01
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0.000000		95.00
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: 15-1307 | Period: From 07/01/2017 To 06/30/2018 | Worksheet C Part I Date/Time Prepared: 11/26/2018 3:30 pm

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,670,887		2,670,887	0	2,670,887	30.00
43.00	04300	NURSERY	0		0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	829,417		829,417	0	829,417	50.00
53.00	05300	ANESTHESIOLOGY	0		0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,609,789		1,609,789	0	1,609,789	54.00
60.00	06000	LABORATORY	1,882,315		1,882,315	0	1,882,315	60.00
65.00	06500	RESPIRATORY THERAPY	156,106	0	156,106	0	156,106	65.00
66.00	06600	PHYSICAL THERAPY	615,335	0	615,335	0	615,335	66.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	99,951		99,951	0	99,951	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	57,582		57,582	0	57,582	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	866,942		866,942	0	866,942	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	2,821,051		2,821,051	0	2,821,051	88.00
88.01	08801	RURAL HEALTH CLINIC II	3,070,104		3,070,104	0	3,070,104	88.01
91.00	09100	EMERGENCY	3,955,774		3,955,774	0	3,955,774	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	647,996		647,996		647,996	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	975,825		975,825	0	975,825	95.00
200.00		Subtotal (see instructions)	20,259,074	0	20,259,074	0	20,259,074	200.00
201.00		Less Observation Beds	647,996		647,996		647,996	201.00
202.00		Total (see instructions)	19,611,078	0	19,611,078	0	19,611,078	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1307 | Period: From 07/01/2017 To 06/30/2018 | Worksheet C Part I Date/Time Prepared: 11/26/2018 3:30 pm

Title XIX | Hospital | Cost

		Cost Center Description	Charges: Inpatient	Charges: Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,481,140		4,481,140			30.00
43.00	04300	NURSERY	0		0			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	151,088	5,071,619	5,222,707	0.158810	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	734,196	15,741,871	16,476,067	0.097705	0.000000	54.00
60.00	06000	LABORATORY	996,557	11,601,428	12,597,985	0.149414	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	84,836	1,501,410	1,586,246	0.098412	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	309,201	1,440,575	1,749,776	0.351665	0.000000	66.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	692,721	882,892	1,575,613	0.063436	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	37,352	190,977	228,329	0.252189	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,030,078	2,532,168	3,562,246	0.243369	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	3,049,081	3,049,081	0.925214	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	2,940,085	2,940,085	1.044223	0.000000	88.01
91.00	09100	EMERGENCY	200,660	16,566,927	16,767,587	0.235918	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	79,037	1,155,126	1,234,163	0.525049	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	2,435,957	2,435,957	0.400592	0.000000	95.00
200.00		Subtotal (see instructions)	8,796,866	65,110,116	73,906,982			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	8,796,866	65,110,116	73,906,982			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1307 | Period: From 07/01/2017 To 06/30/2018 | Worksheet C Part I Date/Time Prepared: 11/26/2018 3:30 pm

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
43.00	04300	NURSERY			43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	06000	LABORATORY	0.000000		60.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	0.000000		88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000		88.01
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0.000000		95.00
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: 15-1307 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part II Date/Time Prepared: 11/26/2018 3:30 pm

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	82,712	5,222,707	0.015837	107,745	1,706	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	87,021	16,476,067	0.005282	345,527	1,825	54.00
60.00	06000	LABORATORY	61,975	12,597,985	0.004919	519,054	2,553	60.00
65.00	06500	RESPIRATORY THERAPY	16,743	1,586,246	0.010555	43,168	456	65.00
66.00	06600	PHYSICAL THERAPY	41,777	1,749,776	0.023876	113,003	2,698	66.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	10,014	1,575,613	0.006356	368,541	2,342	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1,081	228,329	0.004734	19,031	90	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	23,175	3,562,246	0.006506	555,108	3,612	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	107,160	3,049,081	0.035145	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	134,012	2,940,085	0.045581	0	0	88.01
91.00	09100	EMERGENCY	140,027	16,767,587	0.008351	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	36,274	1,234,163	0.029392	10,529	309	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	741,971	66,989,885		2,081,706	15,591	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1307 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part IV Date/Time Prepared: 11/26/2018 3:30 pm

