

This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g).

FORM APPROVED
OMB NO. 0938-0050
EXPIRES 05-31-2019

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 14-1310	Period: From 10/01/2017 To 09/30/2018	Worksheet S Parts I-III Date/Time Prepared: 2/26/2019 11:25 am
--	-----------------------	---	---

PART I - COST REPORT STATUS

Provider use only	1. ☒ Electronically filed cost report	Date: 2/26/2019	Time: 11:25 am
	2. ☐ Manually submitted cost report		
	3. ☐ If this is an amended report enter the number of times the provider resubmitted this cost report		
	4. ☐ Medicare Utilization. Enter "F" for full or "L" for low.		
Contractor use only	5. ☐ Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. ☐ Initial Report for this Provider CCN 9. ☐ Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. ☐ If line 5, column 1 is 4: Enter number of times reopened = 0-9.

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 MENDOTA COMMUNITY HOSPITAL (14-1310) for the cost reporting period beginning 10/01/2017 and ending 09/30/2018 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

(Signed)

Officer or Administrator of Provider(s)

Title

Date

Cost Center Description		Title V	Title XVIII		HIT	Title XIX	
			Part A	Part B			
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	49,198	364,341	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	88,301	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
10.00	RURAL HEALTH CLINIC I	0		-246,030		0	10.00
200.00	Total	0	137,499	118,311	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: 14-1310		Period: From 10/01/2017 To 09/30/2018		Worksheet S-2 Part I Date/Time Prepared: 2/26/2019 11:25 am		
1.00		2.00		3.00		4.00				
Hospital and Hospital Health Care Complex Address:										
1.00	Street: 1401 EAST 12TH ST			PO Box:				1.00		
2.00	City: MENDOTA			State: IL		Zip Code: 61342-9216		County: LA SALLE		
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)		
								V	XVIII	
								XIX		
Hospital and Hospital-Based Component Identification:										
3.00	Hospital		MENDOTA COMMUNITY HOSPITAL	141310	99914	1	01/15/2001	N	O	N
4.00	Subprovider - IPF									
5.00	Subprovider - IRF									
6.00	Subprovider - (Other)									
7.00	Swing Beds - SNF		MENDOTA COMMUNITY SWING BED- SNF	14Z310	99914		01/25/2001	N	O	N
8.00	Swing Beds - NF									
9.00	Hospital-Based SNF									
10.00	Hospital-Based NF									
11.00	Hospital-Based OLTC									
12.00	Hospital-Based HHA									
13.00	Separately Certified ASC									
14.00	Hospital-Based Hospice									
15.00	Hospital-Based Health Clinic - RHC		MENDOTA COMMUNITY HOSPITAL - RHC	148535	99914		02/11/2015	N	O	N
16.00	Hospital-Based Health Clinic - FQHC									
17.00	Hospital-Based (CMHC) I									
18.00	Renal Dialysis									
19.00	Other									
							From:	To:		
							1.00	2.00		
20.00	Cost Reporting Period (mm/dd/yyyy)						10/01/2017	09/30/2018		
21.00	Type of Control (see instructions)						2			
							1.00	2.00		
							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			
22.01	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			
22.02	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			
22.03	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		
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					3	N			

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-1310

Period:
From 10/01/2017
To 09/30/2018Worksheet S-2
Part I
Date/Time Prepared:
2/26/2019 11:25 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	0	25.00
					Urban/Rural S 1.00	Date of Geogr 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: 1.00	Ending: 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 1.00	Y/N 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 1.00	XVIII 2.00	XIX 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
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
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
48.00 Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.					N	N	N
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		
57.00 If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.					N		
58.00 If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.					N		
59.00 Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.					N		

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1310		Period: From 10/01/2017 To 09/30/2018		Worksheet S-2 Part I Date/Time Prepared: 2/26/2019 11:25 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		
61.01	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			
64.00	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. Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)					0.00	0.00	0.000000	64.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-1310

Period:
From 10/01/2017
To 09/30/2018Worksheet S-2
Part I
Date/Time Prepared:
2/26/2019 11:25 am

	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))		
	1.00	2.00	3.00	4.00	5.00		
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000	65.00	
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
			1.00	2.00	3.00		
66.00	Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010						
	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: 14-1310	Period: From 10/01/2017 To 09/30/2018	Worksheet S-2 Part I Date/Time Prepared: 2/26/2019 11:25 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)		Y		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	
			1.00	2.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.		N	N	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: 14-1310	Period: From 10/01/2017 To 09/30/2018	Worksheet S-2 Part I Date/Time Prepared: 2/26/2019 11:25 am	
			1.00	2.00	
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N			111.00
			1.00	2.00	3.00
Miscellaneous Cost Reporting Information					
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	N			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1			118.00
		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	67,018	0	0	
		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.	N			121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N			122.00
Transplant Center Information					
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N			125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.				134.00
All Providers					
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y		149006	140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-1310		Period: From 10/01/2017 To 09/30/2018		Worksheet S-2 Part I Date/Time Prepared: 2/26/2019 11:25 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: OSF HEALTHCARE SYSTEM		Contractor's Name: WPS		Contractor's Number: 00131				141.00	
142.00	Street: 800 N.E. GLEN OAK AVENUE		PO Box:						142.00	
143.00	City: PEORIA		State: IL		Zip Code: 61603				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.				N				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.								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.								Y	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)						10/01/2017	09/30/2018	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: 14-1310	Period: From 10/01/2017 To 09/30/2018	Worksheet S-2 Part II Date/Time Prepared: 2/26/2019 11:25 am
			Y/N 1.00	Date 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 1.00	Date 2.00	V/I 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 1.00	Type 2.00	Date 3.00
Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N		5.00
			Y/N 1.00	Legal Oper. 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 1.00	Date 2.00	Y/N 3.00 Date 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
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	01/29/2019	Y 01/29/2019
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
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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-1310

Period:
From 10/01/2017
To 09/30/2018Worksheet S-2
Part II
Date/Time Prepared:
2/26/2019 11:25 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		Y		29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.		N		30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.		N		31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.		Y		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.	PATRICIA		RACHELL	41.00
42.00	Enter the employer/company name of the cost report preparer.	BKD, LLP			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	(314) 231-5544		PRACHELL@BKD.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-1310

Period:
From 10/01/2017
To 09/30/2018Worksheet S-2
Part II
Date/Time Prepared:
2/26/2019 11:25 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.	DIRECTOR	41.00
42.00	Enter the employer/company name of the cost report preparer.		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.		43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-1310

Period:
From 10/01/2017
To 09/30/2018Worksheet S-3
Part I
Date/Time Prepared:
2/26/2019 11:25 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	27,720.00	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	27,720.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	4	1,460	912.00	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						13.00
14.00 Total (see instructions)		25	9,125	28,632.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RHC (CONSOLIDATED)	88.00				0	26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		25				27.00
28.00 Observation Bed Days					0	28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)		0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00
33.01 LTCH site neutral days and discharges						33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-1310

Period:
From 10/01/2017
To 09/30/2018Worksheet S-3
Part I
Date/Time Prepared:
2/26/2019 11:25 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)	812	99	1,157			1.00
2.00	HMO and other (see instructions)	100	0				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	965	0	1,157			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	57			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,777	99	2,371			7.00
8.00	INTENSIVE CARE UNIT	26	4	36			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)	1,803	103	2,407	0.00	149.58	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RHC (CONSOLIDATED)	7,459	3,645	20,169	0.00	37.35	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	186.93	27.00
28.00	Observation Bed Days		0	402			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-1310

Period:
From 10/01/2017
To 09/30/2018Worksheet S-3
Part I
Date/Time Prepared:
2/26/2019 11:25 am

Component	Full Time Equivalents	Discharges			Total All Patients	
	Nonpaid Workers	Title V	Title XVIII	Title XIX		
	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	290	36	421	1.00
2.00 HMO and other (see instructions)			32	0		2.00
3.00 HMO IPF Subprovider				0		3.00
4.00 HMO IRF Subprovider				0		4.00
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 Hospital Adults & Peds. Swing Bed NF						6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	0.00	0	290	36	421	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
26.00 RHC (CONSOLIDATED)	0.00					26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days			0			33.00
33.01 LTCH site neutral days and discharges			0			33.01

Health Financial Systems		MENDOTA COMMUNITY HOSPITAL		In Lieu of Form CMS-2552-10		
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provider CCN: 14-1310 Component CCN: 14-8535		Period: From 10/01/2017 To 09/30/2018 Worksheet S-8 Date/Time Prepared: 2/26/2019 11:25 am		
		RHC I		Cost		
		1.00				
1.00	Clinic Address and Identification					1.00
	Street	1405 E. 12TH ST.				1.00
		City	State	ZIP Code		
		1.00	2.00	3.00		
2.00	City, State, ZIP Code, County	MENDOTA		IL 61342	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	from	
		1.00	2.00	3.00	4.00	
Facility hours of operations (1)						
11.00	CLINIC	08:00		17:00	08:00	
		1.00		2.00		
12.00	Have you received an approval for an exception to the productivity standard?	N			12.00	
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.	Y		2	13.00	
		Provider name		CCN number		
		1.00		2.00		
14.00	RHC/FQHC name, CCN number	MENDOTA COMMUNITY HOSPITAL - RHC		148535	14.00	
14.01		OSF MEDICAL GROUP WASHINGTON STREET		148567	14.01	
		Y/N	V	XVIII	XIX	
		1.00	2.00	3.00	4.00	
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	LASALLE COUNTY		2.00		

Worksheet S-8

Date/Time Prepared:
2/26/2019 11:25 am

MCRIF32 - 15.3.166.2

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 14-1310	Period: From 10/01/2017 To 09/30/2018	Worksheet S-10 Date/Time Prepared: 2/26/2019 11:25 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)		0.434682	1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid		2,405,039	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		9,810,333	6.00
7.00	Medicaid cost (line 1 times line 6)		4,264,375	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)		1,859,336	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)		1,859,336	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)	1,170,240	172,281	1,342,521
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	508,682	172,281	680,963
22.00	Payments received from patients for amounts previously written off as charity care	4,598	0	4,598
23.00	Cost of charity care (line 21 minus line 22)	504,084	172,281	676,365
			1.00	
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?		N	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit		0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)		1,469,510	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)		539,127	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)		829,427	27.01
28.00	Non-Medicare bad debt expense (see instructions)		640,083	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)		568,533	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		1,244,898	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		3,104,234	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1310

Period:
From 10/01/2017
To 09/30/2018

Worksheet A

Date/Time Prepared:
2/26/2019 11:25 am

Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassificati ons (See A-6)	Reclassified Trial Balance (col. 3 + col. 4)	
			1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT		1,029,049	1,029,049	1,574,433	2,603,482	1.00
1.01	00101	CAP REL COSTS-OFFSITE MOBS		0	0	256	256	1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP		345,353	345,353	2,999	348,352	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	2,887,499	2,887,499	465,204	3,352,703	4.00
5.01	01140	BUSINESS OFFICE	-1,257	118,092	116,835	0	116,835	5.01
5.02	00550	DATA PROCESSING	0	297,305	297,305	1,078,838	1,376,143	5.02
5.03	00570	ADMITTING	0	0	0	0	0	5.03
5.04	00560	PURCHASING RECEIVING AND STORES	97,787	-47,026	50,761	52,369	103,130	5.04
5.05	00590	OTHER A&G	885,430	5,372,319	6,257,749	-2,014,188	4,243,561	5.05
7.00	00700	OPERATION OF PLANT	304,188	567,919	872,107	123,444	995,551	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	57,158	57,158	0	57,158	8.00
9.00	00900	HOUSEKEEPING	326,299	39,355	365,654	0	365,654	9.00
10.00	01000	DIETARY	277,113	132,890	410,003	-282,845	127,158	10.00
11.00	01100	CAFETERIA	0	0	0	282,845	282,845	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	238,847	3,091	241,938	0	241,938	16.00
17.00	01700	SOCIAL SERVICE	0	55	55	216,013	216,068	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,500,905	160,464	1,661,369	175,269	1,836,638	30.00
31.00	03100	INTENSIVE CARE UNIT	26,863	18,650	45,513	850	46,363	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	356,254	330,604	686,858	31,847	718,705	50.00
51.00	05100	RECOVERY ROOM	246,729	20,374	267,103	44	267,147	51.00
53.00	05300	ANESTHESIOLOGY	460,118	47,455	507,573	764	508,337	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	577,112	928,546	1,505,658	-159,103	1,346,555	54.00
56.00	05600	RADIOISOTOPE	3,721	241,706	245,427	-35,502	209,925	56.00
57.00	05700	CT SCAN	179,174	48,559	227,733	-4,807	222,926	57.00
58.00	05800	MRI	90,507	7,100	97,607	44	97,651	58.00
60.00	06000	LABORATORY	599,767	746,704	1,346,471	55,294	1,401,765	60.00
64.00	06400	INTRAVENOUS THERAPY	302,197	22,490	324,687	-70	324,617	64.00
65.00	06500	RESPIRATORY THERAPY	342,096	65,724	407,820	2,724	410,544	65.00
66.00	06600	PHYSICAL THERAPY	549,001	22,873	571,874	22,567	594,441	66.00
67.00	06700	OCCUPATIONAL THERAPY	91,685	2,004	93,689	1,911	95,600	67.00
68.00	06800	SPEECH PATHOLOGY	48,805	6,229	55,034	5,941	60,975	68.00
69.00	06900	ELECTROCARDIOLOGY	138,762	52,614	191,376	4,594	195,970	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	37,847	-32,669	5,178	27,361	32,539	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	211,665	2,064,177	2,275,842	297,718	2,573,560	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.00	03020	CANCER CARE CENTER	44,700	70,735	115,435	0	115,435	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	2,907,224	1,777,608	4,684,832	-438,758	4,246,074	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	1,082,297	2,240,534	3,322,831	5,563	3,328,394	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE		1,494,667	1,494,667	-1,494,667	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	11,925,836	21,140,207	33,066,043	-1,048	33,064,995	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	43,775	43,775	0	43,775	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	74,402	26,281	100,683	1,048	101,731	192.00
194.00	07950	OTHER NRCC	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	169	169	0	169	194.01
194.02	07952	FOUNDATION	0	23,464	23,464	0	23,464	194.02
200.00		TOTAL (SUM OF LINES 118 through 199)	12,000,238	21,233,896	33,234,134	0	33,234,134	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1310

