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: 15-1322	Period: From 01/01/2018 To 12/31/2018	Worksheet S Parts I-III Date/Time Prepared: 5/29/2019 10:24 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report Date: 5/29/2019 Time: 10:24 am
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by PERRY COUNTY HOSPITAL (15-1322) for the cost reporting period beginning 01/01/2018 and ending 12/31/2018 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

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

____
Title

____
Date

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	-21,421	-849,112	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	11,669	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
10.00	RURAL HEALTH CLINIC I	0		297,892		0	10.00
10.01	RURAL HEALTH CLINIC II	0		-3,219		0	10.01
10.02	RURAL HEALTH CLINIC III	0		-5,671		0	10.02
10.03	RURAL HEALTH CLINIC IV	0		12,169		0	10.03
200.00	Total	0	-9,752	-547,941	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: 15-1322 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part I | Date/Time Prepared: 5/29/2019 10:24 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 8885 SR 237	PO Box: X			1.00
2.00	City: TELL CITY	State: IN	Zip Code: 47586	County: PERRY	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	PERRY COUNTY HOSPITAL	151322	99915	1	07/01/2004	N	O	P	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	PERRY COUNTY HOSPITAL SWING	15Z322	99915		07/01/2004	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	PERRY COUNTY HOSPITAL HHA	157177	99915		06/13/1986	N	P	N	12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC	TELL CITY CLINIC	158516	99915		05/18/2015	N	O	N	15.00
15.01	Hospital-Based Health Clinic - RHC II	PERRY CO FAMILY PRACTICE	158517	99915		05/19/2015	N	O	N	15.01
15.02	Hospital-Based Health Clinic - RHC III	TROY CLINIC	158518	99915		11/23/2015	N	O	N	15.02
15.03	Hospital-Based Health Clinic - RHC IV	CANNELTON CLINIC	158519	99915		05/06/2016	N	O	N	15.03
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	01/01/2018	12/31/2018	20.00
21.00	Type of Control (see instructions)	9		21.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-1322	Period: From 01/01/2018 To 12/31/2018	Worksheet S-2 Part I Date/Time Prepared: 5/29/2019 10:24 am

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

		Urban/Rural S	Date of Geogr	
		1.00	2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	2		26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	2		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0		35.00
		Beginning:	Ending:	
		1.00	2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.			36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.	0		37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)			37.01
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.			38.00
		Y/N	Y/N	
		1.00	2.00	
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 “Y” for yes or “N” for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	N	N	39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	N	N	40.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-1322	Period: From 01/01/2018 To 12/31/2018	Worksheet S-2 Part I Date/Time Prepared: 5/29/2019 10:24 am

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

		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).						61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.06

		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1.00	2.00	3.00	4.00	
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.			0.00	0.00	61.10
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.			0.00	0.00	61.20

		1.00	
	ACA Provisions Affecting the Health Resources and Services Administration (HRSA)		
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)	0.00	62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)	0.00	62.01
	Teaching Hospitals that Claim Residents in Nonprovider Settings		
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)	N	63.00

		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
		1.00	2.00	3.00	
	Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.				
64.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000	64.00

		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: 15-1322	Period: From 01/01/2018 To 12/31/2018	Worksheet S-2 Part I Date/Time Prepared: 5/29/2019 10:24 am

			1.00	
	Long Term Care Hospital PPS			
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.		N	80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.		N	81.00
	TEFRA Providers			
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.		N	85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.			86.00
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.		N	87.00
		V	XIX	
		1.00	2.00	
	Title V and XIX Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.06
	Rural Providers			
105.00	Does this hospital qualify as a CAH?	Y		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N		106.00
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II.	N		107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00

		Physical	Occupational	Speech	Respiratory	
		1.00	2.00	3.00	4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	Y	Y	Y	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: 15-1322	Period: From 01/01/2018 To 12/31/2018	Worksheet S-2 Part I Date/Time Prepared: 5/29/2019 10:24 am

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

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

		Premiums 1.00	Losses 2.00	Insurance 3.00	
118.01	List amounts of malpractice premiums and paid losses:	180,275	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	5.01	122.00
	Transplant Center Information			
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y		140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1322 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part I | Date/Time Prepared: 5/29/2019 10:24 am

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

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

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

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

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

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

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

		1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act		
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.	Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)	0	168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)		168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	0.00	169.00

		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	01/01/2018	12/31/2018	170.00

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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-1322 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part II | Date/Time Prepared: 5/29/2019 10:24 am

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

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

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

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

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

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	N		N		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	05/07/2019	Y	05/07/2019	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-1322 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part II Date/Time Prepared: 5/29/2019 10:24 am

		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00

		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00

		1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)		
	Capital Related Cost		
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions	N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.	N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions	N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.	N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.	N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.	N	27.00
	Interest Expense		
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.	N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions	N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.	N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.	N	31.00
	Purchased Services		
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.	N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.	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?	N		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.	N		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.	CLINT	BRILL	41.00
42.00	Enter the employer/company name of the cost report preparer.	BLUE & CO., LLC		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	502-992-3500	CBRILL@BLUEANDCO.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-1322	Period: From 01/01/2018 To 12/31/2018	Worksheet S-2 Part II Date/Time Prepared: 5/29/2019 10:24 am

		3.00		
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	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: 15-1322 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-3 Part I | Date/Time Prepared: 5/29/2019 10:24 am

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	21	7,665	54,264.00	0	1.00
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		21	7,665	54,264.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	4	1,460	3,384.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		25	9,125	57,648.00	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	101.00				0	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	116.00	0	0			24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	88.00				0	26.00
26.01	RURAL HEALTH CLINIC II	88.01				0	26.01
26.02	RURAL HEALTH CLINIC III	88.02				0	26.02
26.03	RURAL HEALTH CLINIC IV	88.03				0	26.03
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		25				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00
33.01	LTCH site neutral days and discharges						33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-1322 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-3 Part I | Date/Time Prepared: 5/29/2019 10:24 am

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	1,397	60	2,261			1.00
2.00	HMO and other (see instructions)	141	309				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	508	0	508			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		68	68			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,905	128	2,837			7.00
8.00	INTENSIVE CARE UNIT	65	7	141			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		18	166			13.00
14.00	Total (see instructions)	1,970	153	3,144	0.00	165.87	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	3,391	0	6,474	0.00	6.74	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	0	0	0	0.00	0.00	24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	3,398	0	13,285	0.00	23.54	26.00
26.01	RURAL HEALTH CLINIC II	165	0	2,598	0.00	3.08	26.01
26.02	RURAL HEALTH CLINIC III	156	0	1,805	0.00	2.12	26.02
26.03	RURAL HEALTH CLINIC IV	664	0	2,220	0.00	2.48	26.03
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	203.83	27.00
28.00	Observation Bed Days		0	483			28.00
29.00	Ambulance Trips	1,055					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	5	43			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: 15-1322 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-3 Part I | Date/Time Prepared: 5/29/2019 10:24 am

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	419	21	767	1.00
2.00	HMO and other (see instructions)			34	77		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	419	21	767	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	0.00					22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	0.00					24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	0.00					26.00
26.01	RURAL HEALTH CLINIC II	0.00					26.01
26.02	RURAL HEALTH CLINIC III	0.00					26.02
26.03	RURAL HEALTH CLINIC IV	0.00					26.03
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

HOME HEALTH AGENCY STATISTICAL DATA

Provider CCN: 15-1322 | Component CCN: 15-7177 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-4 | Date/Time Prepared: 5/29/2019 10:24 am

Home Health Agency I | PPS

		1.00	
0.00	County	PERRY	0.00

		Title V	Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	5.00	
	HOME HEALTH AGENCY STATISTICAL DATA						
1.00	Home Health Aide Hours	0	2,906	669	794	4,369	1.00
2.00	Unduplicated Census Count (see instructions)	0.00	139.00	32.00	38.00	209.00	2.00

		Enter the number of hours in your normal work week	Number of Employees (Full Time Equivalent) Staff	Contract	Total	
		0	1.00	2.00	3.00	
	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES					
3.00	Administrator and Assistant Administrator(s)	40.00	0.00	0.00	0.00	3.00
4.00	Director(s) and Assistant Director(s)		0.00	0.00	0.00	4.00
5.00	Other Administrative Personnel		0.97	0.00	0.97	5.00
6.00	Direct Nursing Service		3.23	0.00	3.23	6.00
7.00	Nursing Supervisor		0.00	0.00	0.00	7.00
8.00	Physical Therapy Service		0.00	0.00	0.00	8.00
9.00	Physical Therapy Supervisor		0.00	0.00	0.00	9.00
10.00	Occupational Therapy Service		0.00	0.00	0.00	10.00
11.00	Occupational Therapy Supervisor		0.00	0.00	0.00	11.00
12.00	Speech Pathology Service		0.00	0.00	0.00	12.00
13.00	Speech Pathology Supervisor		0.00	0.00	0.00	13.00
14.00	Medical Social Service		0.00	0.00	0.00	14.00
15.00	Medical Social Service Supervisor		0.00	0.00	0.00	15.00
16.00	Home Health Aide		2.10	0.00	2.10	16.00
17.00	Home Health Aide Supervisor		0.00	0.00	0.00	17.00
18.00	Other (specify)		0.00	0.00	0.00	18.00
	HOME HEALTH AGENCY CBSA CODES					
19.00	Enter in column 1 the number of CBSAs where you provided services during the cost reporting period.		1			19.00
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).		99915			20.00

		Full Episodes Without Outliers	Full Episodes With Outliers	LUPA Episodes	PEP Only Episodes	Total (cols. 1-4)	
		1.00	2.00	3.00	4.00	5.00	
	PPS ACTIVITY DATA						
21.00	Skilled Nursing Visits	760	163	40	21	984	21.00
22.00	Skilled Nursing Visit Charges	348,910	74,547	18,362	9,660	451,479	22.00
23.00	Physical Therapy Visits	1,046	168	2	16	1,232	23.00
24.00	Physical Therapy Visit Charges	348,774	56,084	654	5,344	410,856	24.00
25.00	Occupational Therapy Visits	635	168	2	2	807	25.00
26.00	Occupational Therapy Visit Charges	184,077	48,864	570	582	234,093	26.00
27.00	Speech Pathology Visits	61	59	0	0	120	27.00
28.00	Speech Pathology Visit Charges	20,374	19,692	0	0	40,066	28.00
29.00	Medical Social Service Visits	1	2	0	0	3	29.00
30.00	Medical Social Service Visit Charges	380	760	0	0	1,140	30.00
31.00	Home Health Aide Visits	166	79	0	0	245	31.00
32.00	Home Health Aide Visit Charges	40,122	19,108	0	0	59,230	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	2,669	639	44	39	3,391	33.00
34.00	Other Charges	0	0	0	0	0	34.00
35.00	Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)	942,637	219,055	19,586	15,586	1,196,864	35.00
36.00	Total Number of Episodes (standard/non outlier)	156		18	4	178	36.00
37.00	Total Number of Outlier Episodes		14		0	14	37.00
38.00	Total Non-Routine Medical Supply Charges	35,126	4,763	4,483	1,096	45,468	38.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA	Provider CCN: 15-1322 Component CCN: 15-8516	Period: From 01/01/2018 To 12/31/2018	Worksheet S-8 Date/Time Prepared: 5/29/2019 10:24 am
		RHC I	Cost

		1.00	
	Clinic Address and Identification		
1.00	Street	109 IN-66	1.00

		City	State	ZIP Code	
		1.00	2.00	3.00	
2.00	City, State, ZIP Code, County	TELL CITY	IN	47586	2.00

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

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

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

		Sunday		Monday		Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
	Facility hours of operations (1)						
11.00	CLINIC			06:30	17:00	06:30	11.00

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

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

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

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

		Tuesday	Wednesday		Thursday		
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)						
11.00	CLINIC	17:00	06:30	17:00	06:30	17:00	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 15-1322 | Component CCN: 15-8516 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-8 | Date/Time Prepared: 5/29/2019 10:24 am

RHC I | Cost

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	CLINIC	06:30	16:00				11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA	Provider CCN: 15-1322 Component CCN: 15-8517	Period: From 01/01/2018 To 12/31/2018	Worksheet S-8 Date/Time Prepared: 5/29/2019 10:24 am
		RHC II	Cost

		1.00	
	Clinic Address and Identification		
1.00	Street	315 MAIN STREET	1.00

		City	State	ZIP Code	
		1.00	2.00	3.00	
2.00	City, State, ZIP Code, County	TROY	IN	47588	2.00

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

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

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

		Sunday		Monday		Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
	Facility hours of operations (1)						
11.00	CLINIC			08:00	17:00	08:00	11.00

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

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

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

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

		Tuesday	Wednesday		Thursday		
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)						
11.00	CLINIC	17:00	10:00	19:00	08:00	17:00	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 15-1322 | Component CCN: 15-8517 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-8 | Date/Time Prepared: 5/29/2019 10:24 am

RHC II | Cost

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	CLINIC	08:00	12:00				11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA	Provider CCN: 15-1322 Component CCN: 15-8518	Period: From 01/01/2018 To 12/31/2018	Worksheet S-8 Date/Time Prepared: 5/29/2019 10:24 am
		RHC III	Cost

		1.00	
	Clinic Address and Identification		
1.00	Street	18485 OLD STATE ROAD 37	1.00

		City	State	ZIP Code	
		1.00	2.00	3.00	
2.00	City, State, ZIP Code, County	LEOPOLD	IN	47551	2.00

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

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

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

		Sunday		Monday		Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
	Facility hours of operations (1)						
11.00	CLINIC			07:00	16:00	07:00	11.00

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

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

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

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

		Tuesday	Wednesday		Thursday		
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)						
11.00	CLINIC	16:00	07:00	11:00	07:00	16:00	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA	Provider CCN: 15-1322 Component CCN: 15-8518	Period: From 01/01/2018 To 12/31/2018	Worksheet S-8 Date/Time Prepared: 5/29/2019 10:24 am
		RHC III	Cost

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	CLINIC	07:00	15:00				11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 15-1322 | Component CCN: 15-8519 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-8 | Date/Time Prepared: 5/29/2019 10:24 am

RHC IV | Cost

		1.00	
	Clinic Address and Identification		
1.00	Street	510 WASHINGTON STREET	1.00

		City	State	ZIP Code	
		1.00	2.00	3.00	
2.00	City, State, ZIP Code, County	CANNELTON	IN	47520	2.00

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

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

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

		Sunday		Monday		Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
	Facility hours of operations (1)						
11.00	CLINIC			08:30	17:00	08:30	11.00

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

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

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

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

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

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 15-1322 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-8

Component CCN: 15-8519 | Date/Time Prepared: 5/29/2019 10:24 am

RHC IV | Cost

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

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 15-1322 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-10 | Date/Time Prepared: 5/29/2019 10:24 am

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.376556	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	2,942,641	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?	Y	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	13,579,331	6.00
7.00	Medicaid cost (line 1 times line 6)	5,113,379	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)	2,170,738	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)	2,170,738	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)	448,686	0	448,686	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	168,955	0	168,955	21.00
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	168,955	0	168,955	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)	2,476,227	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	350,967	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	539,950	27.01
28.00	Non-Medicare bad debt expense (see instructions)	1,936,277	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	918,100	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	1,087,055	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	3,257,793	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1322 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A | Date/Time Prepared: 5/29/2019 10:24 am

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		2,578,729	2,578,729	76,551	2,655,280	1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		0	0	1,200,484	1,200,484	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	110,907	631,606	742,513	0	742,513	4.00
5.01	00540	ADMINISTRATIVE AND GENERAL	462,559	2,554,667	3,017,226	-43,822	2,973,404	5.01
5.02	00590	OTHER ADMINISTRATIVE AND GENERAL	1,282,544	2,127,575	3,410,119	-3,955	3,406,164	5.02
7.00	00700	OPERATION OF PLANT	255,672	748,141	1,003,813	-3,795	1,000,018	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	64	88,833	88,897	0	88,897	8.00
9.00	00900	HOUSEKEEPING	277,435	192,816	470,251	0	470,251	9.00
10.00	01000	DIETARY	0	639,106	639,106	-437,852	201,254	10.00
11.00	01100	CAFETERIA	0	0	0	437,852	437,852	11.00
13.00	01300	NURSING ADMINISTRATION	313,556	30,331	343,887	0	343,887	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	203,779	143,405	347,184	0	347,184	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,294,106	1,181,004	2,475,110	-7,794	2,467,316	30.00
31.00	03100	INTENSIVE CARE UNIT	172,763	353,158	525,921	-300	525,621	31.00
43.00	04300	NURSERY	54,549	0	54,549	0	54,549	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	413,092	986,428	1,399,520	323,715	1,723,235	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	68,663	0	68,663	0	68,663	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	806,706	984,962	1,791,668	-28	1,791,640	54.00
60.00	06000	LABORATORY	696,583	1,349,156	2,045,739	0	2,045,739	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	487	106,831	107,318	0	107,318	62.00
65.00	06500	RESPIRATORY THERAPY	455,014	436,884	891,898	-13,761	878,137	65.00
66.00	06600	PHYSICAL THERAPY	347,039	261,951	608,990	-323	608,667	66.00
67.00	06700	OCCUPATIONAL THERAPY	68,530	90,495	159,025	0	159,025	67.00
68.00	06800	SPEECH PATHOLOGY	33,902	59,957	93,859	0	93,859	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,145	182,097	185,242	183,616	368,858	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	92,551	92,551	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	70,119	2,763,803	2,833,922	-165,901	2,668,021	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,956,077	1,669,372	3,625,449	15,982	3,641,431	88.00
88.01	08801	RURAL HEALTH CLINIC II	236,478	216,749	453,227	17,245	470,472	88.01
88.02	08803	RURAL HEALTH CLINIC III	107,569	95,774	203,343	46,346	249,689	88.02
88.03	08802	RURAL HEALTH CLINIC IV	336,682	100,100	436,782	-64,717	372,065	88.03
90.00	09000	CLINIC	327,938	164,027	491,965	158,609	650,574	90.00
90.01	09001	PAIN MANAGEMENT	35,823	-53,340	-17,517	17,517	0	90.01
90.02	09002	WOUND CARE	176,199	145,612	321,811	79,401	401,212	90.02
90.03	09003	OUTPATIENT CLINIC	49,876	445,241	495,117	-1,132	493,985	90.03
91.00	09100	EMERGENCY	724,972	1,430,858	2,155,830	-1,874	2,153,956	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	840,630	413,885	1,254,515	-32,048	1,222,467	95.00
101.00	10100	HOME HEALTH AGENCY	456,785	317,114	773,899	0	773,899	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		1,200,484	1,200,484	-1,200,484	0	113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	12,640,243	24,637,811	37,278,054	672,083	37,950,137	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,037,646	400,196	1,437,842	-672,083	765,759	192.00
192.01	19201	MARKETING	0	0	0	0	0	192.01
200.00		TOTAL (SUM OF LINES 118 through 199)	13,677,889	25,038,007	38,715,896	0	38,715,896	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1322 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A | Date/Time Prepared: 5/29/2019 10:24 am