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
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-1307 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part IV Date/Time Prepared: 11/26/2018 3:30 pm

Title XVIII | Hospital | Cost

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	5,222,707	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	16,476,067	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	12,597,985	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	1,586,246	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	1,749,776	0.000000	66.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	1,575,613	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	228,329	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	3,562,246	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	3,049,081	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	2,940,085	0.000000	88.01
91.00	09100	EMERGENCY	0	0	0	16,767,587	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	1,234,163	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	66,989,885		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-1307 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part IV Date/Time Prepared: 11/26/2018 3:30 pm

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	107,745	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	345,527	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	519,054	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	43,168	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	113,003	0	0	0	66.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	368,541	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000	19,031	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	555,108	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000	0	0	0	0	88.01
91.00	09100	EMERGENCY	0.000000	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	10,529	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)		2,081,706	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1307 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part V Date/Time Prepared: 11/26/2018 3:30 pm

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	0.158810	0	2,107,873	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.097705	0	5,561,001	0	0	54.00
60.00	06000	LABORATORY	0.149414	0	5,004,973	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.098412	0	681,662	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.351665	0	591,188	0	0	66.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.063436	0	426,403	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.252189	0	59,492	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.243369	0	1,051,480	3,184	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000				0	88.01
91.00	09100	EMERGENCY	0.235918	0	4,690,115	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.525049	0	638,449	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.400592		0			95.00
200.00		Subtotal (see instructions)		0	20,812,636	3,184	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	20,812,636	3,184	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1307 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part V Date/Time Prepared: 11/26/2018 3:30 pm

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	334,751	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	543,338	0		54.00
60.00	06000	LABORATORY	747,813	0		60.00
65.00	06500	RESPIRATORY THERAPY	67,084	0		65.00
66.00	06600	PHYSICAL THERAPY	207,900	0		66.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	27,049	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	15,003	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	255,898	775		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0		88.01
91.00	09100	EMERGENCY	1,106,483	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	335,217	0		92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	3,640,536	775		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	3,640,536	775		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1307 | Component CCN: 15-Z307 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part V Date/Time Prepared: 11/26/2018 3:30 pm

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	0.158810	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.097705	0	0	0	0	54.00
60.00	06000	LABORATORY	0.149414	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.098412	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.351665	0	0	0	0	66.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.063436	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.252189	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.243369	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000				0	88.01
91.00	09100	EMERGENCY	0.235918	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.525049	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.400592		0			95.00
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: 15-1307 | Component CCN: 15-Z307 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part V Date/Time Prepared: 11/26/2018 3:30 pm

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
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
60.00	06000	LABORATORY	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0		88.01
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
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 INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-1307 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part III Date/Time Prepared: 11/26/2018 3:30 pm

Title XIX | Hospital | Cost

		Cost Center Description	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
			1A	1.00	2A	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
200.00		Total (lines 30 through 199)	0	0	0	0	0	200.00

		Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
			4.00	5.00	6.00	7.00	8.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	2,268	0.00	8	30.00
43.00	04300	NURSERY		0	0	0.00	0	43.00
200.00		Total (lines 30 through 199)		0	2,268		8	200.00

		Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
			9.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS	0	30.00
43.00	04300	NURSERY	0	43.00
200.00		Total (lines 30 through 199)	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1307 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part IV Date/Time Prepared: 11/26/2018 3:30 pm

Title XIX | 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
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-1307 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part IV Date/Time Prepared: 11/26/2018 3:30 pm

