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:	Period: From 07/01/2017 To 06/30/2018	Worksheet S Parts I-III Date/Time Prepared: 6/12/2019 8:29 am

PART I - COST REPORT STATUS

Provider use only

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

Contractor use only

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

PART II - CERTIFICATION

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

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

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

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

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

_____
Title

_____
Date

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	52,779	-109,777	0	0	1.00
2.00	Subprovider - IPF	0	10,072	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	6,795	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
7.00	SKILLED NURSING FACILITY	0	0	0		0	7.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
10.00	RURAL HEALTH CLINIC I	0		107,916		0	10.00
200.00	Total	0	69,646	-1,861	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:	Period: From 07/01/2017 To 06/30/2018	Worksheet S-2 Part I Date/Time Prepared: 6/12/2019 8:29 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street:100 MAIN	PO Box:			1.00
2.00	City: ANYWHERE	State:	Zip Code:	County:	2.00

		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
	Hospital and Hospital-Based Component Identification:									
3.00	Hospital	SAMPLE CAH			1	02/15/1968	N	O	N	3.00
4.00	Subprovider - IPF	SAMPLE GERIPSYCH			4	02/15/1968	N	P	N	4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	SAMPLE SWING BED				02/15/1968	N	O	N	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF	SAMPLE HOSPITAL SNF				02/15/1968	N	P	N	9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA	HOSPITAL HHA				06/17/1988	N	P	N	12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice	HOSPITAL HOSPICE				05/01/1997				14.00
15.00	Hospital-Based Health Clinic - RHC	RHC - CONSOLIDATED				10/27/1992	N	O	N	15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	07/01/2017	06/30/2018	20.00
21.00	Type of Control (see instructions)	2		21.00

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

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

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

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-2 Part I Date/Time Prepared: 6/12/2019 8:29 am

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-2 Part I Date/Time Prepared: 6/12/2019 8:29 am

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

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

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

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

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

		V	XIX	
		1.00	2.00	
	Title V and XIX Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	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	Speech	Respiratory	
		1.00	2.00	3.00	4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	Y	Y	N	Y	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:	Period: From 07/01/2017 To 06/30/2018	Worksheet S-2 Part I Date/Time Prepared: 6/12/2019 8:29 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.	Y			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1			118.00

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	1,015,192	0	0	118.01

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

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

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

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

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

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

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

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

		1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act		
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.	Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)	0	168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)	N	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	12/29/2017	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: | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-2 Part II Date/Time Prepared: 6/12/2019 8:29 am

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

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

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

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

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

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	N		N		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	10/17/2018	Y	10/17/2018	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-2 Part II Date/Time Prepared: 6/12/2019 8:29 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.	Y	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.	Y	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.	BKD	LLP	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.	417.865.8701	SFDCOSTREPORTS@BKD.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN:	Period: From 07/01/2017 To 06/30/2018	Worksheet S-2 Part II Date/Time Prepared: 6/12/2019 8:29 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.	COST REPORTS		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

HFS Supplemental Information	Provider CCN:	Period: From 07/01/2017 To 06/30/2018	Worksheet S-2 Part IX Date/Time Prepared: 6/12/2019 8:29 am

		Title V	Title XIX	
		1.00	2.00	
	TITLES V AND/OR XIX FOLLOWING MEDICARE			
1.00	Do Title V or XIX follow Medicare (Title XVIII) for the Interns and Residence post stepdown adjustments on W/S B, Part I, column 25? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX. (see S-2, Part I, line 98)	Y	Y	1.00
2.00	Do Title V or XIX follow Medicare (Title XVIII) for the reporting of charges on W/S C, Part I (e.g. net of Physician's component)? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX. (see S-2, Part I, line 98.01)	Y	Y	2.00
3.00	Do Title V or XIX follow Medicare (Title XVIII) for the calculation of Observation Bed Cost on W/S D-1, Part IV, line 89? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX. (see S-2, Part I, line 98.02)	Y	Y	3.00
3.01	Do Title V or XIX use W/S D-1 for reimbursement?	N	N	3.01
		Inpatient	Outpatient	
		1.00	2.00	
	CRITICAL ACCESS HOSPITALS			
4.00	Does Title V follow Medicare (Title XVIII) for Critical Access Hospitals (CAH) being reimbursed 101% of cost? Enter Y or N in column 1 for inpatient and Y or N in column 2 for outpatient. (see S-2, Part I, lines 98.03 and 98.04)	N	N	4.00
5.00	Does Title XIX follow Medicare (Title XVIII) for Critical Access Hospitals (CAH) being reimbursed 101% of cost? Enter Y or N in column 1 for inpatient and Y or N in column 2 for outpatient. (see S-2, Part I, lines 98.03 and 98.04)	N	N	5.00
		Title V	Title XIX	
		1.00	2.00	
	RCE DISALLOWANCE			
6.00	Do Title V or XIX follow Medicare and add back the RCE Disallowance on W/S C, Part I column 4? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX. (see S-2, Part I, line 98.05)	Y	Y	6.00
	PASS THROUGH COST			
7.00	Do Title V or XIX follow Medicare when cost reimbursed (payment system is "O") for worksheets D, parts I through IV? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX. (see S-2, Part I, line 98.06)	Y	Y	7.00
	RHC			
8.00	Do Title V & XIX impute 20% coinsurance (M-3 Line 16.04)? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	N	N	8.00
	FQHC			
9.00	For fiscal year beginning on/after 10/01/2014, use M-series for Title V and/or Title XIX? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	N	N	9.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-3 Part I Date/Time Prepared: 6/12/2019 8:29 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	96,672.00	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	96,672.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	4	1,460	0.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		25	9,125	96,672.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF	40.00	10	1,940		0	16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	44.00	44	16,060		0	19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	101.00				0	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	116.00	0	0			24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	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)		79				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: | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-3 Part I | Date/Time Prepared: 6/12/2019 8:29 am

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	1,813	32	3,909			1.00
2.00	HMO and other (see instructions)	835	647				2.00
3.00	HMO IPF Subprovider	30	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	404	0	510			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	2,217	32	4,419			7.00
8.00	INTENSIVE CARE UNIT	424	8	855			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		316	578			13.00
14.00	Total (see instructions)	2,641	356	5,852	0.00	463.31	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF	936	0	992	0.00	8.33	16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	1,187	7,781	13,714	0.00	38.79	19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	7,239	0	16,694	0.00	31.80	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	0	0	0	0.00	4.29	24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RHC (CONSOLIDATED)	18,921	472	83,836	0.00	135.57	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	682.09	27.00
28.00	Observation Bed Days		8	939			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	119			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			98			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: | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-3 Part I Date/Time Prepared: 6/12/2019 8:29 am

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	749	16	1,699	1.00
2.00	HMO and other (see instructions)			251	235		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	749	16	1,699	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF	0.00	0	45	0	50	16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	0.00					19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0.00					22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	0.00					24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	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

HOME HEALTH AGENCY STATISTICAL DATA	Provider CCN:	Period: From 07/01/2017 To 06/30/2018	Worksheet S-4
	Component CCN:		Date/Time Prepared: 6/12/2019 8:29 am
		Home Health Agency I	PPS

					1.00		
0.00	County				COUNTY		0.00
		Title V	Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	5.00	
	HOME HEALTH AGENCY STATISTICAL DATA						
1.00	Home Health Aide Hours	0	2,169	0	2,470	4,639	1.00
2.00	Unduplicated Census Count (see instructions)	0.00	336.00	10.00	374.00	720.00	2.00
				Number of Employees (Full Time Equivalent)			
		Enter the number of hours in your normal work week		Staff	Contract	Total	
		0		1.00	2.00	3.00	
	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES						
3.00	Administrator and Assistant Administrator(s)		0.00	0.00	0.00	0.00	3.00
4.00	Director(s) and Assistant Director(s)			2.11	0.00	2.11	4.00
5.00	Other Administrative Personnel			6.81	0.00	6.81	5.00
6.00	Direct Nursing Service			14.00	0.00	14.00	6.00
7.00	Nursing Supervisor			0.00	0.00	0.00	7.00
8.00	Physical Therapy Service			2.86	0.00	2.86	8.00
9.00	Physical Therapy Supervisor			0.00	0.00	0.00	9.00
10.00	Occupational Therapy Service			1.41	0.00	1.41	10.00
11.00	Occupational Therapy Supervisor			0.00	0.00	0.00	11.00
12.00	Speech Pathology Service			1.01	0.00	1.01	12.00
13.00	Speech Pathology Supervisor			0.00	0.00	0.00	13.00
14.00	Medical Social Service			0.80	0.00	0.80	14.00
15.00	Medical Social Service Supervisor			0.00	0.00	0.00	15.00
16.00	Home Health Aide			2.23	0.00	2.23	16.00
17.00	Home Health Aide Supervisor			0.00	0.00	0.00	17.00
18.00	HOMEMAKER			0.56	0.00	0.56	18.00
	HOME HEALTH AGENCY CBSA CODES						
19.00	Enter in column 1 the number of CBSAs where you provided services during the cost reporting period.			2			19.00
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).			99901			20.00
20.01				99902			20.01
		Full Episodes					
		Without Outliers	With Outliers	LUPA Episodes	PEP Only Episodes	Total (cols. 1-4)	
		1.00	2.00	3.00	4.00	5.00	
	PPS ACTIVITY DATA						
21.00	Skilled Nursing Visits	4,358	839	88	50	5,335	21.00
22.00	Skilled Nursing Visit Charges	769,632	148,395	15,576	8,850	942,453	22.00
23.00	Physical Therapy Visits	1,368	69	14	13	1,464	23.00
24.00	Physical Therapy Visit Charges	229,947	10,815	3,095	2,593	246,450	24.00
25.00	Occupational Therapy Visits	490	50	4	17	561	25.00
26.00	Occupational Therapy Visit Charges	119,543	13,508	1,180	2,505	136,736	26.00
27.00	Speech Pathology Visits	359	46	1	0	406	27.00
28.00	Speech Pathology Visit Charges	105,761	13,498	295	0	119,554	28.00
29.00	Medical Social Service Visits	68	17	0	2	87	29.00
30.00	Medical Social Service Visit Charges	20,006	5,006	0	590	25,602	30.00
31.00	Home Health Aide Visits	405	149	1	1	556	31.00
32.00	Home Health Aide Visit Charges	39,165	14,417	97	97	53,776	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	7,048	1,170	108	83	8,409	33.00
34.00	Other Charges	0	0	0	0	0	34.00
35.00	Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)	1,284,054	205,639	20,243	14,635	1,524,571	35.00
36.00	Total Number of Episodes (standard/non outlier)	452		39	7	498	36.00
37.00	Total Number of Outlier Episodes		29		0	29	37.00
38.00	Total Non-Routine Medical Supply Charges	21,907	7,725	1,139	99	30,870	38.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA	Provider CCN:	Period: From 07/01/2017 To 06/30/2018	Worksheet S-7 Date/Time Prepared: 6/12/2019 8:29 am

		1.00	2.00	
1.00	If this facility contains a hospital-based SNF, were all patients under managed care or was there no Medicare utilization? Enter "Y" for yes in column 1 and do not complete the rest of this worksheet.	N		1.00
2.00	Does this hospital have an agreement under either section 1883 or section 1913 for swing beds? Enter "Y" for yes or "N" for no in column 1. If yes, enter the agreement date (mm/dd/yyyy) in column 2.	Y	08/01/2007	2.00

		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
		1.00	2.00	3.00	4.00	
3.00		RUX	0	0	0	3.00
4.00		RUL	0	0	0	4.00
5.00		RVX	0	0	0	5.00
6.00		RVL	0	0	0	6.00
7.00		RHX	0	0	0	7.00
8.00		RHL	0	0	0	8.00
9.00		RMX	0	0	0	9.00
10.00		RML	0	0	0	10.00
11.00		RLX	0	0	0	11.00
12.00		RUC	30	0	30	12.00
13.00		RUB	66	0	66	13.00
14.00		RUA	49	0	49	14.00
15.00		RVC	187	0	187	15.00
16.00		RVB	286	0	286	16.00
17.00		RVA	141	0	141	17.00
18.00		RHC	134	0	134	18.00
19.00		RHB	88	0	88	19.00
20.00		RHA	52	0	52	20.00
21.00		RMC	20	0	20	21.00
22.00		RMB	14	0	14	22.00
23.00		RMA	8	0	8	23.00
24.00		RLB	0	0	0	24.00
25.00		RLA	0	0	0	25.00
26.00		ES3	0	0	0	26.00
27.00		ES2	0	0	0	27.00
28.00		ES1	0	0	0	28.00
29.00		HE2	0	0	0	29.00
30.00		HE1	4	0	4	30.00
31.00		HD2	0	0	0	31.00
32.00		HD1	4	0	4	32.00
33.00		HC2	0	0	0	33.00
34.00		HC1	0	0	0	34.00
35.00		HB2	0	0	0	35.00
36.00		HB1	0	0	0	36.00
37.00		LE2	0	0	0	37.00
38.00		LE1	0	0	0	38.00
39.00		LD2	0	0	0	39.00
40.00		LD1	25	0	25	40.00
41.00		LC2	0	0	0	41.00
42.00		LC1	55	0	55	42.00
43.00		LB2	0	0	0	43.00
44.00		LB1	0	0	0	44.00
45.00		CE2	0	0	0	45.00
46.00		CE1	4	0	4	46.00
47.00		CD2	0	0	0	47.00
48.00		CD1	0	0	0	48.00
49.00		CC2	0	0	0	49.00
50.00		CC1	4	0	4	50.00
51.00		CB2	0	0	0	51.00
52.00		CB1	0	0	0	52.00
53.00		CA2	0	0	0	53.00
54.00		CA1	0	0	0	54.00
55.00		SE3	0	0	0	55.00
56.00		SE2	0	0	0	56.00
57.00		SE1	0	0	0	57.00
58.00		SSC	0	0	0	58.00
59.00		SSB	0	0	0	59.00
60.00		SSA	0	0	0	60.00
61.00		IB2	0	0	0	61.00
62.00		IB1	0	0	0	62.00
63.00		IA2	0	0	0	63.00
64.00		IA1	0	0	0	64.00
65.00		BB2	0	0	0	65.00
66.00		BB1	0	0	0	66.00
67.00		BA2	0	0	0	67.00
68.00		BA1	0	0	0	68.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA	Provider CCN:	Period: From 07/01/2017 To 06/30/2018	Worksheet S-7 Date/Time Prepared: 6/12/2019 8:29 am

		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
		1.00	2.00	3.00	4.00	
69.00		PE2	0	0	0	69.00
70.00		PE1	2	0	2	70.00
71.00		PD2	0	0	0	71.00
72.00		PD1	14	0	14	72.00
73.00		PC2	0	0	0	73.00
74.00		PC1	0	0	0	74.00
75.00		PB2	0	0	0	75.00
76.00		PB1	0	0	0	76.00
77.00		PA2	0	0	0	77.00
78.00		PA1	0	0	0	78.00
199.00		AAA	0	0	0	199.00
200.00	TOTAL		1,187	0	1,187	200.00

		CBSA at Beginning of Cost Reporting Period	CBSA on/after October 1 of the Cost Reporting Period (if applicable)	
		1.00	2.00	
	SNF SERVICES			
201.00	Enter in column 1 the SNF CBSA code or 5 character non-CBSA code if a rural facility, in effect at the beginning of the cost reporting period. Enter in column 2, the code in effect on or after October 1 of the cost reporting period (if applicable).			201.00

		Expenses	Percentage	Associated with Direct Patient Care and Related Expenses?	
		1.00	2.00	3.00	
	A notice published in the Federal Register Volume 68, No. 149 August 4, 2003 provided for an increase in the RUG payments beginning 10/01/2003. Congress expected this increase to be used for direct patient care and related expenses. For lines 202 through 207: Enter in column 1 the amount of the expense for each category. Enter in column 2 the percentage of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 7, column 3. In column 3, enter "Y" for yes or "N" for no if the spending reflects increases associated with direct patient care and related expenses for each category. (see instructions)				
202.00	Staffing	0	0.00		202.00
203.00	Recruitment	0	0.00		203.00
204.00	Retention of employees	0	0.00		204.00
205.00	Training	0	0.00		205.00
206.00	OTHER (SPECIFY)	0	0.00		206.00
207.00	Total SNF revenue (Worksheet G-2, Part I, line 7, column 3)	4,326,791			207.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: | Component CCN: | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-8 | Date/Time Prepared: 6/12/2019 8:29 am