		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	-37,459	2,617,821	1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	26,493	1,226,977	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	742,513	4.00
5.01	00540	ADMINISTRATIVE AND GENERAL	-786,636	2,186,768	5.01
5.02	00590	OTHER ADMINISTRATIVE AND GENERAL	0	3,406,164	5.02
7.00	00700	OPERATION OF PLANT	-3,852	996,166	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	88,897	8.00
9.00	00900	HOUSEKEEPING	0	470,251	9.00
10.00	01000	DIETARY	-421	200,833	10.00
11.00	01100	CAFETERIA	-102,147	335,705	11.00
13.00	01300	NURSING ADMINISTRATION	0	343,887	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-4,693	342,491	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	-183,075	2,284,241	30.00
31.00	03100	INTENSIVE CARE UNIT	0	525,621	31.00
43.00	04300	NURSERY	0	54,549	43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	-986,540	736,695	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	68,663	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-90,114	1,701,526	54.00
60.00	06000	LABORATORY	0	2,045,739	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	107,318	62.00
65.00	06500	RESPIRATORY THERAPY	-208,875	669,262	65.00
66.00	06600	PHYSICAL THERAPY	0	608,667	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	159,025	67.00
68.00	06800	SPEECH PATHOLOGY	0	93,859	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	-66,551	302,307	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	92,551	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-2,445	2,665,576	73.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	-1,320	3,640,111	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	470,472	88.01
88.02	08803	RURAL HEALTH CLINIC III	0	249,689	88.02
88.03	08802	RURAL HEALTH CLINIC IV	0	372,065	88.03
90.00	09000	CLINIC	-2,825	647,749	90.00
90.01	09001	PAIN MANAGEMENT	0	0	90.01
90.02	09002	WOUND CARE	-126,590	274,622	90.02
90.03	09003	OUTPATIENT CLINIC	-434,139	59,846	90.03
91.00	09100	EMERGENCY	0	2,153,956	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	-31,298	1,191,169	95.00
101.00	10100	HOME HEALTH AGENCY	454	774,353	101.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE	0	0	113.00
116.00	11600	HOSPICE	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-3,042,033	34,908,104	118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	765,759	192.00
192.01	19201	MARKETING	0	0	192.01
200.00		TOTAL (SUM OF LINES 118 through 199)	-3,042,033	35,673,863	200.00

RECLASSIFICATIONS | Provider CCN: 15-1322 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-6 | Date/Time Prepared: 5/29/2019 10:24 am

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - CAFETERIA COST				
1.00	CAFETERIA	11.00	0	437,852	1.00
	0		0	437,852	
	B - LEASE EXPENSE				
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	38,625	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
	0		0	38,625	
	C - CAPITAL INSURANCE EXPENSE				
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	37,926	1.00
2.00		0.00	0	0	2.00
	0		0	37,926	
	D - DRUGS CHARGED				
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	21,063	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
	0		0	21,063	
	E - BILLABLE SUPPLIES				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	276,167	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
	0		0	276,167	
	F - IMPLANTABLE DEVICE				
1.00	IMPL. DEV. CHARGED TO PATIENT	72.00	0	92,551	1.00
	0		0	92,551	
	G - WOUND CARE CENTER SALARIES				
1.00	WOUND CARE	90.02	105,000	0	1.00
	0		105,000	0	
	H - RECRUITING				
1.00	RURAL HEALTH CLINIC	88.00	0	14,856	1.00
	0		0	14,856	
	I - IV THERAPY				
1.00	CLINIC	90.00	0	176,340	1.00
	0		0	176,340	
	K - SURGEON RECLASS				
1.00	OPERATING ROOM	50.00	567,083	0	1.00
	0		567,083	0	
	L - INTEREST EXPENSE				
1.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	1,200,484	1.00
	TOTALS		0	1,200,484	
	M - RHC TELL CITY				
1.00	RURAL HEALTH CLINIC	88.00	1,126	0	1.00
2.00	RURAL HEALTH CLINIC II	88.01	111,295	0	2.00
3.00	RURAL HEALTH CLINIC III	88.02	36,177	0	3.00
4.00	RURAL HEALTH CLINIC IV	88.03	60,631	0	4.00
	TOTALS		209,229	0	
	N - RHC CANNELTON				
1.00	RURAL HEALTH CLINIC II	88.01	18,142	0	1.00
2.00	RURAL HEALTH CLINIC III	88.02	14,960	0	2.00
	TOTALS		33,102	0	
	O - PAIN MANAGEMENT RECLASS				
1.00	CLINIC	90.00	35,823	0	1.00
2.00	PAIN MANAGEMENT	90.01	0	53,340	2.00
	TOTALS		35,823	53,340	
500.00	Grand Total: Increases		950,237	2,349,204	500.00

RECLASSIFICATIONS | Provider CCN: 15-1322 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-6 | Date/Time Prepared: 5/29/2019 10:24 am

	Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
	A - CAFETERIA COST					
1.00	DIETARY	10.00	0	437,852	0	1.00
	0		0	437,852		
	B - LEASE EXPENSE					
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.02	0	3,955	9	1.00
2.00	OPERATION OF PLANT	7.00	0	3,795	0	2.00
3.00	ADULTS & PEDIATRICS	30.00	0	2,641	0	3.00
4.00	OPERATING ROOM	50.00	0	493	0	4.00
5.00	RESPIRATORY THERAPY	65.00	0	13,761	0	5.00
6.00	DRUGS CHARGED TO PATIENTS	73.00	0	10,609	0	6.00
7.00	AMBULANCE SERVICES	95.00	0	3,371	0	7.00
	0		0	38,625		
	C - CAPITAL INSURANCE EXPENSE					
1.00	ADMINISTRATIVE AND GENERAL	5.01	0	26,830	10	1.00
2.00	AMBULANCE SERVICES	95.00	0	11,096	0	2.00
	0		0	37,926		
	D - DRUGS CHARGED					
1.00	ADMINISTRATIVE AND GENERAL	5.01	0	2,136	0	1.00
2.00	WOUND CARE	90.02	0	1,896	0	2.00
3.00	OUTPATIENT CLINIC	90.03	0	1,132	0	3.00
4.00	AMBULANCE SERVICES	95.00	0	15,899	0	4.00
	0		0	21,063		
	E - BILLABLE SUPPLIES					
1.00	ADULTS & PEDIATRICS	30.00	0	5,153	0	1.00
2.00	INTENSIVE CARE UNIT	31.00	0	300	0	2.00
3.00	OPERATING ROOM	50.00	0	242,875	0	3.00
4.00	RADIOLOGY-DIAGNOSTIC	54.00	0	28	0	4.00
5.00	PHYSICAL THERAPY	66.00	0	323	0	5.00
6.00	DRUGS CHARGED TO PATIENTS	73.00	0	15	0	6.00
7.00	CLINIC	90.00	0	214	0	7.00
8.00	WOUND CARE	90.02	0	23,703	0	8.00
9.00	EMERGENCY	91.00	0	1,874	0	9.00
10.00	AMBULANCE SERVICES	95.00	0	1,682	0	10.00
	0		0	276,167		
	F - IMPLANTABLE DEVICE					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	92,551	0	1.00
	0		0	92,551		
	G - WOUND CARE CENTER SALARIES					
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	105,000	0	0	1.00
	0		105,000	0		
	H - RECRUITING					
1.00	ADMINISTRATIVE AND GENERAL	5.01	0	14,856	0	1.00
	0		0	14,856		
	I - IV THERAPY					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	176,340	0	1.00
	0		0	176,340		
	K - SURGEON RECLASS					
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	567,083	0	0	1.00
	0		567,083	0		
	L - INTEREST EXPENSE					
1.00	INTEREST EXPENSE	113.00	0	1,200,484	11	1.00
	TOTALS		0	1,200,484		
	M - RHC TELL CITY					
1.00	RURAL HEALTH CLINIC II	88.01	112,192	0	0	1.00
2.00	RURAL HEALTH CLINIC III	88.02	4,791	0	0	2.00
3.00	RURAL HEALTH CLINIC IV	88.03	92,246	0	0	3.00
4.00		0.00	0	0	0	4.00
	TOTALS		209,229	0		
	N - RHC CANNELTON					
1.00	RURAL HEALTH CLINIC IV	88.03	33,102	0	0	1.00
2.00		0.00	0	0	0	2.00
	TOTALS		33,102	0		
	O - PAIN MANAGEMENT RECLASS					
1.00	CLINIC	90.00	0	53,340	0	1.00
2.00	PAIN MANAGEMENT	90.01	35,823	0	0	2.00
	TOTALS		35,823	53,340		
500.00	Grand Total: Decreases		950,237	2,349,204		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1322 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-7 Part I | Date/Time Prepared: 5/29/2019 10:24 am

		Beginning Balances	Acquisitions Purchases	Donation	Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	3,815,753	0	0	0	1,060,000	1.00
2.00	Land Improvements	71,238	2,063	0	2,063	0	2.00
3.00	Buildings and Fixtures	43,907,603	0	0	0	40,631,977	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	2,330,717	0	0	0	2,159,159	5.00
6.00	Movable Equipment	15,817,383	0	0	0	4,649,885	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	65,942,694	2,063	0	2,063	48,501,021	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	65,942,694	2,063	0	2,063	48,501,021	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	2,755,753	0	1.00
2.00	Land Improvements	73,301	0	2.00
3.00	Buildings and Fixtures	3,275,626	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	171,558	0	5.00
6.00	Movable Equipment	11,167,498	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	17,443,736	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	17,443,736	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1322 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-7 Part II | Date/Time Prepared: 5/29/2019 10:24 am

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	NEW CAP REL COSTS-BLDG & FIXT	2,489,553	0	0	84,872	4,304	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	2,489,553	0	0	84,872	4,304	3.00

	Cost Center Description	SUMMARY OF CAPITAL		
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
		14.00	15.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2			
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	2,578,729	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	2.00
3.00	Total (sum of lines 1-2)	0	2,578,729	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1322 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-7 Part III Date/Time Prepared: 5/29/2019 10:24 am

	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	6,276,238	0	6,276,238	0.359799	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	11,167,498	0	11,167,498	0.640201	0	2.00
3.00	Total (sum of lines 1-2)	17,443,736	0	17,443,736	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	2,490,719	37,926	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	26,493	2.00
3.00	Total (sum of lines 1-2)	0	0	0	2,490,719	64,419	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	0	84,872	4,304	0	2,617,821	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	1,200,484	0	0	0	1,226,977	2.00
3.00	Total (sum of lines 1-2)	1,200,484	84,872	4,304	0	3,844,798	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1322 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-8 | Date/Time Prepared: 5/29/2019 10:24 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
				Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)	B	-38,857	NEW CAP REL COSTS-MVBLE EQUIP	2.00	10	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-17,977	ADMINISTRATIVE AND GENERAL	5.01	0	7.00
8.00	Television and radio service (chapter 21)	A	-3,852	OPERATION OF PLANT	7.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-1,846,258			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	65,350			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-102,147	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others	B	-29,016	ADMINISTRATIVE AND GENERAL	5.01	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	B	-2,445	DRUGS CHARGED TO PATIENTS	73.00	0	17.00
18.00	Sale of medical records and abstracts	B	-4,693	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines	B	-421	DIETARY	10.00	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	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - NEW CAP REL COSTS-BLDG & FIXT		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - NEW CAP REL COSTS-MVBLE EQUIP		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1322 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-8 | Date/Time Prepared: 5/29/2019 10:24 am

				Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
	Cost Center Description	Basis/Code (2)	Amount	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	A	-37,459	NEW CAP REL COSTS-BLDG & FIXT	1.00	9	32.00
33.00	ADMINISTRATION MISCELLANEOUS REVENUE	B	-37,894	ADMINISTRATIVE AND GENERAL	5.01	0	33.00
33.01	AMBULANCE MISC REVENUE	B	-31,298	AMBULANCE SERVICES	95.00	0	33.01
33.02	RHC I MISC REVENUE	B	-935	RURAL HEALTH CLINIC	88.00	0	33.02
33.03	HOME HEALTH MISC REVENUE	B	454	HOME HEALTH AGENCY	101.00	0	33.03
33.04	PAIN MANAGEMENT - ADVERTISING	A	-2,825	CLINIC	90.00	0	33.04
33.05	ADMINISTRATION-CONTRIBUTIONS	A	-6,181	ADMINISTRATIVE AND GENERAL	5.01	0	33.05
33.06	ADMINISTRATION-NON-ALLOWABLE	A	-408	ADMINISTRATIVE AND GENERAL	5.01	0	33.06
33.07	ADVERTISING - TELL CITY	A	-385	RURAL HEALTH CLINIC	88.00	0	33.07
33.08	HAF FEES	B	-672,798	ADMINISTRATIVE AND GENERAL	5.01	0	33.08
33.09	MEDICAL SUPPLIES - MISC REVENUE	B	-66,551	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	33.09
33.10	LOBBYING DUES	A	-22,362	ADMINISTRATIVE AND GENERAL	5.01	0	33.10
33.11	ON CALL FEES	A	-183,075	ADULTS & PEDIATRICS	30.00	0	33.11
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-3,042,033				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: 15-1322	Period: From 01/01/2018 To 12/31/2018	Worksheet A-8-1 Date/Time Prepared: 5/29/2019 10:24 am

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	2.00	NEW CAP REL COSTS-MVBLE EQUI	AMBULANCE DEPRECIATION	65,350	0	1.00
2.00	0.00			0	0	2.00
3.00	0.00			0	0	3.00
4.00	0.00			0	0	4.00
5.00	0		0	65,350	0	5.00

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

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

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

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

	Symbol (1)	Name	Percentage of Ownership	Name	Percentage of Ownership	
6.00	B	PERRY CO AMBULA	100.00		0.00	6.00
7.00			0.00		0.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:	OTHER				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: 15-1322	Period: From 01/01/2018 To 12/31/2018	Worksheet A-8-1 Date/Time Prepared: 5/29/2019 10:24 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.	
	6.00	7.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:		
1.00	65,350	10	1.00
2.00	0	0	2.00
3.00	0	0	3.00
4.00	0	0	4.00
5.00	65,350		5.00

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

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

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

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

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

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 15-1322 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-8-2 | Date/Time Prepared: 5/29/2019 10:24 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	50.00	OPERATING ROOM	986,540	986,540	0	0	0	1.00
2.00	54.00	RADIOLOGY-DIAGNOSTIC	90,114	90,114	0	0	0	2.00
3.00	60.00	LABORATORY	18,838	0	18,838	0	0	3.00
4.00	65.00	RESPIRATORY THERAPY	208,875	208,875	0	0	0	4.00
5.00	90.02	WOUND CARE	126,590	126,590	0	0	0	5.00
6.00	90.03	OUTPATIENT CLINIC	434,139	434,139	0	0	0	6.00
7.00	91.00	EMERGENCY	1,079,115	0	1,079,115	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			2,944,211	1,846,258	1,097,953		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	60.00	LABORATORY	0	0	0	0	0	3.00
4.00	65.00	RESPIRATORY THERAPY	0	0	0	0	0	4.00
5.00	90.02	WOUND CARE	0	0	0	0	0	5.00
6.00	90.03	OUTPATIENT CLINIC	0	0	0	0	0	6.00
7.00	91.00	EMERGENCY	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	986,540	1.00
2.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	90,114	2.00
3.00	60.00	LABORATORY	0	0	0	0	3.00
4.00	65.00	RESPIRATORY THERAPY	0	0	0	208,875	4.00
5.00	90.02	WOUND CARE	0	0	0	126,590	5.00
6.00	90.03	OUTPATIENT CLINIC	0	0	0	434,139	6.00
7.00	91.00	EMERGENCY	0	0	0	0	7.00
8.00	0.00		0	0	0	0	8.00
9.00	0.00		0	0	0	0	9.00
10.00	0.00		0	0	0	0	10.00
200.00			0	0	0	1,846,258	200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 15-1322 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-8-3 Parts I-VI Date/Time Prepared: 5/29/2019 10:24 am

Physical Therapy | Cost

		1.00	
	PART I - GENERAL INFORMATION		
1.00	Total number of weeks worked (excluding aides) (see instructions)	52	1.00
2.00	Line 1 multiplied by 15 hours per week	780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)	246	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)	260	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)	0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)	0	6.00
7.00	Standard travel expense rate	0.00	7.00
8.00	Optional travel expense rate per mile	0.00	8.00

		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	3,594.58	7,307.58	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	82.91	62.18	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)	41.46	41.46	31.09			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)	298,027	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)	454,385	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)	752,412	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)	752,412	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)	752,412	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)	10,199	24.00
25.00	Assistants (line 4 times column 3, line 11)	8,083	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)	18,282	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)	18,282	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)	18,282	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)	0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)	0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE		
	Standard Travel Expense		
36.00	Therapists (line 5 times column 2, line 11)	0	36.00
37.00	Assistants (line 6 times column 3, line 11)	0	37.00
38.00	Subtotal (sum of lines 36 and 37)	0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)	0	39.00
	Optional Travel Allowance and Optional Travel Expense		
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)	0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)	0	41.00
42.00	Subtotal (sum of lines 40 and 41)	0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)	0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.		
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)	0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)	0	45.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS	Provider CCN: 15-1322	Period: From 01/01/2018 To 12/31/2018	Worksheet A-8-3 Parts I-VI Date/Time Prepared: 5/29/2019 10:24 am
		Physical Therapy	Cost

		1.00	
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)	0	46.00

		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	82.91	62.18	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)	752,412	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	18,282	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)	9,174	61.00
62.00	Supplies (see instructions)	11,283	62.00
63.00	Total allowance (sum of lines 57-62)	791,151	63.00
64.00	Total cost of outside supplier services (from your records)	166,688	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)	0	65.00
	LINE 33 CALCULATION		
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others	18,282	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	18,282	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

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 15-1322 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-8-3 Parts I-VI Date/Time Prepared: 5/29/2019 10:24 am

Occupational Therapy | Cost

		1.00	
	PART I - GENERAL INFORMATION		
1.00	Total number of weeks worked (excluding aides) (see instructions)	52	1.00
2.00	Line 1 multiplied by 15 hours per week	780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)	257	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)	255	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)	0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)	0	6.00
7.00	Standard travel expense rate	0.00	7.00
8.00	Optional travel expense rate per mile	0.00	8.00

		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	3,362.12	3,430.58	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	78.60	58.95	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)	39.30	39.30	29.48			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)	264,263	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)	202,233	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)	466,496	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)	466,496	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)	466,496	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)	10,100	24.00
25.00	Assistants (line 4 times column 3, line 11)	7,517	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)	17,617	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)	17,617	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)	17,617	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)	0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)	0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE		
	Standard Travel Expense		
36.00	Therapists (line 5 times column 2, line 11)	0	36.00
37.00	Assistants (line 6 times column 3, line 11)	0	37.00
38.00	Subtotal (sum of lines 36 and 37)	0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)	0	39.00
	Optional Travel Allowance and Optional Travel Expense		
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)	0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)	0	41.00
42.00	Subtotal (sum of lines 40 and 41)	0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)	0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.		
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)	0	44.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 15-1322 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-8-3 Parts I-VI Date/Time Prepared: 5/29/2019 10:24 am

Occupational Therapy | Cost

		1.00	
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)	0	45.00
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)	0	46.00

		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	78.60	58.95	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)	466,496	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	17,617	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)	484,113	63.00
64.00	Total cost of outside supplier services (from your records)	65,840	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)	0	65.00
	LINE 33 CALCULATION		
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others	17,617	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	17,617	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

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 15-1322 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-8-3 Parts I-VI Date/Time Prepared: 5/29/2019 10:24 am

Speech Pathology | Cost

		1.00	
	PART I - GENERAL INFORMATION		
1.00	Total number of weeks worked (excluding aides) (see instructions)	52	1.00
2.00	Line 1 multiplied by 15 hours per week	780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)	214	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)	0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)	0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)	0	6.00
7.00	Standard travel expense rate	0.00	7.00
8.00	Optional travel expense rate per mile	0.00	8.00

		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	2,035.53	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	75.55	0.00	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	37.78	37.78	0.00			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01

		1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION		
14.00	Supervisors (column 1, line 9 times column 1, line 10)	0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)	153,784	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)	0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)	153,784	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)	153,784	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)	153,784	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)	8,085	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)	8,085	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)	8,085	28.00
	Optional Travel Allowance and Optional Travel Expense		
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)	0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)	0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)	0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)	0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)	8,085	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)	0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)	0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE		
	Standard Travel Expense		
36.00	Therapists (line 5 times column 2, line 11)	0	36.00
37.00	Assistants (line 6 times column 3, line 11)	0	37.00
38.00	Subtotal (sum of lines 36 and 37)	0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)	0	39.00
	Optional Travel Allowance and Optional Travel Expense		
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)	0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)	0	41.00
42.00	Subtotal (sum of lines 40 and 41)	0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)	0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.		
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)	0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)	0	45.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 15-1322 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-8-3 Parts I-VI Date/Time Prepared: 5/29/2019 10:24 am