Title XIX | Hospital | Cost

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	5,222,707	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	16,476,067	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	12,597,985	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	1,586,246	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	1,749,776	0.000000	66.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	1,575,613	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	228,329	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	3,562,246	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	3,049,081	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	2,940,085	0.000000	88.01
91.00	09100	EMERGENCY	0	0	0	16,767,587	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	1,234,163	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	66,989,885		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-1307 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part IV Date/Time Prepared: 11/26/2018 3:30 pm

Title XIX | 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	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	6,220	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	4,434	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	310	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	0	0	0	0	66.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	2,795	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	10,519	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000	0	0	0	0	88.01
91.00	09100	EMERGENCY	0.000000	879	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)		25,157	0	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-1307	Period: From 07/01/2017 To 06/30/2018	Worksheet D-1 Date/Time Prepared: 11/26/2018 3:30 pm
	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)	2,957	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,268	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	1,551	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	344	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)	343	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	1	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)	1	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	1,156	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)	307	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)	308	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	137.32	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	137.32	20.00
21.00	Total general inpatient routine service cost (see instructions)	2,670,887	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)	137	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)	137	25.00
26.00	Total swing-bed cost (see instructions)	621,157	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	2,049,730	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)	2,049,730	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)	903.76	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,044,747	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)	1,044,747	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1307 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D-1 | Date/Time Prepared: 11/26/2018 3:30 pm

Title XVIII | Hospital | Cost

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	341,214	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	1,385,961	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)	277,454	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	278,358	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	555,812	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)	717	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	903.76	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	647,996	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1307 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D-1 | Date/Time Prepared: 11/26/2018 3:30 pm

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	149,514	2,670,887	0.055979	647,996	36,274	90.00
91.00	Nursing School cost	0	2,670,887	0.000000	647,996	0	91.00
92.00	Allied health cost	0	2,670,887	0.000000	647,996	0	92.00
93.00	All other Medical Education	0	2,670,887	0.000000	647,996	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-1307	Period: From 07/01/2017 To 06/30/2018	Worksheet D-1 Date/Time Prepared: 11/26/2018 3:30 pm
	Title XIX	Hospital	Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	2,957	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,268	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	1,551	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	343	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)	344	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	1	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)	1	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	8	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	137.32	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	137.32	20.00
21.00	Total general inpatient routine service cost (see instructions)	2,670,887	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)	137	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)	137	25.00
26.00	Total swing-bed cost (see instructions)	621,157	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	2,049,730	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)	2,049,730	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)	903.76	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	7,230	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)	7,230	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1307 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D-1 | Date/Time Prepared: 11/26/2018 3:30 pm

Title XIX | Hospital | Cost

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	4,246	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	11,476	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	717	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	903.76	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	647,996	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1307 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D-1 | Date/Time Prepared: 11/26/2018 3:30 pm

Title XIX | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	149,514	2,670,887	0.055979	647,996	36,274	90.00
91.00	Nursing School cost	0	2,670,887	0.000000	647,996	0	91.00
92.00	Allied health cost	0	2,670,887	0.000000	647,996	0	92.00
93.00	All other Medical Education	0	2,670,887	0.000000	647,996	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1307 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D-3 | Date/Time Prepared: 11/26/2018 3:30 pm

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		2,588,374		30.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.158810	107,745	17,111	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.097705	345,527	33,760	54.00
60.00	06000	LABORATORY	0.149414	519,054	77,554	60.00
65.00	06500	RESPIRATORY THERAPY	0.098412	43,168	4,248	65.00
66.00	06600	PHYSICAL THERAPY	0.351665	113,003	39,739	66.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.063436	368,541	23,379	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.252189	19,031	4,799	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.243369	555,108	135,096	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000		0	88.01
91.00	09100	EMERGENCY	0.235918	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.525049	10,529	5,528	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		2,081,706	341,214	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		2,081,706		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-1307 | Component CCN: 15-Z307 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D-3 | Date/Time Prepared: 11/26/2018 3:30 pm