RHC I | Cost

					1.00	
	Clinic Address and Identification					
1.00	Street			100 MAIN		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	ANYWHERE				2.00
					1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0	3.00
			Grant Award		Date	
			1.00		2.00	
	Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)					4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)					5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)					6.00
7.00	Appalachian Regional Commission					7.00
8.00	Look-Alikes					8.00
9.00	OTHER (SPECIFY)					9.00
				1.00	2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N	0	10.00
		Sunday		Monday		Tuesday
		from	to	from	to	from
		1.00	2.00	3.00	4.00	5.00
	Facility hours of operations (1)					
11.00	CLINIC			08:30	19:00	09:00	11.00
					1.00	2.00	
12.00	Have you received an approval for an exception to the productivity standard?				N		12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.				Y	10	13.00
				Provider name		CCN number	
				1.00		2.00	
14.00	RHC/FQHC name, CCN number			RHC 1		1	14.00
14.01				RHC 2		2	14.01
14.02				RHC 3		3	14.02
14.03				RHC 4		4	14.03
14.04				RHC 5		5	14.04
14.05				RHC 6		6	14.05
14.06				RHC 7		7	14.06
14.07				RHC 8		8	14.07
14.08				RHC 9		9	14.08
14.09				RHC 10		10	14.09
		Y/N	V	XVIII	XIX	Total Visits	
		1.00	2.00	3.00	4.00	5.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)						15.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA	Provider CCN: Component CCN:	Period: From 07/01/2017 To 06/30/2018	Worksheet S-8 Date/Time Prepared: 6/12/2019 8:29 am
		RHC I	Cost

			County				
			4.00				
2.00	City, State, ZIP Code, County						2.00
		Tuesday	Wednesday		Thursday		
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)						
11.00	CLINIC	17:00	08:30	17:00	09:00	17:00	11.00
		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	CLINIC	08:30	17:00				11.00

HOSPITAL-BASED HOSPICE IDENTIFICATION DATA	Provider CCN: Hospice CCN:	Period: From 07/01/2017 To 06/30/2018	Worksheet S-9 PARTS I THROUGH IV Date/Time Prepared: 6/12/2019 8:29 am
		Hospice I	

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

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

		Title XVIII	Title XIX	Other	Total (sum of cols. 1 through 3)	
		1.00	2.00	3.00	4.00	
	PART III - ENROLLMENT DAYS FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2015					
10.00	Hospice Continuous Home Care	0	0	0	0	10.00
11.00	Hospice Routine Home Care	4,122	0	284	4,406	11.00
12.00	Hospice Inpatient Respite Care	28	0	0	28	12.00
13.00	Hospice General Inpatient Care	0	0	0	0	13.00
14.00	Total Hospice Days	4,150	0	284	4,434	14.00
	PART IV - CONTRACTED STATISTICAL DATA FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2015					
15.00	Hospice Inpatient Respite Care	0	0	0	0	15.00
16.00	Hospice General Inpatient Care	0	0	0	0	16.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN:	Period: From 07/01/2017 To 06/30/2018	Worksheet S-10 Date/Time Prepared: 6/12/2019 8:29 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)	0.477374	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	13,787,318	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	33,931,539	6.00
7.00	Medicaid cost (line 1 times line 6)	16,198,034	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)	2,410,716	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	175,941	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	2,410,716	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)	355,641	73,085	428,726	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	169,774	73,085	242,859	21.00
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	169,774	73,085	242,859	23.00

		1.00	
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	2,297,289	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	993,142	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	1,527,912	27.01
28.00	Non-Medicare bad debt expense (see instructions)	769,377	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	902,051	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	1,144,910	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	3,555,626	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: | Period: From 07/01/2017 To 06/30/2018 | Worksheet A | Date/Time Prepared: 6/12/2019 8:29 am

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		1,921,903	1,921,903	1,055,107	2,977,010	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		0	0	393,429	393,429	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	534,985	479,469	1,014,454	0	1,014,454	4.00
5.01	00540	NONPATIENT TELEPHONES	0	0	0	211,986	211,986	5.01
5.02	00560	PURCHASING RECEIVING AND STORES	247,228	184,015	431,243	0	431,243	5.02
5.03	00570	ADMITTING	408,791	133,348	542,139	0	542,139	5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE	807,672	1,020,069	1,827,741	0	1,827,741	5.04
5.05	00590	OTHER ADMINISTRATIVE AND GENERAL	2,776,021	3,342,558	6,118,579	728,825	6,847,404	5.05
7.00	00700	OPERATION OF PLANT	722,291	3,054,512	3,776,803	-1,345,457	2,431,346	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	925,522	340,012	1,265,534	0	1,265,534	9.00
10.00	01000	DIETARY	584,624	691,690	1,276,314	0	1,276,314	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	709,397	175,567	884,964	0	884,964	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	123,277	1,028,701	1,151,978	-633,681	518,297	14.00
15.00	01500	PHARMACY	170,354	7,754,997	7,925,351	-4,534,383	3,390,968	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	321,949	297,363	619,312	0	619,312	16.00
18.00	01850	INSERVICE EDUCATION	146,695	151,609	298,304	0	298,304	18.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	1,239,406	1,239,406	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,737,669	1,007,379	3,745,048	-259,773	3,485,275	30.00
31.00	03100	INTENSIVE CARE UNIT	674,376	231,645	906,021	0	906,021	31.00
40.00	04000	SUBPROVIDER - IPF	311,505	398,635	710,140	-244	709,896	40.00
43.00	04300	NURSERY	0	1,813	1,813	142,456	144,269	43.00
44.00	04400	SKILLED NURSING FACILITY	1,625,905	836,725	2,462,630	-113,329	2,349,301	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,550,120	1,099,331	2,649,451	-55,692	2,593,759	50.00
51.00	05100	RECOVERY ROOM	125,238	76,848	202,086	0	202,086	51.00
52.00	05200	LABOR ROOM & DELIVERY ROOM	0	39,736	39,736	117,317	157,053	52.00
53.00	05300	ANESTHESIOLOGY	1,166,451	1,164,442	2,330,893	-1,267,261	1,063,632	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	949,551	1,278,900	2,228,451	-3,966	2,224,485	54.00
56.00	05600	RADIOISOTOPE	58,852	183,334	242,186	0	242,186	56.00
57.00	05700	CT SCAN	69,421	262,176	331,597	0	331,597	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	145,408	461,237	606,645	0	606,645	58.00
60.00	06000	LABORATORY	765,488	1,896,850	2,662,338	0	2,662,338	60.00
65.00	06500	RESPIRATORY THERAPY	459,501	242,410	701,911	0	701,911	65.00
66.00	06600	PHYSICAL THERAPY	1,021,472	792,572	1,814,044	978	1,815,022	66.00
67.00	06700	OCCUPATIONAL THERAPY	111,039	356,688	467,727	0	467,727	67.00
68.00	06800	SPEECH PATHOLOGY	125,884	26,392	152,276	0	152,276	68.00
69.00	06900	ELECTROCARDIOLOGY	214,853	253,714	468,567	-31,922	436,645	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
70.01	03610	SLEEP LAB	105,481	141,790	247,271	0	247,271	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	2,285,864	2,285,864	71.00
72.00	07200	IMP. DEV CHARGED TO PATIENT	0	5,777,010	5,777,010	-1,599,037	4,177,973	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	4,646,144	4,646,144	73.00
76.00	03480	ONCOLOGY	335,632	819,614	1,155,246	0	1,155,246	76.00
76.01	03952	OCCUPATIONAL HEALTH	30,689	13,122	43,811	0	43,811	76.01
76.03	03951	OP DIABETIC EDUCATION	20,147	6,631	26,778	0	26,778	76.03
76.97	07697	CARDIAC REHABILITATION	56,699	24,739	81,438	0	81,438	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	11,624,710	7,333,270	18,957,980	-1,602,669	17,355,311	88.00
90.00	09000	CLINIC	4,160,025	2,594,683	6,754,708	650,413	7,405,121	90.00
90.02	09002	WOUND CARE	74,476	65,489	139,965	0	139,965	90.02
91.00	09100	EMERGENCY	1,819,516	869,841	2,689,357	-35,538	2,653,819	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	1,979,920	1,205,895	3,185,815	-41,348	3,144,467	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	251,440	171,744	423,184	4,763	427,947	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	41,050,274	50,210,468	91,260,742	-47,612	91,213,130	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	796,527	739,557	1,536,084	0	1,536,084	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	COMMUNITY WELLNESS	62,130	29,167	91,297	0	91,297	193.01
193.02	19302	COLE CARE RENTAL	0	0	0	0	0	193.02
193.07	19307	NONREIMB PUB REL &WOMENS HEALTH	0	0	0	47,612	47,612	193.07
200.00		TOTAL (SUM OF LINES 118 through 199)	41,908,931	50,979,192	92,888,123	0	92,888,123	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: | Period: From 07/01/2017 To 06/30/2018 | Worksheet A | Date/Time Prepared: 6/12/2019 8:29 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	-222,657	2,754,353		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-345,260	48,169		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	887,914	1,902,368		4.00
5.01	00540	NONPATIENT TELEPHONES	0	211,986		5.01
5.02	00560	PURCHASING RECEIVING AND STORES	-3,485	427,758		5.02
5.03	00570	ADMITTING	0	542,139		5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE	-229,599	1,598,142		5.04
5.05	00590	OTHER ADMINISTRATIVE AND GENERAL	-699,837	6,147,567		5.05
7.00	00700	OPERATION OF PLANT	-4,923	2,426,423		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0		8.00
9.00	00900	HOUSEKEEPING	0	1,265,534		9.00
10.00	01000	DIETARY	-416,489	859,825		10.00
11.00	01100	CAFETERIA	0	0		11.00
13.00	01300	NURSING ADMINISTRATION	0	884,964		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	518,297		14.00
15.00	01500	PHARMACY	-1,813,716	1,577,252		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	619,312		16.00
18.00	01850	INSERVICE EDUCATION	-18,688	279,616		18.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	-1,239,406	0		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	3,485,275		30.00
31.00	03100	INTENSIVE CARE UNIT	0	906,021		31.00
40.00	04000	SUBPROVIDER - IPF	0	709,896		40.00
43.00	04300	NURSERY	0	144,269		43.00
44.00	04400	SKILLED NURSING FACILITY	-6,222	2,343,079		44.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-22,979	2,570,780		50.00
51.00	05100	RECOVERY ROOM	0	202,086		51.00
52.00	05200	LABOR ROOM & DELIVERY ROOM	0	157,053		52.00
53.00	05300	ANESTHESIOLOGY	-831,469	232,163		53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	-832	2,223,653		54.00
56.00	05600	RADIOISOTOPE	0	242,186		56.00
57.00	05700	CT SCAN	0	331,597		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	606,645		58.00
60.00	06000	LABORATORY	0	2,662,338		60.00
65.00	06500	RESPIRATORY THERAPY	-14,282	687,629		65.00
66.00	06600	PHYSICAL THERAPY	-226,031	1,588,991		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	467,727		67.00
68.00	06800	SPEECH PATHOLOGY	0	152,276		68.00
69.00	06900	ELECTROCARDIOLOGY	0	436,645		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
70.01	03610	SLEEP LAB	-81,650	165,621		70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2,285,864		71.00
72.00	07200	IMP. DEV CHARGED TO PATIENT	0	4,177,973		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	4,646,144		73.00
76.00	03480	ONCOLOGY	0	1,155,246		76.00
76.01	03952	OCCUPATIONAL HEALTH	0	43,811		76.01
76.03	03951	OP DIABETIC EDUCATION	-2,100	24,678		76.03
76.97	07697	CARDIAC REHABILITATION	0	81,438		76.97
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	-1,506,825	15,848,486		88.00
90.00	09000	CLINIC	-5,262,882	2,142,239		90.00
90.02	09002	WOUND CARE	0	139,965		90.02
91.00	09100	EMERGENCY	-8,098	2,645,721		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY	0	3,144,467		101.00
		SPECIAL PURPOSE COST CENTERS				
116.00	11600	HOSPICE	0	427,947		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-12,069,516	79,143,614		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	1,536,084		192.00
193.00	19300	NONPAID WORKERS	0	0		193.00
193.01	19301	COMMUNITY WELLNESS	0	91,297		193.01
193.02	19302	COLE CARE RENTAL	0	0		193.02
193.07	19307	NONREIMB PUB REL &WOMENS HEALTH	0	47,612		193.07
200.00		TOTAL (SUM OF LINES 118 through 199)	-12,069,516	80,818,607		200.00

COST CENTERS USED IN COST REPORT | Provider CCN: | Period: From 07/01/2017 To 06/30/2018 | Worksheet Non-CMS W | Date/Time Prepared: 6/12/2019 8:29 am

	Cost Center Description	CMS Code	Standard Label For Non-Standard Codes	
		1.00	2.00	
	GENERAL SERVICE COST CENTERS			
1.00	CAP REL COSTS-BLDG & FIXT	00100		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	00200		2.00
4.00	EMPLOYEE BENEFITS DEPARTMENT	00400		4.00
5.01	NONPATIENT TELEPHONES	00540	NONPATIENT TELEPHONES	5.01
5.02	PURCHASING RECEIVING AND STORES	00560	PURCHASING RECEIVING AND STORES	5.02
5.03	ADMITTING	00570	ADMITTING	5.03
5.04	CASHIERING/ACCOUNTS RECEIVABLE	00580	CASHIERING/ACCOUNTS RECEIVABLE	5.04
5.05	OTHER ADMINISTRATIVE AND GENERAL	00590		5.05
7.00	OPERATION OF PLANT	00700		7.00
8.00	LAUNDRY & LINEN SERVICE	00800		8.00
9.00	HOUSEKEEPING	00900		9.00
10.00	DIETARY	01000		10.00
11.00	CAFETERIA	01100		11.00
13.00	NURSING ADMINISTRATION	01300		13.00
14.00	CENTRAL SERVICES & SUPPLY	01400		14.00
15.00	PHARMACY	01500		15.00
16.00	MEDICAL RECORDS & LIBRARY	01600		16.00
18.00	INSERVICE EDUCATION	01850		18.00
19.00	NONPHYSICIAN ANESTHETISTS	01900		19.00
	INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	ADULTS & PEDIATRICS	03000		30.00
31.00	INTENSIVE CARE UNIT	03100		31.00
40.00	SUBPROVIDER - IPF	04000		40.00
43.00	NURSERY	04300		43.00
44.00	SKILLED NURSING FACILITY	04400		44.00
	ANCILLARY SERVICE COST CENTERS			
50.00	OPERATING ROOM	05000		50.00
51.00	RECOVERY ROOM	05100		51.00
52.00	LABOR ROOM & DELIVERY ROOM	05200		52.00
53.00	ANESTHESIOLOGY	05300		53.00
54.00	RADIOLOGY - DIAGNOSTIC	05400		54.00
56.00	RADIOISOTOPE	05600		56.00
57.00	CT SCAN	05700		57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	05800		58.00
60.00	LABORATORY	06000		60.00
65.00	RESPIRATORY THERAPY	06500		65.00
66.00	PHYSICAL THERAPY	06600		66.00
67.00	OCCUPATIONAL THERAPY	06700		67.00
68.00	SPEECH PATHOLOGY	06800		68.00
69.00	ELECTROCARDIOLOGY	06900		69.00
70.00	ELECTROENCEPHALOGRAPHY	07000		70.00
70.01	SLEEP LAB	03610	SLEEP LAB	70.01
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	07100		71.00
72.00	IMP. DEV CHARGED TO PATIENT	07200		72.00
73.00	DRUGS CHARGED TO PATIENTS	07300		73.00
76.00	ONCOLOGY	03480	ONCOLOGY	76.00
76.01	OCCUPATIONAL HEALTH	03952		76.01
76.03	OP DIABETIC EDUCATION	03951		76.03
76.97	CARDIAC REHABILITATION	07697		76.97
	OUTPATIENT SERVICE COST CENTERS			
88.00	RURAL HEALTH CLINIC	08800		88.00
90.00	CLINIC	09000		90.00
90.02	WOUND CARE	09002		90.02
91.00	EMERGENCY	09100		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	09200		92.00
	OTHER REIMBURSABLE COST CENTERS			
101.00	HOME HEALTH AGENCY	10100		101.00
	SPECIAL PURPOSE COST CENTERS			
116.00	HOSPICE	11600		116.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)			118.00
	NONREIMBURSABLE COST CENTERS			
190.00	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	19000		190.00
192.00	PHYSICIANS' PRIVATE OFFICES	19200		192.00
193.00	NONPAID WORKERS	19300		193.00
193.01	COMMUNITY WELLNESS	19301		193.01
193.02	COLE CARE RENTAL	19302		193.02
193.07	NONREIMB PUB REL &WOMENS HEALTH	19307		193.07
200.00	TOTAL (SUM OF LINES 118 through 199)			200.00