Speech Pathology | Cost

		1.00	
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)	0	46.00

		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		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)	75.55	0.00	0.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00

		1.00	
	Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT		
57.00	Salary equivalency amount (from line 23)	153,784	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	8,085	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)	13	62.00
63.00	Total allowance (sum of lines 57-62)	161,882	63.00
64.00	Total cost of outside supplier services (from your records)	51,753	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)	0	65.00
	LINE 33 CALCULATION		
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others	8,085	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	8,085	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: 15-1322 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part I Date/Time Prepared: 5/29/2019 10:24 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS NEW BLDG & FIXT	NEW MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	2,617,821	2,617,821				1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	1,226,977		1,226,977			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	742,513	12,350	5,789	760,652		4.00
5.01	00540	ADMINISTRATIVE AND GENERAL	2,186,768	203,692	95,471	28,793	2,514,724	5.01
5.02	00590	OTHER ADMINISTRATIVE AND GENERAL	3,406,164	161,171	75,541	79,836	3,722,712	5.02
7.00	00700	OPERATION OF PLANT	996,166	500,819	234,735	15,915	1,747,635	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	88,897	4,273	2,003	4	95,177	8.00
9.00	00900	HOUSEKEEPING	470,251	28,739	13,470	17,270	529,730	9.00
10.00	01000	DIETARY	200,833	109,014	51,095	0	360,942	10.00
11.00	01100	CAFETERIA	335,705	0	0	0	335,705	11.00
13.00	01300	NURSING ADMINISTRATION	343,887	5,769	2,704	19,518	371,878	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	342,491	32,051	15,022	12,685	402,249	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,284,241	312,450	146,446	80,556	2,823,693	30.00
31.00	03100	INTENSIVE CARE UNIT	525,621	67,285	31,536	10,754	635,196	31.00
43.00	04300	NURSERY	54,549	15,512	7,271	3,396	80,728	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	736,695	279,117	130,823	61,014	1,207,649	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	68,663	68,481	32,097	4,274	173,515	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,701,526	141,279	66,218	50,216	1,959,239	54.00
60.00	06000	LABORATORY	2,045,739	58,375	27,360	43,361	2,174,835	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	107,318	0	0	30	107,348	62.00
65.00	06500	RESPIRATORY THERAPY	669,262	87,776	41,141	28,324	826,503	65.00
66.00	06600	PHYSICAL THERAPY	608,667	43,161	20,230	21,602	693,660	66.00
67.00	06700	OCCUPATIONAL THERAPY	159,025	18,739	8,783	4,266	190,813	67.00
68.00	06800	SPEECH PATHOLOGY	93,859	9,850	4,617	2,110	110,436	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	302,307	0	0	196	302,503	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	92,551	0	0	0	92,551	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,665,576	32,200	15,092	4,365	2,717,233	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	3,640,111	0	0	121,832	3,761,943	88.00
88.01	08801	RURAL HEALTH CLINIC II	470,472	0	0	15,794	486,266	88.01
88.02	08803	RURAL HEALTH CLINIC III	249,689	0	0	9,581	259,270	88.02
88.03	08802	RURAL HEALTH CLINIC IV	372,065	0	0	16,929	388,994	88.03
90.00	09000	CLINIC	647,749	107,006	50,154	22,643	827,552	90.00
90.01	09001	PAIN MANAGEMENT	0	0	0	0	0	90.01
90.02	09002	WOUND CARE	274,622	33,803	15,843	17,504	341,772	90.02
90.03	09003	OUTPATIENT CLINIC	59,846	0	0	0	59,846	90.03
91.00	09100	EMERGENCY	2,153,956	146,514	68,671	45,128	2,414,269	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1,191,169	96,152	45,066	0	1,332,387	95.00
101.00	10100	HOME HEALTH AGENCY	774,353	12,564	5,889	0	792,806	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	34,908,104	2,588,142	1,213,067	737,896	34,841,759	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	29,679	13,910	0	43,589	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	765,759	0	0	22,756	788,515	192.00
192.01	19201	MARKETING	0	0	0	0	0	192.01
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)	35,673,863	2,617,821	1,226,977	760,652	35,673,863	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1322 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part I | Date/Time Prepared: 5/29/2019 10:24 am

		Cost Center Description	ADMINISTRATIVE AND GENERAL	Subtotal	OTHER ADMINISTRATIVE AND GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
			5.01	5A.01	5.02	7.00	8.00	
		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
5.01	00540	ADMINISTRATIVE AND GENERAL	2,514,724					5.01
5.02	00590	OTHER ADMINISTRATIVE AND GENERAL	282,323	4,005,035	4,005,035			5.02
7.00	00700	OPERATION OF PLANT	132,537	1,880,172	244,323	2,124,495		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	7,218	102,395	13,306	5,218	120,919	8.00
9.00	00900	HOUSEKEEPING	40,174	569,904	74,057	35,093	23,666	9.00
10.00	01000	DIETARY	27,373	388,315	50,460	133,120	90	10.00
11.00	01100	CAFETERIA	25,459	361,164	46,932	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	28,202	400,080	51,989	7,045	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	30,506	432,755	56,235	39,138	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	214,143	3,037,836	394,758	381,540	28,256	30.00
31.00	03100	INTENSIVE CARE UNIT	48,172	683,368	88,802	82,163	664	31.00
43.00	04300	NURSERY	6,122	86,850	11,286	18,943	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	91,586	1,299,235	168,832	340,837	11,676	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	13,159	186,674	24,258	83,624	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	148,585	2,107,824	273,905	172,519	11,991	54.00
60.00	06000	LABORATORY	164,935	2,339,770	304,046	71,283	922	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	8,141	115,489	15,007	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	62,680	889,183	115,547	107,185	506	65.00
66.00	06600	PHYSICAL THERAPY	52,606	746,266	96,975	52,705	3,363	66.00
67.00	06700	OCCUPATIONAL THERAPY	14,471	205,284	26,676	22,882	0	67.00
68.00	06800	SPEECH PATHOLOGY	8,375	118,811	15,439	12,028	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	22,941	325,444	42,290	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	7,019	99,570	12,939	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	206,070	2,923,303	379,874	39,320	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	285,299	4,047,242	525,930	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	36,877	523,143	67,981	0	0	88.01
88.02	08803	RURAL HEALTH CLINIC III	19,663	278,933	36,247	0	0	88.02
88.03	08802	RURAL HEALTH CLINIC IV	29,501	418,495	54,382	0	0	88.03
90.00	09000	CLINIC	62,760	890,312	115,693	130,668	4,196	90.00
90.01	09001	PAIN MANAGEMENT	0	0	0	0	0	90.01
90.02	09002	WOUND CARE	25,919	367,691	47,780	41,277	0	90.02
90.03	09003	OUTPATIENT CLINIC	4,539	64,385	8,367	0	0	90.03
91.00	09100	EMERGENCY	183,093	2,597,362	337,519	178,911	35,319	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0				92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	101,046	1,433,433	186,270	117,413	270	95.00
101.00	10100	HOME HEALTH AGENCY	60,125	852,931	110,836	15,342	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,451,619	34,778,654	3,998,941	2,088,254	120,919	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	3,306	46,895	6,094	36,241	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	59,799	848,314	0	0	0	192.00
192.01	19201	MARKETING	0	0	0	0	0	192.01
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)	2,514,724	35,673,863	4,005,035	2,124,495	120,919	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1322 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part I | Date/Time Prepared: 5/29/2019 10:24 am

		Cost Center Description	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	
			9.00	10.00	11.00	13.00	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
5.01	00540	ADMINISTRATIVE AND GENERAL						5.01
5.02	00590	OTHER ADMINISTRATIVE AND GENERAL						5.02
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING	702,720					9.00
10.00	01000	DIETARY	44,884	616,869				10.00
11.00	01100	CAFETERIA	0	0	408,096			11.00
13.00	01300	NURSING ADMINISTRATION	2,375	0	4,149	465,638		13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	13,196	0	16,761	0	558,085	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	128,643	574,937	97,979	212,921	144,754	30.00
31.00	03100	INTENSIVE CARE UNIT	27,703	41,932	11,092	24,104	0	31.00
43.00	04300	NURSERY	6,387	0	0	0	5,232	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	114,919	0	34,302	74,523	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	28,195	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	58,168	0	47,489	0	108,129	54.00
60.00	06000	LABORATORY	24,034	0	52,912	0	81,969	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	36,139	0	30,112	0	47,088	65.00
66.00	06600	PHYSICAL THERAPY	17,771	0	22,800	0	13,952	66.00
67.00	06700	OCCUPATIONAL THERAPY	7,715	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	4,056	0	0	0	6,976	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	13,258	0	5,833	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
88.02	08803	RURAL HEALTH CLINIC III	0	0	0	0	0	88.02
88.03	08802	RURAL HEALTH CLINIC IV	0	0	0	0	0	88.03
90.00	09000	CLINIC	44,057	0	26,867	56,600	118,593	90.00
90.01	09001	PAIN MANAGEMENT	0	0	0	0	0	90.01
90.02	09002	WOUND CARE	13,917	0	12,940	0	0	90.02
90.03	09003	OUTPATIENT CLINIC	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	60,323	0	44,860	97,490	31,392	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	39,588	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	5,173	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	690,501	616,869	408,096	465,638	558,085	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	12,219	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	MARKETING	0	0	0	0	0	192.01
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)	702,720	616,869	408,096	465,638	558,085	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1322 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part I | Date/Time Prepared: 5/29/2019 10:24 am

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00540	ADMINISTRATIVE AND GENERAL					5.01
5.02	00590	OTHER ADMINISTRATIVE AND GENERAL					5.02
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	5,001,624	0	5,001,624		30.00
31.00	03100	INTENSIVE CARE UNIT	959,828	0	959,828		31.00
43.00	04300	NURSERY	128,698	0	128,698		43.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	2,044,324	0	2,044,324		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	322,751	0	322,751		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,780,025	0	2,780,025		54.00
60.00	06000	LABORATORY	2,874,936	0	2,874,936		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	130,496	0	130,496		62.00
65.00	06500	RESPIRATORY THERAPY	1,225,760	0	1,225,760		65.00
66.00	06600	PHYSICAL THERAPY	953,832	0	953,832		66.00
67.00	06700	OCCUPATIONAL THERAPY	262,557	0	262,557		67.00
68.00	06800	SPEECH PATHOLOGY	157,310	0	157,310		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	367,734	0	367,734		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	112,509	0	112,509		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,361,588	0	3,361,588		73.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	4,573,172	0	4,573,172		88.00
88.01	08801	RURAL HEALTH CLINIC II	591,124	0	591,124		88.01
88.02	08803	RURAL HEALTH CLINIC III	315,180	0	315,180		88.02
88.03	08802	RURAL HEALTH CLINIC IV	472,877	0	472,877		88.03
90.00	09000	CLINIC	1,386,986	0	1,386,986		90.00
90.01	09001	PAIN MANAGEMENT	0	0	0		90.01
90.02	09002	WOUND CARE	483,605	0	483,605		90.02
90.03	09003	OUTPATIENT CLINIC	72,752	0	72,752		90.03
91.00	09100	EMERGENCY	3,383,176	0	3,383,176		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0			92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	1,776,974	0	1,776,974		95.00
101.00	10100	HOME HEALTH AGENCY	984,282	0	984,282		101.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
116.00	11600	HOSPICE	0	0	0		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	34,724,100	0	34,724,100		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	101,449	0	101,449		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	848,314	0	848,314		192.00
192.01	19201	MARKETING	0	0	0		192.01
200.00		Cross Foot Adjustments	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	35,673,863	0	35,673,863		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1322 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part II Date/Time Prepared: 5/29/2019 10:24 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
				NEW BLDG & FIXT	NEW MVBLE EQUIP			
			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	12,350	5,789	18,139	18,139	4.00
5.01	00540	ADMINISTRATIVE AND GENERAL	0	203,692	95,471	299,163	686	5.01
5.02	00590	OTHER ADMINISTRATIVE AND GENERAL	0	161,171	75,541	236,712	1,903	5.02
7.00	00700	OPERATION OF PLANT	0	500,819	234,735	735,554	379	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	4,273	2,003	6,276	0	8.00
9.00	00900	HOUSEKEEPING	0	28,739	13,470	42,209	412	9.00
10.00	01000	DIETARY	0	109,014	51,095	160,109	0	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	5,769	2,704	8,473	465	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	32,051	15,022	47,073	302	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	312,450	146,446	458,896	1,920	30.00
31.00	03100	INTENSIVE CARE UNIT	0	67,285	31,536	98,821	256	31.00
43.00	04300	NURSERY	0	15,512	7,271	22,783	81	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	279,117	130,823	409,940	1,455	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	68,481	32,097	100,578	102	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	141,279	66,218	207,497	1,197	54.00
60.00	06000	LABORATORY	0	58,375	27,360	85,735	1,034	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	1	62.00
65.00	06500	RESPIRATORY THERAPY	0	87,776	41,141	128,917	675	65.00
66.00	06600	PHYSICAL THERAPY	0	43,161	20,230	63,391	515	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	18,739	8,783	27,522	102	67.00
68.00	06800	SPEECH PATHOLOGY	0	9,850	4,617	14,467	50	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	5	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	32,200	15,092	47,292	104	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	2,911	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	377	88.01
88.02	08803	RURAL HEALTH CLINIC III	0	0	0	0	228	88.02
88.03	08802	RURAL HEALTH CLINIC IV	0	0	0	0	404	88.03
90.00	09000	CLINIC	0	107,006	50,154	157,160	540	90.00
90.01	09001	PAIN MANAGEMENT	0	0	0	0	0	90.01
90.02	09002	WOUND CARE	0	33,803	15,843	49,646	417	90.02
90.03	09003	OUTPATIENT CLINIC	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	0	146,514	68,671	215,185	1,076	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	96,152	45,066	141,218	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	12,564	5,889	18,453	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	2,588,142	1,213,067	3,801,209	17,597	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	29,679	13,910	43,589	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	542	192.00
192.01	19201	MARKETING	0	0	0	0	0	192.01
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	2,617,821	1,226,977	3,844,798	18,139	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1322 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part II Date/Time Prepared: 5/29/2019 10:24 am

		Cost Center Description	ADMINISTRATIVE AND GENERAL	OTHER ADMINISTRATIVE AND GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.01	5.02	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	ADMINISTRATIVE AND GENERAL	299,849					5.01
5.02	00590	OTHER ADMINISTRATIVE AND GENERAL	33,664	272,279				5.02
7.00	00700	OPERATION OF PLANT	15,804	16,609	768,346			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	861	905	1,887	9,929		8.00
9.00	00900	HOUSEKEEPING	4,790	5,035	12,692	1,943	67,081	9.00
10.00	01000	DIETARY	3,264	3,430	48,144	7	4,285	10.00
11.00	01100	CAFETERIA	3,036	3,191	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	3,363	3,534	2,548	0	227	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,638	3,823	14,155	0	1,260	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	25,535	26,836	137,987	2,320	12,279	30.00
31.00	03100	INTENSIVE CARE UNIT	5,744	6,037	29,715	54	2,644	31.00
43.00	04300	NURSERY	730	767	6,851	0	610	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	10,921	11,477	123,267	959	10,970	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,569	1,649	30,244	0	2,692	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	17,717	18,621	62,393	985	5,553	54.00
60.00	06000	LABORATORY	19,667	20,670	25,780	76	2,294	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	971	1,020	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	7,474	7,855	38,765	42	3,450	65.00
66.00	06600	PHYSICAL THERAPY	6,273	6,593	19,061	276	1,696	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,726	1,813	8,276	0	736	67.00
68.00	06800	SPEECH PATHOLOGY	999	1,050	4,350	0	387	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,736	2,875	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	837	880	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	24,572	25,824	14,221	0	1,266	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	34,007	35,764	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	4,397	4,621	0	0	0	88.01
88.02	08803	RURAL HEALTH CLINIC III	2,345	2,464	0	0	0	88.02
88.03	08802	RURAL HEALTH CLINIC IV	3,518	3,697	0	0	0	88.03
90.00	09000	CLINIC	7,484	7,865	47,257	345	4,206	90.00
90.01	09001	PAIN MANAGEMENT	0	0	0	0	0	90.01
90.02	09002	WOUND CARE	3,091	3,248	14,928	0	1,329	90.02
90.03	09003	OUTPATIENT CLINIC	541	569	0	0	0	90.03
91.00	09100	EMERGENCY	21,832	22,945	64,705	2,900	5,758	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	12,049	12,663	42,464	22	3,779	95.00
101.00	10100	HOME HEALTH AGENCY	7,169	7,535	5,549	0	494	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	292,324	271,865	755,239	9,929	65,915	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	394	414	13,107	0	1,166	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	7,131	0	0	0	0	192.00
192.01	19201	MARKETING	0	0	0	0	0	192.01
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)	299,849	272,279	768,346	9,929	67,081	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1322 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part II Date/Time Prepared: 5/29/2019 10:24 am

		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	Subtotal	
			10.00	11.00	13.00	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
5.01	00540	ADMINISTRATIVE AND GENERAL						5.01
5.02	00590	OTHER ADMINISTRATIVE AND GENERAL						5.02
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	219,239					10.00
11.00	01100	CAFETERIA	0	6,227				11.00
13.00	01300	NURSING ADMINISTRATION	0	63	18,673			13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	256	0	70,507		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	204,336	1,496	8,537	18,287	898,429	30.00
31.00	03100	INTENSIVE CARE UNIT	14,903	169	967	0	159,310	31.00
43.00	04300	NURSERY	0	0	0	661	32,483	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	523	2,989	0	572,501	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	136,834	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	725	0	13,661	328,349	54.00
60.00	06000	LABORATORY	0	807	0	10,356	166,419	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	1,992	62.00
65.00	06500	RESPIRATORY THERAPY	0	459	0	5,949	193,586	65.00
66.00	06600	PHYSICAL THERAPY	0	348	0	1,763	99,916	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	40,175	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	881	22,184	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	5,616	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	1,717	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	89	0	0	113,368	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	72,682	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	9,395	88.01
88.02	08803	RURAL HEALTH CLINIC III	0	0	0	0	5,037	88.02
88.03	08802	RURAL HEALTH CLINIC IV	0	0	0	0	7,619	88.03
90.00	09000	CLINIC	0	410	2,270	14,983	242,520	90.00
90.01	09001	PAIN MANAGEMENT	0	0	0	0	0	90.01
90.02	09002	WOUND CARE	0	197	0	0	72,856	90.02
90.03	09003	OUTPATIENT CLINIC	0	0	0	0	1,110	90.03
91.00	09100	EMERGENCY	0	685	3,910	3,966	342,962	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	212,195	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	39,200	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	219,239	6,227	18,673	70,507	3,778,455	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	58,670	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	7,673	192.00
192.01	19201	MARKETING	0	0	0	0	0	192.01
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)	219,239	6,227	18,673	70,507	3,844,798	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1322 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part II | Date/Time Prepared: 5/29/2019 10:24 am

		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
5.01	00540	ADMINISTRATIVE AND GENERAL			5.01
5.02	00590	OTHER ADMINISTRATIVE AND GENERAL			5.02
7.00	00700	OPERATION OF PLANT			7.00
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
13.00	01300	NURSING ADMINISTRATION			13.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	0	898,429	30.00
31.00	03100	INTENSIVE CARE UNIT	0	159,310	31.00
43.00	04300	NURSERY	0	32,483	43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0	572,501	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	136,834	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	328,349	54.00
60.00	06000	LABORATORY	0	166,419	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	1,992	62.00
65.00	06500	RESPIRATORY THERAPY	0	193,586	65.00
66.00	06600	PHYSICAL THERAPY	0	99,916	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	40,175	67.00
68.00	06800	SPEECH PATHOLOGY	0	22,184	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	5,616	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	1,717	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	113,368	73.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	0	72,682	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	9,395	88.01
88.02	08803	RURAL HEALTH CLINIC III	0	5,037	88.02
88.03	08802	RURAL HEALTH CLINIC IV	0	7,619	88.03
90.00	09000	CLINIC	0	242,520	90.00
90.01	09001	PAIN MANAGEMENT	0	0	90.01
90.02	09002	WOUND CARE	0	72,856	90.02
90.03	09003	OUTPATIENT CLINIC	0	1,110	90.03
91.00	09100	EMERGENCY	0	342,962	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0	212,195	95.00
101.00	10100	HOME HEALTH AGENCY	0	39,200	101.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
116.00	11600	HOSPICE	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	3,778,455	118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	58,670	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	7,673	192.00
192.01	19201	MARKETING	0	0	192.01
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	3,844,798	202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1322 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B-1 | Date/Time Prepared: 5/29/2019 10:24 am