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
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.158810	8,268	1,313	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.097705	73,115	7,144	54.00
60.00	06000	LABORATORY	0.149414	153,375	22,916	60.00
65.00	06500	RESPIRATORY THERAPY	0.098412	10,477	1,031	65.00
66.00	06600	PHYSICAL THERAPY	0.351665	148,310	52,155	66.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.063436	167,452	10,622	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.252189	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.243369	185,744	45,204	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000		0	88.01
91.00	09100	EMERGENCY	0.235918	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.525049	696	365	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		747,437	140,750	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)		747,437		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1307 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D-3 | Date/Time Prepared: 11/26/2018 3:30 pm

Title XIX | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		27,133		30.00
43.00	04300	NURSERY		0		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.158810	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.097705	6,220	608	54.00
60.00	06000	LABORATORY	0.149414	4,434	663	60.00
65.00	06500	RESPIRATORY THERAPY	0.098412	310	31	65.00
66.00	06600	PHYSICAL THERAPY	0.351665	0	0	66.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.063436	2,795	177	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.252189	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.243369	10,519	2,560	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.925214	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	1.044223	0	0	88.01
91.00	09100	EMERGENCY	0.235918	879	207	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.525049	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		25,157	4,246	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)		25,157		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1307	Period: From 07/01/2017 To 06/30/2018	Worksheet E Part B Date/Time Prepared: 11/26/2018 3:30 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	3,641,311	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)	3,641,311	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)	3,677,724	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	0	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	47,164	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	3,094,224	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)	536,336	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)	536,336	30.00
31.00	Primary payer payments	775	31.00
32.00	Subtotal (line 30 minus line 31)	535,561	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)	493,901	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	321,036	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	309,125	36.00
37.00	Subtotal (see instructions)	856,597	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)	856,597	40.00
40.01	Sequestration adjustment (see instructions)	17,132	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
41.00	Interim payments	1,177,337	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	-337,872	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: 15-1307 | Period: From 07/01/2017 To 06/30/2018 | Worksheet E-1 Part I Date/Time Prepared: 11/26/2018 3:30 pm

Title XVIII | Hospital | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,296,725		1,069,137	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	02/08/2018	108,200	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		108,200	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)		1,296,725		1,177,337	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		240,112		337,872	6.02
7.00	Total Medicare program liability (see instructions)		1,056,613		839,465	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: 15-1307 | Component CCN: 15-Z307 | Period: From 07/01/2017 To 06/30/2018 | Worksheet E-1 Part I | Date/Time Prepared: 11/26/2018 3:30 pm

Title XVIII | Swing Beds - SNF | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		826,665		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)		826,665		0	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		146,606		0	6.02
7.00	Total Medicare program liability (see instructions)		680,059		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: 15-1307	Period: From 07/01/2017 To 06/30/2018	Worksheet E-1 Part II Date/Time Prepared: 11/26/2018 3:30 pm
	Title XVIII	Hospital	Cost

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

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS	Provider CCN: 15-1307 Component CCN: 15-Z307	Period: From 07/01/2017 To 06/30/2018	Worksheet E-2 Date/Time Prepared: 11/26/2018 3:30 pm
	Title XVIII	Swing Beds - SNF	Cost