RECLASSIFICATIONS | Provider CCN: | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-6 | Date/Time Prepared: 6/12/2019 8:29 am

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - TO RECLASS INTERNALLY ALLOCATED COST				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	369,132	1.00
2.00		0.00	0	0	2.00
	0		0	369,132	
	B - TO RECLASS CRNA COSTS				
1.00	NONPHYSICIAN ANESTHETISTS	19.00	595,687	643,719	1.00
	0		595,687	643,719	
	C - TO RECLASS NONREIMB COMMUNITY EDUCAT				
1.00	NONREIMB PUB REL &WOMENS HEALTH	193.07	19,239	28,373	1.00
	0		19,239	28,373	
	D - TO RECLASS EHR COSTS				
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	337,380	1.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
	0		0	337,380	
	E - TO RECLASS INS AND AG INTEREST EXP				
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	22,863	1.00
2.00	OTHER ADMINISTRATIVE AND GENERAL	5.05	0	603,433	2.00
	0		0	626,296	
	F - TO RECLASS EMPORIUM PROPERTY TAX				
1.00	PHYSICAL THERAPY	66.00	0	978	1.00
2.00	RURAL HEALTH CLINIC	88.00	0	5,968	2.00
	0		0	6,946	
	G - TO RECLASS NURSERY				
1.00	NURSERY	43.00	129,994	12,462	1.00
2.00	LABOR ROOM & DELIVERY ROOM	52.00	107,054	10,263	2.00
	0		237,048	22,725	
	H - TO RECLASS DRUGS SOLD TO PATIENTS				
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	4,646,144	1.00
2.00		0.00	0	0	2.00
	0		0	4,646,144	
	I - TO RECLASS SUPPLIES SOLD TO PATIENTS				
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	302,943	1.00
2.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	2,285,864	2.00
3.00	IMP. DEV CHARGED TO PATIENT	72.00	0	53,760	3.00
	0		0	2,642,567	
	J - TO RECLASS NONPATIENT TELEPHONE				
1.00	NONPATIENT TELEPHONES	5.01	0	211,986	1.00
	0		0	211,986	
	K - TO RECLASS PLANT DEPRECIATION				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1,312,271	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	33,186	2.00
	0		0	1,345,457	
	L - TO RECLASS ALLOWABLE BENEFITS				
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.05	0	141,282	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
	0		0	141,282	
	M - TO RECLASS ALLOW PHYSICIAN BENEFITS				
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.05	0	511,256	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
	0		0	511,256	
	N - TO RECLASS PROVIDER COSTS				
1.00	CLINIC	90.00	910,560	146,617	1.00
	0		910,560	146,617	
	O - TO RECLASS RENT EXPENSE				
1.00	HOSPICE	116.00	0	6,000	1.00
	0		0	6,000	
500.00	Grand Total: Increases		1,762,534	11,685,880	500.00

RECLASSIFICATIONS | Provider CCN: | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-6 | Date/Time Prepared: 6/12/2019 8:29 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - TO RECLASS INTERNALLY ALLOCATED COST						
1.00	RURAL HEALTH CLINIC	88.00	0	212,340	10		1.00
2.00	CLINIC	90.00	0	156,792	0		2.00
	0		0	369,132			
	B - TO RECLASS CRNA COSTS						
1.00	ANESTHESIOLOGY	53.00	595,687	643,719	0		1.00
	0		595,687	643,719			
	C - TO RECLASS NONREIMB COMMUNITY EDUCAT						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.05	19,239	28,373	0		1.00
	0		19,239	28,373			
	D - TO RECLASS EHR COSTS						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.05	0	267,548	9		1.00
3.00	OPERATING ROOM	50.00	0	165	0		3.00
4.00	RADIOLOGY - DIAGNOSTIC	54.00	0	3,966	0		4.00
5.00	ELECTROCARDIOLOGY	69.00	0	29,646	0		5.00
6.00	EMERGENCY	91.00	0	707	0		6.00
7.00	HOME HEALTH AGENCY	101.00	0	35,348	0		7.00
	0		0	337,380			
	E - TO RECLASS INS AND AG INTEREST EXP						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	626,296	12		1.00
2.00		0.00	0	0	0		2.00
	0		0	626,296			
	F - TO RECLASS EMPORIUM PROPERTY TAX						
1.00	RURAL HEALTH CLINIC	88.00	0	6,946	0		1.00
2.00		0.00	0	0	0		2.00
	0		0	6,946			
	G - TO RECLASS NURSERY						
1.00	ADULTS & PEDIATRICS	30.00	237,048	22,725	0		1.00
2.00		0.00	0	0	0		2.00
	0		237,048	22,725			
	H - TO RECLASS DRUGS SOLD TO PATIENTS						
1.00	PHARMACY	15.00	0	4,534,383	0		1.00
2.00	SKILLED NURSING FACILITY	44.00	0	111,761	0		2.00
	0		0	4,646,144			
	I - TO RECLASS SUPPLIES SOLD TO PATIENTS						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	936,624	0		1.00
2.00	OPERATING ROOM	50.00	0	53,146	0		2.00
3.00	IMP. DEV CHARGED TO PATIENT	72.00	0	1,652,797	0		3.00
	0		0	2,642,567			
	J - TO RECLASS NONPATIENT TELEPHONE						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.05	0	211,986	0		1.00
	0		0	211,986			
	K - TO RECLASS PLANT DEPRECIATION						
1.00	OPERATION OF PLANT	7.00	0	1,345,457	9		1.00
2.00		0.00	0	0	9		2.00
	0		0	1,345,457			
	L - TO RECLASS ALLOWABLE BENEFITS						
1.00	OPERATING ROOM	50.00	0	2,381	0		1.00
2.00	RURAL HEALTH CLINIC	88.00	0	33,645	0		2.00
3.00	CLINIC	90.00	0	105,256	0		3.00
	0		0	141,282			
	M - TO RECLASS ALLOW PHYSICIAN BENEFITS						
1.00	SUBPROVIDER - IPF	40.00	0	244	0		1.00
2.00	SKILLED NURSING FACILITY	44.00	0	1,568	0		2.00
3.00	ANESTHESIOLOGY	53.00	0	27,855	0		3.00
4.00	ELECTROCARDIOLOGY	69.00	0	2,276	0		4.00
5.00	RURAL HEALTH CLINIC	88.00	0	298,529	0		5.00
6.00	CLINIC	90.00	0	144,716	0		6.00
7.00	EMERGENCY	91.00	0	34,831	0		7.00
8.00	HOSPICE	116.00	0	1,237	0		8.00
	0		0	511,256			
	N - TO RECLASS PROVIDER COSTS						
1.00	RURAL HEALTH CLINIC	88.00	910,560	146,617	0		1.00
	0		910,560	146,617			
	O - TO RECLASS RENT EXPENSE						
1.00	HOME HEALTH AGENCY	101.00	0	6,000	0		1.00
	0		0	6,000			
500.00	Grand Total: Decreases		1,762,534	11,685,880			500.00

RECLASSIFICATIONS | Provider CCN: | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-6 Non-CMS Worksheet Date/Time Prepared: 6/12/2019 8:29 am

	Increases				Decreases				
	Cost Center	Line #	Salary	Other	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	6.00	7.00	8.00	9.00	
	A - TO RECLASS INTERNALLY ALLOCATED COST								
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	369,132	RURAL HEALTH CLINIC	88.00	0	212,340	1.00
2.00		0.00	0	0	CLINIC	90.00	0	156,792	2.00
	0		0	369,132	0		0	369,132	
	B - TO RECLASS CRNA COSTS								
1.00	NONPHYSICIAN ANESTHETISTS	19.00	595,687	643,719	ANESTHESIOLOGY	53.00	595,687	643,719	1.00
	0		595,687	643,719	0		595,687	643,719	
	C - TO RECLASS NONREIMB COMMUNITY EDUCAT								
1.00	NONREIMB PUB REL &WOMENS HEALTH	193.07	19,239	28,373	OTHER ADMINISTRATIVE AND GENERAL	5.05	19,239	28,373	1.00
	0		19,239	28,373	0		19,239	28,373	
	D - TO RECLASS EHR COSTS								
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	337,380	OTHER ADMINISTRATIVE AND GENERAL	5.05	0	267,548	1.00
3.00		0.00	0	0	OPERATING ROOM	50.00	0	165	3.00
4.00		0.00	0	0	RADIOLOGY - DIAGNOSTIC	54.00	0	3,966	4.00
5.00		0.00	0	0	ELECTROCARDIOLOGY	69.00	0	29,646	5.00
6.00		0.00	0	0	EMERGENCY	91.00	0	707	6.00
7.00		0.00	0	0	HOME HEALTH AGENCY	101.00	0	35,348	7.00
	0		0	337,380	0		0	337,380	
	E - TO RECLASS INS AND AG INTEREST EXP								
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	22,863	CAP REL COSTS-BLDG & FIXT	1.00	0	626,296	1.00
2.00	OTHER ADMINISTRATIVE AND GENERAL	5.05	0	603,433		0.00	0	0	2.00
	0		0	626,296	0		0	626,296	
	F - TO RECLASS EMPORIUM PROPERTY TAX								
1.00	PHYSICAL THERAPY	66.00	0	978	RURAL HEALTH CLINIC	88.00	0	6,946	1.00
2.00	RURAL HEALTH CLINIC	88.00	0	5,968		0.00	0	0	2.00
	0		0	6,946	0		0	6,946	
	G - TO RECLASS NURSERY								
1.00	NURSERY	43.00	129,994	12,462	ADULTS & PEDIATRICS	30.00	237,048	22,725	1.00
2.00	LABOR ROOM & DELIVERY ROOM	52.00	107,054	10,263		0.00	0	0	2.00
	0		237,048	22,725	0		237,048	22,725	
	H - TO RECLASS DRUGS SOLD TO PATIENTS								
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	4,646,144	PHARMACY	15.00	0	4,534,383	1.00
2.00		0.00	0	0	SKILLED NURSING FACILITY	44.00	0	111,761	2.00
	0		0	4,646,144	0		0	4,646,144	
	I - TO RECLASS SUPPLIES SOLD TO PATIENTS								
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	302,943	CENTRAL SERVICES & SUPPLY	14.00	0	936,624	1.00
2.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	2,285,864	OPERATING ROOM	50.00	0	53,146	2.00
3.00	IMP. DEV CHARGED TO PATIENT	72.00	0	53,760	IMP. DEV CHARGED TO PATIENT	72.00	0	1,652,797	3.00
	0		0	2,642,567	0		0	2,642,567	
	J - TO RECLASS NONPATIENT TELEPHONE								
1.00	NONPATIENT TELEPHONES	5.01	0	211,986	OTHER ADMINISTRATIVE AND GENERAL	5.05	0	211,986	1.00
	0		0	211,986	0		0	211,986	
	K - TO RECLASS PLANT DEPRECIATION								
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1,312,271	OPERATION OF PLANT	7.00	0	1,345,457	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	33,186		0.00	0	0	2.00
	0		0	1,345,457	0		0	1,345,457	
	L - TO RECLASS ALLOWABLE BENEFITS								
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.05	0	141,282	OPERATING ROOM	50.00	0	2,381	1.00
2.00		0.00	0	0	RURAL HEALTH CLINIC	88.00	0	33,645	2.00
3.00		0.00	0	0	CLINIC	90.00	0	105,256	3.00
	0		0	141,282	0		0	141,282	
	M - TO RECLASS ALLOW PHYSICIAN BENEFITS								
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.05	0	511,256	SUBPROVIDER - IPF	40.00	0	244	1.00
2.00		0.00	0	0	SKILLED NURSING FACILITY	44.00	0	1,568	2.00
3.00		0.00	0	0	ANESTHESIOLOGY	53.00	0	27,855	3.00
4.00		0.00	0	0	ELECTROCARDIOLOGY	69.00	0	2,276	4.00

RECLASSIFICATIONS | Provider CCN: | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-6 Non-CMS Worksheet Date/Time Prepared: 6/12/2019 8:29 am

	Increases				Decreases				
	Cost Center	Line #	Salary	Other	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	6.00	7.00	8.00	9.00	
5.00		0.00	0	0	RURAL HEALTH CLINIC	88.00	0	298,529	5.00
6.00		0.00	0	0	CLINIC	90.00	0	144,716	6.00
7.00		0.00	0	0	EMERGENCY	91.00	0	34,831	7.00
8.00		0.00	0	0	HOSPICE	116.00	0	1,237	8.00
	0		0	511,256	0		0	511,256	
	N - TO RECLASS PROVIDER COSTS								
1.00	CLINIC	90.00	910,560	146,617	RURAL HEALTH CLINIC	88.00	910,560	146,617	1.00
	0		910,560	146,617	0		910,560	146,617	
	O - TO RECLASS RENT EXPENSE								
1.00	HOSPICE	116.00	0	6,000	HOME HEALTH AGENCY	101.00	0	6,000	1.00
	0		0	6,000	0		0	6,000	
500.00	Grand Total: Increases		1,762,534	11,685,880	Grand Total: Decreases		1,762,534	11,685,880	500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-7 Part I Date/Time Prepared: 6/12/2019 8:29 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	1,135,847	0	0	0	45,000	1.00
2.00	Land Improvements	1,752,347	0	0	0	0	2.00
3.00	Buildings and Fixtures	26,758,949	0	0	0	0	3.00
4.00	Building Improvements	24,774,628	238,656	0	238,656	0	4.00
5.00	Fixed Equipment	5,816,587	3,133	0	3,133	0	5.00
6.00	Movable Equipment	19,448,941	1,204,681	3,587	1,208,268	529,068	6.00
7.00	HIT designated Assets	4,761,231	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	84,448,530	1,446,470	3,587	1,450,057	574,068	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	84,448,530	1,446,470	3,587	1,450,057	574,068	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	1,090,847	0	1.00
2.00	Land Improvements	1,752,347	0	2.00
3.00	Buildings and Fixtures	26,758,949	0	3.00
4.00	Building Improvements	25,013,284	0	4.00
5.00	Fixed Equipment	5,819,720	0	5.00
6.00	Movable Equipment	20,128,141	0	6.00
7.00	HIT designated Assets	4,761,231	0	7.00
8.00	Subtotal (sum of lines 1-7)	85,324,519	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	85,324,519	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-7 Part II Date/Time Prepared: 6/12/2019 8:29 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	1,921,903	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	1,921,903	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	1,921,903	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	2.00
3.00	Total (sum of lines 1-2)	0	1,921,903	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-7 Part III Date/Time Prepared: 6/12/2019 8:29 am

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: 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	60,435,148	0	60,435,148	0.708298	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	24,889,371	0	24,889,371	0.291702	0	2.00
3.00	Total (sum of lines 1-2)	85,324,519	0	85,324,519	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: 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	3,234,174	368,172	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	25,306	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	3,259,480	368,172	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	-221,697	-626,296	0	0	2,754,353	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	22,863	0	0	48,169	2.00
3.00	Total (sum of lines 1-2)	-221,697	-603,433	0	0	2,802,522	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-8 | Date/Time Prepared: 6/12/2019 8:29 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)	B	-483,353	OTHER ADMINISTRATIVE AND GENERAL	5.05	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)	B	-1,757	PURCHASING RECEIVING AND STORES	5.02	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)	A	-17,111	OTHER ADMINISTRATIVE AND GENERAL	5.05	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-4,932,982			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)	A	-832	RADIOLOGY - DIAGNOSTIC	54.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	0			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-416,489	DIETARY	10.00	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	B	-3,390	PHARMACY	15.00	0	17.00
18.00	Sale of medical records and abstracts		0		0.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)	B	-18,688	INSERVICE EDUCATION	18.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	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
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist	A	-1,239,406	NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	A	-345,260	CAP REL COSTS-MVBLE EQUIP	2.00	9	32.00