		Cost Center Description	CAPITAL RELATED COSTS					
			NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE AND GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A.01	5.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	122,517					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		122,517				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	578	578	12,219,691			4.00
5.01	00540	ADMINISTRATIVE AND GENERAL	9,533	9,533	462,559	-2,514,724	33,159,139	5.01
5.02	00590	OTHER ADMINISTRATIVE AND GENERAL	7,543	7,543	1,282,544	0	3,722,712	5.02
7.00	00700	OPERATION OF PLANT	23,439	23,439	255,672	0	1,747,635	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	200	200	64	0	95,177	8.00
9.00	00900	HOUSEKEEPING	1,345	1,345	277,435	0	529,730	9.00
10.00	01000	DIETARY	5,102	5,102	0	0	360,942	10.00
11.00	01100	CAFETERIA	0	0	0	0	335,705	11.00
13.00	01300	NURSING ADMINISTRATION	270	270	313,556	0	371,878	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,500	1,500	203,779	0	402,249	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	14,623	14,623	1,294,106	0	2,823,693	30.00
31.00	03100	INTENSIVE CARE UNIT	3,149	3,149	172,763	0	635,196	31.00
43.00	04300	NURSERY	726	726	54,549	0	80,728	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	13,063	13,063	980,175	0	1,207,649	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,205	3,205	68,663	0	173,515	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,612	6,612	806,706	0	1,959,239	54.00
60.00	06000	LABORATORY	2,732	2,732	696,583	0	2,174,835	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	487	0	107,348	62.00
65.00	06500	RESPIRATORY THERAPY	4,108	4,108	455,014	0	826,503	65.00
66.00	06600	PHYSICAL THERAPY	2,020	2,020	347,039	0	693,660	66.00
67.00	06700	OCCUPATIONAL THERAPY	877	877	68,530	0	190,813	67.00
68.00	06800	SPEECH PATHOLOGY	461	461	33,902	0	110,436	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	3,145	0	302,503	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	92,551	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,507	1,507	70,119	0	2,717,233	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	1,957,203	0	3,761,943	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	253,723	0	486,266	88.01
88.02	08803	RURAL HEALTH CLINIC III	0	0	153,915	0	259,270	88.02
88.03	08802	RURAL HEALTH CLINIC IV	0	0	271,965	0	388,994	88.03
90.00	09000	CLINIC	5,008	5,008	363,761	0	827,552	90.00
90.01	09001	PAIN MANAGEMENT	0	0	0	0	0	90.01
90.02	09002	WOUND CARE	1,582	1,582	281,199	0	341,772	90.02
90.03	09003	OUTPATIENT CLINIC	0	0	0	0	59,846	90.03
91.00	09100	EMERGENCY	6,857	6,857	724,972	0	2,414,269	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	4,500	4,500	0	0	1,332,387	95.00
101.00	10100	HOME HEALTH AGENCY	588	588	0	0	792,806	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	121,128	121,128	11,854,128	-2,514,724	32,327,035	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,389	1,389	0	0	43,589	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	365,563	0	788,515	192.00
192.01	19201	MARKETING	0	0	0	0	0	192.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	2,617,821	1,226,977	760,652		2,514,724	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	21.367002	10.014749	0.062248		0.075838	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			18,139		299,849	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.001484		0.009043	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: 15-1322 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B-1 | Date/Time Prepared: 5/29/2019 10:24 am

		Cost Center Description	Reconciliation	OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST NO PBP)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	
			5A.02	5.02	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	ADMINISTRATIVE AND GENERAL						5.01
5.02	00590	OTHER ADMINISTRATIVE AND GENERAL	-4,005,035	30,820,514				5.02
7.00	00700	OPERATION OF PLANT	0	1,880,172	81,424			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	102,395	200	10,750		8.00
9.00	00900	HOUSEKEEPING	0	569,904	1,345	2,104	79,879	9.00
10.00	01000	DIETARY	0	388,315	5,102	8	5,102	10.00
11.00	01100	CAFETERIA	0	361,164	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	400,080	270	0	270	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	432,755	1,500	0	1,500	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	3,037,836	14,623	2,512	14,623	30.00
31.00	03100	INTENSIVE CARE UNIT	0	683,368	3,149	59	3,149	31.00
43.00	04300	NURSERY	0	86,850	726	0	726	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	1,299,235	13,063	1,038	13,063	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	186,674	3,205	0	3,205	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,107,824	6,612	1,066	6,612	54.00
60.00	06000	LABORATORY	0	2,339,770	2,732	82	2,732	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	115,489	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	889,183	4,108	45	4,108	65.00
66.00	06600	PHYSICAL THERAPY	0	746,266	2,020	299	2,020	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	205,284	877	0	877	67.00
68.00	06800	SPEECH PATHOLOGY	0	118,811	461	0	461	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	325,444	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	99,570	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,923,303	1,507	0	1,507	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	4,047,242	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	523,143	0	0	0	88.01
88.02	08803	RURAL HEALTH CLINIC III	0	278,933	0	0	0	88.02
88.03	08802	RURAL HEALTH CLINIC IV	0	418,495	0	0	0	88.03
90.00	09000	CLINIC	0	890,312	5,008	373	5,008	90.00
90.01	09001	PAIN MANAGEMENT	0	0	0	0	0	90.01
90.02	09002	WOUND CARE	0	367,691	1,582	0	1,582	90.02
90.03	09003	OUTPATIENT CLINIC	0	64,385	0	0	0	90.03
91.00	09100	EMERGENCY	0	2,597,362	6,857	3,140	6,857	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	1,433,433	4,500	24	4,500	95.00
101.00	10100	HOME HEALTH AGENCY	0	852,931	588	0	588	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-4,005,035	30,773,619	80,035	10,750	78,490	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	46,895	1,389	0	1,389	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	-848,314	0	0	0	0	192.00
192.01	19201	MARKETING	0	0	0	0	0	192.01
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)		4,005,035	2,124,495	120,919	702,720	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)		0.129947	26.091754	11.248279	8.797306	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)		272,279	768,346	9,929	67,081	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)		0.008834	9.436358	0.923628	0.839783	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: 15-1322 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B-1 Date/Time Prepared: 5/29/2019 10:24 am

		Cost Center Description	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	MEDICAL RECORDS & LIBRARY (TIME SPENT)		
			10.00	11.00	13.00	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
5.01	00540	ADMINISTRATIVE AND GENERAL						5.01
5.02	00590	OTHER ADMINISTRATIVE AND GENERAL						5.02
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	11,048					10.00
11.00	01100	CAFETERIA	0	9,934				11.00
13.00	01300	NURSING ADMINISTRATION	0	101	108,488			13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	408	0	320		16.00
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	10,297	2,385	49,608	83		30.00
31.00	03100	INTENSIVE CARE UNIT	751	270	5,616	0		31.00
43.00	04300	NURSERY	0	0	0	3		43.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	835	17,363	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,156	0	62		54.00
60.00	06000	LABORATORY	0	1,288	0	47		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0		62.00
65.00	06500	RESPIRATORY THERAPY	0	733	0	27		65.00
66.00	06600	PHYSICAL THERAPY	0	555	0	8		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	4		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	142	0	0		73.00
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0		88.01
88.02	08803	RURAL HEALTH CLINIC III	0	0	0	0		88.02
88.03	08802	RURAL HEALTH CLINIC IV	0	0	0	0		88.03
90.00	09000	CLINIC	0	654	13,187	68		90.00
90.01	09001	PAIN MANAGEMENT	0	0	0	0		90.01
90.02	09002	WOUND CARE	0	315	0	0		90.02
90.03	09003	OUTPATIENT CLINIC	0	0	0	0		90.03
91.00	09100	EMERGENCY	0	1,092	22,714	18		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0		95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0		101.00
	SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	11,048	9,934	108,488	320		118.00
	NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192.00
192.01	19201	MARKETING	0	0	0	0		192.01
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)	616,869	408,096	465,638	558,085		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	55.835355	41.080733	4.292069	1,744.015625		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	219,239	6,227	18,673	70,507		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	19.844225	0.626837	0.172120	220.334375		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: 15-1322

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

Worksheet C Part I
Date/Time Prepared: 5/29/2019 10:24 am

Title XVIII | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	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	5,001,624		5,001,624	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	959,828		959,828	0	0	31.00
43.00	04300	NURSERY	128,698		128,698	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,044,324		2,044,324	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	322,751		322,751	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,780,025		2,780,025	0	0	54.00
60.00	06000	LABORATORY	2,874,936		2,874,936	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	130,496		130,496	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	1,225,760	0	1,225,760	0	0	65.00
66.00	06600	PHYSICAL THERAPY	953,832	0	953,832	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	262,557	0	262,557	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	157,310	0	157,310	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	367,734		367,734	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	112,509		112,509	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,361,588		3,361,588	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	4,573,172		4,573,172	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	591,124		591,124	0	0	88.01
88.02	08803	RURAL HEALTH CLINIC III	315,180		315,180	0	0	88.02
88.03	08802	RURAL HEALTH CLINIC IV	472,877		472,877	0	0	88.03
90.00	09000	CLINIC	1,386,986		1,386,986	0	0	90.00
90.01	09001	PAIN MANAGEMENT	0		0	0	0	90.01
90.02	09002	WOUND CARE	483,605		483,605	0	0	90.02
90.03	09003	OUTPATIENT CLINIC	72,752		72,752	0	0	90.03
91.00	09100	EMERGENCY	3,383,176		3,383,176	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	741,410		741,410		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1,776,974		1,776,974	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	984,282		984,282		0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0		0		0	116.00
200.00		Subtotal (see instructions)	35,465,510	0	35,465,510	0	0	200.00
201.00		Less Observation Beds	741,410		741,410		0	201.00
202.00		Total (see instructions)	34,724,100	0	34,724,100	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1322 | Period: From 01/01/2018 To 12/31/2018 | Worksheet C Part I Date/Time Prepared: 5/29/2019 10:24 am

Title XVIII | Hospital | Cost

		Cost Center Description	Charges Inpatient	Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,784,638		2,784,638			30.00
31.00	03100	INTENSIVE CARE UNIT	328,462		328,462			31.00
43.00	04300	NURSERY	142,760		142,760			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	906,385	5,494,728	6,401,113	0.319370	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	444,481	287,841	732,322	0.440723	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,460,571	17,748,923	19,209,494	0.144721	0.000000	54.00
60.00	06000	LABORATORY	1,750,553	12,442,635	14,193,188	0.202557	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	98,410	332,035	430,445	0.303165	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	1,273,660	2,158,928	3,432,588	0.357095	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	453,291	2,280,563	2,733,854	0.348896	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	307,430	803,810	1,111,240	0.236274	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	77,900	297,384	375,284	0.419176	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,571,030	2,978,979	4,550,009	0.080820	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	905	184,197	185,102	0.607822	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,684,035	9,878,990	13,563,025	0.247849	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	3,040,848	3,040,848			88.00
88.01	08801	RURAL HEALTH CLINIC II	0	518,488	518,488			88.01
88.02	08803	RURAL HEALTH CLINIC III	0	345,826	345,826			88.02
88.03	08802	RURAL HEALTH CLINIC IV	0	487,915	487,915			88.03
90.00	09000	CLINIC	246,641	879,275	1,125,916	1.231873	0.000000	90.00
90.01	09001	PAIN MANAGEMENT	0	0	0	0.000000	0.000000	90.01
90.02	09002	WOUND CARE	340	1,960,396	1,960,736	0.246645	0.000000	90.02
90.03	09003	OUTPATIENT CLINIC	0	360,893	360,893	0.201589	0.000000	90.03
91.00	09100	EMERGENCY	355,271	7,067,548	7,422,819	0.455780	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	37,148	619,820	656,968	1.128533	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	3,526,364	3,526,364	0.503911	0.000000	95.00
101.00	10100	HOME HEALTH AGENCY	0	2,594,762	2,594,762			101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0			116.00
200.00		Subtotal (see instructions)	15,923,911	76,291,148	92,215,059			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	15,923,911	76,291,148	92,215,059			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1322 | Period: From 01/01/2018 To 12/31/2018 | Worksheet C Part I Date/Time Prepared: 5/29/2019 10:24 am

Title XVIII | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
43.00	04300	NURSERY		43.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	54.00
60.00	06000	LABORATORY	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	68.00
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
88.02	08803	RURAL HEALTH CLINIC III		88.02
88.03	08802	RURAL HEALTH CLINIC IV		88.03
90.00	09000	CLINIC	0.000000	90.00
90.01	09001	PAIN MANAGEMENT	0.000000	90.01
90.02	09002	WOUND CARE	0.000000	90.02
90.03	09003	OUTPATIENT CLINIC	0.000000	90.03
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
101.00	10100	HOME HEALTH AGENCY		101.00
		SPECIAL PURPOSE COST CENTERS		
113.00	11300	INTEREST EXPENSE		113.00
116.00	11600	HOSPICE		116.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1322 | Period: From 01/01/2018 To 12/31/2018 | Worksheet C Part I | Date/Time Prepared: 5/29/2019 10:24 am

Title XIX | Hospital | PPS

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,001,624		5,001,624	0	5,001,624	30.00
31.00	03100	INTENSIVE CARE UNIT	959,828		959,828	0	959,828	31.00
43.00	04300	NURSERY	128,698		128,698	0	128,698	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,044,324		2,044,324	0	2,044,324	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	322,751		322,751	0	322,751	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,780,025		2,780,025	0	2,780,025	54.00
60.00	06000	LABORATORY	2,874,936		2,874,936	0	2,874,936	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	130,496		130,496	0	130,496	62.00
65.00	06500	RESPIRATORY THERAPY	1,225,760	0	1,225,760	0	1,225,760	65.00
66.00	06600	PHYSICAL THERAPY	953,832	0	953,832	0	953,832	66.00
67.00	06700	OCCUPATIONAL THERAPY	262,557	0	262,557	0	262,557	67.00
68.00	06800	SPEECH PATHOLOGY	157,310	0	157,310	0	157,310	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	367,734		367,734	0	367,734	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	112,509		112,509	0	112,509	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,361,588		3,361,588	0	3,361,588	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	4,573,172		4,573,172	0	4,573,172	88.00
88.01	08801	RURAL HEALTH CLINIC II	591,124		591,124	0	591,124	88.01
88.02	08803	RURAL HEALTH CLINIC III	315,180		315,180	0	315,180	88.02
88.03	08802	RURAL HEALTH CLINIC IV	472,877		472,877	0	472,877	88.03
90.00	09000	CLINIC	1,386,986		1,386,986	0	1,386,986	90.00
90.01	09001	PAIN MANAGEMENT	0		0	0	0	90.01
90.02	09002	WOUND CARE	483,605		483,605	0	483,605	90.02
90.03	09003	OUTPATIENT CLINIC	72,752		72,752	0	72,752	90.03
91.00	09100	EMERGENCY	3,383,176		3,383,176	0	3,383,176	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	741,410		741,410		741,410	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1,776,974		1,776,974	0	1,776,974	95.00
101.00	10100	HOME HEALTH AGENCY	984,282		984,282		984,282	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0		0		0	116.00
200.00		Subtotal (see instructions)	35,465,510	0	35,465,510	0	35,465,510	200.00
201.00		Less Observation Beds	741,410		741,410		741,410	201.00
202.00		Total (see instructions)	34,724,100	0	34,724,100	0	34,724,100	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1322 | Period: From 01/01/2018 To 12/31/2018 | Worksheet C Part I Date/Time Prepared: 5/29/2019 10:24 am

Title XIX | Hospital | PPS

		Cost Center Description	Charges Inpatient	Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,784,638		2,784,638			30.00
31.00	03100	INTENSIVE CARE UNIT	328,462		328,462			31.00
43.00	04300	NURSERY	142,760		142,760			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	906,385	5,494,728	6,401,113	0.319370	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	444,481	287,841	732,322	0.440723	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,460,571	17,748,923	19,209,494	0.144721	0.000000	54.00
60.00	06000	LABORATORY	1,750,553	12,442,635	14,193,188	0.202557	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	98,410	332,035	430,445	0.303165	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	1,273,660	2,158,928	3,432,588	0.357095	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	453,291	2,280,563	2,733,854	0.348896	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	307,430	803,810	1,111,240	0.236274	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	77,900	297,384	375,284	0.419176	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,571,030	2,978,979	4,550,009	0.080820	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	905	184,197	185,102	0.607822	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,684,035	9,878,990	13,563,025	0.247849	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	3,040,848	3,040,848	1.503913	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	518,488	518,488	1.140092	0.000000	88.01
88.02	08803	RURAL HEALTH CLINIC III	0	345,826	345,826	0.911383	0.000000	88.02
88.03	08802	RURAL HEALTH CLINIC IV	0	487,915	487,915	0.969179	0.000000	88.03
90.00	09000	CLINIC	246,641	879,275	1,125,916	1.231873	0.000000	90.00
90.01	09001	PAIN MANAGEMENT	0	0	0	0.000000	0.000000	90.01
90.02	09002	WOUND CARE	340	1,960,396	1,960,736	0.246645	0.000000	90.02
90.03	09003	OUTPATIENT CLINIC	0	360,893	360,893	0.201589	0.000000	90.03
91.00	09100	EMERGENCY	355,271	7,067,548	7,422,819	0.455780	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	37,148	619,820	656,968	1.128533	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	3,526,364	3,526,364	0.503911	0.000000	95.00
101.00	10100	HOME HEALTH AGENCY	0	2,594,762	2,594,762			101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0			116.00
200.00		Subtotal (see instructions)	15,923,911	76,291,148	92,215,059			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	15,923,911	76,291,148	92,215,059			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-1322 | Period: From 01/01/2018 To 12/31/2018 | Worksheet C Part I | Date/Time Prepared: 5/29/2019 10:24 am

Title XIX | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
43.00	04300	NURSERY		43.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.319370	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.440723	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.144721	54.00
60.00	06000	LABORATORY	0.202557	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.303165	62.00
65.00	06500	RESPIRATORY THERAPY	0.357095	65.00
66.00	06600	PHYSICAL THERAPY	0.348896	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.236274	67.00
68.00	06800	SPEECH PATHOLOGY	0.419176	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.080820	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.607822	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.247849	73.00
		OUTPATIENT SERVICE COST CENTERS		
88.00	08800	RURAL HEALTH CLINIC	1.503913	88.00
88.01	08801	RURAL HEALTH CLINIC II	1.140092	88.01
88.02	08803	RURAL HEALTH CLINIC III	0.911383	88.02
88.03	08802	RURAL HEALTH CLINIC IV	0.969179	88.03
90.00	09000	CLINIC	1.231873	90.00
90.01	09001	PAIN MANAGEMENT	0.000000	90.01
90.02	09002	WOUND CARE	0.246645	90.02
90.03	09003	OUTPATIENT CLINIC	0.201589	90.03
91.00	09100	EMERGENCY	0.455780	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.128533	92.00
		OTHER REIMBURSABLE COST CENTERS		
95.00	09500	AMBULANCE SERVICES	0.503911	95.00
101.00	10100	HOME HEALTH AGENCY		101.00
		SPECIAL PURPOSE COST CENTERS		
113.00	11300	INTEREST EXPENSE		113.00
116.00	11600	HOSPICE		116.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