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	561,370	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)	142,158	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	615	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)	703,528	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	703,528	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)	703,528	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	10,532	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)	692,996	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)	1,449	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	942	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (see instructions)	693,938	0	19.00
19.01	Sequestration adjustment (see instructions)	13,879	0	19.01
19.02	Demonstration payment adjustment amount after sequestration)	0	0	19.02
20.00	Interim payments	826,665	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)	-146,606	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: 15-1307	Period: From 07/01/2017 To 06/30/2018	Worksheet E-3 Part V Date/Time Prepared: 11/26/2018 3:30 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	1,385,961	1.00
2.00	Nursing and Allied Health Managed Care payment (see instructions)	0	2.00
3.00	Organ acquisition	0	3.00
4.00	Subtotal (sum of lines 1 through 3)	1,385,961	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	1,399,821	6.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
7.00	Routine service charges	0	7.00
8.00	Ancillary service charges	0	8.00
9.00	Organ acquisition charges, net of revenue	0	9.00
10.00	Total reasonable charges	0	10.00
	Customary charges		
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)	0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)	0.000000	13.00
14.00	Total customary charges (see instructions)	0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)	0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)	0	16.00
17.00	Cost of physicians' services in a teaching hospital (see instructions)	0	17.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)	0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)	1,399,821	19.00
20.00	Deductibles (exclude professional component)	334,848	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	1,064,973	22.00
23.00	Coinsurance	1,675	23.00
24.00	Subtotal (line 22 minus line 23)	1,063,298	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	22,891	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	14,879	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	7,255	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	1,078,177	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	29.50
29.99	Demonstration payment adjustment amount before sequestration	0	29.99
30.00	Subtotal (see instructions)	1,078,177	30.00
30.01	Sequestration adjustment (see instructions)	21,564	30.01
30.02	Demonstration payment adjustment amount after sequestration	0	30.02
31.00	Interim payments	1,296,725	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)	-240,112	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: 15-1307	Period: From 07/01/2017 To 06/30/2018	Worksheet E-3 Part VII Date/Time Prepared: 11/26/2018 3:30 pm
	Title XIX	Hospital	Cost