ADJUSTMENTS TO EXPENSES | Provider CCN: | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-8 | Date/Time Prepared: 6/12/2019 8:29 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.00	LOBBYING	A	-4,787	OTHER ADMINISTRATIVE AND GENERAL	5.05	0	33.00
33.01	HR OTHER INCOME	B	-152,343	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.01
33.02	BILLING COSTS OF PC	A	-229,599	CASHIERING/ACCOUNTS RECEIVABLE	5.04	0	33.02
33.03	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.03
33.04	UNRELATED BUSINESS INCOME TAX	A	-16,814	OTHER ADMINISTRATIVE AND GENERAL	5.05	0	33.04
33.05	NONALLOWABLE ADVERTISING	A	-17,428	CLINIC	90.00	0	33.05
33.06	BARBER/BEAUTY SHOP COSTS	A	-6,222	SKILLED NURSING FACILITY	44.00	0	33.06
33.07	NONALLOWABLE RHC COSTS	A	-1,070,562	RURAL HEALTH CLINIC	88.00	0	33.07
33.08	PA SALARIES AND BENEFITS	A	-1,239,873	CLINIC	90.00	0	33.08
33.09	PA SALARIES AND BENEFITS	A	-396,327	RURAL HEALTH CLINIC	88.00	0	33.09
33.10	PA SALARIES AND BENEFITS	A	-22,979	OPERATING ROOM	50.00	0	33.10
33.11	OTHER INCOME REIMBURSEMENTS	B	-4,923	OPERATION OF PLANT	7.00	0	33.11
33.12	RENTAL INCOME	B	-960	CAP REL COSTS-BLDG & FIXT	1.00	10	33.12
33.13	UNNECESSARY BORROWING	A	-221,697	CAP REL COSTS-BLDG & FIXT	1.00	11	33.13
33.14	ER TRANSPORT ASSISTANCE	B	-8,098	EMERGENCY	91.00	0	33.14
33.15	CONTRACTED THERAPY - PT	B	-226,031	PHYSICAL THERAPY	66.00	0	33.15
33.16	RHC OTHER INCOME	B	-39,936	RURAL HEALTH CLINIC	88.00	0	33.16
33.17	SHIPPING FEES	B	-1,728	PURCHASING RECEIVING AND STORES	5.02	0	33.17
33.18	OP DIABETIC INCOME	B	-2,100	OP DIABETIC EDUCATION	76.03	0	33.18
33.19	OTHER OPERATING REVENUE	B	-172,235	OTHER ADMINISTRATIVE AND GENERAL	5.05	0	33.19
33.20	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.20
33.21	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.21
33.22	NONALLOWABLE DRUG COST	A	-1,810,326	PHARMACY	15.00	0	33.22
33.23	NONALLOWABLE ADVERTISING	A	-5,283	OTHER ADMINISTRATIVE AND GENERAL	5.05	0	33.23
33.24	OTHER NONALLOWABLE COSTS	A	-254	OTHER ADMINISTRATIVE AND GENERAL	5.05	0	33.24
34.00	PENSION ADJUSTMENT	A	1,040,257	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	34.00
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-12,069,516				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: | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-8-1 | Date/Time Prepared: 6/12/2019 8:29 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	4.00	EMPLOYEE BENEFITS DEPARTMENT	FEE FOR SERVICE	26,406	26,406	1.00
2.00	5.03	ADMITTING	FEE FOR SERVICE	15,380	15,380	2.00
3.00	5.02	PURCHASING RECEIVING AND STO	FEE FOR SERVICE	2,941	2,941	3.00
3.01	18.00	INSERVICE EDUCATION	FEE FOR SERVICE	434	434	3.01
3.02	44.00	SKILLED NURSING FACILITY	FEE FOR SERVICE	4,322	4,322	3.02
4.00	53.00	ANESTHESIOLOGY	FEE FOR SERVICE	743,190	743,190	4.00
4.01	54.00	RADIOLOGY - DIAGNOSTIC	FEE FOR SERVICE	29,037	29,037	4.01
4.02	69.00	ELECTROCARDIOLOGY	FEE FOR SERVICE	628	628	4.02
4.03	76.01	OCCUPATIONAL HEALTH	FEE FOR SERVICE	14,691	14,691	4.03
4.04	88.00	RURAL HEALTH CLINIC	FEE FOR SERVICE	7,645,456	7,645,456	4.04
4.05	90.00	CLINIC	FEE FOR SERVICE	2,691,246	2,691,246	4.05
4.06	90.02	WOUND CARE	FEE FOR SERVICE	100,988	100,988	4.06
4.07	192.00	PHYSICIANS' PRIVATE OFFICES	FEE FOR SERVICE	606,935	606,935	4.07
4.08	193.01	COMMUNITY WELLNESS	FEE FOR SERVICE	1,263	1,263	4.08
5.00	0		0	11,882,917	11,882,917	5.00

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

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

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

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

6.00	C	CHARLES COLE HO	100.00	COLE MGT	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:	Period: From 07/01/2017 To 06/30/2018	Worksheet A-8-1 Date/Time Prepared: 6/12/2019 8:29 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	0	0		1.00
2.00	0	0		2.00
3.00	0	0		3.00
3.01	0	0		3.01
3.02	0	0		3.02
4.00	0	0		4.00
4.01	0	0		4.01
4.02	0	0		4.02
4.03	0	0		4.03
4.04	0	0		4.04
4.05	0	0		4.05
4.06	0	0		4.06
4.07	0	0		4.07
4.08	0	0		4.08
5.00	0			5.00

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

	Related Organization(s) and/or Home Office		
	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	PHYS OFC MGT		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: | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-8-2 | Date/Time Prepared: 6/12/2019 8:29 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	53.00	ANESTHESIOLOGY	831,469	831,469	0	0	0	1.00
2.00	65.00	RESPIRATORY THERAPY	14,282	14,282	0	0	0	2.00
3.00	0.00		0	0	0	0	0	3.00
4.00	70.01	SLEEP LAB	81,650	81,650	0	0	0	4.00
5.00	90.00	CLINIC	4,005,581	4,005,581	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			4,932,982	4,932,982	0		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	53.00	ANESTHESIOLOGY	0	0	0	0	0	1.00
2.00	65.00	RESPIRATORY THERAPY	0	0	0	0	0	2.00
3.00	0.00		0	0	0	0	0	3.00
4.00	70.01	SLEEP LAB	0	0	0	0	0	4.00
5.00	90.00	CLINIC	0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	53.00	ANESTHESIOLOGY	0	0	0	831,469		1.00
2.00	65.00	RESPIRATORY THERAPY	0	0	0	14,282		2.00
3.00	0.00		0	0	0	0		3.00
4.00	70.01	SLEEP LAB	0	0	0	81,650		4.00
5.00	90.00	CLINIC	0	0	0	4,005,581		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	4,932,982		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS	Provider CCN:	Period: From 07/01/2017 To 06/30/2018	Worksheet A-8-3 Parts I-VI Date/Time Prepared: 6/12/2019 8:29 am
		Physical Therapy	Cost

						1.00	
	PART I - GENERAL INFORMATION						
1.00	Total number of weeks worked (excluding aides) (see instructions)					52	1.00
2.00	Line 1 multiplied by 15 hours per week					780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					352	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00
7.00	Standard travel expense rate					0.00	7.00
8.00	Optional travel expense rate per mile					0.00	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	478.00	3,349.00	647.00	985.00	0.00	9.00
10.00	AHSEA (see instructions)	83.38	83.38	62.54	41.69	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	41.69	41.69	31.27			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01
						1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION						
14.00	Supervisors (column 1, line 9 times column 1, line 10)					39,856	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					279,240	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)					40,463	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					359,559	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)					41,065	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)					0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)					400,624	20.00
	If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.						
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)					0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					0	22.00
23.00	Total salary equivalency (see instructions)					400,624	23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE						
	Standard Travel Allowance						
24.00	Therapists (line 3 times column 2, line 11)					14,675	24.00
25.00	Assistants (line 4 times column 3, line 11)					0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					14,675	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					0	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					14,675	28.00
	Optional Travel Allowance and Optional Travel Expense						
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)					0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)					0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)					0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)					14,675	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE						
	Standard Travel Expense						
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00
	Optional Travel Allowance and Optional Travel Expense						
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.						
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-8-3 Parts I-VI Date/Time Prepared: 6/12/2019 8:29 am

Physical Therapy | Cost

						1.00	
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00
		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	83.38	62.54	41.69	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00

		1.00		
	Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT			
57.00	Salary equivalency amount (from line 23)	400,624		57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	14,675		58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)	0		59.00
60.00	Overtime allowance (from column 5, line 56)	0		60.00
61.00	Equipment cost (see instructions)	0		61.00
62.00	Supplies (see instructions)	0		62.00
63.00	Total allowance (sum of lines 57-62)	415,299		63.00
64.00	Total cost of outside supplier services (from your records)	363,676		64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)	0		65.00
	LINE 33 CALCULATION			
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others	14,675		100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	0		100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	14,675		100.02
	LINE 34 CALCULATION			
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	0		101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0		101.01
101.02	Line 34 = sum of lines 27 and 31	0		101.02
	LINE 35 CALCULATION			
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0		102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others	0		102.01
102.02	Line 35 = sum of lines 31 and 32	0		102.02

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS	Provider CCN:	Period: From 07/01/2017 To 06/30/2018	Worksheet A-8-3 Parts I-VI Date/Time Prepared: 6/12/2019 8:29 am
		Respiratory Therapy	Cost

							1.00	
	PART I - GENERAL INFORMATION							
1.00	Total number of weeks worked (excluding aides) (see instructions)						13	1.00
2.00	Line 1 multiplied by 15 hours per week						195	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)						47	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)						0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)						0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)						0	6.00
7.00	Standard travel expense rate						0.00	7.00
8.00	Optional travel expense rate per mile						0.00	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees		
		1.00	2.00	3.00	4.00	5.00		
9.00	Total hours worked	0.00	661.00	0.00	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	65.56	65.56	49.17	32.78	0.00		10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	32.78	32.78	24.59				11.00
12.00	Number of travel hours (provider site)	0	0	0				12.00
12.01	Number of travel hours (offsite)							12.01
13.00	Number of miles driven (provider site)	0	0	0				13.00
13.01	Number of miles driven (offsite)							13.01
							1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION							
14.00	Supervisors (column 1, line 9 times column 1, line 10)						0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)						43,335	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)						0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)						43,335	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)						0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)						0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)						43,335	20.00
	If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.							
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)						0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)						0	22.00
23.00	Total salary equivalency (see instructions)						43,335	23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE							
	Standard Travel Allowance							
24.00	Therapists (line 3 times column 2, line 11)						1,541	24.00
25.00	Assistants (line 4 times column 3, line 11)						0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)						1,541	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)						0	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)						1,541	28.00
	Optional Travel Allowance and Optional Travel Expense							
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)						0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)						0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)						0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)						0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)						1,541	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)						0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)						0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE							
	Standard Travel Expense							
36.00	Therapists (line 5 times column 2, line 11)						0	36.00
37.00	Assistants (line 6 times column 3, line 11)						0	37.00
38.00	Subtotal (sum of lines 36 and 37)						0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)						0	39.00
	Optional Travel Allowance and Optional Travel Expense							
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)						0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)						0	41.00
42.00	Subtotal (sum of lines 40 and 41)						0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)						0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.							
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)						0	44.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS	Provider CCN:	Period: From 07/01/2017 To 06/30/2018	Worksheet A-8-3 Parts I-VI Date/Time Prepared: 6/12/2019 8:29 am
		Respiratory Therapy	Cost

						1.00	
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00
		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	65.56	0.00	32.78	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00

		1.00		
	Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT			
57.00	Salary equivalency amount (from line 23)	43,335	57.00	
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	1,541	58.00	
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)	0	59.00	
60.00	Overtime allowance (from column 5, line 56)	0	60.00	
61.00	Equipment cost (see instructions)	0	61.00	
62.00	Supplies (see instructions)	0	62.00	
63.00	Total allowance (sum of lines 57-62)	44,876	63.00	
64.00	Total cost of outside supplier services (from your records)	31,716	64.00	
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)	0	65.00	
	LINE 33 CALCULATION			
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others	1,541	100.00	
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	0	100.01	
100.02	Line 33 = line 28 = sum of lines 26 and 27	1,541	100.02	
	LINE 34 CALCULATION			
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	0	101.00	
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0	101.01	
101.02	Line 34 = sum of lines 27 and 31	0	101.02	
	LINE 35 CALCULATION			
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0	102.00	
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others	0	102.01	
102.02	Line 35 = sum of lines 31 and 32	0	102.02	

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS	Provider CCN:	Period: From 07/01/2017 To 06/30/2018	Worksheet A-8-3 Parts I-VI Date/Time Prepared: 6/12/2019 8:29 am
		Occupational Therapy	Cost

						1.00	
	PART I - GENERAL INFORMATION						
1.00	Total number of weeks worked (excluding aides) (see instructions)					52	1.00
2.00	Line 1 multiplied by 15 hours per week					780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					301	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					23	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00
7.00	Standard travel expense rate					0.00	7.00
8.00	Optional travel expense rate per mile					0.00	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	432.00	2,147.00	2,063.00	894.00	0.00	9.00
10.00	AHSEA (see instructions)	79.05	79.05	59.29	39.53	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	39.53	39.53	29.65			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01
						1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION						
14.00	Supervisors (column 1, line 9 times column 1, line 10)					34,150	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					169,720	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)					122,315	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					326,185	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)					35,340	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)					0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)					361,525	20.00
	If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.						
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)					0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					0	22.00
23.00	Total salary equivalency (see instructions)					361,525	23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE						
	Standard Travel Allowance						
24.00	Therapists (line 3 times column 2, line 11)					11,899	24.00
25.00	Assistants (line 4 times column 3, line 11)					682	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					12,581	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					0	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					12,581	28.00
	Optional Travel Allowance and Optional Travel Expense						
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)					0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)					0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)					0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)					12,581	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE						
	Standard Travel Expense						
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00
	Optional Travel Allowance and Optional Travel Expense						
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.						
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS	Provider CCN:	Period: From 07/01/2017 To 06/30/2018	Worksheet A-8-3 Parts I-VI Date/Time Prepared: 6/12/2019 8:29 am
		Occupational Therapy	Cost

						1.00	
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00
		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	79.05	59.29	39.53	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00

		1.00		
	Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT			
57.00	Salary equivalency amount (from line 23)	361,525		57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	12,581		58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)	0		59.00
60.00	Overtime allowance (from column 5, line 56)	0		60.00
61.00	Equipment cost (see instructions)	0		61.00
62.00	Supplies (see instructions)	0		62.00
63.00	Total allowance (sum of lines 57-62)	374,106		63.00
64.00	Total cost of outside supplier services (from your records)	329,741		64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)	0		65.00
	LINE 33 CALCULATION			
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others	12,581		100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	0		100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	12,581		100.02
	LINE 34 CALCULATION			
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	0		101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0		101.01
101.02	Line 34 = sum of lines 27 and 31	0		101.02
	LINE 35 CALCULATION			
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0		102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others	0		102.01
102.02	Line 35 = sum of lines 31 and 32	0		102.02