Period:
From 10/01/2017
To 09/30/2018

Worksheet A

Date/Time Prepared:
2/26/2019 11:25 am

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	1,288,734	3,892,216	1.00
1.01	00101	CAP REL COSTS-OFFSITE MOBS	0	256	1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP	534,807	883,159	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-44,508	3,308,195	4.00
5.01	01140	BUSINESS OFFICE	0	116,835	5.01
5.02	00550	DATA PROCESSING	0	1,376,143	5.02
5.03	00570	ADMITTING	0	0	5.03
5.04	00560	PURCHASING RECEIVING AND STORES	0	103,130	5.04
5.05	00590	OTHER A&G	-778,611	3,464,950	5.05
7.00	00700	OPERATION OF PLANT	0	995,551	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	57,158	8.00
9.00	00900	HOUSEKEEPING	0	365,654	9.00
10.00	01000	DIETARY	0	127,158	10.00
11.00	01100	CAFETERIA	-76,613	206,232	11.00
13.00	01300	NURSING ADMINISTRATION	146,889	146,889	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-4,149	237,789	16.00
17.00	01700	SOCIAL SERVICE	0	216,068	17.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-207,311	1,629,327	30.00
31.00	03100	INTENSIVE CARE UNIT	0	46,363	31.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	718,705	50.00
51.00	05100	RECOVERY ROOM	0	267,147	51.00
53.00	05300	ANESTHESIOLOGY	-460,118	48,219	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,346,555	54.00
56.00	05600	RADIOISOTOPE	0	209,925	56.00
57.00	05700	CT SCAN	0	222,926	57.00
58.00	05800	MRI	0	97,651	58.00
60.00	06000	LABORATORY	-20,847	1,380,918	60.00
64.00	06400	INTRAVENOUS THERAPY	0	324,617	64.00
65.00	06500	RESPIRATORY THERAPY	0	410,544	65.00
66.00	06600	PHYSICAL THERAPY	0	594,441	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	95,600	67.00
68.00	06800	SPEECH PATHOLOGY	-30,773	30,202	68.00
69.00	06900	ELECTROCARDIOLOGY	-4,178	191,792	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	32,539	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,573,560	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	75.00
76.00	03020	CANCER CARE CENTER	-70,735	44,700	76.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	-61,348	4,184,726	88.00
90.00	09000	CLINIC	0	0	90.00
91.00	09100	EMERGENCY	-1,424,745	1,903,649	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-1,213,506	31,851,489	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	43,775	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	101,731	192.00
194.00	07950	OTHER NRCC	0	0	194.00
194.01	07951	MARKETING	0	169	194.01
194.02	07952	FOUNDATION	0	23,464	194.02
200.00		TOTAL (SUM OF LINES 118 through 199)	-1,213,506	32,020,628	200.00

RECLASSIFICATIONS

Provider CCN: 14-1310

Period:
From 10/01/2017
To 09/30/2018

Worksheet A-6

Date/Time Prepared:
2/26/2019 11:25 am

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - TO RECLASS INTEREST EXPENSE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1,402,919		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	91,748		2.00
	0		0	1,494,667		
	B - TO RECLASS COPIER LEASE EXPENSE					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	20,162		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
	0		0	20,162		
	D - TO RECLASS CAFETERIA COSTS					
1.00	CAFETERIA	11.00	191,169	91,676		1.00
	0		191,169	91,676		
	G - TO RECLASS PHY CLNC OFF EQPMT DPR					
1.00	CAP REL COSTS-OFFSITE MOBS	1.01	0	256		1.00
2.00	CAP REL COSTS-BLDG & FIXT	1.00	0	108,655		2.00
	0		0	108,911		
	H - TO RECLASS PROPERTY INS EXP					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	37,187		1.00
	0		0	37,187		
	I - TO RECLASS AUTO & OTHER PROP INSUR					
1.00	OTHER A&G	5.05	0	1,414		1.00
2.00	CAP REL COSTS-BLDG & FIXT	1.00	0	25,672		2.00
	0		0	27,086		
	K - TO RECLASS IMPLANTS AND O2 EXP					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	24,104		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
	0		0	24,104		
	L - TO RECLASS DRUGS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	260,466		1.00
2.00	RADIOLOGY-DIAGNOSTIC	54.00	0	80		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
	0		0	260,546		
	V - RHC PHYSICIAN HOSP COSTS					
1.00	ADULTS & PEDIATRICS	30.00	170,139	0		1.00
	TOTALS		170,139	0		
	X - UTILITY EXPENSE					
1.00	OPERATION OF PLANT	7.00	0	48,892		1.00
	0		0	48,892		
	Y - CLINICAL ENGINEERING DEPT					
1.00	OTHER A&G	5.05	0	2,891		1.00
2.00	ADULTS & PEDIATRICS	30.00	0	5,130		2.00
3.00	INTENSIVE CARE UNIT	31.00	0	850		3.00
4.00	OPERATING ROOM	50.00	0	56,257		4.00
5.00	RECOVERY ROOM	51.00	0	44		5.00
6.00	ANESTHESIOLOGY	53.00	0	764		6.00
7.00	MRI	58.00	0	44		7.00
8.00	LABORATORY	60.00	0	74,219		8.00
9.00	RESPIRATORY THERAPY	65.00	0	2,724		9.00
10.00	PHYSICAL THERAPY	66.00	0	751		10.00
11.00	ELECTROCARDIOLOGY	69.00	0	5,080		11.00
12.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	3,257		12.00
13.00	DRUGS CHARGED TO PATIENTS	73.00	0	116		13.00
14.00	RURAL HEALTH CLINIC	88.00	0	445		14.00
15.00	EMERGENCY	91.00	0	5,563		15.00
16.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	1,048		16.00
	0		0	159,183		
	Z - MINISTRY RECLASS					
1.00	OPERATION OF PLANT	7.00	0	74,552		1.00
2.00	DRUGS CHARGED TO PATIENTS	73.00	0	37,136		2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	492,290		3.00
4.00	PHYSICAL THERAPY	66.00	0	21,816		4.00
5.00	OCCUPATIONAL THERAPY	67.00	0	1,911		5.00
6.00	SPEECH PATHOLOGY	68.00	0	5,941		6.00
7.00	PURCHASING RECEIVING AND STORES	5.04	0	52,809		7.00
8.00	DATA PROCESSING	5.02	0	1,078,838		8.00
9.00	SOCIAL SERVICE	17.00	0	216,013		9.00
	TOTALS		0	1,981,306		
500.00	Grand Total: Increases		361,308	4,253,720		500.00

RECLASSIFICATIONS

Provider CCN: 14-1310

Period:
From 10/01/2017
To 09/30/2018

Worksheet A-6

Date/Time Prepared:
2/26/2019 11:25 am

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - TO RECLASS INTEREST EXPENSE						
1.00	INTEREST EXPENSE	113.00	0	1,494,667	11		1.00
2.00		0.00	0	0	11		2.00
	0		0	1,494,667			
	B - TO RECLASS COPIER LEASE EXPENSE						
1.00	LABORATORY	60.00	0	18,925	10		1.00
2.00	ELECTROCARDIOLOGY	69.00	0	486	0		2.00
3.00	RURAL HEALTH CLINIC	88.00	0	751	0		3.00
	0		0	20,162			
	D - TO RECLASS CAFETERIA COSTS						
1.00	DIETARY	10.00	191,169	91,676	0		1.00
	0		191,169	91,676			
	G - TO RECLASS PHY CLNC OFF EQPMT DPR						
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	108,911	9		1.00
2.00		0.00	0	0	9		2.00
	0		0	108,911			
	H - TO RECLASS PROPERTY INS EXP						
1.00	OTHER A&G	5.05	0	37,187	14		1.00
	0		0	37,187			
	I - TO RECLASS AUTO & OTHER PROP INSUR						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	27,086	0		1.00
2.00		0.00	0	0	14		2.00
	0		0	27,086			
	K - TO RECLASS IMPLANTS AND O2 EXP						
1.00	OPERATING ROOM	50.00	0	23,660	0		1.00
2.00	PURCHASING RECEIVING AND STORES	5.04	0	440	0		2.00
3.00	RURAL HEALTH CLINIC	88.00	0	4	0		3.00
	0		0	24,104			
	L - TO RECLASS DRUGS						
1.00	OPERATING ROOM	50.00	0	750	0		1.00
2.00	RADIOISOTOPE	56.00	0	35,502	0		2.00
3.00	CT SCAN	57.00	0	4,807	0		3.00
4.00	INTRAVENOUS THERAPY	64.00	0	70	0		4.00
5.00	RURAL HEALTH CLINIC	88.00	0	219,417	0		5.00
	0		0	260,546			
	V - RHC PHYSICIAN HOSP COSTS						
1.00	RURAL HEALTH CLINIC	88.00	170,139	0	0		1.00
	TOTALS		170,139	0			
	X - UTILITY EXPENSE						
1.00	RURAL HEALTH CLINIC	88.00	0	48,892	0		1.00
	0		0	48,892			
	Y - CLINICAL ENGINEERING DEPT						
1.00	RADIOLOGY-DIAGNOSTIC	54.00	0	159,183	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
7.00		0.00	0	0	0		7.00
8.00		0.00	0	0	0		8.00
9.00		0.00	0	0	0		9.00
10.00		0.00	0	0	0		10.00
11.00		0.00	0	0	0		11.00
12.00		0.00	0	0	0		12.00
13.00		0.00	0	0	0		13.00
14.00		0.00	0	0	0		14.00
15.00		0.00	0	0	0		15.00
16.00		0.00	0	0	0		16.00
	0		0	159,183			
	Z - MINISTRY RECLASS						
1.00	OTHER A&G	5.05	0	1,981,306	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
7.00		0.00	0	0	0		7.00
8.00		0.00	0	0	0		8.00
9.00		0.00	0	0	0		9.00
	TOTALS		0	1,981,306			
500.00	Grand Total: Decreases		361,308	4,253,720			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1310

Period:
From 10/01/2017
To 09/30/2018Worksheet A-7
Part I
Date/Time Prepared:
2/26/2019 11:25 am

		Beginning Balances	Acquisitions			Disposals and Retirements		
			Purchases	Donation	Total			
		1.00	2.00	3.00	4.00	5.00		
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	1,927,000	0	0	0	0	1.00	
2.00	Land Improvements	2,643,598	238,398	0	238,398	834,394	2.00	
3.00	Buildings and Fixtures	18,099,272	767,828	0	767,828	2,600,594	3.00	
4.00	Building Improvements	0	0	0	0	0	4.00	
5.00	Fixed Equipment	0	0	0	0	0	5.00	
6.00	Movable Equipment	16,259,019	1,060,465	0	1,060,465	2,144,581	6.00	
7.00	HIT designated Assets	0	0	0	0	0	7.00	
8.00	Subtotal (sum of lines 1-7)	38,928,889	2,066,691	0	2,066,691	5,579,569	8.00	
9.00	Reconciling Items	25,830	0	0	0	6,598	9.00	
10.00	Total (line 8 minus line 9)	38,903,059	2,066,691	0	2,066,691	5,572,971	10.00	
		Ending Balance	Fully Depreciated Assets					
		6.00	7.00					
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	1,927,000	0				1.00	
2.00	Land Improvements	2,047,602	0				2.00	
3.00	Buildings and Fixtures	16,266,506	0				3.00	
4.00	Building Improvements	0	0				4.00	
5.00	Fixed Equipment	0	0				5.00	
6.00	Movable Equipment	15,174,903	0				6.00	
7.00	HIT designated Assets	0	0				7.00	
8.00	Subtotal (sum of lines 1-7)	35,416,011	0				8.00	
9.00	Reconciling Items	19,232	0				9.00	
10.00	Total (line 8 minus line 9)	35,396,779	0				10.00	

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1310

Period:
From 10/01/2017
To 09/30/2018Worksheet A-7
Part II
Date/Time Prepared:
2/26/2019 11:25 am

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	1,029,049	0	0	0	0	1.00
1.01	CAP REL COSTS-OFFSITE MOBS	0	0	0	0	0	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	345,353	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	1,374,402	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	0	1,029,049				1.00
1.01	CAP REL COSTS-OFFSITE MOBS	0	0				1.01
2.00	CAP REL COSTS-MVBLE EQUIP	0	345,353				2.00
3.00	Total (sum of lines 1-2)	0	1,374,402				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1310

Period:
From 10/01/2017
To 09/30/2018Worksheet A-7
Part III
Date/Time Prepared:
2/26/2019 11:25 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	CAP REL COSTS-BLDG & FIXT	20,238,868	0	20,238,868	0.571461	0	1.00
1.01	CAP REL COSTS-OFFSITE MOBS	2,240	0	2,240	0.000063	0	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	15,174,903	0	15,174,903	0.428476	0	2.00
3.00	Total (sum of lines 1-2)	35,416,011	0	35,416,011	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	CAP REL COSTS-BLDG & FIXT	0	0	0	850,373	-33,677	1.00
1.01	CAP REL COSTS-OFFSITE MOBS	0	0	0	256	0	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	705,432	20,162	2.00
3.00	Total (sum of lines 1-2)	0	0	0	1,556,061	-13,515	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	CAP REL COSTS-BLDG & FIXT	1,547,111	0	0	1,528,409	3,892,216	1.00
1.01	CAP REL COSTS-OFFSITE MOBS	0	0	0	0	256	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	157,565	0	0	0	883,159	2.00
3.00	Total (sum of lines 1-2)	1,704,676	0	0	1,528,409	4,775,631	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1310