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

Provider CCN: 15-1322 | Period: From 01/01/2018 To 12/31/2018 | Worksheet C Part II | Date/Time Prepared: 5/29/2019 10:24 am

Title XIX | Hospital | PPS

		Cost Center Description	Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount	
			1.00	2.00	3.00	4.00	5.00	
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	2,044,324	572,501	1,471,823	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	322,751	136,834	185,917	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,780,025	328,349	2,451,676	0	0	54.00
60.00	06000	LABORATORY	2,874,936	166,419	2,708,517	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	130,496	1,992	128,504	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	1,225,760	193,586	1,032,174	0	0	65.00
66.00	06600	PHYSICAL THERAPY	953,832	99,916	853,916	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	262,557	40,175	222,382	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	157,310	22,184	135,126	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	367,734	5,616	362,118	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	112,509	1,717	110,792	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,361,588	113,368	3,248,220	0	0	73.00
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	4,573,172	72,682	4,500,490	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	591,124	9,395	581,729	0	0	88.01
88.02	08803	RURAL HEALTH CLINIC III	315,180	5,037	310,143	0	0	88.02
88.03	08802	RURAL HEALTH CLINIC IV	472,877	7,619	465,258	0	0	88.03
90.00	09000	CLINIC	1,386,986	242,520	1,144,466	0	0	90.00
90.01	09001	PAIN MANAGEMENT	0	0	0	0	0	90.01
90.02	09002	WOUND CARE	483,605	72,856	410,749	0	0	90.02
90.03	09003	OUTPATIENT CLINIC	72,752	1,110	71,642	0	0	90.03
91.00	09100	EMERGENCY	3,383,176	342,962	3,040,214	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	741,410	133,177	608,233	0	0	92.00
	OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	1,776,974	212,195	1,564,779	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	984,282	39,200	945,082	0	0	101.00
	SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
200.00		Subtotal (sum of lines 50 thru 199)	29,375,360	2,821,410	26,553,950	0	0	200.00
201.00		Less Observation Beds	741,410	133,177	608,233	0	0	201.00
202.00		Total (line 200 minus line 201)	28,633,950	2,688,233	25,945,717	0	0	202.00

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

Provider CCN: 15-1322 | Period: From 01/01/2018 To 12/31/2018 | Worksheet C Part II | Date/Time Prepared: 5/29/2019 10:24 am

Title XIX | Hospital | PPS

		Cost Center Description	Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)	
			6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	2,044,324	6,401,113	0.319370	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	322,751	732,322	0.440723	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,780,025	19,209,494	0.144721	54.00
60.00	06000	LABORATORY	2,874,936	14,193,188	0.202557	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	130,496	430,445	0.303165	62.00
65.00	06500	RESPIRATORY THERAPY	1,225,760	3,432,588	0.357095	65.00
66.00	06600	PHYSICAL THERAPY	953,832	2,733,854	0.348896	66.00
67.00	06700	OCCUPATIONAL THERAPY	262,557	1,111,240	0.236274	67.00
68.00	06800	SPEECH PATHOLOGY	157,310	375,284	0.419176	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	367,734	4,550,009	0.080820	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	112,509	185,102	0.607822	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,361,588	13,563,025	0.247849	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	4,573,172	3,040,848	1.503913	88.00
88.01	08801	RURAL HEALTH CLINIC II	591,124	518,488	1.140092	88.01
88.02	08803	RURAL HEALTH CLINIC III	315,180	345,826	0.911383	88.02
88.03	08802	RURAL HEALTH CLINIC IV	472,877	487,915	0.969179	88.03
90.00	09000	CLINIC	1,386,986	1,125,916	1.231873	90.00
90.01	09001	PAIN MANAGEMENT	0	0	0.000000	90.01
90.02	09002	WOUND CARE	483,605	1,960,736	0.246645	90.02
90.03	09003	OUTPATIENT CLINIC	72,752	360,893	0.201589	90.03
91.00	09100	EMERGENCY	3,383,176	7,422,819	0.455780	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	741,410	656,968	1.128533	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	1,776,974	3,526,364	0.503911	95.00
101.00	10100	HOME HEALTH AGENCY	984,282	2,594,762	0.379334	101.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE				113.00
116.00	11600	HOSPICE	0	0	0.000000	116.00
200.00		Subtotal (sum of lines 50 thru 199)	29,375,360	88,959,199		200.00
201.00		Less Observation Beds	741,410	0		201.00
202.00		Total (line 200 minus line 201)	28,633,950	88,959,199		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-1322 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part II Date/Time Prepared: 5/29/2019 10:24 am

Title XVIII | Hospital | Cost

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	572,501	6,401,113	0.089438	416,628	37,262	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	136,834	732,322	0.186850	234	44	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	328,349	19,209,494	0.017093	782,689	13,379	54.00
60.00	06000	LABORATORY	166,419	14,193,188	0.011725	792,874	9,296	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	1,992	430,445	0.004628	48,474	224	62.00
65.00	06500	RESPIRATORY THERAPY	193,586	3,432,588	0.056397	668,120	37,680	65.00
66.00	06600	PHYSICAL THERAPY	99,916	2,733,854	0.036548	206,509	7,547	66.00
67.00	06700	OCCUPATIONAL THERAPY	40,175	1,111,240	0.036153	101,968	3,686	67.00
68.00	06800	SPEECH PATHOLOGY	22,184	375,284	0.059113	39,405	2,329	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	5,616	4,550,009	0.001234	703,373	868	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1,717	185,102	0.009276	905	8	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	113,368	13,563,025	0.008359	2,015,965	16,851	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	72,682	3,040,848	0.023902	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	9,395	518,488	0.018120	0	0	88.01
88.02	08803	RURAL HEALTH CLINIC III	5,037	345,826	0.014565	0	0	88.02
88.03	08802	RURAL HEALTH CLINIC IV	7,619	487,915	0.015615	0	0	88.03
90.00	09000	CLINIC	242,520	1,125,916	0.215398	110,953	23,899	90.00
90.01	09001	PAIN MANAGEMENT	0	0	0.000000	0	0	90.01
90.02	09002	WOUND CARE	72,856	1,960,736	0.037157	0	0	90.02
90.03	09003	OUTPATIENT CLINIC	1,110	360,893	0.003076	0	0	90.03
91.00	09100	EMERGENCY	342,962	7,422,819	0.046204	46,916	2,168	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	133,177	656,968	0.202715	1,087	220	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	2,570,015	82,838,073		5,936,100	155,461	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1322 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part IV | Date/Time Prepared: 5/29/2019 10:24 am

Title XVIII | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
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
88.02	08803	RURAL HEALTH CLINIC III	0	0	0	0	0	88.02
88.03	08802	RURAL HEALTH CLINIC IV	0	0	0	0	0	88.03
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	PAIN MANAGEMENT	0	0	0	0	0	90.01
90.02	09002	WOUND CARE	0	0	0	0	0	90.02
90.03	09003	OUTPATIENT CLINIC	0	0	0	0	0	90.03
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: 15-1322 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part IV | Date/Time Prepared: 5/29/2019 10:24 am

Title XVIII | Hospital | Cost

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	6,401,113	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	732,322	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	19,209,494	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	14,193,188	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	430,445	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	3,432,588	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	2,733,854	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,111,240	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	375,284	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	4,550,009	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	185,102	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	13,563,025	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	3,040,848	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	518,488	0.000000	88.01
88.02	08803	RURAL HEALTH CLINIC III	0	0	0	345,826	0.000000	88.02
88.03	08802	RURAL HEALTH CLINIC IV	0	0	0	487,915	0.000000	88.03
90.00	09000	CLINIC	0	0	0	1,125,916	0.000000	90.00
90.01	09001	PAIN MANAGEMENT	0	0	0	0	0.000000	90.01
90.02	09002	WOUND CARE	0	0	0	1,960,736	0.000000	90.02
90.03	09003	OUTPATIENT CLINIC	0	0	0	360,893	0.000000	90.03
91.00	09100	EMERGENCY	0	0	0	7,422,819	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	656,968	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	82,838,073		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1322 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part IV | Date/Time Prepared: 5/29/2019 10:24 am

Title XVIII | Hospital | Cost

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	416,628	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	234	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	782,689	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	792,874	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	48,474	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.000000	668,120	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	206,509	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	101,968	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	39,405	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	703,373	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000	905	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	2,015,965	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
88.02	08803	RURAL HEALTH CLINIC III	0.000000	0	0	0	0	88.02
88.03	08802	RURAL HEALTH CLINIC IV	0.000000	0	0	0	0	88.03
90.00	09000	CLINIC	0.000000	110,953	0	0	0	90.00
90.01	09001	PAIN MANAGEMENT	0.000000	0	0	0	0	90.01
90.02	09002	WOUND CARE	0.000000	0	0	0	0	90.02
90.03	09003	OUTPATIENT CLINIC	0.000000	0	0	0	0	90.03
91.00	09100	EMERGENCY	0.000000	46,916	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	1,087	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)		5,936,100	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1322 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part V Date/Time Prepared: 5/29/2019 10:24 am

Title XVIII | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs	
				PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.319370	0	1,425,284	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.440723	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.144721	0	6,219,313	0	0	54.00
60.00	06000	LABORATORY	0.202557	0	3,182,884	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.303165	0	200,709	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.357095	0	804,301	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.348896	0	897,487	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.236274	0	228,286	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.419176	0	46,060	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.080820	0	772,734	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.607822	0	105,460	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.247849	0	4,826,642	10,170	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
88.02	08803	RURAL HEALTH CLINIC III	0.000000				0	88.02
88.03	08802	RURAL HEALTH CLINIC IV	0.000000				0	88.03
90.00	09000	CLINIC	1.231873	0	426,036	1,806	0	90.00
90.01	09001	PAIN MANAGEMENT	0.000000	0	0	0	0	90.01
90.02	09002	WOUND CARE	0.246645	0	1,081,088	0	0	90.02
90.03	09003	OUTPATIENT CLINIC	0.201589	0	0	0	0	90.03
91.00	09100	EMERGENCY	0.455780	0	2,052,566	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.128533	0	292,596	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.503911		0			95.00
200.00		Subtotal (see instructions)		0	22,561,446	11,976	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	22,561,446	11,976	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1322 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part V Date/Time Prepared: 5/29/2019 10:24 am

Title XVIII | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
			6.00	7.00	
	ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	455,193	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	900,065	0	54.00
60.00	06000	LABORATORY	644,715	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	60,848	0	62.00
65.00	06500	RESPIRATORY THERAPY	287,212	0	65.00
66.00	06600	PHYSICAL THERAPY	313,130	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	53,938	0	67.00
68.00	06800	SPEECH PATHOLOGY	19,307	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	62,452	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	64,101	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,196,278	2,521	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
88.02	08803	RURAL HEALTH CLINIC III	0	0	88.02
88.03	08802	RURAL HEALTH CLINIC IV	0	0	88.03
90.00	09000	CLINIC	524,822	2,225	90.00
90.01	09001	PAIN MANAGEMENT	0	0	90.01
90.02	09002	WOUND CARE	266,645	0	90.02
90.03	09003	OUTPATIENT CLINIC	0	0	90.03
91.00	09100	EMERGENCY	935,519	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	330,204	0	92.00
	OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0		95.00
200.00		Subtotal (see instructions)	6,114,429	4,746	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	6,114,429	4,746	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-1322 | Component CCN: 15-Z322 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part V | Date/Time Prepared: 5/29/2019 10:24 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.319370	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.440723	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.144721	0	0	0	0	54.00
60.00	06000	LABORATORY	0.202557	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.303165	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.357095	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.348896	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.236274	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.419176	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.080820	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.607822	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.247849	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
88.02	08803	RURAL HEALTH CLINIC III	0.000000				0	88.02
88.03	08802	RURAL HEALTH CLINIC IV	0.000000				0	88.03
90.00	09000	CLINIC	1.231873	0	0	0	0	90.00
90.01	09001	PAIN MANAGEMENT	0.000000	0	0	0	0	90.01
90.02	09002	WOUND CARE	0.246645	0	0	0	0	90.02
90.03	09003	OUTPATIENT CLINIC	0.201589	0	0	0	0	90.03
91.00	09100	EMERGENCY	0.455780	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.128533	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.503911		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: 15-1322 | Component CCN: 15-Z322 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part V | Date/Time Prepared: 5/29/2019 10:24 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Costs		
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
			6.00	7.00	
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
60.00	06000	LABORATORY	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
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
88.02	08803	RURAL HEALTH CLINIC III	0	0	88.02
88.03	08802	RURAL HEALTH CLINIC IV	0	0	88.03
90.00	09000	CLINIC	0	0	90.00
90.01	09001	PAIN MANAGEMENT	0	0	90.01
90.02	09002	WOUND CARE	0	0	90.02
90.03	09003	OUTPATIENT CLINIC	0	0	90.03
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 CAPITAL COSTS | Provider CCN: 15-1322 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part I Date/Time Prepared: 5/29/2019 10:24 am

Title XIX | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	898,429	140,344	758,085	2,744	276.27	30.00
31.00	INTENSIVE CARE UNIT	159,310		159,310	141	1,129.86	31.00
43.00	NURSERY	32,483		32,483	166	195.68	43.00
200.00	Total (lines 30 through 199)	1,090,222		949,878	3,051		200.00

	Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)	
		6.00	7.00	
	INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	ADULTS & PEDIATRICS	60	16,576	30.00
31.00	INTENSIVE CARE UNIT	7	7,909	31.00
43.00	NURSERY	18	3,522	43.00
200.00	Total (lines 30 through 199)	85	28,007	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-1322 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part II Date/Time Prepared: 5/29/2019 10:24 am

Title XIX | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	572,501	6,401,113	0.089438	184,013	16,458	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	136,834	732,322	0.186850	115,007	21,489	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	328,349	19,209,494	0.017093	127,586	2,181	54.00
60.00	06000	LABORATORY	166,419	14,193,188	0.011725	245,607	2,880	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	1,992	430,445	0.004628	4,946	23	62.00
65.00	06500	RESPIRATORY THERAPY	193,586	3,432,588	0.056397	112,228	6,329	65.00
66.00	06600	PHYSICAL THERAPY	99,916	2,733,854	0.036548	7,736	283	66.00
67.00	06700	OCCUPATIONAL THERAPY	40,175	1,111,240	0.036153	1,882	68	67.00
68.00	06800	SPEECH PATHOLOGY	22,184	375,284	0.059113	2,770	164	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	5,616	4,550,009	0.001234	162,699	201	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1,717	185,102	0.009276	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	113,368	13,563,025	0.008359	341,286	2,853	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	72,682	3,040,848	0.023902	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	9,395	518,488	0.018120	0	0	88.01
88.02	08803	RURAL HEALTH CLINIC III	5,037	345,826	0.014565	0	0	88.02
88.03	08802	RURAL HEALTH CLINIC IV	7,619	487,915	0.015615	0	0	88.03
90.00	09000	CLINIC	242,520	1,125,916	0.215398	36,100	7,776	90.00
90.01	09001	PAIN MANAGEMENT	0	0	0.000000	0	0	90.01
90.02	09002	WOUND CARE	72,856	1,960,736	0.037157	0	0	90.02
90.03	09003	OUTPATIENT CLINIC	1,110	360,893	0.003076	0	0	90.03
91.00	09100	EMERGENCY	342,962	7,422,819	0.046204	108,491	5,013	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	133,438	656,968	0.203112	7,516	1,527	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	2,570,276	82,838,073		1,457,867	67,245	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1322 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part III | Date/Time Prepared: 5/29/2019 10:24 am

Title XIX | Hospital | PPS

		Cost Center Description	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
			1A	1.00	2A	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
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	2,744	0.00	60	30.00
31.00	03100	INTENSIVE CARE UNIT		0	141	0.00	7	31.00
43.00	04300	NURSERY		0	166	0.00	18	43.00
200.00		Total (lines 30 through 199)		0	3,051		85	200.00

		Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
			9.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	31.00
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: 15-1322 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part IV | Date/Time Prepared: 5/29/2019 10:24 am

Title XIX | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
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
88.02	08803	RURAL HEALTH CLINIC III	0	0	0	0	0	88.02
88.03	08802	RURAL HEALTH CLINIC IV	0	0	0	0	0	88.03
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	PAIN MANAGEMENT	0	0	0	0	0	90.01
90.02	09002	WOUND CARE	0	0	0	0	0	90.02
90.03	09003	OUTPATIENT CLINIC	0	0	0	0	0	90.03
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: 15-1322 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part IV Date/Time Prepared: 5/29/2019 10:24 am

Title XIX | Hospital | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	6,401,113	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	732,322	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	19,209,494	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	14,193,188	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	430,445	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	3,432,588	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	2,733,854	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,111,240	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	375,284	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	4,550,009	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	185,102	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	13,563,025	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	3,040,848	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	518,488	0.000000	88.01
88.02	08803	RURAL HEALTH CLINIC III	0	0	0	345,826	0.000000	88.02
88.03	08802	RURAL HEALTH CLINIC IV	0	0	0	487,915	0.000000	88.03
90.00	09000	CLINIC	0	0	0	1,125,916	0.000000	90.00
90.01	09001	PAIN MANAGEMENT	0	0	0	0	0.000000	90.01
90.02	09002	WOUND CARE	0	0	0	1,960,736	0.000000	90.02
90.03	09003	OUTPATIENT CLINIC	0	0	0	360,893	0.000000	90.03
91.00	09100	EMERGENCY	0	0	0	7,422,819	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	656,968	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	82,838,073		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1322 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part IV | Date/Time Prepared: 5/29/2019 10:24 am

Title XIX | Hospital | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	184,013	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	115,007	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	127,586	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	245,607	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	4,946	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.000000	112,228	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	7,736	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	1,882	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	2,770	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	162,699	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	341,286	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
88.02	08803	RURAL HEALTH CLINIC III	0.000000	0	0	0	0	88.02
88.03	08802	RURAL HEALTH CLINIC IV	0.000000	0	0	0	0	88.03
90.00	09000	CLINIC	0.000000	36,100	0	0	0	90.00
90.01	09001	PAIN MANAGEMENT	0.000000	0	0	0	0	90.01
90.02	09002	WOUND CARE	0.000000	0	0	0	0	90.02
90.03	09003	OUTPATIENT CLINIC	0.000000	0	0	0	0	90.03
91.00	09100	EMERGENCY	0.000000	108,491	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	7,516	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)		1,457,867	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1322 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part V Date/Time Prepared: 5/29/2019 10:24 am

Title XIX | Hospital | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.319370	0	674,441	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.440723	0	853	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.144721	0	2,076,384	0	0	54.00
60.00	06000	LABORATORY	0.202557	0	1,503,562	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.303165	0	26,179	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.357095	0	245,053	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.348896	0	236,645	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.236274	0	104,990	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.419176	0	34,473	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.080820	0	384,290	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.607822	0	4,366	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.247849	0	694,575	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1.503913				0	88.00
88.01	08801	RURAL HEALTH CLINIC II	1.140092				0	88.01
88.02	08803	RURAL HEALTH CLINIC III	0.911383				0	88.02
88.03	08802	RURAL HEALTH CLINIC IV	0.969179				0	88.03
90.00	09000	CLINIC	1.231873	0	63,842	0	0	90.00
90.01	09001	PAIN MANAGEMENT	0.000000	0	0	0	0	90.01
90.02	09002	WOUND CARE	0.246645	0	83,882	0	0	90.02
90.03	09003	OUTPATIENT CLINIC	0.201589	0	0	0	0	90.03
91.00	09100	EMERGENCY	0.455780	0	1,217,722	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.128533	0	86,952	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.503911	0	191,371			95.00
200.00		Subtotal (see instructions)		0	7,629,580	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	7,629,580	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1322 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part V Date/Time Prepared: 5/29/2019 10:24 am