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	11,476		1.00
2.00	Medical and other services		0	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	11,476	0	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	11,476	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	51,831		8.00
9.00	Ancillary service charges	25,157	0	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	76,988	0	12.00
	CUSTOMARY CHARGES			
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	76,988	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	65,512	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	11,476	0	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.			
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0		24.00
25.00	Capital exception payments (see instructions)	0		25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	11,476	0	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30.00	Excess of reasonable cost (from line 18)	0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	11,476	0	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	11,476	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	11,476	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	11,476	0	40.00
41.00	Interim payments	11,476	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 15-1307 | Period: From 07/01/2017 To 06/30/2018 | Worksheet G | Date/Time Prepared: 11/26/2018 3:30 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	213,842	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	5,987,460	0	0	0	4.00
5.00	Other receivable	134,728	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-3,036,394	0	0	0	6.00
7.00	Inventory	262,029	0	0	0	7.00
8.00	Prepaid expenses	295	0	0	0	8.00
9.00	Other current assets	6,890	0	0	0	9.00
10.00	Due from other funds	1,515,232	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	5,084,082	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	174,050	0	0	0	12.00
13.00	Land improvements	159,079	0	0	0	13.00
14.00	Accumulated depreciation	-106,154	0	0	0	14.00
15.00	Buildings	8,420,526	0	0	0	15.00
16.00	Accumulated depreciation	-4,887,929	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	1,676,790	0	0	0	19.00
20.00	Accumulated depreciation	-897,136	0	0	0	20.00
21.00	Automobiles and trucks	51,450	0	0	0	21.00
22.00	Accumulated depreciation	-51,450	0	0	0	22.00
23.00	Major movable equipment	3,776,547	0	0	0	23.00
24.00	Accumulated depreciation	-3,110,709	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	5,205,064	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	251,935	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	6,579	234,891	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	258,514	234,891	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	10,547,660	234,891	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	671,977	0	0	0	37.00
38.00	Salaries, wages, and fees payable	707,180	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	54,544	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	2,031,875	0	0	0	43.00
44.00	Other current liabilities	1,476,448	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	4,942,024	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	3,827,178	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)	3,827,178	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	8,769,202	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	1,778,458				52.00
53.00	Specific purpose fund		234,891			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)	1,778,458	234,891	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	10,547,660	234,891	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-1307 | Period: From 07/01/2017 To 06/30/2018 | Worksheet G-1 | Date/Time Prepared: 11/26/2018 3:30 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		1,535,849		485,057		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		614,074				2.00
3.00	Total (sum of line 1 and line 2)		2,149,923		485,057		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00	Contributions/Donations/Grant Revenue	234,891		-250,166		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00	Rounding	0		0		0	9.00
10.00	Total additions (sum of line 4-9)		234,891		-250,166		10.00
11.00	Subtotal (line 3 plus line 10)		2,384,814		234,891		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00	Transfers from Affiliates	-56,193		0		0	14.00
15.00		0		0		0	15.00
16.00	Released Capital	662,549		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		606,356		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		1,778,458		234,891		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	Contributions/Donations/Grant Revenue		0			6.00
7.00			0			7.00
8.00			0			8.00
9.00	Rounding		0			9.00
10.00	Total additions (sum of line 4-9)	0		0		10.00
11.00	Subtotal (line 3 plus line 10)	0		0		11.00
12.00	Deductions (debit adjustments) (specify)		0			12.00
13.00			0			13.00
14.00	Transfers from Affiliates		0			14.00
15.00			0			15.00
16.00	Released Capital		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: 15-1307 | Period: From 07/01/2017 To 06/30/2018 | Worksheet G-2 Parts I & II Date/Time Prepared: 11/26/2018 3:30 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	5,555,075		5,555,075	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	5,555,075		5,555,075	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	5,555,075		5,555,075	17.00
18.00	Ancillary services	4,036,536	38,402,878	42,439,414	18.00
19.00	Outpatient services	279,697	17,708,597	17,988,294	19.00
20.00	RURAL HEALTH CLINIC	0	3,049,081	3,049,081	20.00
20.01	RURAL HEALTH CLINIC II	0	2,940,085	2,940,085	20.01
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES	0	2,435,957	2,435,957	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
27.03	Ortho Clinic	0	648,027	648,027	27.03
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	9,871,308	65,184,625	75,055,933	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		20,698,378		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		20,698,378		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 15-1307	Period: From 07/01/2017 To 06/30/2018	Worksheet G-3 Date/Time Prepared: 11/26/2018 3:30 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	75,055,933	1.00
2.00	Less contractual allowances and discounts on patients' accounts	55,319,523	2.00
3.00	Net patient revenues (line 1 minus line 2)	19,736,410	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	20,698,378	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-961,968	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	7,507	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	277	13.00
14.00	Revenue from meals sold to employees and guests	0	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	5,356	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER (SPECIFY)	0	24.00
24.01	Other - Credentialing	744,344	24.01
24.02	Other - Pharmacy Services	93	24.02
24.04	Rental Income - ENT Clinic	169,713	24.04
24.11	Other - Grant Revenue	200,863	24.11
24.14	Other - Food Services	16,810	24.14
24.15	Other - State Program Revenue	46,750	24.15
24.19	Other - South Clinic	47,321	24.19
24.22	Other - Unrestr Donation Revenue	1,942	24.22
24.23	Other - Phys Fund Rev IC	334,925	24.23
24.24	Other - Unclaimed Property Exemptions	141	24.24
25.00	Total other income (sum of lines 6-24)	1,576,042	25.00
26.00	Total (line 5 plus line 25)	614,074	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)	614,074	29.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1307 | Component CCN: 15-3993 | Period: From 07/01/2017 To 06/30/2018 | Worksheet M-1 | Date/Time Prepared: 11/26/2018 3:30 pm

RHC I | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	420,811	0	420,811	0	420,811	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	361,077	0	361,077	-12,519	348,558	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	219,509	0	219,509	0	219,509	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	194,122	0	194,122	0	194,122	9.00
10.00	Subtotal (sum of lines 1 through 9)	1,195,519	0	1,195,519	-12,519	1,183,000	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	5,609	5,609	0	5,609	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	366,474	366,474	0	366,474	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	372,083	372,083	0	372,083	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	1,195,519	372,083	1,567,602	-12,519	1,555,083	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	0	0	0	0	29.00
30.00	Administrative Costs	0	0	0	0	0	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	0	0	0	0	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	1,195,519	372,083	1,567,602	-12,519	1,555,083	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS | Provider CCN: 15-1307 | Component CCN: 15-3993 | Period: From 07/01/2017 To 06/30/2018 | Worksheet M-1 | Date/Time Prepared: 11/26/2018 3:30 pm