Period:
From 10/01/2017
To 09/30/2018

Worksheet A-8

Date/Time Prepared:
2/26/2019 11:25 am

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
1.00				3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-54,083	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
1.01	Investment income - CAP REL COSTS-OFFSITE MOBS (chapter 2)		0	CAP REL COSTS-OFFSITE MOBS	1.01	0	1.01
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)	B	-725	CAP REL COSTS-MVBLE EQUIP	2.00	11	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)	B	-33,677	CAP REL COSTS-BLDG & FIXT	1.00	10	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-4,630	OTHER A&G	5.05	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-2,163,858			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	573,206			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-75,842	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-4,149	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	-771	CAFETERIA	11.00	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 - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
26.01	Depreciation - CAP REL COSTS-OFFSITE MOBS		0	CAP REL COSTS-OFFSITE MOBS	1.01	0	26.01
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** 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

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1310

Period:
From 10/01/2017
To 09/30/2018

Worksheet A-8

Date/Time Prepared:
2/26/2019 11:25 am

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
1.00	2.00	3.00	4.00	5.00			
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	A	-5,311	CAP REL COSTS-MVBLE EQUIP	2.00	9	32.00
33.00	MISCELLANEOUS INCOME	B	-40	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.00
33.01	MISCELLANEOUS INCOME	B	-37,284	OTHER A&G	5.05	0	33.01
33.02	MISCELLANEOUS INCOME	B	-19,898	LABORATORY	60.00	0	33.02
33.03	MISCELLANEOUS INCOME	B	-30,773	SPEECH PATHOLOGY	68.00	0	33.03
33.04	MISCELLANEOUS INCOME	B	-4,178	ELECTROCARDIOLOGY	69.00	0	33.04
33.05	MISCELLANEOUS INCOME	B	-36,578	RURAL HEALTH CLINIC	88.00	0	33.05
33.06	MISCELLANEOUS INCOME	B	-1,780	OTHER A&G	5.05	0	33.06
33.07	MISCELLANEOUS INCOME	B	-343	OTHER A&G	5.05	0	33.07
33.08	CABLE TV EXPENSE	A	-3,302	OTHER A&G	5.05	0	33.08
33.09	INCOME TAXES	A	-290	OTHER A&G	5.05	0	33.09
33.10	MOB PROPERTY TAXES	A	-13,476	OTHER A&G	5.05	0	33.10
33.11	MOB PROPERTY TAXES	A	-3,709	RURAL HEALTH CLINIC	88.00	0	33.11
33.12	COMMUNITY HEALTH EXPENSE	A	-24,722	OTHER A&G	5.05	0	33.12
33.13	COMMUNITY HEALTH BENEFIT EXPENSE	A	-5,640	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.13
33.14	LOBBYING EXPENSE	A	-14,761	OTHER A&G	5.05	0	33.14
33.15	CRNA BENEFIT EXPENSE	A	-38,828	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.15
33.16	PROVIDER TAX IDPA EXPENSE	A	-628,122	OTHER A&G	5.05	0	33.16
33.17	LEGAL EXPENSE ADJUSTMENT	A	-23,687	OTHER A&G	5.05	0	33.17
33.18	VENDING MACHINES	B	-744	OTHER A&G	5.05	0	33.18
33.19	NON RHC PHYSICIAN BENEFITS	A	-21,061	RURAL HEALTH CLINIC	88.00	0	33.19
33.20	BOND SERIES EXPENSES	A	1,465,550	CAP REL COSTS-BLDG & FIXT	1.00	14	33.20
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-1,213,506				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: 14-1310

Period:
From 10/01/2017
To 09/30/2018

Worksheet A-8-1

Date/Time Prepared:
2/26/2019 11:25 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	1.00	CAP REL COSTS-BLDG & FIXT	CAPITAL BLDG HO BLDG CAPITA	108,237	395,568	1.00
2.00	2.00	CAP REL COSTS-MVBLE EQUIP	CAPITAL MME HO MME CAPITAL	474,301	0	2.00
3.00	5.05	OTHER A&G	HO POOLED - ADMIN & GENERAL	626,577	2,393,751	3.00
3.01	4.00	EMPLOYEE BENEFITS DEPARTMENT	MINISTRY ALLOCATION	492,290	492,290	3.01
3.02	5.02	DATA PROCESSING	MINISTRY ALLOCATION	1,078,838	1,078,838	3.02
3.03	5.04	PURCHASING RECEIVING AND STO	MINISTRY ALLOCATION	52,809	52,809	3.03
3.04	7.00	OPERATION OF PLANT	MINISTRY ALLOCATION	74,552	74,552	3.04
3.05	17.00	SOCIAL SERVICE	MINISTRY ALLOCATION	216,013	216,013	3.05
3.06	31.00	INTENSIVE CARE UNIT	MINISTRY ALLOCATION	4,158	4,158	3.06
3.07	66.00	PHYSICAL THERAPY	MINISTRY ALLOCATION	21,816	21,816	3.07
3.08	67.00	OCCUPATIONAL THERAPY	MINISTRY ALLOCATION	1,911	1,911	3.08
3.09	68.00	SPEECH PATHOLOGY	MINISTRY ALLOCATION	5,941	5,941	3.09
3.10	73.00	DRUGS CHARGED TO PATIENTS	MINISTRY ALLOCATION	111,028	111,028	3.10
4.00	1.00	CAP REL COSTS-BLDG & FIXT	HO INTEREST (OPERATING)	198,275	0	4.00
4.01	2.00	CAP REL COSTS-MVBLE EQUIP	HO INTEREST (OPERATING)	66,542	0	4.01
4.02	13.00	NURSING ADMINISTRATION	HO FUNCTIONAL - NURSING ADMI	146,889	0	4.02
4.03	5.05	OTHER A&G	HO FUNCTIONAL - ADMIN & GEN	1,743,311	0	4.03
4.04	5.05	OTHER A&G	RELATED PARTY SFI	2,236	3,843	4.04
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			5,425,724	4,852,518	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.

6.00	B		0.00	OSF HEALTHCARE	100.00	6.00
7.00			0.00		0.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

(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: 14-1310

Period:
From 10/01/2017
To 09/30/2018

Worksheet A-8-1

Date/Time Prepared:
2/26/2019 11:25 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	-287,331	9		1.00
2.00	474,301	9		2.00
3.00	-1,767,174	0		3.00
3.01	0	0		3.01
3.02	0	0		3.02
3.03	0	0		3.03
3.04	0	0		3.04
3.05	0	0		3.05
3.06	0	0		3.06
3.07	0	0		3.07
3.08	0	0		3.08
3.09	0	0		3.09
3.10	0	0		3.10
4.00	198,275	11		4.00
4.01	66,542	11		4.01
4.02	146,889	0		4.02
4.03	1,743,311	0		4.03
4.04	-1,607	0		4.04
5.00	573,206			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	HOME OFFICE		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: 14-1310

Period:
From 10/01/2017
To 09/30/2018

Worksheet A-8-2

Date/Time Prepared:
2/26/2019 11:25 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	5.05	OTHER A&G	67,427	0	67,427	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	207,311	207,311	0	0	0	2.00
3.00	53.00	ANESTHESIOLOGY	460,118	460,118	0	0	0	3.00
4.00	60.00	LABORATORY	16,620	949	15,671	0	0	4.00
5.00	76.00	CANCER CARE CENTER	70,735	70,735	0	0	0	5.00
6.00	91.00	EMERGENCY	2,076,888	1,424,745	652,143	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			2,899,099	2,163,858	735,241		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	5.05	OTHER A&G	0	0	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	2.00
3.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	3.00
4.00	60.00	LABORATORY	0	0	0	0	0	4.00
5.00	76.00	CANCER CARE CENTER	0	0	0	0	0	5.00
6.00	91.00	EMERGENCY	0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	5.05	OTHER A&G	0	0	0	0		1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	207,311		2.00
3.00	53.00	ANESTHESIOLOGY	0	0	0	460,118		3.00
4.00	60.00	LABORATORY	0	0	0	949		4.00
5.00	76.00	CANCER CARE CENTER	0	0	0	70,735		5.00
6.00	91.00	EMERGENCY	0	0	0	1,424,745		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	2,163,858		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1310

Period:
From 10/01/2017
To 09/30/2018Worksheet B
Part I
Date/Time Prepared:
2/26/2019 11:25 am

Cost Center Description		Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT	
			BLDG & FIXT	OFFSITE MOBS	MVBLE EQUIP		
		0	1.00	1.01	2.00	4.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	3,892,216	3,892,216			1.00
1.01	00101	CAP REL COSTS-OFFSITE MOBS	256	0	256		1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP	883,159		883,159		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	3,308,195	5,490	1,246	3,314,931	4.00
5.01	01140	BUSINESS OFFICE	116,835	51,788	11,751	0	5.01
5.02	00550	DATA PROCESSING	1,376,143	60,472	13,721	0	5.02
5.03	00570	ADMITTING	0	31,930	7,245	0	5.03
5.04	00560	PURCHASING RECEIVING AND STORES	103,130	14,174	3,216	35,749	5.04
5.05	00590	OTHER A&G	3,464,950	758,015	171,998	315,044	5.05
7.00	00700	OPERATION OF PLANT	995,551	174,561	39,609	111,204	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	57,158	18,457	4,188	0	8.00
9.00	00900	HOUSEKEEPING	365,654	42,599	9,666	119,288	9.00
10.00	01000	DIETARY	127,158	105,952	24,041	31,419	10.00
11.00	01100	CAFETERIA	206,232	41,820	9,489	69,887	11.00
13.00	01300	NURSING ADMINISTRATION	146,889	13,823	3,137	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	237,789	34,538	7,837	87,317	16.00
17.00	01700	SOCIAL SERVICE	216,068	11,643	2,642	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	1,629,327	594,864	134,977	535,110	30.00
31.00	03100	INTENSIVE CARE UNIT	46,363	90,104	20,445	9,821	31.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	718,705	170,200	38,619	130,239	50.00
51.00	05100	RECOVERY ROOM	267,147	190,954	43,328	90,199	51.00
53.00	05300	ANESTHESIOLOGY	48,219	5,023	1,140	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,346,555	148,901	33,786	210,979	54.00
56.00	05600	RADIOISOTOPE	209,925	26,751	6,070	1,360	56.00
57.00	05700	CT SCAN	222,926	18,029	4,091	65,502	57.00
58.00	05800	MRI	97,651	40,379	9,162	33,087	58.00
60.00	06000	LABORATORY	1,380,918	73,905	16,769	219,262	60.00
64.00	06400	INTRAVENOUS THERAPY	324,617	174,912	39,688	110,477	64.00
65.00	06500	RESPIRATORY THERAPY	410,544	84,302	19,128	125,063	65.00
66.00	06600	PHYSICAL THERAPY	594,441	81,537	18,501	200,703	66.00
67.00	06700	OCCUPATIONAL THERAPY	95,600	10,630	2,412	33,518	67.00
68.00	06800	SPEECH PATHOLOGY	30,202	3,933	892	17,842	68.00
69.00	06900	ELECTROCARDIOLOGY	191,792	3,972	901	50,728	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	32,539	108,911	24,712	13,836	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,573,560	30,800	6,989	77,380	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	75.00
76.00	03020	CANCER CARE CENTER	44,700	8,489	1,926	16,341	76.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	4,184,726	326,733	74,137	180,712	88.00
90.00	09000	CLINIC	0	0	0	0	90.00
91.00	09100	EMERGENCY	1,903,649	192,668	43,717	395,664	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	31,851,489	3,751,259	851,176	3,287,731	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	43,775	9,423	2,138	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	101,731	126,940	28,803	27,200	192.00
194.00	07950	OTHER NRCC	0	0	0	0	194.00
194.01	07951	MARKETING	169	2,297	521	0	194.01
194.02	07952	FOUNDATION	23,464	2,297	521	0	194.02
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers		0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	32,020,628	3,892,216	883,159	3,314,931	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1310

Period:
From 10/01/2017
To 09/30/2018Worksheet B
Part I
Date/Time Prepared:
2/26/2019 11:25 am

Cost Center Description			Subtotal	BUSINESS OFFICE	DATA PROCESSING	Subtotal	ADMITTING	
			4A	5.01	5.02	5A.02	5.03	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-OFFSITE MOBS						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	01140	BUSINESS OFFICE	180,374	180,374				5.01
5.02	00550	DATA PROCESSING	1,450,336	8,238	1,458,574			5.02
5.03	00570	ADMITTING	39,175	223	0	39,398	39,398	5.03
5.04	00560	PURCHASING RECEIVING AND STORES	156,269	888	27,068	184,225	272	5.04
5.05	00590	OTHER A&G	4,710,007	26,753	741,729	5,478,489	8,105	5.05
7.00	00700	OPERATION OF PLANT	1,320,925	7,503	3,270	1,331,698	1,968	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	79,803	453	0	80,256	119	8.00
9.00	00900	HOUSEKEEPING	537,207	3,051	0	540,258	799	9.00
10.00	01000	DIETARY	288,570	1,639	63,582	353,791	523	10.00
11.00	01100	CAFETERIA	327,428	1,860	0	329,288	487	11.00
13.00	01300	NURSING ADMINISTRATION	163,849	931	0	164,780	244	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	367,481	2,087	28,521	398,089	588	16.00
17.00	01700	SOCIAL SERVICE	230,353	1,308	7,267	238,928	353	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	2,894,278	16,439	0	2,910,717	4,302	30.00
31.00	03100	INTENSIVE CARE UNIT	166,733	947	1,817	169,497	251	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,057,763	6,008	202,373	1,266,144	1,871	50.00
51.00	05100	RECOVERY ROOM	591,628	3,360	545	595,533	880	51.00
53.00	05300	ANESTHESIOLOGY	54,382	309	0	54,691	81	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,740,221	9,884	48,141	1,798,246	2,658	54.00
56.00	05600	RADIOISOTOPE	244,106	1,387	0	245,493	363	56.00
57.00	05700	CT SCAN	310,548	1,764	0	312,312	462	57.00
58.00	05800	MRI	180,279	1,024	0	181,303	268	58.00
60.00	06000	LABORATORY	1,690,854	9,604	43,236	1,743,694	2,577	60.00
64.00	06400	INTRAVENOUS THERAPY	649,694	3,690	0	653,384	966	64.00
65.00	06500	RESPIRATORY THERAPY	639,037	3,630	0	642,667	950	65.00
66.00	06600	PHYSICAL THERAPY	895,182	5,085	13,261	913,528	1,350	66.00
67.00	06700	OCCUPATIONAL THERAPY	142,160	807	59,949	202,916	300	67.00
68.00	06800	SPEECH PATHOLOGY	52,869	300	0	53,169	79	68.00
69.00	06900	ELECTROCARDIOLOGY	247,393	1,405	36,151	284,949	421	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	179,998	1,022	0	181,020	268	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,688,729	15,272	3,452	2,707,453	4,002	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.00	03020	CANCER CARE CENTER	71,456	406	0	71,862	106	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	4,766,308	27,076	167,312	4,960,696	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	2,535,698	14,403	10,900	2,561,001	3,785	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	31,651,093	178,756	1,458,574	31,649,475	39,398	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	55,336	0	0	55,336	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	284,930	1,618	0	286,548	0	192.00
194.00	07950	OTHER NRCC	0	0	0	0	0	194.00
194.01	07951	MARKETING	2,987	0	0	2,987	0	194.01
194.02	07952	FOUNDATION	26,282	0	0	26,282	0	194.02
200.00		Cross Foot Adjustments	0	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	32,020,628	180,374	1,458,574	32,020,628	39,398	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1310