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: | Period: From 07/01/2017 To 06/30/2018 | Worksheet B Part I Date/Time Prepared: 6/12/2019 8:29 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	NONPATIENT TELEPHONES	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	4.00	5.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	2,754,353	2,754,353				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	48,169		48,169			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,902,368	39,892	12	1,942,272		4.00
5.01	00540	NONPATIENT TELEPHONES	211,986	0	0	0	211,986	5.01
5.02	00560	PURCHASING RECEIVING AND STORES	427,758	52,740	143	13,115	1,111	5.02
5.03	00570	ADMITTING	542,139	25,159	0	21,686	6,668	5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE	1,598,142	25,730	102	37,463	9,168	5.04
5.05	00590	OTHER ADMINISTRATIVE AND GENERAL	6,147,567	117,471	4,273	146,242	23,616	5.05
7.00	00700	OPERATION OF PLANT	2,426,423	304,108	1,235	38,316	4,723	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	8,424	0	0	0	8.00
9.00	00900	HOUSEKEEPING	1,265,534	8,630	244	49,097	0	9.00
10.00	01000	DIETARY	859,825	47,905	180	31,013	2,778	10.00
11.00	01100	CAFETERIA	0	18,632	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	884,964	9,213	23	37,632	1,389	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	518,297	21,044	144	6,540	1,667	14.00
15.00	01500	PHARMACY	1,577,252	16,746	133	9,037	3,612	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	619,312	45,985	155	17,079	4,167	16.00
18.00	01850	INSERVICE EDUCATION	279,616	24,644	88	7,782	1,389	18.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,485,275	287,820	2,464	132,653	14,725	30.00
31.00	03100	INTENSIVE CARE UNIT	906,021	36,006	605	35,774	1,667	31.00
40.00	04000	SUBPROVIDER - IPF	709,896	97,045	94	16,525	4,167	40.00
43.00	04300	NURSERY	144,269	29,022	43	6,896	0	43.00
44.00	04400	SKILLED NURSING FACILITY	2,343,079	226,541	1,047	86,251	3,890	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,570,780	252,957	4,520	81,110	8,891	50.00
51.00	05100	RECOVERY ROOM	202,086	28,359	430	6,644	0	51.00
52.00	05200	LABOR ROOM & DELIVERY ROOM	157,053	38,304	38	5,679	0	52.00
53.00	05300	ANESTHESIOLOGY	232,163	0	387	1,063	556	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	2,223,653	65,463	10,554	50,372	9,446	54.00
56.00	05600	RADIOISOTOPE	242,186	6,012	1,732	3,122	556	56.00
57.00	05700	CT SCAN	331,597	11,362	4,633	3,683	556	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	606,645	11,362	1	7,714	278	58.00
60.00	06000	LABORATORY	2,662,338	52,260	170	40,608	5,557	60.00
65.00	06500	RESPIRATORY THERAPY	687,629	9,739	573	24,376	1,389	65.00
66.00	06600	PHYSICAL THERAPY	1,588,991	86,186	199	54,187	9,168	66.00
67.00	06700	OCCUPATIONAL THERAPY	467,727	26,302	0	5,890	1,111	67.00
68.00	06800	SPEECH PATHOLOGY	152,276	8,767	6	6,678	278	68.00
69.00	06900	ELECTROCARDIOLOGY	436,645	10,105	1,102	11,398	3,334	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
70.01	03610	SLEEP LAB	165,621	19,718	373	5,596	833	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,285,864	0	0	0	0	71.00
72.00	07200	IMP. DEV CHARGED TO PATIENT	4,177,973	21,044	2,174	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,646,144	0	0	0	0	73.00
76.00	03480	ONCOLOGY	1,155,246	87,832	1,962	17,805	7,501	76.00
76.01	03952	OCCUPATIONAL HEALTH	43,811	3,041	21	1,628	833	76.01
76.03	03951	OP DIABETIC EDUCATION	24,678	8,767	0	1,069	0	76.03
76.97	07697	CARDIAC REHABILITATION	81,438	31,628	388	3,008	556	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	15,848,486	207,932	2,965	549,352	54,457	88.00
90.00	09000	CLINIC	2,142,239	137,600	225	102,776	0	90.00
90.02	09002	WOUND CARE	139,965	15,180	20	3,951	1,945	90.02
91.00	09100	EMERGENCY	2,645,721	89,227	2,818	96,522	7,779	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	3,144,467	0	151	105,031	6,668	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	427,947	0	0	13,338	278	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	79,143,614	2,671,904	46,427	1,895,701	206,707	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	5,910	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,536,084	44,465	1,379	42,254	556	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	COMMUNITY WELLNESS	91,297	0	363	3,296	4,723	193.01
193.02	19302	COLE CARE RENTAL	0	32,074	0	0	0	193.02
193.07	19307	NONREIMB PUB REL &WOMENS HEALTH	47,612	0	0	1,021	0	193.07
200.00		Cross Foot Adjustments						200.00

COST ALLOCATION - GENERAL SERVICE COSTS	Provider CCN:	Period: From 07/01/2017 To 06/30/2018	Worksheet B Part I Date/Time Prepared: 6/12/2019 8:29 am

	Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	NONPATIENT TELEPHONES	
			BLDG & FIXT	MVBLE EQUIP			
		0	1.00	2.00	4.00	5.01	
201.00	Negative Cost Centers		0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	80,818,607	2,754,353	48,169	1,942,272	211,986	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: | Period: From 07/01/2017 To 06/30/2018 | Worksheet B Part I Date/Time Prepared: 6/12/2019 8:29 am

		Cost Center Description	PURCHASING RECEIVING AND STORES	ADMITTING	CASHIERING/ACCOUNTS RECEIVABLE	Subtotal	OTHER ADMINISTRATIVE AND GENERAL	
			5.02	5.03	5.04	5A.04	5.05	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00560	PURCHASING RECEIVING AND STORES	494,867					5.02
5.03	00570	ADMITTING	997	596,649				5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE	583	0	1,671,188			5.04
5.05	00590	OTHER ADMINISTRATIVE AND GENERAL	7,190	0	0	6,446,359	6,446,359	5.05
7.00	00700	OPERATION OF PLANT	3,309	0	0	2,778,114	240,799	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	8,424	730	8.00
9.00	00900	HOUSEKEEPING	11,004	0	0	1,334,509	115,671	9.00
10.00	01000	DIETARY	7,855	0	0	949,556	82,305	10.00
11.00	01100	CAFETERIA	0	0	0	18,632	1,615	11.00
13.00	01300	NURSING ADMINISTRATION	413	0	0	933,634	80,925	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	15,512	0	0	563,204	48,817	14.00
15.00	01500	PHARMACY	5,062	0	0	1,611,842	139,710	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	351	0	0	687,049	59,551	16.00
18.00	01850	INSERVICE EDUCATION	650	0	0	314,169	27,231	18.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	18,162	28,452	63,298	4,032,849	349,555	30.00
31.00	03100	INTENSIVE CARE UNIT	3,920	6,509	14,481	1,004,983	87,109	31.00
40.00	04000	SUBPROVIDER - IPF	770	3,891	8,656	841,044	72,899	40.00
43.00	04300	NURSERY	0	1,109	2,468	183,807	15,932	43.00
44.00	04400	SKILLED NURSING FACILITY	9,500	17,439	38,797	2,726,544	236,329	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	9,952	70,472	156,782	3,155,464	273,506	50.00
51.00	05100	RECOVERY ROOM	3,672	5,484	12,199	258,874	22,438	51.00
52.00	05200	LABOR ROOM & DELIVERY ROOM	0	3,289	7,318	211,681	18,348	52.00
53.00	05300	ANESTHESIOLOGY	8,512	31,317	69,671	343,669	29,788	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	4,326	38,271	85,143	2,487,228	215,585	54.00
56.00	05600	RADIOISOTOPE	8,202	5,184	11,533	278,527	24,142	56.00
57.00	05700	CT SCAN	5,397	35,110	78,111	470,449	40,777	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	2,535	17,158	38,172	683,865	59,275	58.00
60.00	06000	LABORATORY	43,510	92,838	206,722	3,104,003	269,046	60.00
65.00	06500	RESPIRATORY THERAPY	2,030	8,568	19,061	753,365	65,299	65.00
66.00	06600	PHYSICAL THERAPY	2,422	19,818	44,091	1,805,062	156,457	66.00
67.00	06700	OCCUPATIONAL THERAPY	151	7,549	16,794	525,524	45,551	67.00
68.00	06800	SPEECH PATHOLOGY	57	1,791	3,984	173,837	15,068	68.00
69.00	06900	ELECTROCARDIOLOGY	7,432	11,769	26,182	507,967	44,029	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
70.01	03610	SLEEP LAB	1,611	3,271	7,278	204,301	17,708	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	237,162	18,082	40,228	2,581,336	223,742	71.00
72.00	07200	IMP. DEV CHARGED TO PATIENT	0	38,833	86,392	4,326,416	375,001	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	84,822	188,705	4,919,671	426,422	73.00
76.00	03480	ONCOLOGY	1,281	18,314	40,744	1,330,685	115,340	76.00
76.01	03952	OCCUPATIONAL HEALTH	156	0	0	49,490	4,290	76.01
76.03	03951	OP DIABETIC EDUCATION	79	475	1,057	36,125	3,131	76.03
76.97	07697	CARDIAC REHABILITATION	130	436	969	118,553	10,276	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	32,401	0	135,858	16,831,451	1,458,897	88.00
90.00	09000	CLINIC	5,259	0	147,859	2,535,958	219,809	90.00
90.02	09002	WOUND CARE	1,882	1,763	3,922	168,628	14,616	90.02
91.00	09100	EMERGENCY	8,279	24,635	54,805	2,929,786	253,945	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	4,948	0	33,005	3,294,270	285,537	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	1,950	0	5,857	449,370	38,950	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	478,614	596,649	1,650,142	78,970,274	6,286,151	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	5,910	512	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	15,738	0	21,046	1,661,522	144,016	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	COMMUNITY WELLNESS	515	0	0	100,194	8,685	193.01
193.02	19302	COLE CARE RENTAL	0	0	0	32,074	2,780	193.02
193.07	19307	NONREIMB PUB REL &WOMENS HEALTH	0	0	0	48,633	4,215	193.07
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)	494,867	596,649	1,671,188	80,818,607	6,446,359	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: | Period: From 07/01/2017 To 06/30/2018 | Worksheet B Part I Date/Time Prepared: 6/12/2019 8:29 am

		Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	00570	ADMITTING						5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.04
5.05	00590	OTHER ADMINISTRATIVE AND GENERAL						5.05
7.00	00700	OPERATION OF PLANT	3,018,913					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	11,617	20,771				8.00
9.00	00900	HOUSEKEEPING	11,901	0	1,462,081			9.00
10.00	01000	DIETARY	66,060	991	32,244	1,131,156		10.00
11.00	01100	CAFETERIA	25,693	0	12,541	749,360	807,841	11.00
13.00	01300	NURSING ADMINISTRATION	12,704	0	6,201	0	24,739	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	29,018	360	14,164	0	8,779	14.00
15.00	01500	PHARMACY	23,092	0	11,271	0	13,880	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	63,412	0	30,952	0	21,696	16.00
18.00	01850	INSERVICE EDUCATION	33,984	0	16,588	0	5,626	18.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	396,895	4,250	193,728	86,988	104,078	30.00
31.00	03100	INTENSIVE CARE UNIT	49,651	612	24,235	15,829	22,922	31.00
40.00	04000	SUBPROVIDER - IPF	133,822	318	65,320	16,406	18,237	40.00
43.00	04300	NURSERY	40,021	79	19,534	0	3,678	43.00
44.00	04400	SKILLED NURSING FACILITY	312,394	3,487	152,482	262,573	84,922	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	348,820	5,078	170,263	0	58,716	50.00
51.00	05100	RECOVERY ROOM	39,106	0	19,088	0	4,225	51.00
52.00	05200	LABOR ROOM & DELIVERY ROOM	52,820	297	25,782	0	3,021	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	10,158	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	90,271	720	44,062	0	35,028	54.00
56.00	05600	RADIOISOTOPE	8,291	102	4,047	0	2,211	56.00
57.00	05700	CT SCAN	15,668	419	7,648	0	3,218	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	15,668	308	7,648	0	5,714	58.00
60.00	06000	LABORATORY	72,065	10	35,176	0	42,822	60.00
65.00	06500	RESPIRATORY THERAPY	13,430	0	6,555	0	17,930	65.00
66.00	06600	PHYSICAL THERAPY	118,848	279	58,011	0	15,938	66.00
67.00	06700	OCCUPATIONAL THERAPY	36,269	0	17,703	0	3,722	67.00
68.00	06800	SPEECH PATHOLOGY	12,090	0	5,901	0	2,518	68.00
69.00	06900	ELECTROCARDIOLOGY	13,934	183	6,801	0	7,947	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
70.01	03610	SLEEP LAB	27,190	131	13,272	0	4,532	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMP. DEV CHARGED TO PATIENT	29,018	0	14,164	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03480	ONCOLOGY	121,118	0	59,119	0	10,771	76.00
76.01	03952	OCCUPATIONAL HEALTH	4,193	0	2,047	0	1,095	76.01
76.03	03951	OP DIABETIC EDUCATION	12,090	0	5,901	0	766	76.03
76.97	07697	CARDIAC REHABILITATION	43,614	0	21,289	0	2,277	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	286,733	234	139,957	0	127,526	88.00
90.00	09000	CLINIC	189,747	96	92,617	0	72,574	90.00
90.02	09002	WOUND CARE	20,932	11	10,217	0	4,466	90.02
91.00	09100	EMERGENCY	123,041	2,785	60,057	0	58,891	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,905,220	20,750	1,406,585	1,131,156	804,623	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	8,149	0	3,978	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	61,315	0	29,929	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	COMMUNITY WELLNESS	0	21	0	0	2,649	193.01
193.02	19302	COLE CARE RENTAL	44,229	0	21,589	0	0	193.02
193.07	19307	NONREIMB PUB REL &WOMENS HEALTH	0	0	0	0	569	193.07
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)	3,018,913	20,771	1,462,081	1,131,156	807,841	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: | Period: From 07/01/2017 To 06/30/2018 | Worksheet B Part I Date/Time Prepared: 6/12/2019 8:29 am

		Cost Center Description	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	OTHER GENERAL SERVICE INSERVICE EDUCATION	
			13.00	14.00	15.00	16.00	18.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	00570	ADMITTING						5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.04
5.05	00590	OTHER ADMINISTRATIVE AND GENERAL						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	1,058,203					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	664,342				14.00
15.00	01500	PHARMACY	0	5,381	1,805,176			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	20	0	862,680		16.00
18.00	01850	INSERVICE EDUCATION	180	190	0	0	397,968	18.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	463,223	25,520	5,615	36,492	39,314	30.00
31.00	03100	INTENSIVE CARE UNIT	147,203	5,355	1,374	8,348	8,658	31.00
40.00	04000	SUBPROVIDER - IPF	94,698	443	92	4,990	6,889	40.00
43.00	04300	NURSERY	0	0	0	1,423	1,389	43.00
44.00	04400	SKILLED NURSING FACILITY	105,775	11,001	36,668	22,367	32,078	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,458	3,094	1,971	90,387	22,179	50.00
51.00	05100	RECOVERY ROOM	180	6,485	24	7,033	1,596	51.00
52.00	05200	LABOR ROOM & DELIVERY ROOM	0	0	0	4,219	1,141	52.00
53.00	05300	ANESTHESIOLOGY	0	14,223	16,304	40,167	3,837	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0	3,502	55	49,086	15,977	54.00
56.00	05600	RADIOISOTOPE	0	331	151	6,649	835	56.00
57.00	05700	CT SCAN	0	9,581	489	45,032	1,216	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	4,659	93	22,007	2,158	58.00
60.00	06000	LABORATORY	0	57,700	10	119,122	16,175	60.00
65.00	06500	RESPIRATORY THERAPY	0	2,587	162	10,989	6,773	65.00
66.00	06600	PHYSICAL THERAPY	0	1,394	0	25,419	17,465	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	97	0	9,682	1,406	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	2,297	951	68.00
69.00	06900	ELECTROCARDIOLOGY	45	10,914	704	15,095	3,002	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
70.01	03610	SLEEP LAB	0	1,759	6	4,196	1,712	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	438,888	0	23,192	0	71.00
72.00	07200	IMP. DEV CHARGED TO PATIENT	0	0	0	49,806	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	1,397,277	108,792	0	73.00
76.00	03480	ONCOLOGY	0	1,181	816	23,489	4,069	76.00
76.01	03952	OCCUPATIONAL HEALTH	0	175	927	0	413	76.01
76.03	03951	OP DIABETIC EDUCATION	0	25	0	609	289	76.03
76.97	07697	CARDIAC REHABILITATION	0	34	0	559	860	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	32,063	256,493	0	112,114	88.00
90.00	09000	CLINIC	0	5,383	67,469	85,243	28,927	90.00
90.02	09002	WOUND CARE	2,567	2,571	85	2,261	1,687	90.02
91.00	09100	EMERGENCY	239,874	10,114	2,169	31,596	22,245	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	6,452	565	0	26,297	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	2,809	15,081	0	3,548	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,058,203	663,931	1,804,600	850,547	385,200	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	411	393	12,133	11,346	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	COMMUNITY WELLNESS	0	0	183	0	1,207	193.01
193.02	19302	COLE CARE RENTAL	0	0	0	0	0	193.02
193.07	19307	NONREIMB PUB REL &WOMENS HEALTH	0	0	0	0	215	193.07
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,058,203	664,342	1,805,176	862,680	397,968	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: | Period: From 07/01/2017 To 06/30/2018 | Worksheet B Part I Date/Time Prepared: 6/12/2019 8:29 am