Title XIX | Hospital | PPS

		Cost Center Description	Costs		
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
			6.00	7.00	
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	215,396	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	376	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	300,496	0	54.00
60.00	06000	LABORATORY	304,557	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	7,937	0	62.00
65.00	06500	RESPIRATORY THERAPY	87,507	0	65.00
66.00	06600	PHYSICAL THERAPY	82,564	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	24,806	0	67.00
68.00	06800	SPEECH PATHOLOGY	14,450	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	31,058	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	2,654	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	172,150	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
88.02	08803	RURAL HEALTH CLINIC III	0	0	88.02
88.03	08802	RURAL HEALTH CLINIC IV	0	0	88.03
90.00	09000	CLINIC	78,645	0	90.00
90.01	09001	PAIN MANAGEMENT	0	0	90.01
90.02	09002	WOUND CARE	20,689	0	90.02
90.03	09003	OUTPATIENT CLINIC	0	0	90.03
91.00	09100	EMERGENCY	555,013	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	98,128	0	92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	96,434		95.00
200.00		Subtotal (see instructions)	2,092,860	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	2,092,860	0	202.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-1322	Period: From 01/01/2018 To 12/31/2018	Worksheet D-1 Date/Time Prepared: 5/29/2019 10:24 am
	Title XVIII	Hospital	Cost

	Cost Center Description		
		1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	3,320	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,744	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	2,261	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	508	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	63	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	1,397	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)	508	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	155.02	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	155.02	20.00
21.00	Total general inpatient routine service cost (see instructions)	5,001,624	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)	9,766	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	789,551	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	4,212,073	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)	4,212,073	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)	1,535.01	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	2,144,409	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	2,144,409	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1322 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-1 | Date/Time Prepared: 5/29/2019 10:24 am

Title XVIII | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	959,828	141	6,807.29	65	442,474	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	1,489,315	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	4,076,198	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)	779,785	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)	779,785	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)	483	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,535.01	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	741,410	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1322 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-1 | Date/Time Prepared: 5/29/2019 10:24 am

		Title XVIII		Hospital	Cost	
	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	898,429	5,001,624	0.179627	741,410	133,177	90.00
91.00	Nursing School cost	0	5,001,624	0.000000	741,410	0	91.00
92.00	Allied health cost	0	5,001,624	0.000000	741,410	0	92.00
93.00	All other Medical Education	0	5,001,624	0.000000	741,410	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1322 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-1 | Date/Time Prepared: 5/29/2019 10:24 am

Title XIX | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	3,320	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,744	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	2,261	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	508	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	68	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	60	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	68	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)	166	15.00
16.00	Nursery days (title V or XIX only)	18	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	5,001,624	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	781,309	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	4,220,315	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)	4,220,315	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)	1,538.02	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	92,281	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)	92,281	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1322 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-1 | Date/Time Prepared: 5/29/2019 10:24 am

Title XIX | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	128,698	166	775.29	18	13,955	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	959,828	141	6,807.29	7	47,651	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)	423,684	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	577,571	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)	28,007	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	67,245	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	95,252	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	482,319	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)	483	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,538.02	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	742,864	89.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-1322	Period: From 01/01/2018 To 12/31/2018	Worksheet D-1 Date/Time Prepared: 5/29/2019 10:24 am
	Title XIX	Hospital	PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	898,429	5,001,624	0.179627	742,864	133,438	90.00
91.00	Nursing School cost	0	5,001,624	0.000000	742,864	0	91.00
92.00	Allied health cost	0	5,001,624	0.000000	742,864	0	92.00
93.00	All other Medical Education	0	5,001,624	0.000000	742,864	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1322 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-3 | Date/Time Prepared: 5/29/2019 10:24 am

Title XVIII | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
	INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		1,622,753		30.00
31.00	03100	INTENSIVE CARE UNIT		140,344		31.00
43.00	04300	NURSERY				43.00
	ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.319370	416,628	133,058	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.440723	234	103	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.144721	782,689	113,272	54.00
60.00	06000	LABORATORY	0.202557	792,874	160,602	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.303165	48,474	14,696	62.00
65.00	06500	RESPIRATORY THERAPY	0.357095	668,120	238,582	65.00
66.00	06600	PHYSICAL THERAPY	0.348896	206,509	72,050	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.236274	101,968	24,092	67.00
68.00	06800	SPEECH PATHOLOGY	0.419176	39,405	16,518	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.080820	703,373	56,847	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.607822	905	550	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.247849	2,015,965	499,655	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
88.02	08803	RURAL HEALTH CLINIC III	0.000000		0	88.02
88.03	08802	RURAL HEALTH CLINIC IV	0.000000		0	88.03
90.00	09000	CLINIC	1.231873	110,953	136,680	90.00
90.01	09001	PAIN MANAGEMENT	0.000000	0	0	90.01
90.02	09002	WOUND CARE	0.246645	0	0	90.02
90.03	09003	OUTPATIENT CLINIC	0.201589	0	0	90.03
91.00	09100	EMERGENCY	0.455780	46,916	21,383	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.128533	1,087	1,227	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)		5,936,100	1,489,315	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)		5,936,100		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-1322 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-3

Component CCN: 15-Z322 | Date/Time Prepared: 5/29/2019 10:24 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.319370	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.440723	17	7	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.144721	27,815	4,025	54.00
60.00	06000	LABORATORY	0.202557	54,057	10,950	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.303165	3,269	991	62.00
65.00	06500	RESPIRATORY THERAPY	0.357095	56,689	20,243	65.00
66.00	06600	PHYSICAL THERAPY	0.348896	158,801	55,405	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.236274	152,349	35,996	67.00
68.00	06800	SPEECH PATHOLOGY	0.419176	27,287	11,438	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.080820	66,745	5,394	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.607822	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.247849	230,568	57,146	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
88.02	08803	RURAL HEALTH CLINIC III	0.000000		0	88.02
88.03	08802	RURAL HEALTH CLINIC IV	0.000000		0	88.03
90.00	09000	CLINIC	1.231873	7,282	8,970	90.00
90.01	09001	PAIN MANAGEMENT	0.000000	0	0	90.01
90.02	09002	WOUND CARE	0.246645	0	0	90.02
90.03	09003	OUTPATIENT CLINIC	0.201589	0	0	90.03
91.00	09100	EMERGENCY	0.455780	49	22	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.128533	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)		784,928	210,587	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)		784,928		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1322 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-3 | Date/Time Prepared: 5/29/2019 10:24 am

Title XIX | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		213,650		30.00
31.00	03100	INTENSIVE CARE UNIT		56,828		31.00
43.00	04300	NURSERY		15,480		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.319370	184,013	58,768	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.440723	115,007	50,686	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.144721	127,586	18,464	54.00
60.00	06000	LABORATORY	0.202557	245,607	49,749	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.303165	4,946	1,499	62.00
65.00	06500	RESPIRATORY THERAPY	0.357095	112,228	40,076	65.00
66.00	06600	PHYSICAL THERAPY	0.348896	7,736	2,699	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.236274	1,882	445	67.00
68.00	06800	SPEECH PATHOLOGY	0.419176	2,770	1,161	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.080820	162,699	13,149	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.607822	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.247849	341,286	84,587	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	1.503913	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	1.140092	0	0	88.01
88.02	08803	RURAL HEALTH CLINIC III	0.911383	0	0	88.02
88.03	08802	RURAL HEALTH CLINIC IV	0.969179	0	0	88.03
90.00	09000	CLINIC	1.231873	36,100	44,471	90.00
90.01	09001	PAIN MANAGEMENT	0.000000	0	0	90.01
90.02	09002	WOUND CARE	0.246645	0	0	90.02
90.03	09003	OUTPATIENT CLINIC	0.201589	0	0	90.03
91.00	09100	EMERGENCY	0.455780	108,491	49,448	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.128533	7,516	8,482	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)		1,457,867	423,684	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		1,457,867		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-1322 | Period: From 01/01/2018 To 12/31/2018 | Worksheet E Part B | Date/Time Prepared: 5/29/2019 10:24 am

Title XVIII | Hospital | Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	6,119,175	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)	6,119,175	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)	6,180,367	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	0	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)	65,197	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	3,842,349	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	2,272,821	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	2,272,821	30.00
31.00	Primary payer payments	214	31.00
32.00	Subtotal (line 30 minus line 31)	2,272,607	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)	497,511	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	323,382	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	364,293	36.00
37.00	Subtotal (see instructions)	2,595,989	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)	2,595,989	40.00
40.01	Sequestration adjustment (see instructions)	51,920	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
41.00	Interim payments	3,393,181	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	-849,112	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: 15-1322 | Period: From 01/01/2018 To 12/31/2018 | Worksheet E-1 Part I Date/Time Prepared: 5/29/2019 10:24 am

Title XVIII | Hospital | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		3,343,906		3,153,481	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	11/12/2018	48,000	11/12/2018	203,000	3.01
3.02		08/13/2018	274,500	08/13/2018	36,700	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)		322,500		239,700	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)		3,666,406		3,393,181	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		21,421		849,112	6.02
7.00	Total Medicare program liability (see instructions)		3,644,985		2,544,069	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: 15-1322 Component CCN: 15-Z322	Period: From 01/01/2018 To 12/31/2018	Worksheet E-1 Part I Date/Time Prepared: 5/29/2019 10:24 am
	Title XVIII	Swing Beds - SNF	Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		959,244		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)		959,244		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		11,669		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		970,913		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: 15-1322	Period: From 01/01/2018 To 12/31/2018	Worksheet E-1 Part II Date/Time Prepared: 5/29/2019 10:24 am
	Title XVIII	Hospital	Cost

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

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS	Provider CCN: 15-1322 Component CCN: 15-Z322	Period: From 01/01/2018 To 12/31/2018	Worksheet E-2 Date/Time Prepared: 5/29/2019 10:24 am
	Title XVIII	Swing Beds - SNF	Cost

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	787,583	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)	212,693	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	508	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)		0	6.00
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	1,000,276	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	1,000,276	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0	0	11.00
12.00	Subtotal (line 10 minus line 11)	1,000,276	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	9,548	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)	990,728	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)			16.50
16.55	Rural community hospital demonstration project (§410A Demonstration) payment adjustment (see instructions)	0		16.55
16.99	Demonstration payment adjustment amount before sequestration	0	0	16.99
17.00	Allowable bad debts (see instructions)	0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (see instructions)	990,728	0	19.00
19.01	Sequestration adjustment (see instructions)	19,815	0	19.01
19.02	Demonstration payment adjustment amount after sequestration)	0	0	19.02
20.00	Interim payments	959,244	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)	11,669	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: 15-1322	Period: From 01/01/2018 To 12/31/2018	Worksheet E-3 Part V Date/Time Prepared: 5/29/2019 10:24 am
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	4,076,198	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)	4,076,198	4.00
5.00	Primary payer payments	8,825	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	4,108,135	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)	4,108,135	19.00
20.00	Deductibles (exclude professional component)	414,003	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	3,694,132	22.00
23.00	Coinsurance	2,345	23.00
24.00	Subtotal (line 22 minus line 23)	3,691,787	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	42,439	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	27,585	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	23,227	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	3,719,372	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)	3,719,372	30.00
30.01	Sequestration adjustment (see instructions)	74,387	30.01
30.02	Demonstration payment adjustment amount after sequestration	0	30.02
31.00	Interim payments	3,666,406	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)	-21,421	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	34.00

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

Provider CCN: 15-1322 | Period: From 01/01/2018 To 12/31/2018 | Worksheet G | Date/Time Prepared: 5/29/2019 10:24 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	5,262,629	0	0	0	1.00
2.00	Temporary investments	2,914,478	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	10,989,956	0	0	0	4.00
5.00	Other receivable	405,963	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-6,894,256	0	0	0	6.00
7.00	Inventory	789,771	0	0	0	7.00
8.00	Prepaid expenses	380,954	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	1,820,000	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	15,669,495	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	2,755,753	0	0	0	12.00
13.00	Land improvements	73,301	0	0	0	13.00
14.00	Accumulated depreciation	-15,041	0	0	0	14.00
15.00	Buildings	3,275,626	0	0	0	15.00
16.00	Accumulated depreciation	-2,459,632	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	171,558	0	0	0	19.00
20.00	Accumulated depreciation	-165,062	0	0	0	20.00
21.00	Automobiles and trucks	477,834	0	0	0	21.00
22.00	Accumulated depreciation	-236,098	0	0	0	22.00
23.00	Major movable equipment	10,689,664	0	0	0	23.00
24.00	Accumulated depreciation	-8,647,891	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)	5,920,012	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	0	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	0	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	21,589,507	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	1,177,824	0	0	0	37.00
38.00	Salaries, wages, and fees payable	0	0	0	0	38.00
39.00	Payroll taxes payable	744,692	0	0	0	39.00
40.00	Notes and loans payable (short term)	252,298	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	1,720,191	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	3,895,005	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	0	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	3,895,005	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	17,694,502				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	17,694,502	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	21,589,507	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 15-1322 | Period: From 01/01/2018 To 12/31/2018 | Worksheet G-1 | Date/Time Prepared: 5/29/2019 10:24 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		17,280,500		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		414,002				2.00
3.00	Total (sum of line 1 and line 2)		17,694,502		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		17,694,502		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		17,694,502		0		19.00

		Endowment Fund	Plant Fund		
		6.00	7.00	8.00	
1.00	Fund balances at beginning of period	0		0	1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)				2.00
3.00	Total (sum of line 1 and line 2)	0		0	3.00
4.00	Additions (credit adjustments) (specify)		0		4.00
5.00			0		5.00
6.00			0		6.00
7.00			0		7.00
8.00			0		8.00
9.00			0		9.00
10.00	Total additions (sum of line 4-9)	0		0	10.00
11.00	Subtotal (line 3 plus line 10)	0		0	11.00
12.00	Deductions (debit adjustments) (specify)		0		12.00
13.00			0		13.00
14.00			0		14.00
15.00			0		15.00
16.00			0		16.00
17.00			0		17.00
18.00	Total deductions (sum of lines 12-17)	0		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0	19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 15-1322 | Period: From 01/01/2018 To 12/31/2018 | Worksheet G-2 Parts I & II Date/Time Prepared: 5/29/2019 10:24 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	2,831,202		2,831,202	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	2,831,202		2,831,202	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	362,865		362,865	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)	362,865		362,865	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	3,194,067		3,194,067	17.00
18.00	Ancillary services	12,737,863	66,967,751	79,705,614	18.00
19.00	Outpatient services	0	0	0	19.00
20.00	RURAL HEALTH CLINIC	0	3,040,848	3,040,848	20.00
20.01	RURAL HEALTH CLINIC II	0	518,488	518,488	20.01
20.02	RURAL HEALTH CLINIC III	0	345,826	345,826	20.02
20.03	RURAL HEALTH CLINIC IV	0	487,915	487,915	20.03
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		2,594,762	2,594,762	22.00
23.00	AMBULANCE SERVICES	0	3,526,364	3,526,364	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE	0	0	0	26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	15,931,930	77,481,954	93,413,884	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		38,715,896		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)		38,715,896		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 15-1322	Period: From 01/01/2018 To 12/31/2018	Worksheet G-3 Date/Time Prepared: 5/29/2019 10:24 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	93,413,884	1.00
2.00	Less contractual allowances and discounts on patients' accounts	56,259,315	2.00
3.00	Net patient revenues (line 1 minus line 2)	37,154,569	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	38,715,896	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-1,561,327	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	330,752	6.00
7.00	Income from investments	75,993	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	66,551	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	102,147	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	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	29,016	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER OPERATING INCOME	1,370,870	24.00
25.00	Total other income (sum of lines 6-24)	1,975,329	25.00
26.00	Total (line 5 plus line 25)	414,002	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)	414,002	29.00

ANALYSIS OF HOSPITAL-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 15-1322 | HHA CCN: 15-7177 | Period: From 01/01/2018 To 12/31/2018 | Worksheet H | Date/Time Prepared: 5/29/2019 10:24 am

Home Health Agency I | PPS

		Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased Services	Other Costs	Total (sum of cols. 1 thru 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures			0		0	0	1.00
2.00	Capital Related - Movable Equipment			0		0	0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0	0	0	3.00
4.00	Transportation	0	0	0	0	0	0	4.00
5.00	Administrative and General	100,777	142,899	0	68,693	98,188	410,557	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	208,461	0	0	0	0	208,461	6.00
7.00	Physical Therapy	0	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	0	8.00
9.00	Speech Pathology	0	0	0	0	0	0	9.00
10.00	Medical Social Services	90,173	0	0	0	0	90,173	10.00
11.00	Home Health Aide	55,186	0	0	0	0	55,186	11.00
12.00	Supplies (see instructions)	0	0	0	0	7,955	7,955	12.00
13.00	Drugs	0	0	0	0	160	160	13.00
14.00	DME	0	0	0	0	1,407	1,407	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	454,597	142,899	0	68,693	107,710	773,899	24.00

		Reclassification	Reclassified Trial Balance (col. 6 + col.7)	Adjustments	Net Expenses for Allocation (col. 8 + col. 9)	
		7.00	8.00	9.00	10.00	
	GENERAL SERVICE COST CENTERS					
1.00	Capital Related - Bldg. & Fixtures	0	0	0	0	1.00
2.00	Capital Related - Movable Equipment	0	0	0	0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0	3.00
4.00	Transportation	0	0	0	0	4.00
5.00	Administrative and General	-111,964	298,593	454	299,047	5.00
	HHA REIMBURSABLE SERVICES					
6.00	Skilled Nursing Care	0	208,461	0	208,461	6.00
7.00	Physical Therapy	112,331	112,331	0	112,331	7.00
8.00	Occupational Therapy	78,687	78,687	0	78,687	8.00
9.00	Speech Pathology	11,092	11,092	0	11,092	9.00
10.00	Medical Social Services	-90,146	27	0	27	10.00
11.00	Home Health Aide	0	55,186	0	55,186	11.00
12.00	Supplies (see instructions)	0	7,955	0	7,955	12.00
13.00	Drugs	0	160	0	160	13.00
14.00	DME	0	1,407	0	1,407	14.00
	HHA NONREIMBURSABLE SERVICES					
15.00	Home Dialysis Aide Services	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	0	773,899	454	774,353	24.00

Column, 6 line 24 should agree with the Worksheet A, column 3, line 101, or subscript as applicable.