Period:
From 10/01/2017
To 09/30/2018Worksheet B
Part I
Date/Time Prepared:
2/26/2019 11:25 am

Cost Center Description			PURCHASING RECEIVING AND STORES	Subtotal	OTHER A&G	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
			5.04	5A.04	5.05	7.00	8.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-OFFSITE MOBS						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	01140	BUSINESS OFFICE						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00570	ADMITTING						5.03
5.04	00560	PURCHASING RECEIVING AND STORES	184,497					5.04
5.05	00590	OTHER A&G	4,143	5,490,737	5,490,737			5.05
7.00	00700	OPERATION OF PLANT	6,694	1,340,360	277,406	1,617,766		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	9	80,384	16,637	10,680	107,701	8.00
9.00	00900	HOUSEKEEPING	7,667	548,724	113,566	24,650	0	9.00
10.00	01000	DIETARY	981	355,295	73,533	61,308	0	10.00
11.00	01100	CAFETERIA	2,182	331,957	68,703	24,199	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	165,024	34,154	7,999	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	303	398,980	82,574	19,985	0	16.00
17.00	01700	SOCIAL SERVICE	0	239,281	49,523	6,737	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	12,565	2,927,584	605,904	344,215	34,748	30.00
31.00	03100	INTENSIVE CARE UNIT	333	170,081	35,201	52,138	0	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	50,890	1,318,905	272,966	98,485	10,610	50.00
51.00	05100	RECOVERY ROOM	3,526	599,939	124,166	110,495	5,186	51.00
53.00	05300	ANESTHESIOLOGY	4,822	59,594	12,334	2,907	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,518	1,803,422	373,243	86,161	8,618	54.00
56.00	05600	RADIOISOTOPE	3,786	249,642	51,667	15,479	1,549	56.00
57.00	05700	CT SCAN	8,670	321,444	66,527	10,432	1,043	57.00
58.00	05800	MRI	2,280	183,851	38,051	23,365	2,337	58.00
60.00	06000	LABORATORY	12,463	1,758,734	363,995	42,765	0	60.00
64.00	06400	INTRAVENOUS THERAPY	4,163	658,513	136,288	101,212	0	64.00
65.00	06500	RESPIRATORY THERAPY	10,181	653,798	135,313	48,781	1,202	65.00
66.00	06600	PHYSICAL THERAPY	2,170	917,048	189,796	47,181	9,081	66.00
67.00	06700	OCCUPATIONAL THERAPY	303	203,519	42,121	6,151	1,184	67.00
68.00	06800	SPEECH PATHOLOGY	0	53,248	11,020	2,276	0	68.00
69.00	06900	ELECTROCARDIOLOGY	4,569	289,939	60,007	2,298	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	181,288	37,520	63,021	75	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,588	2,716,043	562,123	17,822	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.00	03020	CANCER CARE CENTER	0	71,968	14,895	4,912	0	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	6,926	4,967,622	1,028,124	189,062	1,476	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	15,417	2,580,203	534,009	111,486	30,570	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	172,149	31,637,127	5,411,366	1,536,202	107,679	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	9,403	64,739	13,399	5,453	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2,794	289,342	59,883	73,453	22	192.00
194.00	07950	OTHER NRCC	0	0	0	0	0	194.00
194.01	07951	MARKETING	37	3,024	626	1,329	0	194.01
194.02	07952	FOUNDATION	114	26,396	5,463	1,329	0	194.02
200.00		Cross Foot Adjustments	0	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	184,497	32,020,628	5,490,737	1,617,766	107,701	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1310

Period:
From 10/01/2017
To 09/30/2018Worksheet B
Part I
Date/Time Prepared:
2/26/2019 11:25 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	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-OFFSITE MOBS						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	01140	BUSINESS OFFICE						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00570	ADMITTING						5.03
5.04	00560	PURCHASING RECEIVING AND STORES						5.04
5.05	00590	OTHER A&G						5.05
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING	686,940					9.00
10.00	01000	DIETARY	13,726	503,862				10.00
11.00	01100	CAFETERIA	5,457	0	430,316			11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	207,177		13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,961	0	14,301	0	520,801	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	246,400	453,675	81,592	67,331	180,208	30.00
31.00	03100	INTENSIVE CARE UNIT	14,056	8,043	6,489	5,364	515	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	36,381	0	16,946	13,991	0	50.00
51.00	05100	RECOVERY ROOM	40,846	15,315	12,825	10,584	31,408	51.00
53.00	05300	ANESTHESIOLOGY	0	0	6,274	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	30,428	0	26,018	21,471	15,961	54.00
56.00	05600	RADIOISOTOPE	5,457	0	154	124	2,832	56.00
57.00	05700	CT SCAN	3,638	0	8,919	7,369	2,060	57.00
58.00	05800	MRI	8,268	0	3,937	3,246	4,376	58.00
60.00	06000	LABORATORY	20,836	0	34,845	28,762	28,833	60.00
64.00	06400	INTRAVENOUS THERAPY	25,467	0	15,039	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	17,033	0	17,499	0	9,268	65.00
66.00	06600	PHYSICAL THERAPY	18,356	0	21,713	0	13,129	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,315	0	3,475	0	2,060	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	2,337	0	1,030	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	7,104	5,864	2,574	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,315	0	4,459	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,961	0	7,504	6,194	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.00	03020	CANCER CARE CENTER	0	0	2,337	0	0	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	88,637	7,382	89,556	0	40,933	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	63,005	19,447	44,686	36,877	146,483	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	652,543	503,862	428,009	207,177	481,670	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	34,397	0	2,307	0	39,131	192.00
194.00	07950	OTHER NRCC	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	0	0	0	0	194.01
194.02	07952	FOUNDATION	0	0	0	0	0	194.02
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)	686,940	503,862	430,316	207,177	520,801	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1310

Period:
From 10/01/2017
To 09/30/2018Worksheet B
Part I
Date/Time Prepared:
2/26/2019 11:25 am

Cost Center Description			SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			17.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	CAP REL COSTS-OFFSITE MOBS					1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	01140	BUSINESS OFFICE					5.01
5.02	00550	DATA PROCESSING					5.02
5.03	00570	ADMITTING					5.03
5.04	00560	PURCHASING RECEIVING AND STORES					5.04
5.05	00590	OTHER A&G					5.05
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
17.00	01700	SOCIAL SERVICE	295,541				17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	273,949	5,215,606	0	5,215,606	30.00
31.00	03100	INTENSIVE CARE UNIT	0	291,887	0	291,887	31.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	1,768,284	0	1,768,284	50.00
51.00	05100	RECOVERY ROOM	0	950,764	0	950,764	51.00
53.00	05300	ANESTHESIOLOGY	0	81,109	0	81,109	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,365,322	0	2,365,322	54.00
56.00	05600	RADIOISOTOPE	0	326,904	0	326,904	56.00
57.00	05700	CT SCAN	0	421,432	0	421,432	57.00
58.00	05800	MRI	0	267,431	0	267,431	58.00
60.00	06000	LABORATORY	0	2,278,770	0	2,278,770	60.00
64.00	06400	INTRAVENOUS THERAPY	0	936,519	0	936,519	64.00
65.00	06500	RESPIRATORY THERAPY	0	882,894	0	882,894	65.00
66.00	06600	PHYSICAL THERAPY	0	1,216,304	0	1,216,304	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	260,825	0	260,825	67.00
68.00	06800	SPEECH PATHOLOGY	0	69,911	0	69,911	68.00
69.00	06900	ELECTROCARDIOLOGY	0	367,786	0	367,786	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	288,678	0	288,678	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,314,647	0	3,314,647	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	75.00
76.00	03020	CANCER CARE CENTER	0	94,112	0	94,112	76.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	4,723	6,417,515	0	6,417,515	88.00
90.00	09000	CLINIC	0	0	0	0	90.00
91.00	09100	EMERGENCY	16,869	3,583,635	0	3,583,635	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			0		92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	295,541	31,400,335	0	31,400,335	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	83,591	0	83,591	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	498,535	0	498,535	192.00
194.00	07950	OTHER NRCC	0	0	0	0	194.00
194.01	07951	MARKETING	0	4,979	0	4,979	194.01
194.02	07952	FOUNDATION	0	33,188	0	33,188	194.02
200.00		Cross Foot Adjustments	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	295,541	32,020,628	0	32,020,628	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1310

Period:
From 10/01/2017
To 09/30/2018Worksheet B
Part II
Date/Time Prepared:
2/26/2019 11:25 am

Cost Center Description		Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS			Subtotal	
			BLDG & FIXT	OFFSITE MOBS	MVBLE EQUIP		
		0	1.00	1.01	2.00	2A	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	CAP REL COSTS-OFFSITE MOBS					1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	5,490	0	1,246	4.00
5.01	01140	BUSINESS OFFICE	0	51,788	0	11,751	5.01
5.02	00550	DATA PROCESSING	0	60,472	0	13,721	5.02
5.03	00570	ADMITTING	0	31,930	0	7,245	5.03
5.04	00560	PURCHASING RECEIVING AND STORES	0	14,174	0	3,216	5.04
5.05	00590	OTHER A&G	0	758,015	0	171,998	5.05
7.00	00700	OPERATION OF PLANT	0	174,561	0	39,609	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	18,457	0	4,188	8.00
9.00	00900	HOUSEKEEPING	0	42,599	0	9,666	9.00
10.00	01000	DIETARY	0	105,952	0	24,041	10.00
11.00	01100	CAFETERIA	0	41,820	0	9,489	11.00
13.00	01300	NURSING ADMINISTRATION	0	13,823	0	3,137	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	34,538	0	7,837	16.00
17.00	01700	SOCIAL SERVICE	0	11,643	0	2,642	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	594,864	0	134,977	30.00
31.00	03100	INTENSIVE CARE UNIT	0	90,104	0	20,445	31.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	170,200	0	38,619	50.00
51.00	05100	RECOVERY ROOM	0	190,954	0	43,328	51.00
53.00	05300	ANESTHESIOLOGY	0	5,023	0	1,140	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	148,901	0	33,786	54.00
56.00	05600	RADIOISOTOPE	0	26,751	0	6,070	56.00
57.00	05700	CT SCAN	0	18,029	0	4,091	57.00
58.00	05800	MRI	0	40,379	0	9,162	58.00
60.00	06000	LABORATORY	0	73,905	0	16,769	60.00
64.00	06400	INTRAVENOUS THERAPY	0	174,912	0	39,688	64.00
65.00	06500	RESPIRATORY THERAPY	0	84,302	0	19,128	65.00
66.00	06600	PHYSICAL THERAPY	0	81,537	0	18,501	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	10,630	0	2,412	67.00
68.00	06800	SPEECH PATHOLOGY	0	3,933	0	892	68.00
69.00	06900	ELECTROCARDIOLOGY	0	3,972	0	901	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	108,911	0	24,712	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	30,800	0	6,989	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	75.00
76.00	03020	CANCER CARE CENTER	0	8,489	0	1,926	76.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	326,733	0	74,137	88.00
90.00	09000	CLINIC	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	192,668	0	43,717	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE	0	0	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	3,751,259	0	851,176	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	9,423	0	2,138	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	126,940	256	28,803	192.00
194.00	07950	OTHER NRCC	0	0	0	0	194.00
194.01	07951	MARKETING	0	2,297	0	521	194.01
194.02	07952	FOUNDATION	0	2,297	0	521	194.02
200.00		Cross Foot Adjustments	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	3,892,216	256	883,159	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1310

Period:
From 10/01/2017
To 09/30/2018Worksheet B
Part II
Date/Time Prepared:
2/26/2019 11:25 am