RHC I | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	-26,954	393,857		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	-2,160	346,398		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	219,509		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	194,122		9.00
10.00	Subtotal (sum of lines 1 through 9)	-29,114	1,153,886		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	5,609		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	366,474		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	372,083		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-29,114	1,525,969		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	0		29.00
30.00	Administrative Costs	0	0		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	0		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-29,114	1,525,969		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1307 | Component CCN: 15-3994 | Period: From 07/01/2017 To 06/30/2018 | Worksheet M-1 | Date/Time Prepared: 11/26/2018 3:30 pm

RHC II | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	568,569	0	568,569	0	568,569	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	202,168	0	202,168	12,519	214,687	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	328,755	0	328,755	0	328,755	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	207,038	0	207,038	0	207,038	9.00
10.00	Subtotal (sum of lines 1 through 9)	1,306,530	0	1,306,530	12,519	1,319,049	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	4,218	4,218	0	4,218	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	359,097	359,097	0	359,097	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	363,315	363,315	0	363,315	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	1,306,530	363,315	1,669,845	12,519	1,682,364	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	0	0	0	0	29.00
30.00	Administrative Costs	0	0	0	0	0	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	0	0	0	0	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	1,306,530	363,315	1,669,845	12,519	1,682,364	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS | Provider CCN: 15-1307 | Component CCN: 15-3994 | Period: From 07/01/2017 To 06/30/2018 | Worksheet M-1 | Date/Time Prepared: 11/26/2018 3:30 pm

RHC II | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	-58,558	510,011		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	214,687		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	328,755		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	207,038		9.00
10.00	Subtotal (sum of lines 1 through 9)	-58,558	1,260,491		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	4,218		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	359,097		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	363,315		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-58,558	1,623,806		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	0		29.00
30.00	Administrative Costs	0	0		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	0		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-58,558	1,623,806		32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 15-1307 | Component CCN: 15-3993 | Period: From 07/01/2017 To 06/30/2018 | Worksheet M-2 | Date/Time Prepared: 11/26/2018 3:30 pm

RHC I | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	1.62	6,755	4,200	6,804		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	3.00	8,826	2,100	6,300		3.00
4.00	Subtotal (sum of lines 1 through 3)	4.62	15,581		13,104	15,581	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)	4.62	15,581			15,581	8.00
9.00	Physician Services Under Agreements		0			0	9.00
						1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)					1,525,969	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					1,525,969	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)					0	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					1,295,082	15.00
16.00	Total overhead (sum of lines 14 and 15)					1,295,082	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					1,295,082	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					1,295,082	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					2,821,051	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 15-1307 | Component CCN: 15-3994 | Period: From 07/01/2017 To 06/30/2018 | Worksheet M-2 | Date/Time Prepared: 11/26/2018 3:30 pm

RHC II | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	1.71	10,797	4,200	7,182		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	2.06	5,245	2,100	4,326		3.00
4.00	Subtotal (sum of lines 1 through 3)	3.77	16,042		11,508	16,042	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	3.77	16,042			16,042	8.00
9.00	Physician Services Under Agreements		0			0	9.00
						1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)					1,623,806	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					1,623,806	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)					0	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					1,446,298	15.00
16.00	Total overhead (sum of lines 14 and 15)					1,446,298	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					1,446,298	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					1,446,298	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					3,070,104	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 15-1307 Component CCN: 15-3993	Period: From 07/01/2017 To 06/30/2018	Worksheet M-3 Date/Time Prepared: 11/26/2018 3:30 pm
	Title XVIII	RHC I	Cost