COST ALLOCATION - HHA GENERAL SERVICE COST

Provider CCN: 15-1322 | HHA CCN: 15-7177 | Period: From 01/01/2018 To 12/31/2018 | Worksheet H-1 Part I | Date/Time Prepared: 5/29/2019 10:24 am

Home Health Agency I | PPS

		Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Capital Related Costs		Plant Operation & Maintenance	Transportation	Subtotal (cols. 0-4)	
			Bldgs & Fixtures	Movable Equipment				
		0	1.00	2.00	3.00	4.00	4A.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0				0	1.00
2.00	Capital Related - Movable Equipment	0		0			0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0		0	3.00
4.00	Transportation	0	0	0	0	0		4.00
5.00	Administrative and General	299,047	0	0	0	0	299,047	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	208,461	0	0	0	0	208,461	6.00
7.00	Physical Therapy	112,331	0	0	0	0	112,331	7.00
8.00	Occupational Therapy	78,687	0	0	0	0	78,687	8.00
9.00	Speech Pathology	11,092	0	0	0	0	11,092	9.00
10.00	Medical Social Services	27	0	0	0	0	27	10.00
11.00	Home Health Aide	55,186	0	0	0	0	55,186	11.00
12.00	Supplies (see instructions)	7,955	0	0	0	0	7,955	12.00
13.00	Drugs	160	0	0	0		160	13.00
14.00	DME	1,407	0	0	0	0	1,407	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	774,353	0	0	0	0	774,353	24.00

		Administrative & General	Total (cols. 4A + 5)	
		5.00	6.00	
	GENERAL SERVICE COST CENTERS			
1.00	Capital Related - Bldg. & Fixtures			1.00
2.00	Capital Related - Movable Equipment			2.00
3.00	Plant Operation & Maintenance			3.00
4.00	Transportation			4.00
5.00	Administrative and General	299,047		5.00
	HHA REIMBURSABLE SERVICES			
6.00	Skilled Nursing Care	131,157	339,618	6.00
7.00	Physical Therapy	70,675	183,006	7.00
8.00	Occupational Therapy	49,507	128,194	8.00
9.00	Speech Pathology	6,979	18,071	9.00
10.00	Medical Social Services	17	44	10.00
11.00	Home Health Aide	34,721	89,907	11.00
12.00	Supplies (see instructions)	5,005	12,960	12.00
13.00	Drugs	101	261	13.00
14.00	DME	885	2,292	14.00
	HHA NONREIMBURSABLE SERVICES			
15.00	Home Dialysis Aide Services	0	0	15.00
16.00	Respiratory Therapy	0	0	16.00
17.00	Private Duty Nursing	0	0	17.00
18.00	Clinic	0	0	18.00
19.00	Health Promotion Activities	0	0	19.00
20.00	Day Care Program	0	0	20.00
21.00	Home Delivered Meals Program	0	0	21.00
22.00	Homemaker Service	0	0	22.00
23.00	All Others (specify)	0	0	23.00
23.50	Telemedicine	0	0	23.50
24.00	Total (sum of lines 1-23)		774,353	24.00

COST ALLOCATION - HHA STATISTICAL BASIS

Provider CCN: 15-1322 | HHA CCN: 15-7177 | Period: From 01/01/2018 To 12/31/2018 | Worksheet H-1 Part II | Date/Time Prepared: 5/29/2019 10:24 am

Home Health Agency I | PPS

		Capital Related Costs						
		Bldgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)	Plant Operation & Maintenance (SQUARE FEET)	Transportation (MILEAGE)	Reconciliation	Administrative & General (ACCUM. COST)	
		1.00	2.00	3.00	4.00	5A.00	5.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0				0		1.00
2.00	Capital Related - Movable Equipment		0			0		2.00
3.00	Plant Operation & Maintenance	0	0	0		0		3.00
4.00	Transportation (see instructions)	0	0	0	0			4.00
5.00	Administrative and General	0	0	0	0	-299,047	475,306	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	0	208,461	6.00
7.00	Physical Therapy	0	0	0	0	0	112,331	7.00
8.00	Occupational Therapy	0	0	0	0	0	78,687	8.00
9.00	Speech Pathology	0	0	0	0	0	11,092	9.00
10.00	Medical Social Services	0	0	0	0	0	27	10.00
11.00	Home Health Aide	0	0	0	0	0	55,186	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	7,955	12.00
13.00	Drugs	0	0	0		0	160	13.00
14.00	DME	0	0	0	0	0	1,407	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	0	0	0	0	-299,047	475,306	24.00
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0	0		299,047	25.00
26.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000		0.629167	26.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 15-1322 | HHA CCN: 15-7177

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

Worksheet H-2 Part I

Date/Time Prepared: 5/29/2019 10:24 am

Home Health Agency I | PPS

	Cost Center Description	HHA Trial Balance (1)	CAPITAL RELATED COSTS NEW BLDG & FIXT	NEW MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE AND GENERAL	
		0	1.00	2.00	4.00	4A	5.01	
1.00	Administrative and General	0	12,564	5,889	0	18,453	1,399	1.00
2.00	Skilled Nursing Care	339,618	0	0	0	339,618	25,757	2.00
3.00	Physical Therapy	183,006	0	0	0	183,006	13,879	3.00
4.00	Occupational Therapy	128,194	0	0	0	128,194	9,722	4.00
5.00	Speech Pathology	18,071	0	0	0	18,071	1,370	5.00
6.00	Medical Social Services	44	0	0	0	44	3	6.00
7.00	Home Health Aide	89,907	0	0	0	89,907	6,818	7.00
8.00	Supplies (see instructions)	12,960	0	0	0	12,960	983	8.00
9.00	Drugs	261	0	0	0	261	20	9.00
10.00	DME	2,292	0	0	0	2,292	174	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	774,353	12,564	5,889	0	792,806	60,125	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.					0.000000		21.00

	Cost Center Description	Subtotal	OTHER ADMINISTRATIVE AND GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5A.01	5.02	7.00	8.00	9.00	10.00	
1.00	Administrative and General	19,852	2,580	15,342	0	5,173	0	1.00
2.00	Skilled Nursing Care	365,375	47,479	0	0	0	0	2.00
3.00	Physical Therapy	196,885	25,585	0	0	0	0	3.00
4.00	Occupational Therapy	137,916	17,922	0	0	0	0	4.00
5.00	Speech Pathology	19,441	2,526	0	0	0	0	5.00
6.00	Medical Social Services	47	6	0	0	0	0	6.00
7.00	Home Health Aide	96,725	12,569	0	0	0	0	7.00
8.00	Supplies (see instructions)	13,943	1,812	0	0	0	0	8.00
9.00	Drugs	281	37	0	0	0	0	9.00
10.00	DME	2,466	320	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	852,931	110,836	15,342	0	5,173	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.	0.000000						21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 15-1322 | HHA CCN: 15-7177

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

Worksheet H-2 Part I

Date/Time Prepared: 5/29/2019 10:24 am

Home Health Agency I | PPS

	Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	
		11.00	13.00	16.00	24.00	25.00	26.00	
1.00	Administrative and General	0	0	0	42,947	0	42,947	1.00
2.00	Skilled Nursing Care	0	0	0	412,854	0	412,854	2.00
3.00	Physical Therapy	0	0	0	222,470	0	222,470	3.00
4.00	Occupational Therapy	0	0	0	155,838	0	155,838	4.00
5.00	Speech Pathology	0	0	0	21,967	0	21,967	5.00
6.00	Medical Social Services	0	0	0	53	0	53	6.00
7.00	Home Health Aide	0	0	0	109,294	0	109,294	7.00
8.00	Supplies (see instructions)	0	0	0	15,755	0	15,755	8.00
9.00	Drugs	0	0	0	318	0	318	9.00
10.00	DME	0	0	0	2,786	0	2,786	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	0	0	0	984,282	0	984,282	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

	Cost Center Description	Allocated HHA A&G (see Part II)	Total HHA Costs	
		27.00	28.00	
1.00	Administrative and General			1.00
2.00	Skilled Nursing Care	18,836	431,690	2.00
3.00	Physical Therapy	10,150	232,620	3.00
4.00	Occupational Therapy	7,110	162,948	4.00
5.00	Speech Pathology	1,002	22,969	5.00
6.00	Medical Social Services	2	55	6.00
7.00	Home Health Aide	4,986	114,280	7.00
8.00	Supplies (see instructions)	719	16,474	8.00
9.00	Drugs	15	333	9.00
10.00	DME	127	2,913	10.00
11.00	Home Dialysis Aide Services	0	0	11.00
12.00	Respiratory Therapy	0	0	12.00
13.00	Private Duty Nursing	0	0	13.00
14.00	Clinic	0	0	14.00
15.00	Health Promotion Activities	0	0	15.00
16.00	Day Care Program	0	0	16.00
17.00	Home Delivered Meals Program	0	0	17.00
18.00	Homemaker Service	0	0	18.00
19.00	All Others (specify)	0	0	19.00
19.50	Telemedicine	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	42,947	984,282	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.	0.045624		21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 15-1322 | HHA CCN: 15-7177

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

Worksheet H-2 Part II | Date/Time Prepared: 5/29/2019 10:24 am

Home Health Agency I | PPS

	Cost Center Description	CAPITAL RELATED COSTS NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE AND GENERAL (ACCUM. COST)	Reconciliation	
		1.00	2.00	4.00	5A.01	5.01	5A.02	
1.00	Administrative and General	588	588	0	0	18,453	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	339,618	0	2.00
3.00	Physical Therapy	0	0	0	0	183,006	0	3.00
4.00	Occupational Therapy	0	0	0	0	128,194	0	4.00
5.00	Speech Pathology	0	0	0	0	18,071	0	5.00
6.00	Medical Social Services	0	0	0	0	44	0	6.00
7.00	Home Health Aide	0	0	0	0	89,907	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	12,960	0	8.00
9.00	Drugs	0	0	0	0	261	0	9.00
10.00	DME	0	0	0	0	2,292	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	588	588	0		792,806		20.00
21.00	Total cost to be allocated	12,564	5,889	0		60,125		21.00
22.00	Unit cost multiplier	21.367347	10.015306	0.000000		0.075838		22.00

	Cost Center Description	OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST NO PBP)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	
		5.02	7.00	8.00	9.00	10.00	11.00	
1.00	Administrative and General	19,852	588	0	588	0	0	1.00
2.00	Skilled Nursing Care	365,375	0	0	0	0	0	2.00
3.00	Physical Therapy	196,885	0	0	0	0	0	3.00
4.00	Occupational Therapy	137,916	0	0	0	0	0	4.00
5.00	Speech Pathology	19,441	0	0	0	0	0	5.00
6.00	Medical Social Services	47	0	0	0	0	0	6.00
7.00	Home Health Aide	96,725	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	13,943	0	0	0	0	0	8.00
9.00	Drugs	281	0	0	0	0	0	9.00
10.00	DME	2,466	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	852,931	588	0	588	0	0	20.00
21.00	Total cost to be allocated	110,836	15,342	0	5,173	0	0	21.00
22.00	Unit cost multiplier	0.129947	26.091837	0.000000	8.797619	0.000000	0.000000	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 15-1322
HHA CCN: 15-7177

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

Worksheet H-2
Part II
Date/Time Prepared:
5/29/2019 10:24 am

Home Health Agency I | PPS

	Cost Center Description	NURSING ADMINISTRATION (DIRECT NRSING HRS)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	
		13.00	16.00	
1.00	Administrative and General	0	0	1.00
2.00	Skilled Nursing Care	0	0	2.00
3.00	Physical Therapy	0	0	3.00
4.00	Occupational Therapy	0	0	4.00
5.00	Speech Pathology	0	0	5.00
6.00	Medical Social Services	0	0	6.00
7.00	Home Health Aide	0	0	7.00
8.00	Supplies (see instructions)	0	0	8.00
9.00	Drugs	0	0	9.00
10.00	DME	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	11.00
12.00	Respiratory Therapy	0	0	12.00
13.00	Private Duty Nursing	0	0	13.00
14.00	Clinic	0	0	14.00
15.00	Health Promotion Activities	0	0	15.00
16.00	Day Care Program	0	0	16.00
17.00	Home Delivered Meals Program	0	0	17.00
18.00	Homemaker Service	0	0	18.00
19.00	All Others (specify)	0	0	19.00
19.50	Telemedicine	0	0	19.50
20.00	Total (sum of lines 1-19)	0	0	20.00
21.00	Total cost to be allocated	0	0	21.00
22.00	Unit cost multiplier	0.000000	0.000000	22.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 15-1322 | HHA CCN: 15-7177 | Period: From 01/01/2018 To 12/31/2018 | Worksheet H-3 Part I | Date/Time Prepared: 5/29/2019 10:24 am

Title XVIII | Home Health Agency I | PPS

	Cost Center Description	From, Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Visits	Average Cost Per Visit (col. 3 ÷ col. 4)	
		0	1.00	2.00	3.00	4.00	5.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	2.00	431,690		431,690	2,046	210.99	1.00
2.00	Physical Therapy	3.00	232,620	0	232,620	1,833	126.91	2.00
3.00	Occupational Therapy	4.00	162,948	0	162,948	1,284	126.91	3.00
4.00	Speech Pathology	5.00	22,969	0	22,969	181	126.90	4.00
5.00	Medical Social Services	6.00	55		55	1	55.00	5.00
6.00	Home Health Aide	7.00	114,280		114,280	1,129	101.22	6.00
7.00	Total (sum of lines 1-6)		964,562	0	964,562	6,474		7.00

	Cost Center Description	Cost Limits	CBSA No. (1)	Program Visits Part A	Program Visits Part B Not Subject to Deductibles & Coinsurance	Program Visits Part B Subject to Deductibles		
		0	1.00	2.00	3.00	4.00	5.00	
	Limitation Cost Computation							
8.00	Skilled Nursing Care		99915	0	984			8.00
9.00	Physical Therapy		99915	0	1,232			9.00
10.00	Occupational Therapy		99915	0	807			10.00
11.00	Speech Pathology		99915	0	120			11.00
12.00	Medical Social Services		99915	0	3			12.00
13.00	Home Health Aide		99915	0	245			13.00
14.00	Total (sum of lines 8-13)			0	3,391			14.00

	Cost Center Description	From Wkst. H-2 Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Charges (from HHA Records)	Ratio (col. 3 ÷ col. 4)	
		0	1.00	2.00	3.00	4.00	5.00	
	Supplies and Drugs Cost Computations							
15.00	Cost of Medical Supplies	8.00	16,474	0	16,474	7,955	2.070899	15.00
16.00	Cost of Drugs	9.00	333	0	333	160	2.081250	16.00

	Cost Center Description	Program Visits Part A	Program Visits Part B Not Subject to Deductibles & Coinsurance	Program Visits Part B Subject to Deductibles & Coinsurance	Cost of Services Part A	Cost of Services Part B Not Subject to Deductibles & Coinsurance	Cost of Services Part B Subject to Deductibles & Coinsurance	
		6.00	7.00	8.00	9.00	10.00	11.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	0	984		0	207,614		1.00
2.00	Physical Therapy	0	1,232		0	156,353		2.00
3.00	Occupational Therapy	0	807		0	102,416		3.00
4.00	Speech Pathology	0	120		0	15,228		4.00
5.00	Medical Social Services	0	3		0	165		5.00
6.00	Home Health Aide	0	245		0	24,799		6.00
7.00	Total (sum of lines 1-6)	0	3,391		0	506,575		7.00

	Cost Center Description							
		6.00	7.00	8.00	9.00	10.00	11.00	
	Limitation Cost Computation							
8.00	Skilled Nursing Care							8.00
9.00	Physical Therapy							9.00
10.00	Occupational Therapy							10.00
11.00	Speech Pathology							11.00
12.00	Medical Social Services							12.00
13.00	Home Health Aide							13.00
14.00	Total (sum of lines 8-13)							14.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 15-1322 | HHA CCN: 15-7177 | Period: From 01/01/2018 To 12/31/2018 | Worksheet H-3 Part I | Date/Time Prepared: 5/29/2019 10:24 am

Title XVIII | Home Health Agency I | PPS

	Cost Center Description	Program Covered Charges Part A	Program Covered Charges Part B Not Subject to Deductibles & Coinsurance	Program Covered Charges Part B Subject to Deductibles & Coinsurance	Cost of Services Part A	Cost of Services Part B Not Subject to Deductibles & Coinsurance	Cost of Services Part B Subject to Deductibles & Coinsurance	
		6.00	7.00	8.00	9.00	10.00	11.00	
	Supplies and Drugs Cost Computations							
15.00	Cost of Medical Supplies	0	45,468	0	0	94,160	0	15.00
16.00	Cost of Drugs		330	0		687	0	16.00

	Cost Center Description	Total Program Cost (sum of cols. 9-10)	
		12.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION		
	Cost Per Visit Computation		
1.00	Skilled Nursing Care	207,614	1.00
2.00	Physical Therapy	156,353	2.00
3.00	Occupational Therapy	102,416	3.00
4.00	Speech Pathology	15,228	4.00
5.00	Medical Social Services	165	5.00
6.00	Home Health Aide	24,799	6.00
7.00	Total (sum of lines 1-6)	506,575	7.00

	Cost Center Description		
		12.00	
	Limitation Cost Computation		
8.00	Skilled Nursing Care		8.00
9.00	Physical Therapy		9.00
10.00	Occupational Therapy		10.00
11.00	Speech Pathology		11.00
12.00	Medical Social Services		12.00
13.00	Home Health Aide		13.00
14.00	Total (sum of lines 8-13)		14.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 15-1322 | HHA CCN: 15-7177 | Period: From 01/01/2018 To 12/31/2018 | Worksheet H-3 Part II | Date/Time Prepared: 5/29/2019 10:24 am

Title XVIII | Home Health Agency I | PPS

	Cost Center Description	From Wkst. C, Part I, col. 9, line	Cost to Charge Ratio	Total HHA Charge (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)	Transfer to Part I as Indicated	
		0	1.00	2.00	3.00	4.00	
	PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS						
1.00	Physical Therapy	66.00	0.348896	0	0	col. 2, line 2.00	1.00
2.00	Occupational Therapy	67.00	0.236274	0	0	col. 2, line 3.00	2.00
3.00	Speech Pathology	68.00	0.419176	0	0	col. 2, line 4.00	3.00
4.00	Cost of Medical Supplies	71.00	0.080820	0	0	col. 2, line 15.00	4.00
5.00	Cost of Drugs	73.00	0.247849	0	0	col. 2, line 16.00	5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT

Provider CCN: 15-1322 | HHA CCN: 15-7177 | Period: From 01/01/2018 To 12/31/2018 | Worksheet H-4 Part I-II | Date/Time Prepared: 5/29/2019 10:24 am

Title XVIII | Home Health Agency I | PPS

		Part A	Part B		
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
		1.00	2.00	3.00	
	PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES				
	Reasonable Cost of Part A & Part B Services				
1.00	Reasonable cost of services (see instructions)	0	687	0	1.00
2.00	Total charges	0	330	0	2.00
	Customary Charges				
3.00	Amount actually collected from patients liable for payment for services on a charge basis (from your records)	0	0	0	3.00
4.00	Amount 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(b)	0	0	0	4.00
5.00	Ratio of line 3 to line 4 (not to exceed 1.000000)	0.000000	0.000000	0.000000	5.00
6.00	Total customary charges (see instructions)	0	330	0	6.00
7.00	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)	0	0	0	7.00
8.00	Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6)	0	357	0	8.00
9.00	Primary payer amounts	0	0	0	9.00

		Part A Services	Part B Services	
		1.00	2.00	
	PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT			
10.00	Total reasonable cost (see instructions)	0	687	10.00
11.00	Total PPS Reimbursement - Full Episodes without Outliers	0	497,492	11.00
12.00	Total PPS Reimbursement - Full Episodes with Outliers	0	65,084	12.00
13.00	Total PPS Reimbursement - LUPA Episodes	0	6,208	13.00
14.00	Total PPS Reimbursement - PEP Episodes	0	3,570	14.00
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers	0	13,401	15.00
16.00	Total PPS Outlier Reimbursement - PEP Episodes	0	0	16.00
17.00	Total Other Payments	0	0	17.00
18.00	DME Payments	0	0	18.00
19.00	Oxygen Payments	0	0	19.00
20.00	Prosthetic and Orthotic Payments	0	0	20.00
21.00	Part B deductibles billed to Medicare patients (exclude coinsurance)		0	21.00
22.00	Subtotal (sum of lines 10 thru 20 minus line 21)	0	586,442	22.00
23.00	Excess reasonable cost (from line 8)	0	357	23.00
24.00	Subtotal (line 22 minus line 23)	0	586,085	24.00
25.00	Coinsurance billed to program patients (from your records)		0	25.00
26.00	Net cost (line 24 minus line 25)	0	586,085	26.00
27.00	Reimbursable bad debts (from your records)			27.00
28.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)			28.00
29.00	Total costs - current cost reporting period (line 26 plus line 27)	0	586,085	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	0	30.50
30.99	Demonstration payment adjustment amount before sequestration	0	0	30.99
31.00	Subtotal (see instructions)	0	586,085	31.00
31.01	Sequestration adjustment (see instructions)	0	11,722	31.01
31.02	Demonstration payment adjustment amount after sequestration	0	0	31.02
32.00	Interim payments (see instructions)	0	574,363	32.00
33.00	Tentative settlement (for contractor use only)	0	0	33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 32, and 33)	0	0	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	35.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED HHAs FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 15-1322 HHA CCN: 15-7177	Period: From 01/01/2018 To 12/31/2018	Worksheet H-5 Date/Time Prepared: 5/29/2019 10:24 am
		Home Health Agency I	PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		0		574,363	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			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			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. H-4, Part II, column as appropriate, line 32)		0		574,363	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		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50			0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		0		574,363	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1322 | Period: From 01/01/2018 To 12/31/2018 | Worksheet M-1