Cost Center Description			EMPLOYEE BENEFITS DEPARTMENT	BUSINESS OFFICE	DATA PROCESSING	ADMITTING	PURCHASING RECEIVING AND STORES	
			4.00	5.01	5.02	5.03	5.04	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-OFFSITE MOBS						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	6,736					4.00
5.01	01140	BUSINESS OFFICE	0	63,539				5.01
5.02	00550	DATA PROCESSING	0	2,902	77,095			5.02
5.03	00570	ADMITTING	0	78	0	39,253		5.03
5.04	00560	PURCHASING RECEIVING AND STORES	73	313	1,431	271	19,478	5.04
5.05	00590	OTHER A&G	640	9,425	39,203	8,068	437	5.05
7.00	00700	OPERATION OF PLANT	226	2,643	173	1,962	707	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	160	0	118	1	8.00
9.00	00900	HOUSEKEEPING	242	1,075	0	796	809	9.00
10.00	01000	DIETARY	64	577	3,361	521	104	10.00
11.00	01100	CAFETERIA	142	655	0	485	230	11.00
13.00	01300	NURSING ADMINISTRATION	0	328	0	243	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	177	735	1,508	586	32	16.00
17.00	01700	SOCIAL SERVICE	0	461	384	352	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,088	5,791	0	4,287	1,327	30.00
31.00	03100	INTENSIVE CARE UNIT	20	334	96	250	35	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	265	2,117	10,697	1,865	5,373	50.00
51.00	05100	RECOVERY ROOM	183	1,184	29	877	372	51.00
53.00	05300	ANESTHESIOLOGY	0	109	0	81	509	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	429	3,482	2,545	2,649	266	54.00
56.00	05600	RADIOISOTOPE	3	488	0	362	400	56.00
57.00	05700	CT SCAN	133	621	0	460	915	57.00
58.00	05800	MRI	67	361	0	267	241	58.00
60.00	06000	LABORATORY	446	3,383	2,285	2,568	1,316	60.00
64.00	06400	INTRAVENOUS THERAPY	225	1,300	0	962	439	64.00
65.00	06500	RESPIRATORY THERAPY	254	1,279	0	947	1,075	65.00
66.00	06600	PHYSICAL THERAPY	408	1,791	701	1,346	229	66.00
67.00	06700	OCCUPATIONAL THERAPY	68	284	3,169	299	32	67.00
68.00	06800	SPEECH PATHOLOGY	36	106	0	78	0	68.00
69.00	06900	ELECTROCARDIOLOGY	103	495	1,911	420	482	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	28	360	0	267	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	157	5,380	182	3,988	484	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.00	03020	CANCER CARE CENTER	33	143	0	106	0	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	367	9,535	8,844	0	731	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	804	5,074	576	3,772	1,628	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	6,681	62,969	77,095	39,253	18,174	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	993	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	55	570	0	0	295	192.00
194.00	07950	OTHER NRCC	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	0	0	0	4	194.01
194.02	07952	FOUNDATION	0	0	0	0	12	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	6,736	63,539	77,095	39,253	19,478	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1310

Period:
From 10/01/2017
To 09/30/2018Worksheet B
Part II
Date/Time Prepared:
2/26/2019 11:25 am

Cost Center Description			OTHER A&G	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.05	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-OFFSITE MOBS						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	01140	BUSINESS OFFICE						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00570	ADMITTING						5.03
5.04	00560	PURCHASING RECEIVING AND STORES						5.04
5.05	00590	OTHER A&G	987,786					5.05
7.00	00700	OPERATION OF PLANT	49,906	269,787				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,993	1,781	27,698			8.00
9.00	00900	HOUSEKEEPING	20,431	4,111	0	79,729		9.00
10.00	01000	DIETARY	13,229	10,224	0	1,593	159,666	10.00
11.00	01100	CAFETERIA	12,360	4,036	0	633	0	11.00
13.00	01300	NURSING ADMINISTRATION	6,144	1,334	0	0	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	14,855	3,333	0	576	0	16.00
17.00	01700	SOCIAL SERVICE	8,909	1,123	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	109,003	57,400	8,936	28,597	143,763	30.00
31.00	03100	INTENSIVE CARE UNIT	6,333	8,695	0	1,631	2,549	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	49,107	16,424	2,729	4,223	0	50.00
51.00	05100	RECOVERY ROOM	22,338	18,427	1,334	4,741	4,853	51.00
53.00	05300	ANESTHESIOLOGY	2,219	485	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	67,147	14,369	2,216	3,532	0	54.00
56.00	05600	RADIOISOTOPE	9,295	2,581	398	633	0	56.00
57.00	05700	CT SCAN	11,968	1,740	268	422	0	57.00
58.00	05800	MRI	6,845	3,897	601	960	0	58.00
60.00	06000	LABORATORY	65,483	7,132	0	2,418	0	60.00
64.00	06400	INTRAVENOUS THERAPY	24,518	16,879	0	2,956	0	64.00
65.00	06500	RESPIRATORY THERAPY	24,343	8,135	309	1,977	0	65.00
66.00	06600	PHYSICAL THERAPY	34,144	7,868	2,336	2,130	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	7,578	1,026	304	269	0	67.00
68.00	06800	SPEECH PATHOLOGY	1,983	380	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	10,795	383	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	6,750	10,510	19	269	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	101,126	2,972	0	576	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.00	03020	CANCER CARE CENTER	2,680	819	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	184,956	31,529	380	10,288	2,339	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	96,069	18,592	7,862	7,313	6,162	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	973,507	256,185	27,692	75,737	159,666	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,410	909	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	10,773	12,249	6	3,992	0	192.00
194.00	07950	OTHER NRCC	0	0	0	0	0	194.00
194.01	07951	MARKETING	113	222	0	0	0	194.01
194.02	07952	FOUNDATION	983	222	0	0	0	194.02
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)	987,786	269,787	27,698	79,729	159,666	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1310

Period:
From 10/01/2017
To 09/30/2018Worksheet B
Part II
Date/Time Prepared:
2/26/2019 11:25 am

Cost Center Description			CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	
			11.00	13.00	16.00	17.00	24.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-OFFSITE MOBS						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	01140	BUSINESS OFFICE						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00570	ADMITTING						5.03
5.04	00560	PURCHASING RECEIVING AND STORES						5.04
5.05	00590	OTHER A&G						5.05
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	69,850					11.00
13.00	01300	NURSING ADMINISTRATION	0	25,009				13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,321	0	66,498			16.00
17.00	01700	SOCIAL SERVICE	0	0	0	25,514		17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	13,244	8,125	23,010	23,650	1,158,062	30.00
31.00	03100	INTENSIVE CARE UNIT	1,053	648	66	0	132,259	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	2,751	1,689	0	0	306,059	50.00
51.00	05100	RECOVERY ROOM	2,082	1,278	4,010	0	295,990	51.00
53.00	05300	ANESTHESIOLOGY	1,018	0	0	0	10,584	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,223	2,592	2,038	0	288,175	54.00
56.00	05600	RADIOISOTOPE	25	15	362	0	47,383	56.00
57.00	05700	CT SCAN	1,448	890	263	0	41,248	57.00
58.00	05800	MRI	639	392	559	0	64,370	58.00
60.00	06000	LABORATORY	5,656	3,472	3,682	0	188,515	60.00
64.00	06400	INTRAVENOUS THERAPY	2,441	0	0	0	264,320	64.00
65.00	06500	RESPIRATORY THERAPY	2,841	0	1,183	0	145,773	65.00
66.00	06600	PHYSICAL THERAPY	3,524	0	1,676	0	156,191	66.00
67.00	06700	OCCUPATIONAL THERAPY	564	0	263	0	26,898	67.00
68.00	06800	SPEECH PATHOLOGY	379	0	131	0	7,918	68.00
69.00	06900	ELECTROCARDIOLOGY	1,153	708	329	0	21,652	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	724	0	0	0	152,550	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,218	748	0	0	154,620	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.00	03020	CANCER CARE CENTER	379	0	0	0	14,575	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	14,539	0	5,226	408	670,012	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	7,254	4,452	18,704	1,456	416,103	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	69,476	25,009	61,502	25,514	4,563,257	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	15,873	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	374	0	4,996	0	189,309	192.00
194.00	07950	OTHER NRCC	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	0	0	0	3,157	194.01
194.02	07952	FOUNDATION	0	0	0	0	4,035	194.02
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)	69,850	25,009	66,498	25,514	4,775,631	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1310

Period:
From 10/01/2017
To 09/30/2018Worksheet B
Part II
Date/Time Prepared:
2/26/2019 11:25 am

Cost Center Description			Intern & Residents Cost & Post Stepdown Adjustments	Total	
			25.00	26.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
1.01	00101	CAP REL COSTS-OFFSITE MOBS			1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.01	01140	BUSINESS OFFICE			5.01
5.02	00550	DATA PROCESSING			5.02
5.03	00570	ADMITTING			5.03
5.04	00560	PURCHASING RECEIVING AND STORES			5.04
5.05	00590	OTHER A&G			5.05
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
17.00	01700	SOCIAL SERVICE			17.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	0	1,158,062	30.00
31.00	03100	INTENSIVE CARE UNIT	0	132,259	31.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	306,059	50.00
51.00	05100	RECOVERY ROOM	0	295,990	51.00
53.00	05300	ANESTHESIOLOGY	0	10,584	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	288,175	54.00
56.00	05600	RADIOISOTOPE	0	47,383	56.00
57.00	05700	CT SCAN	0	41,248	57.00
58.00	05800	MRI	0	64,370	58.00
60.00	06000	LABORATORY	0	188,515	60.00
64.00	06400	INTRAVENOUS THERAPY	0	264,320	64.00
65.00	06500	RESPIRATORY THERAPY	0	145,773	65.00
66.00	06600	PHYSICAL THERAPY	0	156,191	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	26,898	67.00
68.00	06800	SPEECH PATHOLOGY	0	7,918	68.00
69.00	06900	ELECTROCARDIOLOGY	0	21,652	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	152,550	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	154,620	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	75.00
76.00	03020	CANCER CARE CENTER	0	14,575	76.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	670,012	88.00
90.00	09000	CLINIC	0	0	90.00
91.00	09100	EMERGENCY	0	416,103	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		92.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE			113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	4,563,257	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	15,873	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	189,309	192.00
194.00	07950	OTHER NRCC	0	0	194.00
194.01	07951	MARKETING	0	3,157	194.01
194.02	07952	FOUNDATION	0	4,035	194.02
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	4,775,631	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1310

Period:
From 10/01/2017
To 09/30/2018

Worksheet B-1

Date/Time Prepared:
2/26/2019 11:25 am

Cost Center Description			CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	
			BLDG & FIXT (SQUARE FEET)	OFFSITE MOBS (MOB SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)			
			1.00	1.01	2.00			
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT	99,958					1.00
1.01	00101	CAP REL COSTS-OFFSITE MOBS	0	100				1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP			99,958			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	141	0	141	9,067,638		4.00
5.01	01140	BUSINESS OFFICE	1,330	0	1,330	0	-180,374	5.01
5.02	00550	DATA PROCESSING	1,553	0	1,553	0	0	5.02
5.03	00570	ADMITTING	820	0	820	0	0	5.03
5.04	00560	PURCHASING RECEIVING AND STORES	364	0	364	97,787	0	5.04
5.05	00590	OTHER A&G	19,467	0	19,467	861,769	0	5.05
7.00	00700	OPERATION OF PLANT	4,483	0	4,483	304,188	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	474	0	474	0	0	8.00
9.00	00900	HOUSEKEEPING	1,094	0	1,094	326,299	0	9.00
10.00	01000	DIETARY	2,721	0	2,721	85,944	0	10.00
11.00	01100	CAFETERIA	1,074	0	1,074	191,169	0	11.00
13.00	01300	NURSING ADMINISTRATION	355	0	355	0	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	887	0	887	238,847	0	16.00
17.00	01700	SOCIAL SERVICE	299	0	299	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	15,277	0	15,277	1,463,733	0	30.00
31.00	03100	INTENSIVE CARE UNIT	2,314	0	2,314	26,863	0	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	4,371	0	4,371	356,254	0	50.00
51.00	05100	RECOVERY ROOM	4,904	0	4,904	246,729	0	51.00
53.00	05300	ANESTHESIOLOGY	129	0	129	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,824	0	3,824	577,112	0	54.00
56.00	05600	RADIOISOTOPE	687	0	687	3,721	0	56.00
57.00	05700	CT SCAN	463	0	463	179,174	0	57.00
58.00	05800	MRI	1,037	0	1,037	90,507	0	58.00
60.00	06000	LABORATORY	1,898	0	1,898	599,767	0	60.00
64.00	06400	INTRAVENOUS THERAPY	4,492	0	4,492	302,197	0	64.00
65.00	06500	RESPIRATORY THERAPY	2,165	0	2,165	342,096	0	65.00
66.00	06600	PHYSICAL THERAPY	2,094	0	2,094	549,001	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	273	0	273	91,685	0	67.00
68.00	06800	SPEECH PATHOLOGY	101	0	101	48,805	0	68.00
69.00	06900	ELECTROCARDIOLOGY	102	0	102	138,762	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,797	0	2,797	37,847	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	791	0	791	211,665	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.00	03020	CANCER CARE CENTER	218	0	218	44,700	0	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	8,391	0	8,391	494,318	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	4,948	0	4,948	1,082,297	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	96,338	0	96,338	8,993,236	-180,374	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	242	0	242	0	-55,336	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	3,260	100	3,260	74,402	0	192.00
194.00	07950	OTHER NRCC	0	0	0	0	0	194.00
194.01	07951	MARKETING	59	0	59	0	-2,987	194.01
194.02	07952	FOUNDATION	59	0	59	0	-26,282	194.02
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)	3,892,216	256	883,159	3,314,931		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	38.938514	2.560000	8.835301	0.365578		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)				6,736		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)				0.000743		205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1310