		Cost Center Description	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			19.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	00570	ADMITTING						5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.04
5.05	00590	OTHER ADMINISTRATIVE AND GENERAL						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
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
18.00	01850	INSERVICE EDUCATION						18.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0					19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	5,738,507	0	5,738,507		30.00
31.00	03100	INTENSIVE CARE UNIT	0	1,376,279	0	1,376,279		31.00
40.00	04000	SUBPROVIDER - IPF	0	1,255,158	0	1,255,158		40.00
43.00	04300	NURSERY	0	265,863	0	265,863		43.00
44.00	04400	SKILLED NURSING FACILITY	0	3,986,620	0	3,986,620		44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	4,133,936	0	4,133,936		50.00
51.00	05100	RECOVERY ROOM	0	359,049	0	359,049		51.00
52.00	05200	LABOR ROOM & DELIVERY ROOM	0	317,309	0	317,309		52.00
53.00	05300	ANESTHESIOLOGY	0	458,146	0	458,146		53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0	2,941,514	0	2,941,514		54.00
56.00	05600	RADIOISOTOPE	0	325,286	0	325,286		56.00
57.00	05700	CT SCAN	0	594,497	0	594,497		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	801,395	0	801,395		58.00
60.00	06000	LABORATORY	0	3,716,129	0	3,716,129		60.00
65.00	06500	RESPIRATORY THERAPY	0	877,090	0	877,090		65.00
66.00	06600	PHYSICAL THERAPY	0	2,198,873	0	2,198,873		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	639,954	0	639,954		67.00
68.00	06800	SPEECH PATHOLOGY	0	212,662	0	212,662		68.00
69.00	06900	ELECTROCARDIOLOGY	0	610,621	0	610,621		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0		70.00
70.01	03610	SLEEP LAB	0	274,807	0	274,807		70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	3,267,158	0	3,267,158		71.00
72.00	07200	IMP. DEV CHARGED TO PATIENT	0	4,794,405	0	4,794,405		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	6,852,162	0	6,852,162		73.00
76.00	03480	ONCOLOGY	0	1,666,588	0	1,666,588		76.00
76.01	03952	OCCUPATIONAL HEALTH	0	62,630	0	62,630		76.01
76.03	03951	OP DIABETIC EDUCATION	0	58,936	0	58,936		76.03
76.97	07697	CARDIAC REHABILITATION	0	197,462	0	197,462		76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	19,245,468	0	19,245,468		88.00
90.00	09000	CLINIC	0	3,297,823	0	3,297,823		90.00
90.02	09002	WOUND CARE	0	228,041	0	228,041		90.02
91.00	09100	EMERGENCY	0	3,734,503	0	3,734,503		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0			92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	3,613,121	0	3,613,121		101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE		509,758	0	509,758		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	78,611,750	0	78,611,750		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	18,549	0	18,549		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	1,921,065	0	1,921,065		192.00
193.00	19300	NONPAID WORKERS	0	0	0	0		193.00
193.01	19301	COMMUNITY WELLNESS	0	112,939	0	112,939		193.01
193.02	19302	COLE CARE RENTAL	0	100,672	0	100,672		193.02
193.07	19307	NONREIMB PUB REL &WOMENS HEALTH	0	53,632	0	53,632		193.07
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	80,818,607	0	80,818,607		202.00

COST ALLOCATION STATISTICS	Provider CCN:	Period: From 07/01/2017 To 06/30/2018	Worksheet Non-CMS W Date/Time Prepared: 6/12/2019 8:29 am

	Cost Center Description	Statistics Code	Statistics Description	
		1.00	2.00	
	GENERAL SERVICE COST CENTERS			
1.00	CAP REL COSTS-BLDG & FIXT	1	SQUARE FEET	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2	DOLLAR VALUE	2.00
4.00	EMPLOYEE BENEFITS DEPARTMENT	4	GROSS SALARIES	4.00
5.01	NONPATIENT TELEPHONES	3	EXTENSION	5.01
5.02	PURCHASING RECEIVING AND STORES	6	SUPPLIES EXPENSE	5.02
5.03	ADMITTING	7	GROSS CHARGES	5.03
5.04	CASHIERING/ACCOUNTS RECEIVABLE	11	GROSS CHARGES	5.04
5.05	OTHER ADMINISTRATIVE AND GENERAL	-5	ACCUM. COST	5.05
7.00	OPERATION OF PLANT	1	SQUARE FEET	7.00
8.00	LAUNDRY & LINEN SERVICE	8	POUNDS OF LAUNDRY	8.00
9.00	HOUSEKEEPING	1	SQUARE FEET	9.00
10.00	DIETARY	10	MEALS SERVED	10.00
11.00	CAFETERIA	25	FTE'S	11.00
13.00	NURSING ADMINISTRATION	13	DIRECT NURS. HRS.	13.00
14.00	CENTRAL SERVICES & SUPPLY	14	COSTED REQUIS.	14.00
15.00	PHARMACY	15	COSTED REQUIS.	15.00
16.00	MEDICAL RECORDS & LIBRARY	26	GROSS CHARGES	16.00
18.00	INSERVICE EDUCATION	27	FTE'S	18.00
19.00	NONPHYSICIAN ANESTHETISTS	19	ASSIGNED TIME	19.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: | Period: From 07/01/2017 To 06/30/2018 | Worksheet B Part II Date/Time Prepared: 6/12/2019 8:29 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	335	39,892	12	40,239	40,239	4.00
5.01	00540	NONPATIENT TELEPHONES	0	0	0	0	0	5.01
5.02	00560	PURCHASING RECEIVING AND STORES	3,838	52,740	143	56,721	272	5.02
5.03	00570	ADMITTING	0	25,159	0	25,159	449	5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE	26,832	25,730	102	52,664	776	5.04
5.05	00590	OTHER ADMINISTRATIVE AND GENERAL	1,006,916	117,471	4,273	1,128,660	3,030	5.05
7.00	00700	OPERATION OF PLANT	10,618	304,108	1,235	315,961	794	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	8,424	0	8,424	0	8.00
9.00	00900	HOUSEKEEPING	6,563	8,630	244	15,437	1,017	9.00
10.00	01000	DIETARY	13,857	47,905	180	61,942	643	10.00
11.00	01100	CAFETERIA	0	18,632	0	18,632	0	11.00
13.00	01300	NURSING ADMINISTRATION	619	9,213	23	9,855	780	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	5,767	21,044	144	26,955	135	14.00
15.00	01500	PHARMACY	3,697	16,746	133	20,576	187	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	21,116	45,985	155	67,256	354	16.00
18.00	01850	INSERVICE EDUCATION	2,361	24,644	88	27,093	161	18.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	108,590	287,820	2,464	398,874	2,748	30.00
31.00	03100	INTENSIVE CARE UNIT	18,234	36,006	605	54,845	741	31.00
40.00	04000	SUBPROVIDER - IPF	36,622	97,045	94	133,761	342	40.00
43.00	04300	NURSERY	1,161	29,022	43	30,226	143	43.00
44.00	04400	SKILLED NURSING FACILITY	33,556	226,541	1,047	261,144	1,787	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	436,275	252,957	4,520	693,752	1,680	50.00
51.00	05100	RECOVERY ROOM	13,536	28,359	430	42,325	138	51.00
52.00	05200	LABOR ROOM & DELIVERY ROOM	37,378	38,304	38	75,720	118	52.00
53.00	05300	ANESTHESIOLOGY	10,395	0	387	10,782	22	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	307,769	65,463	10,554	383,786	1,044	54.00
56.00	05600	RADIOISOTOPE	48,353	6,012	1,732	56,097	65	56.00
57.00	05700	CT SCAN	131,005	11,362	4,633	147,000	76	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	301,858	11,362	1	313,221	160	58.00
60.00	06000	LABORATORY	58,226	52,260	170	110,656	841	60.00
65.00	06500	RESPIRATORY THERAPY	49,233	9,739	573	59,545	505	65.00
66.00	06600	PHYSICAL THERAPY	73,197	86,186	199	159,582	1,123	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	26,302	0	26,302	122	67.00
68.00	06800	SPEECH PATHOLOGY	154	8,767	6	8,927	138	68.00
69.00	06900	ELECTROCARDIOLOGY	60,934	10,105	1,102	72,141	236	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
70.01	03610	SLEEP LAB	12,065	19,718	373	32,156	116	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMP. DEV CHARGED TO PATIENT	58,521	21,044	2,174	81,739	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03480	ONCOLOGY	129,737	87,832	1,962	219,531	369	76.00
76.01	03952	OCCUPATIONAL HEALTH	561	3,041	21	3,623	34	76.01
76.03	03951	OP DIABETIC EDUCATION	0	8,767	0	8,767	22	76.03
76.97	07697	CARDIAC REHABILITATION	10,432	31,628	388	42,448	62	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	675,522	207,932	2,965	886,419	11,382	88.00
90.00	09000	CLINIC	101,450	137,600	225	239,275	2,129	90.00
90.02	09002	WOUND CARE	3,910	15,180	20	19,110	82	90.02
91.00	09100	EMERGENCY	76,437	89,227	2,818	168,482	2,000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	63,415	0	151	63,566	2,176	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	1,170	0	0	1,170	276	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	3,962,215	2,671,904	46,427	6,680,546	39,275	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	5,910	0	5,910	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	73,644	44,465	1,379	119,488	875	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	COMMUNITY WELLNESS	0	0	363	363	68	193.01
193.02	19302	COLE CARE RENTAL	0	32,074	0	32,074	0	193.02
193.07	19307	NONREIMB PUB REL &WOMENS HEALTH	0	0	0	0	21	193.07
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: | Period: From 07/01/2017 To 06/30/2018 | Worksheet B Part II Date/Time Prepared: 6/12/2019 8:29 am

	Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			BLDG & FIXT	MVBLE EQUIP			
		0	1.00	2.00	2A	4.00	
202.00	TOTAL (sum lines 118 through 201)	4,035,859	2,754,353	48,169	6,838,381	40,239	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: | Period: From 07/01/2017 To 06/30/2018 | Worksheet B Part II Date/Time Prepared: 6/12/2019 8:29 am

		Cost Center Description	NONPATIENT TELEPHONES	PURCHASING RECEIVING AND STORES	ADMITTING	CASHIERING/ACCOUNTS RECEIVABLE	OTHER ADMINISTRATIVE AND GENERAL	
			5.01	5.02	5.03	5.04	5.05	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES	0					5.01
5.02	00560	PURCHASING RECEIVING AND STORES	0	56,993				5.02
5.03	00570	ADMITTING	0	115	25,723			5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	67	0	53,507		5.04
5.05	00590	OTHER ADMINISTRATIVE AND GENERAL	0	828	0	0	1,132,518	5.05
7.00	00700	OPERATION OF PLANT	0	381	0	0	42,305	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	128	8.00
9.00	00900	HOUSEKEEPING	0	1,267	0	0	20,322	9.00
10.00	01000	DIETARY	0	905	0	0	14,460	10.00
11.00	01100	CAFETERIA	0	0	0	0	284	11.00
13.00	01300	NURSING ADMINISTRATION	0	48	0	0	14,217	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,786	0	0	8,576	14.00
15.00	01500	PHARMACY	0	583	0	0	24,545	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	40	0	0	10,462	16.00
18.00	01850	INSERVICE EDUCATION	0	75	0	0	4,784	18.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	2,092	1,229	2,028	61,412	30.00
31.00	03100	INTENSIVE CARE UNIT	0	451	281	464	15,304	31.00
40.00	04000	SUBPROVIDER - IPF	0	89	168	277	12,807	40.00
43.00	04300	NURSERY	0	0	48	79	2,799	43.00
44.00	04400	SKILLED NURSING FACILITY	0	1,094	753	1,243	41,520	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	1,146	3,045	5,022	48,051	50.00
51.00	05100	RECOVERY ROOM	0	423	237	391	3,942	51.00
52.00	05200	LABOR ROOM & DELIVERY ROOM	0	0	142	234	3,223	52.00
53.00	05300	ANESTHESIOLOGY	0	980	1,353	2,232	5,233	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0	498	1,654	2,728	37,876	54.00
56.00	05600	RADIOISOTOPE	0	945	224	369	4,241	56.00
57.00	05700	CT SCAN	0	622	1,517	2,502	7,164	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	292	741	1,223	10,414	58.00
60.00	06000	LABORATORY	0	5,011	3,957	6,592	47,268	60.00
65.00	06500	RESPIRATORY THERAPY	0	234	370	611	11,472	65.00
66.00	06600	PHYSICAL THERAPY	0	279	856	1,412	27,487	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	17	326	538	8,003	67.00
68.00	06800	SPEECH PATHOLOGY	0	7	77	128	2,647	68.00
69.00	06900	ELECTROCARDIOLOGY	0	856	509	839	7,735	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
70.01	03610	SLEEP LAB	0	186	141	233	3,111	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	27,312	781	1,289	39,309	71.00
72.00	07200	IMP. DEV CHARGED TO PATIENT	0	0	1,678	2,768	65,883	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	3,665	6,045	74,917	73.00
76.00	03480	ONCOLOGY	0	147	791	1,305	20,264	76.00
76.01	03952	OCCUPATIONAL HEALTH	0	18	0	0	754	76.01
76.03	03951	OP DIABETIC EDUCATION	0	9	21	34	550	76.03
76.97	07697	CARDIAC REHABILITATION	0	15	19	31	1,805	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	3,732	0	4,352	256,288	88.00
90.00	09000	CLINIC	0	606	0	4,737	38,618	90.00
90.02	09002	WOUND CARE	0	217	76	126	2,568	90.02
91.00	09100	EMERGENCY	0	953	1,064	1,756	44,615	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	570	0	1,057	50,165	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	225	0	188	6,843	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	55,121	25,723	52,833	1,104,371	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	90	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	1,813	0	674	25,302	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	COMMUNITY WELLNESS	0	59	0	0	1,526	193.01
193.02	19302	COLE CARE RENTAL	0	0	0	0	488	193.02
193.07	19307	NONREIMB PUB REL &WOMENS HEALTH	0	0	0	0	741	193.07
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)	0	56,993	25,723	53,507	1,132,518	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: | Period: From 07/01/2017 To 06/30/2018 | Worksheet B Part II Date/Time Prepared: 6/12/2019 8:29 am

		Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	00570	ADMITTING						5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.04
5.05	00590	OTHER ADMINISTRATIVE AND GENERAL						5.05
7.00	00700	OPERATION OF PLANT	359,441					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,383	9,935				8.00
9.00	00900	HOUSEKEEPING	1,417	0	39,460			9.00
10.00	01000	DIETARY	7,865	474	870	87,159		10.00
11.00	01100	CAFETERIA	3,059	0	338	57,740	80,053	11.00
13.00	01300	NURSING ADMINISTRATION	1,513	0	167	0	2,451	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3,455	172	382	0	870	14.00
15.00	01500	PHARMACY	2,749	0	304	0	1,375	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	7,550	0	835	0	2,150	16.00
18.00	01850	INSERVICE EDUCATION	4,046	0	448	0	558	18.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	47,259	2,033	5,231	6,703	10,314	30.00
31.00	03100	INTENSIVE CARE UNIT	5,912	293	654	1,220	2,271	31.00
40.00	04000	SUBPROVIDER - IPF	15,933	152	1,763	1,264	1,807	40.00
43.00	04300	NURSERY	4,765	38	527	0	364	43.00
44.00	04400	SKILLED NURSING FACILITY	37,195	1,668	4,115	20,232	8,415	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	41,532	2,431	4,595	0	5,818	50.00
51.00	05100	RECOVERY ROOM	4,656	0	515	0	419	51.00
52.00	05200	LABOR ROOM & DELIVERY ROOM	6,289	142	696	0	299	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	1,007	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	10,748	344	1,189	0	3,471	54.00
56.00	05600	RADIOISOTOPE	987	49	109	0	219	56.00
57.00	05700	CT SCAN	1,865	200	206	0	319	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,865	147	206	0	566	58.00
60.00	06000	LABORATORY	8,580	5	949	0	4,243	60.00
65.00	06500	RESPIRATORY THERAPY	1,599	0	177	0	1,777	65.00
66.00	06600	PHYSICAL THERAPY	14,150	133	1,566	0	1,579	66.00
67.00	06700	OCCUPATIONAL THERAPY	4,318	0	478	0	369	67.00
68.00	06800	SPEECH PATHOLOGY	1,439	0	159	0	249	68.00
69.00	06900	ELECTROCARDIOLOGY	1,659	87	184	0	788	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
70.01	03610	SLEEP LAB	3,237	62	358	0	449	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMP. DEV CHARGED TO PATIENT	3,455	0	382	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03480	ONCOLOGY	14,421	0	1,596	0	1,067	76.00
76.01	03952	OCCUPATIONAL HEALTH	499	0	55	0	108	76.01
76.03	03951	OP DIABETIC EDUCATION	1,439	0	159	0	76	76.03
76.97	07697	CARDIAC REHABILITATION	5,193	0	575	0	226	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	34,139	112	3,777	0	12,639	88.00
90.00	09000	CLINIC	22,592	46	2,500	0	7,192	90.00
90.02	09002	WOUND CARE	2,492	5	276	0	443	90.02
91.00	09100	EMERGENCY	14,650	1,332	1,621	0	5,836	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	345,905	9,925	37,962	87,159	79,734	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	970	0	107	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	7,300	0	808	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	COMMUNITY WELLNESS	0	10	0	0	263	193.01
193.02	19302	COLE CARE RENTAL	5,266	0	583	0	0	193.02
193.07	19307	NONREIMB PUB REL &WOMENS HEALTH	0	0	0	0	56	193.07
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)	359,441	9,935	39,460	87,159	80,053	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: | Period: From 07/01/2017 To 06/30/2018 | Worksheet B Part II Date/Time Prepared: 6/12/2019 8:29 am

		Cost Center Description	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	OTHER GENERAL SERVICE INSERVICE EDUCATION	
			13.00	14.00	15.00	16.00	18.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	00570	ADMITTING						5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.04
5.05	00590	OTHER ADMINISTRATIVE AND GENERAL						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	29,031					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	42,331				14.00
15.00	01500	PHARMACY	0	343	50,662			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1	0	88,648		16.00
18.00	01850	INSERVICE EDUCATION	5	12	0	0	37,182	18.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	12,709	1,626	158	3,752	3,673	30.00
31.00	03100	INTENSIVE CARE UNIT	4,038	341	39	858	809	31.00
40.00	04000	SUBPROVIDER - IPF	2,598	28	3	513	644	40.00
43.00	04300	NURSERY	0	0	0	146	130	43.00
44.00	04400	SKILLED NURSING FACILITY	2,902	701	1,029	2,299	2,997	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	122	197	55	9,292	2,072	50.00
51.00	05100	RECOVERY ROOM	5	413	1	723	149	51.00
52.00	05200	LABOR ROOM & DELIVERY ROOM	0	0	0	434	107	52.00
53.00	05300	ANESTHESIOLOGY	0	906	458	4,129	358	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0	223	2	5,046	1,493	54.00
56.00	05600	RADIOISOTOPE	0	21	4	684	78	56.00
57.00	05700	CT SCAN	0	610	14	4,630	114	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	297	3	2,262	202	58.00
60.00	06000	LABORATORY	0	3,677	0	12,208	1,511	60.00
65.00	06500	RESPIRATORY THERAPY	0	165	5	1,130	633	65.00
66.00	06600	PHYSICAL THERAPY	0	89	0	2,613	1,632	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	6	0	995	131	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	236	89	68.00
69.00	06900	ELECTROCARDIOLOGY	1	695	20	1,552	280	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
70.01	03610	SLEEP LAB	0	112	0	431	160	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	27,968	0	2,384	0	71.00
72.00	07200	IMP. DEV CHARGED TO PATIENT	0	0	0	5,120	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	39,213	11,185	0	73.00
76.00	03480	ONCOLOGY	0	75	23	2,415	380	76.00
76.01	03952	OCCUPATIONAL HEALTH	0	11	26	0	39	76.01
76.03	03951	OP DIABETIC EDUCATION	0	2	0	63	27	76.03
76.97	07697	CARDIAC REHABILITATION	0	2	0	57	80	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	2,043	7,198	0	10,474	88.00
90.00	09000	CLINIC	0	343	1,893	8,764	2,703	90.00
90.02	09002	WOUND CARE	70	164	2	232	158	90.02
91.00	09100	EMERGENCY	6,581	644	61	3,248	2,078	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	411	16	0	2,457	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	179	423	0	331	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	29,031	42,305	50,646	87,401	35,989	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	26	11	1,247	1,060	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	COMMUNITY WELLNESS	0	0	5	0	113	193.01
193.02	19302	COLE CARE RENTAL	0	0	0	0	0	193.02
193.07	19307	NONREIMB PUB REL &WOMENS HEALTH	0	0	0	0	20	193.07
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)	29,031	42,331	50,662	88,648	37,182	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: | Period: From 07/01/2017 To 06/30/2018 | Worksheet B Part II Date/Time Prepared: 6/12/2019 8:29 am

		Cost Center Description	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			19.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	00570	ADMITTING						5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.04
5.05	00590	OTHER ADMINISTRATIVE AND GENERAL						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
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
18.00	01850	INSERVICE EDUCATION						18.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0					19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS		561,841	0	561,841		30.00
31.00	03100	INTENSIVE CARE UNIT		88,521	0	88,521		31.00
40.00	04000	SUBPROVIDER - IPF		172,149	0	172,149		40.00
43.00	04300	NURSERY		39,265	0	39,265		43.00
44.00	04400	SKILLED NURSING FACILITY		389,094	0	389,094		44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM		818,810	0	818,810		50.00
51.00	05100	RECOVERY ROOM		54,337	0	54,337		51.00
52.00	05200	LABOR ROOM & DELIVERY ROOM		87,404	0	87,404		52.00
53.00	05300	ANESTHESIOLOGY		27,460	0	27,460		53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC		450,102	0	450,102		54.00
56.00	05600	RADIOISOTOPE		64,092	0	64,092		56.00
57.00	05700	CT SCAN		166,839	0	166,839		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)		331,599	0	331,599		58.00
60.00	06000	LABORATORY		205,498	0	205,498		60.00
65.00	06500	RESPIRATORY THERAPY		78,223	0	78,223		65.00
66.00	06600	PHYSICAL THERAPY		212,501	0	212,501		66.00
67.00	06700	OCCUPATIONAL THERAPY		41,605	0	41,605		67.00
68.00	06800	SPEECH PATHOLOGY		14,096	0	14,096		68.00
69.00	06900	ELECTROCARDIOLOGY		87,582	0	87,582		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY		0	0	0		70.00
70.01	03610	SLEEP LAB		40,752	0	40,752		70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS		99,043	0	99,043		71.00
72.00	07200	IMP. DEV CHARGED TO PATIENT		161,025	0	161,025		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		135,025	0	135,025		73.00
76.00	03480	ONCOLOGY		262,384	0	262,384		76.00
76.01	03952	OCCUPATIONAL HEALTH		5,167	0	5,167		76.01
76.03	03951	OP DIABETIC EDUCATION		11,169	0	11,169		76.03
76.97	07697	CARDIAC REHABILITATION		50,513	0	50,513		76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC		1,232,555	0	1,232,555		88.00
90.00	09000	CLINIC		331,398	0	331,398		90.00
90.02	09002	WOUND CARE		26,021	0	26,021		90.02
91.00	09100	EMERGENCY		254,921	0	254,921		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0			92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY		120,418	0	120,418		101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE		9,635	0	9,635		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	6,631,044	0	6,631,044		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN		7,077	0	7,077		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES		158,604	0	158,604		192.00
193.00	19300	NONPAID WORKERS		0	0	0		193.00
193.01	19301	COMMUNITY WELLNESS		2,407	0	2,407		193.01
193.02	19302	COLE CARE RENTAL		38,411	0	38,411		193.02
193.07	19307	NONREIMB PUB REL &WOMENS HEALTH		838	0	838		193.07
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	6,838,381	0	6,838,381		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: | Period: From 07/01/2017 To 06/30/2018 | Worksheet B-1 | Date/Time Prepared: 6/12/2019 8:29 am

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	NONPATIENT TELEPHONES (EXTENSION)	PURCHASING RECEIVING AND STORES (SUPPLIES EXPENSE)	
			1.00	2.00	4.00	5.01	5.02	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	240,965					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		1,294,682				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	3,490	335	36,613,457			4.00
5.01	00540	NONPATIENT TELEPHONES	0	0	0	763		5.01
5.02	00560	PURCHASING RECEIVING AND STORES	4,614	3,837	247,228	4	4,769,660	5.02
5.03	00570	ADMITTING	2,201	0	408,791	24	9,608	5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE	2,251	2,744	706,213	33	5,623	5.04
5.05	00590	OTHER ADMINISTRATIVE AND GENERAL	10,277	114,844	2,756,782	85	69,297	5.05
7.00	00700	OPERATION OF PLANT	26,605	33,186	722,291	17	31,893	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	737	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	755	6,563	925,522	0	106,057	9.00
10.00	01000	DIETARY	4,191	4,826	584,624	10	75,707	10.00
11.00	01100	CAFETERIA	1,630	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	806	619	709,397	5	3,982	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,841	3,877	123,277	6	149,507	14.00
15.00	01500	PHARMACY	1,465	3,579	170,354	13	48,785	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,023	4,169	321,949	15	3,381	16.00
18.00	01850	INSERVICE EDUCATION	2,156	2,361	146,695	5	6,261	18.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	25,180	66,234	2,500,621	53	175,048	30.00
31.00	03100	INTENSIVE CARE UNIT	3,150	16,248	674,376	6	37,785	31.00
40.00	04000	SUBPROVIDER - IPF	8,490	2,519	311,505	15	7,426	40.00
43.00	04300	NURSERY	2,539	1,161	129,994	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	19,819	28,153	1,625,905	14	91,559	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	22,130	121,502	1,528,987	32	95,918	50.00
51.00	05100	RECOVERY ROOM	2,481	11,550	125,238	0	35,389	51.00
52.00	05200	LABOR ROOM & DELIVERY ROOM	3,351	1,008	107,054	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	10,395	20,037	2	82,040	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	5,727	283,658	949,551	34	41,692	54.00
56.00	05600	RADIOISOTOPE	526	46,566	58,852	2	79,055	56.00
57.00	05700	CT SCAN	994	124,516	69,421	2	52,017	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	994	26	145,408	1	24,433	58.00
60.00	06000	LABORATORY	4,572	4,577	765,488	20	419,359	60.00
65.00	06500	RESPIRATORY THERAPY	852	15,393	459,501	5	19,568	65.00
66.00	06600	PHYSICAL THERAPY	7,540	5,357	1,021,472	33	23,341	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,301	0	111,039	4	1,458	67.00
68.00	06800	SPEECH PATHOLOGY	767	154	125,884	1	553	68.00
69.00	06900	ELECTROCARDIOLOGY	884	29,626	214,853	12	71,633	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
70.01	03610	SLEEP LAB	1,725	10,015	105,481	3	15,532	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	2,285,864	71.00
72.00	07200	IMP. DEV CHARGED TO PATIENT	1,841	58,445	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03480	ONCOLOGY	7,684	52,737	335,632	27	12,344	76.00
76.01	03952	OCCUPATIONAL HEALTH	266	561	30,689	3	1,501	76.01
76.03	03951	OP DIABETIC EDUCATION	767	0	20,147	0	763	76.03
76.97	07697	CARDIAC REHABILITATION	2,767	10,432	56,699	2	1,249	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	18,191	79,704	10,355,840	196	312,288	88.00
90.00	09000	CLINIC	12,038	6,054	1,937,413	0	50,687	90.00
90.02	09002	WOUND CARE	1,328	546	74,476	7	18,136	90.02
91.00	09100	EMERGENCY	7,806	75,730	1,819,516	28	79,792	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	4,067	1,979,920	24	47,691	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	251,439	1	18,792	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	233,752	1,247,874	35,735,561	744	4,613,014	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	517	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	3,890	37,064	796,527	2	151,687	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	COMMUNITY WELLNESS	0	9,744	62,130	17	4,959	193.01
193.02	19302	COLE CARE RENTAL	2,806	0	0	0	0	193.02
193.07	19307	NONREIMB PUB REL &WOMENS HEALTH	0	0	19,239	0	0	193.07
200.00		Cross Foot Adjustments						200.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: | Period: From 07/01/2017 To 06/30/2018 | Worksheet B-1 | Date/Time Prepared: 6/12/2019 8:29 am

	Cost Center Description	CAPITAL RELATED COSTS					
		BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	NONPATIENT TELEPHONES (EXTENSION)	PURCHASING RECEIVING AND STORES (SUPPLIES EXPENSE)	
		1.00	2.00	4.00	5.01	5.02	
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	2,754,353	48,169	1,942,272	211,986	494,867	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	11.430511	0.037205	0.053048	277.832241	0.103753	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)			40,239	0	56,993	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)			0.001099	0.000000	0.011949	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: | Period: From 07/01/2017 To 06/30/2018 | Worksheet B-1 | Date/Time Prepared: 6/12/2019 8:29 am

		Cost Center Description	ADMITTING (GROSS CHARGES)	CASHIERING/ACCOUNTS RECEIVABLE (GROSS CHARGES)	Reconciliation	OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
			5.03	5.04	5A.05	5.05	7.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	00570	ADMITTING	148,176,562					5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	186,531,736				5.04
5.05	00590	OTHER ADMINISTRATIVE AND GENERAL	0	0	-6,446,359	74,372,248		5.05
7.00	00700	OPERATION OF PLANT	0	0	0	2,778,114	191,527	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	8,424	737	8.00
9.00	00900	HOUSEKEEPING	0	0	0	1,334,509	755	9.00
10.00	01000	DIETARY	0	0	0	949,556	4,191	10.00
11.00	01100	CAFETERIA	0	0	0	18,632	1,630	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	933,634	806	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	563,204	1,841	14.00
15.00	01500	PHARMACY	0	0	0	1,611,842	1,465	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	687,049	4,023	16.00
18.00	01850	INSERVICE EDUCATION	0	0	0	314,169	2,156	18.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,065,293	7,065,293	0	4,032,849	25,180	30.00
31.00	03100	INTENSIVE CARE UNIT	1,616,316	1,616,316	0	1,004,983	3,150	31.00
40.00	04000	SUBPROVIDER - IPF	966,141	966,141	0	841,044	8,490	40.00
43.00	04300	NURSERY	275,457	275,457	0	183,807	2,539	43.00
44.00	04400	SKILLED NURSING FACILITY	4,330,458	4,330,458	0	2,726,544	19,819	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	17,499,914	17,499,914	0	3,155,464	22,130	50.00
51.00	05100	RECOVERY ROOM	1,361,693	1,361,693	0	258,874	2,481	51.00
52.00	05200	LABOR ROOM & DELIVERY ROOM	816,817	816,817	0	211,681	3,351	52.00
53.00	05300	ANESTHESIOLOGY	7,776,681	7,776,681	0	343,669	0	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	9,503,605	9,503,605	0	2,487,228	5,727	54.00
56.00	05600	RADIOISOTOPE	1,287,357	1,287,357	0	278,527	526	56.00
57.00	05700	CT SCAN	8,718,749	8,718,749	0	470,449	994	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	4,260,751	4,260,751	0	683,865	994	58.00
60.00	06000	LABORATORY	23,068,827	23,068,827	0	3,104,003	4,572	60.00
65.00	06500	RESPIRATORY THERAPY	2,127,613	2,127,613	0	753,365	852	65.00
66.00	06600	PHYSICAL THERAPY	4,921,404	4,921,404	0	1,805,062	7,540	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,874,522	1,874,522	0	525,524	2,301	67.00
68.00	06800	SPEECH PATHOLOGY	444,709	444,709	0	173,837	767	68.00
69.00	06900	ELECTROCARDIOLOGY	2,922,459	2,922,459	0	507,967	884	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
70.01	03610	SLEEP LAB	812,335	812,335	0	204,301	1,725	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,490,185	4,490,185	0	2,581,336	0	71.00
72.00	07200	IMP. DEV CHARGED TO PATIENT	9,643,039	9,643,039	0	4,326,416	1,841	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	21,063,214	21,063,214	0	4,919,671	0	73.00
76.00	03480	ONCOLOGY	4,547,792	4,547,792	0	1,330,685	7,684	76.00
76.01	03952	OCCUPATIONAL HEALTH	0	0	0	49,490	266	76.01
76.03	03951	OP DIABETIC EDUCATION	117,933	117,933	0	36,125	767	76.03
76.97	07697	CARDIAC REHABILITATION	108,149	108,149	0	118,553	2,767	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	15,164,405	0	16,831,451	18,191	88.00
90.00	09000	CLINIC	0	16,503,932	0	2,535,958	12,038	90.00
90.02	09002	WOUND CARE	437,806	437,806	0	168,628	1,328	90.02
91.00	09100	EMERGENCY	6,117,343	6,117,343	0	2,929,786	7,806	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	3,683,955	0	3,294,270	0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	653,716	0	449,370	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	148,176,562	184,182,570	-6,446,359	72,523,915	184,314	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	5,910	517	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	2,349,166	0	1,661,522	3,890	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	COMMUNITY WELLNESS	0	0	0	100,194	0	193.01
193.02	19302	COLE CARE RENTAL	0	0	0	32,074	2,806	193.02
193.07	19307	NONREIMB PUB REL &WOMENS HEALTH	0	0	0	48,633	0	193.07
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: | Period: From 07/01/2017 To 06/30/2018 | Worksheet B-1 | Date/Time Prepared: 6/12/2019 8:29 am