Component CCN: 15-8516 | Date/Time Prepared: 5/29/2019 10:24 am

RHC I | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	1,190,256	25,000	1,215,256	0	1,215,256	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	198,651	0	198,651	1,126	199,777	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	311,513	0	311,513	0	311,513	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	85,218	0	85,218	0	85,218	9.00
10.00	Subtotal (sum of lines 1 through 9)	1,785,638	25,000	1,810,638	1,126	1,811,764	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	32,458	32,458	0	32,458	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	32,458	32,458	0	32,458	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	1,785,638	57,458	1,843,096	1,126	1,844,222	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	57,407	57,407	0	57,407	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	57,407	57,407	0	57,407	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	0	0	0	0	29.00
30.00	Administrative Costs	170,439	1,554,507	1,724,946	14,856	1,739,802	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	170,439	1,554,507	1,724,946	14,856	1,739,802	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	1,956,077	1,669,372	3,625,449	15,982	3,641,431	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1322 | Component CCN: 15-8516 | Period: From 01/01/2018 To 12/31/2018 | Worksheet M-1 | Date/Time Prepared: 5/29/2019 10:24 am

RHC I | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
		6.00	7.00	
	FACILITY HEALTH CARE STAFF COSTS			
1.00	Physician	0	1,215,256	1.00
2.00	Physician Assistant	0	0	2.00
3.00	Nurse Practitioner	0	199,777	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	311,513	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	85,218	9.00
10.00	Subtotal (sum of lines 1 through 9)	0	1,811,764	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	32,458	15.00
16.00	Transportation (Health Care Staff)	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	17.00
18.00	Professional Liability Insurance	0	0	18.00
19.00	Other Health Care Costs	0	0	19.00
20.00	Allowable GME Costs			20.00
21.00	Subtotal (sum of lines 15 through 20)	0	32,458	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	1,844,222	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES			
23.00	Pharmacy	0	57,407	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	57,407	28.00
	FACILITY OVERHEAD			
29.00	Facility Costs	0	0	29.00
30.00	Administrative Costs	-1,320	1,738,482	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-1,320	1,738,482	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-1,320	3,640,111	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1322 | Period: From 01/01/2018 To 12/31/2018 | Worksheet M-1
Component CCN: 15-8517 | Date/Time Prepared: 5/29/2019 10:24 am

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	125,130	0	125,130	-112,192	12,938	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	42,661	0	42,661	129,437	172,098	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	0	0	0	0	0	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	40,878	0	40,878	0	40,878	9.00
10.00	Subtotal (sum of lines 1 through 9)	208,669	0	208,669	17,245	225,914	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	1,076	1,076	0	1,076	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	1,076	1,076	0	1,076	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	208,669	1,076	209,745	17,245	226,990	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	9,866	9,866	0	9,866	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	9,866	9,866	0	9,866	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	0	0	0	0	29.00
30.00	Administrative Costs	27,809	205,807	233,616	0	233,616	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	27,809	205,807	233,616	0	233,616	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	236,478	216,749	453,227	17,245	470,472	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1322 | Component CCN: 15-8517 | Period: From 01/01/2018 To 12/31/2018 | Worksheet M-1 | Date/Time Prepared: 5/29/2019 10:24 am

RHC II | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
		6.00	7.00	
	FACILITY HEALTH CARE STAFF COSTS			
1.00	Physician	0	12,938	1.00
2.00	Physician Assistant	0	0	2.00
3.00	Nurse Practitioner	0	172,098	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	0	5.00
6.00	Clinical Psychologist	0	0	6.00
7.00	Clinical Social Worker	0	0	7.00
8.00	Laboratory Technician	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	40,878	9.00
10.00	Subtotal (sum of lines 1 through 9)	0	225,914	10.00
11.00	Physician Services Under Agreement	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	12.00
13.00	Other Costs Under Agreement	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	14.00
15.00	Medical Supplies	0	1,076	15.00
16.00	Transportation (Health Care Staff)	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	17.00
18.00	Professional Liability Insurance	0	0	18.00
19.00	Other Health Care Costs	0	0	19.00
20.00	Allowable GME Costs			20.00
21.00	Subtotal (sum of lines 15 through 20)	0	1,076	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	226,990	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES			
23.00	Pharmacy	0	9,866	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	9,866	28.00
	FACILITY OVERHEAD			
29.00	Facility Costs	0	0	29.00
30.00	Administrative Costs	0	233,616	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	233,616	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	470,472	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1322 | Component CCN: 15-8518 | Period: From 01/01/2018 To 12/31/2018 | Worksheet M-1 | Date/Time Prepared: 5/29/2019 10:24 am

RHC III | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	0	15,037	15,037	0	15,037	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	55,854	0	55,854	46,346	102,200	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	0	0	0	0	0	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	55,854	15,037	70,891	46,346	117,237	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	1,103	1,103	0	1,103	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	1,103	1,103	0	1,103	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	55,854	16,140	71,994	46,346	118,340	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	7,298	7,298	0	7,298	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	7,298	7,298	0	7,298	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	0	0	0	0	29.00
30.00	Administrative Costs	51,715	72,336	124,051	0	124,051	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	51,715	72,336	124,051	0	124,051	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	107,569	95,774	203,343	46,346	249,689	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1322 | Component CCN: 15-8518 | Period: From 01/01/2018 To 12/31/2018 | Worksheet M-1 | Date/Time Prepared: 5/29/2019 10:24 am

RHC III | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
		6.00	7.00	
	FACILITY HEALTH CARE STAFF COSTS			
1.00	Physician	0	15,037	1.00
2.00	Physician Assistant	0	0	2.00
3.00	Nurse Practitioner	0	102,200	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	0	5.00
6.00	Clinical Psychologist	0	0	6.00
7.00	Clinical Social Worker	0	0	7.00
8.00	Laboratory Technician	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	0	117,237	10.00
11.00	Physician Services Under Agreement	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	12.00
13.00	Other Costs Under Agreement	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	14.00
15.00	Medical Supplies	0	1,103	15.00
16.00	Transportation (Health Care Staff)	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	17.00
18.00	Professional Liability Insurance	0	0	18.00
19.00	Other Health Care Costs	0	0	19.00
20.00	Allowable GME Costs			20.00
21.00	Subtotal (sum of lines 15 through 20)	0	1,103	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	118,340	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES			
23.00	Pharmacy	0	7,298	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	7,298	28.00
	FACILITY OVERHEAD			
29.00	Facility Costs	0	0	29.00
30.00	Administrative Costs	0	124,051	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	124,051	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	249,689	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1322 | Component CCN: 15-8519 | Period: From 01/01/2018 To 12/31/2018 | Worksheet M-1 | Date/Time Prepared: 5/29/2019 10:24 am

RHC IV | 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	293,327	0	293,327	-101,927	191,400	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	0	0	0	37,210	37,210	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	0	0	0	0	0	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	293,327	0	293,327	-64,717	228,610	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	189	189	0	189	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	189	189	0	189	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	293,327	189	293,516	-64,717	228,799	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	8,009	8,009	0	8,009	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	8,009	8,009	0	8,009	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	0	0	0	0	29.00
30.00	Administrative Costs	43,355	91,902	135,257	0	135,257	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	43,355	91,902	135,257	0	135,257	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	336,682	100,100	436,782	-64,717	372,065	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS	Provider CCN: 15-1322 Component CCN: 15-8519	Period: From 01/01/2018 To 12/31/2018	Worksheet M-1 Date/Time Prepared: 5/29/2019 10:24 am
		RHC IV	Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
		6.00	7.00	
	FACILITY HEALTH CARE STAFF COSTS			
1.00	Physician	0	191,400	1.00
2.00	Physician Assistant	0	0	2.00
3.00	Nurse Practitioner	0	37,210	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	0	5.00
6.00	Clinical Psychologist	0	0	6.00
7.00	Clinical Social Worker	0	0	7.00
8.00	Laboratory Technician	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	0	228,610	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	189	15.00
16.00	Transportation (Health Care Staff)	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	17.00
18.00	Professional Liability Insurance	0	0	18.00
19.00	Other Health Care Costs	0	0	19.00
20.00	Allowable GME Costs			20.00
21.00	Subtotal (sum of lines 15 through 20)	0	189	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	228,799	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES			
23.00	Pharmacy	0	8,009	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	8,009	28.00
	FACILITY OVERHEAD			
29.00	Facility Costs	0	0	29.00
30.00	Administrative Costs	0	135,257	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	135,257	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	372,065	32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 15-1322 Component CCN: 15-8516	Period: From 01/01/2018 To 12/31/2018	Worksheet M-2 Date/Time Prepared: 5/29/2019 10:24 am
		RHC I	Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	2.31	7,414	4,200	9,702		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	1.63	5,871	2,100	3,423		3.00
4.00	Subtotal (sum of lines 1 through 3)	3.94	13,285		13,125	13,285	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)	3.94	13,285			13,285	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)	1,844,222	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)	57,407	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)	1,901,629	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)	0.969812	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)	1,738,482	14.00
15.00	Parent provider overhead allocated to facility (see instructions)	933,061	15.00
16.00	Total overhead (sum of lines 14 and 15)	2,671,543	16.00
17.00	Allowable GME overhead (see instructions)	0	17.00
18.00	Enter the amount from line 16	2,671,543	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)	2,590,894	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)	4,435,116	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 15-1322 | Component CCN: 15-8517 | Period: From 01/01/2018 To 12/31/2018 | Worksheet M-2 | Date/Time Prepared: 5/29/2019 10:24 am

RHC II | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	0.05	431	4,200	210		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	0.96	2,167	2,100	2,016		3.00
4.00	Subtotal (sum of lines 1 through 3)	1.01	2,598		2,226	2,598	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	1.01	2,598			2,598	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)	226,990	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)	9,866	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)	236,856	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)	0.958346	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)	233,616	14.00
15.00	Parent provider overhead allocated to facility (see instructions)	120,652	15.00
16.00	Total overhead (sum of lines 14 and 15)	354,268	16.00
17.00	Allowable GME overhead (see instructions)	0	17.00
18.00	Enter the amount from line 16	354,268	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)	339,511	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)	566,501	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES | Provider CCN: 15-1322 | Component CCN: 15-8518 | Period: From 01/01/2018 To 12/31/2018 | Worksheet M-2 | Date/Time Prepared: 5/29/2019 10:24 am

RHC III | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	0.06	56	4,200	252		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	0.83	1,749	2,100	1,743		3.00
4.00	Subtotal (sum of lines 1 through 3)	0.89	1,805		1,995	1,995	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	0.89	1,805			1,995	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)	118,340	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)	7,298	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)	125,638	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)	0.941912	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)	124,051	14.00
15.00	Parent provider overhead allocated to facility (see instructions)	65,491	15.00
16.00	Total overhead (sum of lines 14 and 15)	189,542	16.00
17.00	Allowable GME overhead (see instructions)	0	17.00
18.00	Enter the amount from line 16	189,542	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)	178,532	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)	296,872	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 15-1322 | Component CCN: 15-8519 | Period: From 01/01/2018 To 12/31/2018 | Worksheet M-2 | Date/Time Prepared: 5/29/2019 10:24 am

RHC IV | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	0.48	896	2,681	1,287		1.00
2.00	Physician Assistant	0.00	0	1,341	0		2.00
3.00	Nurse Practitioner	0.54	1,324	1,341	724		3.00
4.00	Subtotal (sum of lines 1 through 3)	1.02	2,220		2,011	2,220	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	1.02	2,220			2,220	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)	228,799	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)	8,009	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)	236,808	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)	0.966179	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)	135,257	14.00
15.00	Parent provider overhead allocated to facility (see instructions)	100,812	15.00
16.00	Total overhead (sum of lines 14 and 15)	236,069	16.00
17.00	Allowable GME overhead (see instructions)	0	17.00
18.00	Enter the amount from line 16	236,069	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)	228,085	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)	456,884	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 15-1322 Component CCN: 15-8516	Period: From 01/01/2018 To 12/31/2018	Worksheet M-3 Date/Time Prepared: 5/29/2019 10:24 am
	Title XVIII	RHC I	Cost

			1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES			
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)		4,435,116	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)		130,979	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		4,304,137	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		13,285	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)		13,285	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		323.98	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)	323.98	323.98	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	3,398	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	1,100,884	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	1,100,884	16.00
16.01	Total program charges (see instructions)(from contractor's records)		685,451	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		57,592	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		92,497	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.)		768,808	16.04
16.05	Total program cost (see instructions)	0	861,305	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		47,377	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		116,089	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		861,305	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		66,162	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		927,467	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)		927,467	26.00
26.01	Sequestration adjustment (see instructions)		18,549	26.01
26.02	Demonstration payment adjustment amount after sequestration		0	26.02
27.00	Interim payments		611,026	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)		297,892	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: 15-1322 | Component CCN: 15-8517 | Period: From 01/01/2018 To 12/31/2018 | Worksheet M-3 | Date/Time Prepared: 5/29/2019 10:24 am

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)	566,501	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)	20,490	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)	546,011	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)	2,598	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)	2,598	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)	210.17	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)	210.17	210.17	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	165	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	34,678	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	34,678	16.00
16.01	Total program charges (see instructions)(from contractor's records)		36,726	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		3,648	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		3,445	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.)		22,760	16.04
16.05	Total program cost (see instructions)	0	26,205	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		2,783	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		6,059	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		26,205	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		4,184	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		30,389	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)		30,389	26.00
26.01	Sequestration adjustment (see instructions)		608	26.01
26.02	Demonstration payment adjustment amount after sequestration		0	26.02
27.00	Interim payments		33,000	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)		-3,219	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: 15-1322 Component CCN: 15-8518	Period: From 01/01/2018 To 12/31/2018	Worksheet M-3 Date/Time Prepared: 5/29/2019 10:24 am
	Title XVIII	RHC III	Cost

			1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES			
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)		296,872	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)		4,581	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		292,291	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		1,995	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)		0	5.00
6.00	Total adjusted visits (line 4 plus line 5)		1,995	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		146.51	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)	146.51	146.51	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	156	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	22,856	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	22,856	16.00
16.01	Total program charges (see instructions)(from contractor's records)		29,814	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		2,399	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		1,839	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.)		13,376	16.04
16.05	Total program cost (see instructions)	0	15,215	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		4,297	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		4,624	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		15,215	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		1,538	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		16,753	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)		16,753	26.00
26.01	Sequestration adjustment (see instructions)		335	26.01
26.02	Demonstration payment adjustment amount after sequestration		0	26.02
27.00	Interim payments		22,089	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)		-5,671	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: 15-1322 | Component CCN: 15-8519 | Period: From 01/01/2018 To 12/31/2018 | Worksheet M-3 | Date/Time Prepared: 5/29/2019 10:24 am

Title XVIII | RHC IV | 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)		456,884	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)		2,737	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		454,147	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		2,220	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)		2,220	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		204.57	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)	204.57	204.57	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	664	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	135,834	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	135,834	16.00
16.01	Total program charges (see instructions)(from contractor's records)		110,692	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		7,795	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		9,566	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.)		87,289	16.04
16.05	Total program cost (see instructions)	0	96,855	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		17,157	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		17,147	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		96,855	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		1,117	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		97,972	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)		97,972	26.00
26.01	Sequestration adjustment (see instructions)		1,959	26.01
26.02	Demonstration payment adjustment amount after sequestration		0	26.02
27.00	Interim payments		83,844	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)		12,169	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: 15-1322 | Component CCN: 15-8516 | Period: From 01/01/2018 To 12/31/2018 | Worksheet M-4 | Date/Time Prepared: 5/29/2019 10:24 am

Title XVIII | RHC I | Cost

		Pneumococcal	Influenza	
		1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	1,811,764	1,811,764	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.003559	0.017958	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	6,448	32,536	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	6,650	8,830	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	13,098	41,366	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	1,844,222	1,844,222	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	2,590,894	2,590,894	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.007102	0.022430	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	18,401	58,114	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	31,499	99,480	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	175	883	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	179.99	112.66	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	141	362	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	25,379	40,783	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)		130,979	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)		66,162	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA VACCINE COST	Provider CCN: 15-1322 Component CCN: 15-8517	Period: From 01/01/2018 To 12/31/2018	Worksheet M-4 Date/Time Prepared: 5/29/2019 10:24 am
	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)	225,914	225,914	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000873	0.021577	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	197	4,875	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	418	2,720	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	615	7,595	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	226,990	226,990	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	339,511	339,511	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.002709	0.033460	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	920	11,360	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	1,535	18,955	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	11	272	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	139.55	69.69	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	10	40	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	1,396	2,788	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)		20,490	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)		4,184	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA VACCINE COST	Provider CCN: 15-1322 Component CCN: 15-8518	Period: From 01/01/2018 To 12/31/2018	Worksheet M-4 Date/Time Prepared: 5/29/2019 10:24 am
	Title XVIII	RHC III	Cost

		Pneumococcal	Influenza	
		1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	117,237	117,237	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000450	0.006933	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	53	813	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	190	770	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	243	1,583	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	118,340	118,340	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	178,532	178,532	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.002053	0.013377	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	367	2,388	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	610	3,971	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	5	77	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	122.00	51.57	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	5	18	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	610	928	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)		4,581	15.00
16.00	Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3, line 21)		1,538	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA VACCINE COST	Provider CCN: 15-1322 Component CCN: 15-8519	Period: From 01/01/2018 To 12/31/2018	Worksheet M-4 Date/Time Prepared: 5/29/2019 10:24 am
	Title XVIII	RHC IV	Cost

		Pneumococcal	Influenza	
		1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	228,610	228,610	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000707	0.002435	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	162	557	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	342	310	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	504	867	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	228,799	228,799	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	228,085	228,085	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.002203	0.003789	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	502	864	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	1,006	1,731	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	9	31	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	111.78	55.84	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	8	4	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	894	223	14.00
15.00	Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2)		2,737	15.00
16.00	Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3, line 21)		1,117	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 15-1322 Component CCN: 15-8516	Period: From 01/01/2018 To 12/31/2018	Worksheet M-5 Date/Time Prepared: 5/29/2019 10:24 am
		RHC I	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		611,026	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)		611,026	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		297,892	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		908,918	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: 15-1322 Component CCN: 15-8517	Period: From 01/01/2018 To 12/31/2018	Worksheet M-5 Date/Time Prepared: 5/29/2019 10:24 am
		RHC II	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		33,000	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)		33,000	4.00
	TO BE COMPLETED BY CONTRACTOR			
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			5.00
	Program to Provider			
5.01			0	5.01
5.02			0	5.02
5.03			0	5.03
	Provider to Program			
5.50			0	5.50
5.51			0	5.51
5.52			0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00
6.01	SETTLEMENT TO PROVIDER		0	6.01
6.02	SETTLEMENT TO PROGRAM		3,219	6.02
7.00	Total Medicare program liability (see instructions)		29,781	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: 15-1322 Component CCN: 15-8518	Period: From 01/01/2018 To 12/31/2018	Worksheet M-5 Date/Time Prepared: 5/29/2019 10:24 am
		RHC III	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		22,089	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)		22,089	4.00
	TO BE COMPLETED BY CONTRACTOR			
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			5.00
	Program to Provider			
5.01			0	5.01
5.02			0	5.02
5.03			0	5.03
	Provider to Program			
5.50			0	5.50
5.51			0	5.51
5.52			0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00
6.01	SETTLEMENT TO PROVIDER		0	6.01
6.02	SETTLEMENT TO PROGRAM		5,671	6.02
7.00	Total Medicare program liability (see instructions)		16,418	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: 15-1322 Component CCN: 15-8519	Period: From 01/01/2018 To 12/31/2018	Worksheet M-5 Date/Time Prepared: 5/29/2019 10:24 am
		RHC IV	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		83,844	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	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)		83,844	4.00
	TO BE COMPLETED BY CONTRACTOR			
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			5.00
	Program to Provider			
5.01			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		12,169	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		96,013	7.00

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