Period:
From 10/01/2017
To 09/30/2018

Worksheet B-1

Date/Time Prepared:
2/26/2019 11:25 am

Cost Center Description			BUSINESS OFFICE (ACCUM. COST)	DATA PROCESSING (MACHINE HO URS)	Reconciliation	ADMITTING (ACCUM. COST)	PURCHASING RECEIVING AND STORES (COSTED REQUIS.)	
			5.01	5.02	5A.03	5.03	5.04	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-OFFSITE MOBS						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	01140	BUSINESS OFFICE	31,755,649					5.01
5.02	00550	DATA PROCESSING	1,450,336	8,029				5.02
5.03	00570	ADMITTING	39,175	0	-39,398	26,649,381		5.03
5.04	00560	PURCHASING RECEIVING AND STORES	156,269	149	0	184,225	853,817	5.04
5.05	00590	OTHER A&G	4,710,007	4,083	0	5,478,489	19,175	5.05
7.00	00700	OPERATION OF PLANT	1,320,925	18	0	1,331,698	30,979	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	79,803	0	0	80,256	40	8.00
9.00	00900	HOUSEKEEPING	537,207	0	0	540,258	35,483	9.00
10.00	01000	DIETARY	288,570	350	0	353,791	4,539	10.00
11.00	01100	CAFETERIA	327,428	0	0	329,288	10,096	11.00
13.00	01300	NURSING ADMINISTRATION	163,849	0	0	164,780	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	367,481	157	0	398,089	1,400	16.00
17.00	01700	SOCIAL SERVICE	230,353	40	0	238,928	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	2,894,278	0	0	2,910,717	58,148	30.00
31.00	03100	INTENSIVE CARE UNIT	166,733	10	0	169,497	1,543	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,057,763	1,114	0	1,266,144	235,514	50.00
51.00	05100	RECOVERY ROOM	591,628	3	0	595,533	16,318	51.00
53.00	05300	ANESTHESIOLOGY	54,382	0	0	54,691	22,317	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,740,221	265	0	1,798,246	11,654	54.00
56.00	05600	RADIOISOTOPE	244,106	0	0	245,493	17,522	56.00
57.00	05700	CT SCAN	310,548	0	0	312,312	40,125	57.00
58.00	05800	MRI	180,279	0	0	181,303	10,552	58.00
60.00	06000	LABORATORY	1,690,854	238	0	1,743,694	57,676	60.00
64.00	06400	INTRAVENOUS THERAPY	649,694	0	0	653,384	19,264	64.00
65.00	06500	RESPIRATORY THERAPY	639,037	0	0	642,667	47,114	65.00
66.00	06600	PHYSICAL THERAPY	895,182	73	0	913,528	10,041	66.00
67.00	06700	OCCUPATIONAL THERAPY	142,160	330	0	202,916	1,402	67.00
68.00	06800	SPEECH PATHOLOGY	52,869	0	0	53,169	0	68.00
69.00	06900	ELECTROCARDIOLOGY	247,393	199	0	284,949	21,144	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	179,998	0	0	181,020	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,688,729	19	0	2,707,453	21,232	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.00	03020	CANCER CARE CENTER	71,456	0	0	71,862	0	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	4,766,308	921	-4,960,696	0	32,051	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	2,535,698	60	0	2,561,001	71,349	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	31,470,719	8,029	-5,000,094	26,649,381	796,678	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	-55,336	0	43,515	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	284,930	0	-286,548	0	12,928	192.00
194.00	07950	OTHER NRCC	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	0	-2,987	0	169	194.01
194.02	07952	FOUNDATION	0	0	-26,282	0	527	194.02
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)	180,374	1,458,574		39,398	184,497	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.005680	181.663221		0.001478	0.216085	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	63,539	77,095		39,253	19,478	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.002001	9.602068		0.001473	0.022813	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1310

Period:
From 10/01/2017
To 09/30/2018

Worksheet B-1

Date/Time Prepared:
2/26/2019 11:25 am

Cost Center Description		Reconciliation	OTHER A&G (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	
		5A.05	5.05	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	CAP REL COSTS-OFFSITE MOBS					1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	01140	BUSINESS OFFICE					5.01
5.02	00550	DATA PROCESSING					5.02
5.03	00570	ADMITTING					5.03
5.04	00560	PURCHASING RECEIVING AND STORES					5.04
5.05	00590	OTHER A&G	-5,490,737	26,529,891			5.05
7.00	00700	OPERATION OF PLANT	0	1,340,360	71,800		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	80,384	474	94,366	8.00
9.00	00900	HOUSEKEEPING	0	548,724	1,094	0	9.00
10.00	01000	DIETARY	0	355,295	2,721	0	10.00
11.00	01100	CAFETERIA	0	331,957	1,074	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	165,024	355	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	398,980	887	0	16.00
17.00	01700	SOCIAL SERVICE	0	239,281	299	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	2,927,584	15,277	30,446	30.00
31.00	03100	INTENSIVE CARE UNIT	0	170,081	2,314	0	31.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	1,318,905	4,371	9,296	50.00
51.00	05100	RECOVERY ROOM	0	599,939	4,904	4,544	51.00
53.00	05300	ANESTHESIOLOGY	0	59,594	129	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,803,422	3,824	7,551	54.00
56.00	05600	RADIOISOTOPE	0	249,642	687	1,357	56.00
57.00	05700	CT SCAN	0	321,444	463	914	57.00
58.00	05800	MRI	0	183,851	1,037	2,048	58.00
60.00	06000	LABORATORY	0	1,758,734	1,898	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	658,513	4,492	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	653,798	2,165	1,053	65.00
66.00	06600	PHYSICAL THERAPY	0	917,048	2,094	7,957	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	203,519	273	1,037	67.00
68.00	06800	SPEECH PATHOLOGY	0	53,248	101	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	289,939	102	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	181,288	2,797	66	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,716,043	791	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	75.00
76.00	03020	CANCER CARE CENTER	0	71,968	218	0	76.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	4,967,622	8,391	1,293	88.00
90.00	09000	CLINIC	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	2,580,203	4,948	26,785	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	381	92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-5,490,737	26,146,390	68,180	94,347	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	64,739	242	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	289,342	3,260	19	192.00
194.00	07950	OTHER NRCC	0	0	0	0	194.00
194.01	07951	MARKETING	0	3,024	59	0	194.01
194.02	07952	FOUNDATION	0	26,396	59	0	194.02
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)		5,490,737	1,617,766	107,701	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)		0.206964	22.531560	1.141311	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)		987,786	269,787	27,698	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)		0.037233	3.757479	0.293517	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)					206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)					207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1310

Period:
From 10/01/2017
To 09/30/2018

Worksheet B-1

Date/Time Prepared:
2/26/2019 11:25 am

Cost Center Description			DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	NURSING ADMINISTRATION (DIRECT NRSNG HRS)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (TIME SPENT)	
			10.00	11.00	13.00	16.00	17.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-OFFSITE MOBS						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	01140	BUSINESS OFFICE						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00570	ADMITTING						5.03
5.04	00560	PURCHASING RECEIVING AND STORES						5.04
5.05	00590	OTHER A&G						5.05
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	9,146					10.00
11.00	01100	CAFETERIA	0	13,992				11.00
13.00	01300	NURSING ADMINISTRATION	0	0	169,787			13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	465	0	2,023		16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	438	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	8,235	2,653	55,179	700	406	30.00
31.00	03100	INTENSIVE CARE UNIT	146	211	4,396	2	0	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	551	11,466	0	0	50.00
51.00	05100	RECOVERY ROOM	278	417	8,674	122	0	51.00
53.00	05300	ANESTHESIOLOGY	0	204	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	846	17,596	62	0	54.00
56.00	05600	RADIOISOTOPE	0	5	102	11	0	56.00
57.00	05700	CT SCAN	0	290	6,039	8	0	57.00
58.00	05800	MRI	0	128	2,660	17	0	58.00
60.00	06000	LABORATORY	0	1,133	23,571	112	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	489	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	569	0	36	0	65.00
66.00	06600	PHYSICAL THERAPY	0	706	0	51	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	113	0	8	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	76	0	4	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	231	4,806	10	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	145	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	244	5,076	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.00	03020	CANCER CARE CENTER	0	76	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	134	2,912	0	159	7	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	353	1,453	30,222	569	25	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	9,146	13,917	169,787	1,871	438	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	0	75	0	152	0	192.00
194.00	07950	OTHER NRCC	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	0	0	0	0	194.01
194.02	07952	FOUNDATION	0	0	0	0	0	194.02
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)	503,862	430,316	207,177	520,801	295,541	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	55.090969	30.754431	1.220217	257.439941	674.751142	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	159,666	69,850	25,009	66,498	25,514	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	17.457468	4.992138	0.147296	32.870984	58.251142	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: 14-1310

Period:
From 10/01/2017
To 09/30/2018Worksheet C
Part I
Date/Time Prepared:
2/26/2019 11:25 am

				Title XVIII		Hospital		Cost	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs				
					Total Costs	RCE Disallowance	Total Costs		
			1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	5,215,606		5,215,606	0	0	30.00	
31.00	03100	INTENSIVE CARE UNIT	291,887		291,887	0	0	31.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	1,768,284		1,768,284	0	0	50.00	
51.00	05100	RECOVERY ROOM	950,764		950,764	0	0	51.00	
53.00	05300	ANESTHESIOLOGY	81,109		81,109	0	0	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,365,322		2,365,322	0	0	54.00	
56.00	05600	RADIOISOTOPE	326,904		326,904	0	0	56.00	
57.00	05700	CT SCAN	421,432		421,432	0	0	57.00	
58.00	05800	MRI	267,431		267,431	0	0	58.00	
60.00	06000	LABORATORY	2,278,770		2,278,770	0	0	60.00	
64.00	06400	INTRAVENOUS THERAPY	936,519		936,519	0	0	64.00	
65.00	06500	RESPIRATORY THERAPY	882,894	0	882,894	0	0	65.00	
66.00	06600	PHYSICAL THERAPY	1,216,304	0	1,216,304	0	0	66.00	
67.00	06700	OCCUPATIONAL THERAPY	260,825	0	260,825	0	0	67.00	
68.00	06800	SPEECH PATHOLOGY	69,911	0	69,911	0	0	68.00	
69.00	06900	ELECTROCARDIOLOGY	367,786		367,786	0	0	69.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	288,678		288,678	0	0	71.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	3,314,647		3,314,647	0	0	73.00	
75.00	07500	ASC (NON-DISTINCT PART)	0		0	0	0	75.00	
76.00	03020	CANCER CARE CENTER	94,112		94,112	0	0	76.00	
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC	6,417,515		6,417,515	0	0	88.00	
90.00	09000	CLINIC	0		0	0	0	90.00	
91.00	09100	EMERGENCY	3,583,635		3,583,635	0	0	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	770,682		770,682		0	92.00	
SPECIAL PURPOSE COST CENTERS									
113.00	11300	INTEREST EXPENSE						113.00	
200.00		Subtotal (see instructions)	32,171,017	0	32,171,017	0	0	200.00	
201.00		Less Observation Beds	770,682		770,682		0	201.00	
202.00		Total (see instructions)	31,400,335	0	31,400,335	0	0	202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1310

Period:
From 10/01/2017
To 09/30/2018Worksheet C
Part I
Date/Time Prepared:
2/26/2019 11:25 am

			Title XVIII			Hospital	Cost	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
			Inpatient	Outpatient	Total (col. 6 + col. 7)			
			6.00	7.00	8.00			
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	2,688,263		2,688,263			30.00
31.00	03100	INTENSIVE CARE UNIT	83,224		83,224			31.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	284,996	3,977,702	4,262,698	0.414827	0.000000	50.00
51.00	05100	RECOVERY ROOM	13,764	1,010,617	1,024,381	0.928135	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	145,832	1,520,947	1,666,779	0.048662	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	213,462	4,575,401	4,788,863	0.493921	0.000000	54.00
56.00	05600	RADIOISOTOPE	30,135	1,017,116	1,047,251	0.312154	0.000000	56.00
57.00	05700	CT SCAN	546,340	9,152,560	9,698,900	0.043452	0.000000	57.00
58.00	05800	MRI	91,742	3,004,042	3,095,784	0.086386	0.000000	58.00
60.00	06000	LABORATORY	1,157,966	10,799,838	11,957,804	0.190568	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	288	652,800	653,088	1.433986	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	746,027	531,186	1,277,213	0.691266	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	350,659	3,265,334	3,615,993	0.336368	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	40,827	576,766	617,593	0.422325	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	13,485	299,866	313,351	0.223108	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	238,752	2,996,803	3,235,555	0.113670	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	806,734	232,496	1,039,230	0.277781	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,707,860	7,717,105	9,424,965	0.351688	0.000000	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0.000000	0.000000	75.00
76.00	03020	CANCER CARE CENTER	0	64,630	64,630	1.456166	0.000000	76.00
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	5,603,355	5,603,355			88.00
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
91.00	09100	EMERGENCY	165,241	5,273,868	5,439,109	0.658864	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	70,449	568,964	639,413	1.205296	0.000000	92.00
	SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	9,396,046	62,841,396	72,237,442			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	9,396,046	62,841,396	72,237,442			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES				Provider CCN: 14-1310	Period: From 10/01/2017 To 09/30/2018	Worksheet C Part I Date/Time Prepared: 2/26/2019 11:25 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
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000			50.00
51.00	05100	RECOVERY ROOM	0.000000			51.00
53.00	05300	ANESTHESIOLOGY	0.000000			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000			54.00
56.00	05600	RADIOISOTOPE	0.000000			56.00
57.00	05700	CT SCAN	0.000000			57.00
58.00	05800	MRI	0.000000			58.00
60.00	06000	LABORATORY	0.000000			60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000			64.00
65.00	06500	RESPIRATORY THERAPY	0.000000			65.00
66.00	06600	PHYSICAL THERAPY	0.000000			66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000			67.00
68.00	06800	SPEECH PATHOLOGY	0.000000			68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000			69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000			71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000			73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000			75.00
76.00	03020	CANCER CARE CENTER	0.000000			76.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC				88.00
90.00	09000	CLINIC	0.000000			90.00
91.00	09100	EMERGENCY	0.000000			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000			92.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
200.00		Subtotal (see instructions)				200.00
201.00		Less Observation Beds				201.00
202.00		Total (see instructions)				202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-1310

Period:
From 10/01/2017
To 09/30/2018Worksheet D
Part II
Date/Time Prepared:
2/26/2019 11:25 am