			1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES			
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)		2,821,051	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)		157,770	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		2,663,281	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		15,581	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)		15,581	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		170.93	7.00
		Calculation of Limit (1)		
		Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	82.30	83.45	8.00
9.00	Rate for Program covered visits (see instructions)	170.93	170.93	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	1,501	1,489	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	256,566	254,515	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	511,081	16.00
16.01	Total program charges (see instructions)(from contractor's records)		545,045	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		84,134	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		78,891	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.)		299,526	16.04
16.05	Total program cost (see instructions)	0	378,417	16.05
17.00	Primary payer amounts		110	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		57,783	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		80,626	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		378,307	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		70,953	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		449,260	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)		449,260	26.00
26.01	Sequestration adjustment (see instructions)		8,985	26.01
26.02	Demonstration payment adjustment amount after sequestration		0	26.02
27.00	Interim payments		312,246	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)		128,029	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0	30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 15-1307 Component CCN: 15-3994	Period: From 07/01/2017 To 06/30/2018	Worksheet M-3 Date/Time Prepared: 11/26/2018 3:30 pm
	Title XVIII	RHC II	Cost

			1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES			
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)		3,070,104	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)		175,379	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		2,894,725	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		16,042	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)		16,042	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		180.45	7.00
		Calculation of Limit (1)		
		Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	82.30	83.45	8.00
9.00	Rate for Program covered visits (see instructions)	180.45	180.45	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	2,788	2,828	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	503,095	510,313	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)			15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *	0	1,013,408	16.00
16.01	Total program charges (see instructions)(from contractor's records)		807,356	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		60,846	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		76,375	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.)		682,402	16.04
16.05	Total program cost (see instructions)	0	758,777	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		84,031	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		132,496	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		758,777	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		83,140	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		841,917	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)		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)		841,917	26.00
26.01	Sequestration adjustment (see instructions)		16,838	26.01
26.02	Demonstration payment adjustment amount after sequestration		0	26.02
27.00	Interim payments		696,572	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)		128,507	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: 15-1307 | Component CCN: 15-3993 | Period: From 07/01/2017 To 06/30/2018 | Worksheet M-4 | Date/Time Prepared: 11/26/2018 3:30 pm

Title XVIII | RHC I | Cost

		Pneumococcal	Influenza	
		1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	1,153,886	1,153,886	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000749	0.000728	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	864	840	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	71,866	11,771	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	72,730	12,611	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	1,525,969	1,525,969	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	1,295,082	1,295,082	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.047662	0.008264	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	61,726	10,703	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	134,456	23,314	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	422	410	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	318.62	56.86	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	182	228	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	57,989	12,964	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)		157,770	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)		70,953	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA VACCINE COST

Provider CCN: 15-1307 | Component CCN: 15-3994 | Period: From 07/01/2017 To 06/30/2018 | Worksheet M-4 | Date/Time Prepared: 11/26/2018 3:30 pm

Title XVIII | RHC II | Cost

		Pneumococcal	Influenza	
		1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	1,260,491	1,260,491	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000738	0.000964	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	930	1,215	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	74,250	16,364	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	75,180	17,579	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	1,623,806	1,623,806	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	1,446,298	1,446,298	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.046299	0.010826	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	66,962	15,658	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	142,142	33,237	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	436	570	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	326.01	58.31	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	218	207	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	71,070	12,070	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)		175,379	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)		83,140	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 15-1307 Component CCN: 15-3993	Period: From 07/01/2017 To 06/30/2018	Worksheet M-5 Date/Time Prepared: 11/26/2018 3:30 pm
		RHC I	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		312,246	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)		312,246	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		128,029	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		440,275	7.00

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

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 15-1307 Component CCN: 15-3994	Period: From 07/01/2017 To 06/30/2018	Worksheet M-5 Date/Time Prepared: 11/26/2018 3:30 pm
		RHC II	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		696,572	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)		696,572	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		128,507	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		825,079	7.00

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