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)	Cost
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	306,059	4,262,698	0.071799	138,056	9,912	50.00
51.00	05100 RECOVERY ROOM	295,990	1,024,381	0.288945	4,015	1,160	51.00
53.00	05300 ANESTHESIOLOGY	10,584	1,666,779	0.006350	67,220	427	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	288,175	4,788,863	0.060176	94,938	5,713	54.00
56.00	05600 RADIOISOTOPE	47,383	1,047,251	0.045245	14,202	643	56.00
57.00	05700 CT SCAN	41,248	9,698,900	0.004253	160,861	684	57.00
58.00	05800 MRI	64,370	3,095,784	0.020793	39,232	816	58.00
60.00	06000 LABORATORY	188,515	11,957,804	0.015765	522,508	8,237	60.00
64.00	06400 INTRAVENOUS THERAPY	264,320	653,088	0.404723	192	78	64.00
65.00	06500 RESPIRATORY THERAPY	145,773	1,277,213	0.114134	307,349	35,079	65.00
66.00	06600 PHYSICAL THERAPY	156,191	3,615,993	0.043194	50,061	2,162	66.00
67.00	06700 OCCUPATIONAL THERAPY	26,898	617,593	0.043553	3,057	133	67.00
68.00	06800 SPEECH PATHOLOGY	7,918	313,351	0.025269	7,006	177	68.00
69.00	06900 ELECTROCARDIOLOGY	21,652	3,235,555	0.006692	147,517	987	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	152,550	1,039,230	0.146791	414,524	60,848	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	154,620	9,424,965	0.016405	649,319	10,652	73.00
75.00	07500 ASC (NON-DISTINCT PART)	0	0	0.000000	0	0	75.00
76.00	03020 CANCER CARE CENTER	14,575	64,630	0.225514	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	670,012	5,603,355	0.119573	0	0	88.00
90.00	09000 CLINIC	0	0	0.000000	0	0	90.00
91.00	09100 EMERGENCY	416,103	5,439,109	0.076502	2,254	172	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	171,121	639,413	0.267622	6,645	1,778	92.00
200.00	Total (lines 50 through 199)	3,444,057	69,465,955		2,628,956	139,658	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1310

Period:
From 10/01/2017
To 09/30/2018Worksheet D
Part IV
Date/Time Prepared:
2/26/2019 11:25 am

Cost Center Description		Title XVIII		Hospital		Cost	
		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	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	75.00
76.00	03020	CANCER CARE CENTER	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1310

Period:
From 10/01/2017
To 09/30/2018Worksheet D
Part IV
Date/Time Prepared:
2/26/2019 11:25 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	4,262,698	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	1,024,381	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	1,666,779	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	4,788,863	0.000000	54.00
56.00	05600	RADIOISOTOPE	0	0	0	1,047,251	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	9,698,900	0.000000	57.00
58.00	05800	MRI	0	0	0	3,095,784	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	11,957,804	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	653,088	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	1,277,213	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	3,615,993	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	617,593	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	313,351	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	3,235,555	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	1,039,230	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	9,424,965	0.000000	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0.000000	75.00
76.00	03020	CANCER CARE CENTER	0	0	0	64,630	0.000000	76.00
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	5,603,355	0.000000	88.00
90.00	09000	CLINIC	0	0	0	0	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	5,439,109	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	639,413	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	69,465,955		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1310

Period:
From 10/01/2017
To 09/30/2018

Worksheet D
Part IV
Date/Time Prepared:
2/26/2019 11:25 am

Cost Center Description		Title XVIII			Hospital		Cost	
		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	138,056	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	4,015	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.000000	67,220	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	94,938	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0.000000	14,202	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	160,861	0	0	0	57.00
58.00	05800	MRI	0.000000	39,232	0	0	0	58.00
60.00	06000	LABORATORY	0.000000	522,508	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	192	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	307,349	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	50,061	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	3,057	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	7,006	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	147,517	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	414,524	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	649,319	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	0	0	0	75.00
76.00	03020	CANCER CARE CENTER	0.000000	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.000000	2,254	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	6,645	0	0	0	92.00
200.00		Total (lines 50 through 199)		2,628,956	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1310

Period:
From 10/01/2017
To 09/30/2018Worksheet D
Part V
Date/Time Prepared:
2/26/2019 11:25 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	0.414827	0	1,585,323	0	0	50.00
51.00	05100	RECOVERY ROOM	0.928135	0	414,270	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.048662	0	574,047	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.493921	0	1,527,454	0	0	54.00
56.00	05600	RADIOISOTOPE	0.312154	0	556,662	0	0	56.00
57.00	05700	CT SCAN	0.043452	0	4,043,052	0	0	57.00
58.00	05800	MRI	0.086386	0	1,009,357	0	0	58.00
60.00	06000	LABORATORY	0.190568	0	4,423,464	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	1.433986	0	421,865	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.691266	0	244,479	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.336368	0	1,312,770	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.422325	0	114,469	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.223108	0	50,540	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.113670	0	1,454,613	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.277781	0	112,613	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.351688	0	3,732,457	16,884	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	0	0	0	75.00
76.00	03020	CANCER CARE CENTER	1.456166	0	44,527	0	0	76.00
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.658864	0	1,835,926	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.205296	0	332,443	0	0	92.00
200.00		Subtotal (see instructions)		0	23,790,331	16,884	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	23,790,331	16,884	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1310

Period:
From 10/01/2017
To 09/30/2018Worksheet D
Part V
Date/Time Prepared:
2/26/2019 11:25 am

			Title XVIII		Hospital	Cost
	Cost Center Description	Costs				
		Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)			
		6.00	7.00			
	ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	657,635	0		50.00
51.00	05100	RECOVERY ROOM	384,498	0		51.00
53.00	05300	ANESTHESIOLOGY	27,934	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	754,442	0		54.00
56.00	05600	RADIOISOTOPE	173,764	0		56.00
57.00	05700	CT SCAN	175,679	0		57.00
58.00	05800	MRI	87,194	0		58.00
60.00	06000	LABORATORY	842,971	0		60.00
64.00	06400	INTRAVENOUS THERAPY	604,949	0		64.00
65.00	06500	RESPIRATORY THERAPY	169,000	0		65.00
66.00	06600	PHYSICAL THERAPY	441,574	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	48,343	0		67.00
68.00	06800	SPEECH PATHOLOGY	11,276	0		68.00
69.00	06900	ELECTROCARDIOLOGY	165,346	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	31,282	0		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,312,660	5,938		73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0		75.00
76.00	03020	CANCER CARE CENTER	64,839	0		76.00
	OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	1,209,626	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	400,692	0		92.00
200.00		Subtotal (see instructions)	7,563,704	5,938		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	7,563,704	5,938		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1310

Period:

Worksheet D

Component CCN: 14-Z310

From 10/01/2017
To 09/30/2018Part V
Date/Time Prepared:
2/26/2019 11:25 am

			Title XVIII		Swing Beds - SNF		Cost	
Cost Center Description			Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs		
				PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0.414827	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.928135	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.048662	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.493921	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0.312154	0	0	0	0	56.00
57.00	05700	CT SCAN	0.043452	0	0	0	0	57.00
58.00	05800	MRI	0.086386	0	0	0	0	58.00
60.00	06000	LABORATORY	0.190568	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	1.433986	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.691266	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.336368	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.422325	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.223108	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.113670	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.277781	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.351688	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	0	0	0	75.00
76.00	03020	CANCER CARE CENTER	1.456166	0	0	0	0	76.00
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.658864	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.205296	0	0	0	0	92.00
200.00		Subtotal (see instructions)		0	0	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1310

Period:

Worksheet D

Component CCN: 14-Z310

From 10/01/2017
To 09/30/2018Part V
Date/Time Prepared:
2/26/2019 11:25 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
51.00	05100	RECOVERY ROOM	0	0					51.00
53.00	05300	ANESTHESIOLOGY	0	0					53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0					54.00
56.00	05600	RADIOISOTOPE	0	0					56.00
57.00	05700	CT SCAN	0	0					57.00
58.00	05800	MRI	0	0					58.00
60.00	06000	LABORATORY	0	0					60.00
64.00	06400	INTRAVENOUS THERAPY	0	0					64.00
65.00	06500	RESPIRATORY THERAPY	0	0					65.00
66.00	06600	PHYSICAL THERAPY	0	0					66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0					67.00
68.00	06800	SPEECH PATHOLOGY	0	0					68.00
69.00	06900	ELECTROCARDIOLOGY	0	0					69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0					71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0					73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0					75.00
76.00	03020	CANCER CARE CENTER	0	0					76.00
	OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0					88.00
90.00	09000	CLINIC	0	0					90.00
91.00	09100	EMERGENCY	0	0					91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0					92.00
200.00		Subtotal (see instructions)	0	0					200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0						201.00
202.00		Net Charges (line 200 - line 201)	0	0					202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-1310	Period: From 10/01/2017 To 09/30/2018	Worksheet D-1 Date/Time Prepared: 2/26/2019 11:25 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)			2,773	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			1,559	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.			0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)			1,157	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period			289	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)			868	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period			14	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)			43	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)			812	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)			241	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)			724	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			152.66	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period			152.66	20.00
21.00	Total general inpatient routine service cost (see instructions)			5,215,606	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)			2,137	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)			6,564	25.00
26.00	Total swing-bed cost (see instructions)			2,226,809	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)			2,988,797	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT					
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)			0	28.00
29.00	Private room charges (excluding swing-bed charges)			0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)			0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)			0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)			0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)			0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)			0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)			2,988,797	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)			1,917.12	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			1,556,701	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)			0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)			1,556,701	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1310

Period:
From 10/01/2017
To 09/30/2018

Worksheet D-1

Date/Time Prepared:
2/26/2019 11:25 am

Cost Center Description		Title XVIII		Hospital		Cost
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
		1.00	2.00	3.00	4.00	5.00
42.00	NURSERY (title V & XIX only)					42.00
Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	291,887	36	8,107.97	26	210,807
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)					827,738
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					2,595,246
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
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0
52.00	Total Program excludable cost (sum of lines 50 and 51)					0
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0
TARGET AMOUNT AND LIMIT COMPUTATION						
54.00	Program discharges					0
55.00	Target amount per discharge					0.00
56.00	Target amount (line 54 x line 55)					0
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0
58.00	Bonus payment (see instructions)					0
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
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00
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
62.00	Relief payment (see instructions)					0
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0
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)					462,026
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					1,387,995
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					1,850,021
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
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
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0
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)					402
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,917.12
89.00	Observation bed cost (line 87 x line 88) (see instructions)					770,682

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1310

Period:
From 10/01/2017
To 09/30/2018

Worksheet D-1

Date/Time Prepared:
2/26/2019 11:25 am

Cost Center Description		Title XVIII		Hospital		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	1,158,062	5,215,606	0.222038	770,682	171,121	90.00
91.00	Nursing School cost	0	5,215,606	0.000000	770,682	0	91.00
92.00	Allied health cost	0	5,215,606	0.000000	770,682	0	92.00
93.00	All other Medical Education	0	5,215,606	0.000000	770,682	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-1310	Period: From 10/01/2017 To 09/30/2018	Worksheet D-3 Date/Time Prepared: 2/26/2019 11:25 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		916,778		30.00
31.00	03100	INTENSIVE CARE UNIT		52,680		31.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.414827	138,056	57,269	50.00
51.00	05100	RECOVERY ROOM	0.928135	4,015	3,726	51.00
53.00	05300	ANESTHESIOLOGY	0.048662	67,220	3,271	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.493921	94,938	46,892	54.00
56.00	05600	RADIOISOTOPE	0.312154	14,202	4,433	56.00
57.00	05700	CT SCAN	0.043452	160,861	6,990	57.00
58.00	05800	MRI	0.086386	39,232	3,389	58.00
60.00	06000	LABORATORY	0.190568	522,508	99,573	60.00
64.00	06400	INTRAVENOUS THERAPY	1.433986	192	275	64.00
65.00	06500	RESPIRATORY THERAPY	0.691266	307,349	212,460	65.00
66.00	06600	PHYSICAL THERAPY	0.336368	50,061	16,839	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.422325	3,057	1,291	67.00
68.00	06800	SPEECH PATHOLOGY	0.223108	7,006	1,563	68.00
69.00	06900	ELECTROCARDIOLOGY	0.113670	147,517	16,768	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.277781	414,524	115,147	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.351688	649,319	228,358	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	0	75.00
76.00	03020	CANCER CARE CENTER	1.456166	0	0	76.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000	CLINIC	0.000000	0	0	90.00
91.00	09100	EMERGENCY	0.658864	2,254	1,485	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.205296	6,645	8,009	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		2,628,956	827,738	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		2,628,956		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-1310 Component CCN: 14-Z310	Period: From 10/01/2017 To 09/30/2018	Worksheet D-3 Date/Time Prepared: 2/26/2019 11:25 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
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.414827	0	0	50.00
51.00	05100	RECOVERY ROOM	0.928135	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.048662	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.493921	34,265	16,924	54.00
56.00	05600	RADIOISOTOPE	0.312154	0	0	56.00
57.00	05700	CT SCAN	0.043452	24,607	1,069	57.00
58.00	05800	MRI	0.086386	7,278	629	58.00
60.00	06000	LABORATORY	0.190568	225,081	42,893	60.00
64.00	06400	INTRAVENOUS THERAPY	1.433986	96	138	64.00
65.00	06500	RESPIRATORY THERAPY	0.691266	205,481	142,042	65.00
66.00	06600	PHYSICAL THERAPY	0.336368	228,356	76,812	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.422325	29,554	12,481	67.00
68.00	06800	SPEECH PATHOLOGY	0.223108	5,550	1,238	68.00
69.00	06900	ELECTROCARDIOLOGY	0.113670	11,025	1,253	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.277781	159,692	44,359	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.351688	524,421	184,433	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	0	75.00
76.00	03020	CANCER CARE CENTER	1.456166	0	0	76.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000	CLINIC	0.000000	0	0	90.00
91.00	09100	EMERGENCY	0.658864	4,552	2,999	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.205296	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		1,459,958	527,270	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)		1,459,958		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-1310	Period: From 10/01/2017 To 09/30/2018	Worksheet E Part B Date/Time Prepared: 2/26/2019 11:25 am
		Title XVIII	Hospital	Cost
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		7,569,642	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)		7,569,642	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)		7,645,338	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)		40,325	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		3,873,005	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)		3,732,008	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)		3,732,008	30.00
31.00	Primary payer payments		304	31.00
32.00	Subtotal (line 30 minus line 31)		3,731,704	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)		770,771	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		501,001	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		518,199	36.00
37.00	Subtotal (see instructions)		4,232,705	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)		4,232,705	40.00
40.01	Sequestration adjustment (see instructions)		84,654	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
41.00	Interim payments		3,783,710	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		364,341	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-1310

Period:
From 10/01/2017
To 09/30/2018Worksheet E-1
Part I
Date/Time Prepared:
2/26/2019 11:25 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		2,614,898		4,416,668	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	04/19/2018	253,149		0	3.50
3.51		09/19/2018	77,477	09/19/2018	632,958	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)		-330,626		-632,958	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)		2,284,272		3,783,710	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		49,198		364,341	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		2,333,470		4,148,051	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-1310

Period:

Worksheet E-1

Component CCN: 14-Z310

From 10/01/2017
To 09/30/2018Part I
Date/Time Prepared:
2/26/2019 11:25 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		2,386,647		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	09/19/2018	146,158		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)		-146,158		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)		2,240,489		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		88,301		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		2,328,790		0	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

Provider CCN: 14-1310

Period:
From 10/01/2017
To 09/30/2018Worksheet E-1
Part II
Date/Time Prepared:
2/26/2019 11:25 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: 14-1310 Component CCN: 14-Z310	Period: From 10/01/2017 To 09/30/2018	Worksheet E-2 Date/Time Prepared: 2/26/2019 11:25 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)	1,868,521	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)	532,543	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	965	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)	2,401,064	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	2,401,064	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)	2,401,064	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	24,748	0	13.00
14.00	80% of Part B costs (line 12 x 80%)			14.00
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)	2,376,316	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)	2,376,316	0	19.00
19.01	Sequestration adjustment (see instructions)	47,526	0	19.01
19.02	Demonstration payment adjustment amount after sequestration)	0	0	19.02
20.00	Interim payments	2,240,489	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)	88,301	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: 14-1310	Period: From 10/01/2017 To 09/30/2018	Worksheet E-3 Part V Date/Time Prepared: 2/26/2019 11:25 am
		Title XVIII	Hospital	Cost
		1.00		
PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT				
1.00	Inpatient services		2,595,246	1.00
2.00	Nursing and Allied Health Managed Care payment (see instructions)		0	2.00
3.00	Organ acquisition		0	3.00
4.00	Subtotal (sum of lines 1 through 3)		2,595,246	4.00
5.00	Primary payer payments		0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)		2,621,198	6.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
7.00	Routine service charges		0	7.00
8.00	Ancillary service charges		0	8.00
9.00	Organ acquisition charges, net of revenue		0	9.00
10.00	Total reasonable charges		0	10.00
Customary charges				
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)		0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)		0.000000	13.00
14.00	Total customary charges (see instructions)		0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)		0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)		0	16.00
17.00	Cost of physicians' services in a teaching hospital (see instructions)		0	17.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)		0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)		2,621,198	19.00
20.00	Deductibles (exclude professional component)		276,228	20.00
21.00	Excess reasonable cost (from line 16)		0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)		2,344,970	22.00
23.00	Coinsurance		2,004	23.00
24.00	Subtotal (line 22 minus line 23)		2,342,966	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		58,656	25.00
26.00	Adjusted reimbursable bad debts (see instructions)		38,126	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		36,529	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)		2,381,092	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	29.50
29.99	Demonstration payment adjustment amount before sequestration		0	29.99
30.00	Subtotal (see instructions)		2,381,092	30.00
30.01	Sequestration adjustment (see instructions)		47,622	30.01
30.02	Demonstration payment adjustment amount after sequestration		0	30.02
31.00	Interim payments		2,284,272	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)		49,198	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		279,048	34.00

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

Provider CCN: 14-1310

Period:
From 10/01/2017
To 09/30/2018

Worksheet G

Date/Time Prepared:
2/26/2019 11:25 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	1,320,442	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	12,340,156	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-6,747,465	0	0	0	6.00
7.00	Inventory	775,070	0	0	0	7.00
8.00	Prepaid expenses	0	0	0	0	8.00
9.00	Other current assets	113,426	0	0	0	9.00
10.00	Due from other funds	13,281	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	7,814,910	0	0	0	11.00
FIXED ASSETS						
12.00	Land	1,927,000	0	0	0	12.00
13.00	Land improvements	2,047,602	0	0	0	13.00
14.00	Accumulated depreciation	-1,597,103	0	0	0	14.00
15.00	Buildings	16,247,274	0	0	0	15.00
16.00	Accumulated depreciation	-7,233,235	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	15,174,903	0	0	0	23.00
24.00	Accumulated depreciation	-12,750,741	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	19,232	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	13,834,932	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	74,420	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	12,617,788	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	12,692,208	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	34,342,050	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	548,882	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,132,342	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	750,000	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	1,185,458	0	0	0	43.00
44.00	Other current liabilities	23,721	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	3,640,403	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	29,418,534	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	29,418,534	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	33,058,937	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	1,283,113				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)	1,283,113	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	34,342,050	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-1310

Period:
From 10/01/2017
To 09/30/2018

Worksheet G-1

Date/Time Prepared:
2/26/2019 11:25 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		1,235,350		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-79,106				2.00
3.00	Total (sum of line 1 and line 2)		1,156,244		0		3.00
4.00	ROUNDING/EQUITY TRANSFER	126,869		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)		126,869		0		10.00
11.00	Subtotal (line 3 plus line 10)		1,283,113		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)		1,283,113		0		19.00
		Endowment Fund		Plant Fund			
		6.00	7.00	8.00			
1.00	Fund balances at beginning of period	0		0			1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)						2.00
3.00	Total (sum of line 1 and line 2)	0		0			3.00
4.00	ROUNDING/EQUITY TRANSFER		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: 14-1310

Period:
From 10/01/2017
To 09/30/2018Worksheet G-2
Parts I & II
Date/Time Prepared:
2/26/2019 11:25 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	1,609,017		1,609,017	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	1,028,573		1,028,573	5.00
6.00	Swing bed - NF	50,673		50,673	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)	2,688,263		2,688,263	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	83,224		83,224	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)	83,224		83,224	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	2,771,487		2,771,487	17.00
18.00	Ancillary services	6,388,869	51,395,209	57,784,078	18.00
19.00	Outpatient services	235,690	5,842,832	6,078,522	19.00
20.00	RURAL HEALTH CLINIC	0	5,603,355	5,603,355	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PRO FEES	158,751	4,089,314	4,248,065	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	9,554,797	66,930,710	76,485,507	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		33,234,134		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)		33,234,134		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-1310

Period:
From 10/01/2017
To 09/30/2018

Worksheet G-3

Date/Time Prepared:
2/26/2019 11:25 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	76,485,507	1.00
2.00	Less contractual allowances and discounts on patients' accounts	41,719,242	2.00
3.00	Net patient revenues (line 1 minus line 2)	34,766,265	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	33,234,134	4.00
5.00	Net income from service to patients (line 3 minus line 4)	1,532,131	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	29,550	6.00
7.00	Income from investments	7,109	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	75,842	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	4,149	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	795	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	52,583	20.00
21.00	Rental of vending machines	771	21.00
22.00	Rental of hospital space	33,677	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER INCOME	-1,185,929	24.00
25.00	Total other income (sum of lines 6-24)	-981,453	25.00
26.00	Total (line 5 plus line 25)	550,678	26.00
27.00	EQUITY TRANSFER	629,784	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	629,784	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-79,106	29.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1310

Period:

Worksheet M-1

Component CCN: 14-8535

From 10/01/2017
To 09/30/2018Date/Time Prepared:
2/26/2019 11:25 am

				RHC I		Cost	
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassificati ons	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	1,181,884	147,727	1,329,611	-170,139	1,159,472	1.00
2.00	Physician Assistant	182,971	0	182,971	0	182,971	2.00
3.00	Nurse Practitioner	311,347	0	311,347	0	311,347	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	938,704	308,234	1,246,938	0	1,246,938	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	51,504	16,965	68,469	0	68,469	9.00
10.00	Subtotal (sum of lines 1 through 9)	2,666,410	472,926	3,139,336	-170,139	2,969,197	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	241,451	241,451	-219,417	22,034	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	23,538	23,538	0	23,538	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	264,989	264,989	-219,417	45,572	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	2,666,410	737,915	3,404,325	-389,556	3,014,769	22.00
COSTS OTHER THAN RHC/FQHC SERVICES							
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
25.01	Telehealth	0	0	0	0	0	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs	0	0	0	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0	28.00
FACILITY OVERHEAD							
29.00	Facility Costs	0	69,111	69,111	-48,892	20,219	29.00
30.00	Administrative Costs	240,814	970,578	1,211,392	-306	1,211,086	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	240,814	1,039,689	1,280,503	-49,198	1,231,305	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	2,907,224	1,777,604	4,684,828	-438,754	4,246,074	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1310

Period:

Worksheet M-1

Component CCN: 14-8535

From 10/01/2017
To 09/30/2018Date/Time Prepared:
2/26/2019 11:25 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	-21,061	1,138,411	1.00
2.00	Physician Assistant	0	182,971	2.00
3.00	Nurse Practitioner	0	311,347	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	1,246,938	5.00
6.00	Clinical Psychologist	0	0	6.00
7.00	Clinical Social Worker	0	0	7.00
8.00	Laboratory Technician	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	68,469	9.00
10.00	Subtotal (sum of lines 1 through 9)	-21,061	2,948,136	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	22,034	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	23,538	18.00
19.00	Other Health Care Costs	0	0	19.00
20.00	Allowable GME Costs	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	45,572	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-21,061	2,993,708	22.00
COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0	23.00
24.00	Dental	0	0	24.00
25.00	Optometry	0	0	25.00
25.01	Telehealth	0	0	25.01
25.02	Chronic Care Management	0	0	25.02
26.00	All other nonreimbursable costs	0	0	26.00
27.00	Nonallowable GME costs	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	28.00
FACILITY OVERHEAD				
29.00	Facility Costs	0	20,219	29.00
30.00	Administrative Costs	-40,287	1,170,799	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-40,287	1,191,018	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-61,348	4,184,726	32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1310

Period:

Worksheet M-2

Component CCN: 14-8535

From 10/01/2017
To 09/30/2018Date/Time Prepared:
2/26/2019 11:25 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	3.09	11,103	4,200	12,978		1.00
2.00	Physician Assistant	1.58	3,757	2,100	3,318		2.00
3.00	Nurse Practitioner	2.66	5,309	2,100	5,586		3.00
4.00	Subtotal (sum of lines 1 through 3)	7.33	20,169		21,882	21,882	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)	7.33	20,169			21,882	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)					2,993,708	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					2,993,708	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					1.000000	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					1,191,018	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					2,232,789	15.00
16.00	Total overhead (sum of lines 14 and 15)					3,423,807	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					3,423,807	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					3,423,807	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					6,417,515	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 14-1310 Component CCN: 14-8535	Period: From 10/01/2017 To 09/30/2018	Worksheet M-3 Date/Time Prepared: 2/26/2019 11:25 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)			6,417,515	1.00	
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			329,045	2.00	
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			6,088,470	3.00	
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			21,882	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)			21,882	6.00	
7.00	Adjusted cost per visit (line 3 divided by line 6)			278.24	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)			278.24	278.24	9.00
CALCULATION OF SETTLEMENT						
10.00	Program covered visits excluding mental health services (from contractor records)			1,865	5,594	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)			518,918	1,556,475	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	2,075,393	16.00
16.01	Total program charges (see instructions)(from contractor's records)				1,572,375	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)				6,820	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)				9,001	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.)				1,538,815	16.04
16.05	Total program cost (see instructions)			0	1,547,816	16.05
17.00	Primary payer amounts				73	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)				142,873	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)				284,530	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)				1,547,743	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)				179,716	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)				1,727,459	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)				1,727,459	26.00
26.01	Sequestration adjustment (see instructions)				34,549	26.01
26.02	Demonstration payment adjustment amount after sequestration				0	26.02
27.00	Interim payments				1,938,940	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)				-246,030	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2				0	30.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA VACCINE COST		Provider CCN: 14-1310 Component CCN: 14-8535	Period: From 10/01/2017 To 09/30/2018	Worksheet M-4 Date/Time Prepared: 2/26/2019 11:25 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)		2,948,136	2,948,136	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time		0.000656	0.000656	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)		1,934	1,934	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)		121,701	27,928	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)		123,635	29,862	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)		2,993,708	2,993,708	6.00
7.00	Total overhead (from Wkst. M-2, line 19)		3,423,807	3,423,807	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)		0.041298	0.009975	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)		141,396	34,152	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)		265,031	64,014	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)		966	1,775	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)		274.36	36.06	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries		570	647	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)		156,385	23,331	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)			329,045	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)			179,716	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN: 14-1310 Component CCN: 14-8535	Period: From 10/01/2017 To 09/30/2018	Worksheet M-5 Date/Time Prepared: 2/26/2019 11:25 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		1,221,120	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		09/18/2018	519,817	3.01	
3.02		09/18/2018	198,003	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)		717,820	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		1,938,940	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		246,030	6.02	
7.00	Total Medicare program liability (see instructions)		1,692,910	7.00	
		Contractor Number	NPR Date (Mo/Day/Yr)		
		0	1.00	2.00	
8.00	Name of Contractor				8.00