		Cost Center Description	ADMITTING (GROSS CHARGES)	CASHIERING/ACCOUNTS RECEIVABLE (GROSS CHARGES)	Reconciliation	OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
			5.03	5.04	5A.05	5.05	7.00	
202.00		Cost to be allocated (per Wkst. B, Part I)	596,649	1,671,188		6,446,359	3,018,913	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.004027	0.008959		0.086677	15.762336	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	25,723	53,507		1,132,518	359,441	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000174	0.000287		0.015228	1.876712	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: | Period: From 07/01/2017 To 06/30/2018 | Worksheet B-1 | Date/Time Prepared: 6/12/2019 8:29 am

		Cost Center Description	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	
			8.00	9.00	10.00	11.00	13.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	00570	ADMITTING						5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.04
5.05	00590	OTHER ADMINISTRATIVE AND GENERAL						5.05
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE	308,491					8.00
9.00	00900	HOUSEKEEPING	0	190,035				9.00
10.00	01000	DIETARY	14,716	4,191	176,433			10.00
11.00	01100	CAFETERIA	0	1,630	116,882	36,900		11.00
13.00	01300	NURSING ADMINISTRATION	0	806	0	1,130	23,500	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	5,343	1,841	0	401	0	14.00
15.00	01500	PHARMACY	0	1,465	0	634	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	4,023	0	991	0	16.00
18.00	01850	INSERVICE EDUCATION	0	2,156	0	257	4	18.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	63,116	25,180	13,568	4,754	10,287	30.00
31.00	03100	INTENSIVE CARE UNIT	9,087	3,150	2,469	1,047	3,269	31.00
40.00	04000	SUBPROVIDER - IPF	4,719	8,490	2,559	833	2,103	40.00
43.00	04300	NURSERY	1,177	2,539	0	168	0	43.00
44.00	04400	SKILLED NURSING FACILITY	51,787	19,819	40,955	3,879	2,349	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	75,453	22,130	0	2,682	99	50.00
51.00	05100	RECOVERY ROOM	0	2,481	0	193	4	51.00
52.00	05200	LABOR ROOM & DELIVERY ROOM	4,417	3,351	0	138	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	464	0	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	10,690	5,727	0	1,600	0	54.00
56.00	05600	RADIOISOTOPE	1,518	526	0	101	0	56.00
57.00	05700	CT SCAN	6,225	994	0	147	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	4,570	994	0	261	0	58.00
60.00	06000	LABORATORY	143	4,572	0	1,956	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	852	0	819	0	65.00
66.00	06600	PHYSICAL THERAPY	4,143	7,540	0	728	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	2,301	0	170	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	767	0	115	0	68.00
69.00	06900	ELECTROCARDIOLOGY	2,713	884	0	363	1	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
70.01	03610	SLEEP LAB	1,939	1,725	0	207	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMP. DEV CHARGED TO PATIENT	0	1,841	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03480	ONCOLOGY	0	7,684	0	492	0	76.00
76.01	03952	OCCUPATIONAL HEALTH	0	266	0	50	0	76.01
76.03	03951	OP DIABETIC EDUCATION	0	767	0	35	0	76.03
76.97	07697	CARDIAC REHABILITATION	0	2,767	0	104	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	3,478	18,191	0	5,825	0	88.00
90.00	09000	CLINIC	1,419	12,038	0	3,315	0	90.00
90.02	09002	WOUND CARE	163	1,328	0	204	57	90.02
91.00	09100	EMERGENCY	41,365	7,806	0	2,690	5,327	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	308,181	182,822	176,433	36,753	23,500	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	517	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	3,890	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	COMMUNITY WELLNESS	310	0	0	121	0	193.01
193.02	19302	COLE CARE RENTAL	0	2,806	0	0	0	193.02
193.07	19307	NONREIMB PUB REL &WOMENS HEALTH	0	0	0	26	0	193.07
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: | Period: From 07/01/2017 To 06/30/2018 | Worksheet B-1 | Date/Time Prepared: 6/12/2019 8:29 am

		Cost Center Description	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	
			8.00	9.00	10.00	11.00	13.00	
202.00		Cost to be allocated (per Wkst. B, Part I)	20,771	1,462,081	1,131,156	807,841	1,058,203	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.067331	7.693746	6.411250	21.892710	45.029915	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	9,935	39,460	87,159	80,053	29,031	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.032205	0.207646	0.494006	2.169458	1.235362	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: | Period: From 07/01/2017 To 06/30/2018 | Worksheet B-1 | Date/Time Prepared: 6/12/2019 8:29 am

		Cost Center Description	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	OTHER GENERAL SERVICE INSERVICE EDUCATION (FTE'S)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	
			14.00	15.00	16.00	18.00	19.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	00570	ADMITTING						5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.04
5.05	00590	OTHER ADMINISTRATIVE AND GENERAL						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
14.00	01400	CENTRAL SERVICES & SUPPLY	3,460,090					14.00
15.00	01500	PHARMACY	28,024	5,858,084				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	103	0	167,029,660			16.00
18.00	01850	INSERVICE EDUCATION	987	0	0	48,124		18.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	132,917	18,223	7,065,293	4,754	0	30.00
31.00	03100	INTENSIVE CARE UNIT	27,891	4,459	1,616,316	1,047	0	31.00
40.00	04000	SUBPROVIDER - IPF	2,306	300	966,141	833	0	40.00
43.00	04300	NURSERY	0	0	275,457	168	0	43.00
44.00	04400	SKILLED NURSING FACILITY	57,297	118,993	4,330,458	3,879	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	16,113	6,395	17,499,914	2,682	0	50.00
51.00	05100	RECOVERY ROOM	33,774	78	1,361,693	193	0	51.00
52.00	05200	LABOR ROOM & DELIVERY ROOM	0	0	816,817	138	0	52.00
53.00	05300	ANESTHESIOLOGY	74,080	52,909	7,776,681	464	0	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	18,238	177	9,503,605	1,932	0	54.00
56.00	05600	RADIOISOTOPE	1,723	491	1,287,357	101	0	56.00
57.00	05700	CT SCAN	49,901	1,587	8,718,749	147	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	24,266	303	4,260,751	261	0	58.00
60.00	06000	LABORATORY	300,518	32	23,068,827	1,956	0	60.00
65.00	06500	RESPIRATORY THERAPY	13,472	526	2,127,613	819	0	65.00
66.00	06600	PHYSICAL THERAPY	7,262	0	4,921,404	2,112	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	503	0	1,874,522	170	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	444,709	115	0	68.00
69.00	06900	ELECTROCARDIOLOGY	56,845	2,284	2,922,459	363	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
70.01	03610	SLEEP LAB	9,163	18	812,335	207	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,285,864	0	4,490,185	0	0	71.00
72.00	07200	IMP. DEV CHARGED TO PATIENT	0	0	9,643,039	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	4,534,383	21,063,214	0	0	73.00
76.00	03480	ONCOLOGY	6,153	2,649	4,547,792	492	0	76.00
76.01	03952	OCCUPATIONAL HEALTH	914	3,009	0	50	0	76.01
76.03	03951	OP DIABETIC EDUCATION	131	0	117,933	35	0	76.03
76.97	07697	CARDIAC REHABILITATION	175	0	108,149	104	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	166,994	832,362	0	13,557	0	88.00
90.00	09000	CLINIC	28,034	218,948	16,503,932	3,498	0	90.00
90.02	09002	WOUND CARE	13,393	275	437,806	204	0	90.02
91.00	09100	EMERGENCY	52,675	7,040	6,117,343	2,690	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	33,606	1,835	0	3,180	0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	14,629	48,941	0	429		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	3,457,951	5,856,217	164,680,494	46,580	0	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	2,139	1,274	2,349,166	1,372	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	COMMUNITY WELLNESS	0	593	0	146	0	193.01
193.02	19302	COLE CARE RENTAL	0	0	0	0	0	193.02
193.07	19307	NONREIMB PUB REL &WOMENS HEALTH	0	0	0	26	0	193.07
200.00		Cross Foot Adjustments						200.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: | Period: From 07/01/2017 To 06/30/2018 | Worksheet B-1 | Date/Time Prepared: 6/12/2019 8:29 am

	Cost Center Description	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	OTHER GENERAL SERVICE INSERVICE EDUCATION (FTE'S)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	
		14.00	15.00	16.00	18.00	19.00	
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	664,342	1,805,176	862,680	397,968	0	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	0.192001	0.308151	0.005165	8.269637	0.000000	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	42,331	50,662	88,648	37,182	0	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.012234	0.008648	0.000531	0.772629	0.000000	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: | Period: From 07/01/2017 To 06/30/2018 | Worksheet C Part I Date/Time Prepared: 6/12/2019 8:29 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	5,738,507		5,738,507	0	5,738,507	30.00
31.00	03100	INTENSIVE CARE UNIT	1,376,279		1,376,279	0	1,376,279	31.00
40.00	04000	SUBPROVIDER - IPF	1,255,158		1,255,158	0	1,255,158	40.00
43.00	04300	NURSERY	265,863		265,863	0	265,863	43.00
44.00	04400	SKILLED NURSING FACILITY	3,986,620		3,986,620	0	3,986,620	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,133,936		4,133,936	0	4,133,936	50.00
51.00	05100	RECOVERY ROOM	359,049		359,049	0	359,049	51.00
52.00	05200	LABOR ROOM & DELIVERY ROOM	317,309		317,309	0	317,309	52.00
53.00	05300	ANESTHESIOLOGY	458,146		458,146	0	458,146	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	2,941,514		2,941,514	0	2,941,514	54.00
56.00	05600	RADIOISOTOPE	325,286		325,286	0	325,286	56.00
57.00	05700	CT SCAN	594,497		594,497	0	594,497	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	801,395		801,395	0	801,395	58.00
60.00	06000	LABORATORY	3,716,129		3,716,129	0	3,716,129	60.00
65.00	06500	RESPIRATORY THERAPY	877,090	0	877,090	0	877,090	65.00
66.00	06600	PHYSICAL THERAPY	2,198,873	0	2,198,873	0	2,198,873	66.00
67.00	06700	OCCUPATIONAL THERAPY	639,954	0	639,954	0	639,954	67.00
68.00	06800	SPEECH PATHOLOGY	212,662	0	212,662	0	212,662	68.00
69.00	06900	ELECTROCARDIOLOGY	610,621		610,621	0	610,621	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0		0	0	0	70.00
70.01	03610	SLEEP LAB	274,807		274,807	0	274,807	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,267,158		3,267,158	0	3,267,158	71.00
72.00	07200	IMP. DEV CHARGED TO PATIENT	4,794,405		4,794,405	0	4,794,405	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,852,162		6,852,162	0	6,852,162	73.00
76.00	03480	ONCOLOGY	1,666,588		1,666,588	0	1,666,588	76.00
76.01	03952	OCCUPATIONAL HEALTH	62,630		62,630	0	62,630	76.01
76.03	03951	OP DIABETIC EDUCATION	58,936		58,936	0	58,936	76.03
76.97	07697	CARDIAC REHABILITATION	197,462		197,462	0	197,462	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	19,245,468		19,245,468	0	19,245,468	88.00
90.00	09000	CLINIC	3,297,823		3,297,823	0	3,297,823	90.00
90.02	09002	WOUND CARE	228,041		228,041	0	228,041	90.02
91.00	09100	EMERGENCY	3,734,503		3,734,503	0	3,734,503	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,005,688		1,005,688		1,005,688	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	3,613,121		3,613,121		3,613,121	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	509,758		509,758		509,758	116.00
200.00		Subtotal (see instructions)	79,617,438	0	79,617,438	0	79,617,438	200.00
201.00		Less Observation Beds	1,005,688		1,005,688		1,005,688	201.00
202.00		Total (see instructions)	78,611,750	0	78,611,750	0	78,611,750	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: | Period: From 07/01/2017 To 06/30/2018 | Worksheet C Part I Date/Time Prepared: 6/12/2019 8:29 am

Title XVIII | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,244,777		4,244,777			30.00
31.00	03100	INTENSIVE CARE UNIT	1,294,671		1,294,671			31.00
40.00	04000	SUBPROVIDER - IPF	966,141		966,141			40.00
43.00	04300	NURSERY	274,601		274,601			43.00
44.00	04400	SKILLED NURSING FACILITY	4,326,791		4,326,791			44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,890,420	14,609,494	17,499,914	0.236226	0.000000	50.00
51.00	05100	RECOVERY ROOM	342,453	1,019,240	1,361,693	0.263678	0.000000	51.00
52.00	05200	LABOR ROOM & DELIVERY ROOM	254,362	395,394	649,756	0.488351	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	482,674	1,863,583	2,346,257	0.195267	0.000000	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	336,318	9,167,287	9,503,605	0.309516	0.000000	54.00
56.00	05600	RADIOISOTOPE	56,050	1,231,307	1,287,357	0.252677	0.000000	56.00
57.00	05700	CT SCAN	648,497	8,070,252	8,718,749	0.068186	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	151,131	4,109,620	4,260,751	0.188088	0.000000	58.00
60.00	06000	LABORATORY	2,321,519	20,747,308	23,068,827	0.161089	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	1,402,186	725,427	2,127,613	0.412241	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	1,137,923	3,783,481	4,921,404	0.446798	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,291,303	583,219	1,874,522	0.341396	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	270,803	173,906	444,709	0.478205	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	312,277	2,610,182	2,922,459	0.208941	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	0.000000	70.00
70.01	03610	SLEEP LAB	0	812,335	812,335	0.338293	0.000000	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,547,197	2,942,988	4,490,185	0.727622	0.000000	71.00
72.00	07200	IMP. DEV CHARGED TO PATIENT	3,646,279	5,996,760	9,643,039	0.497188	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,689,159	18,374,055	21,063,214	0.325314	0.000000	73.00
76.00	03480	ONCOLOGY	2,568	4,545,224	4,547,792	0.366461	0.000000	76.00
76.01	03952	OCCUPATIONAL HEALTH	0	4,386	4,386	14.279526	0.000000	76.01
76.03	03951	OP DIABETIC EDUCATION	0	117,933	117,933	0.499741	0.000000	76.03
76.97	07697	CARDIAC REHABILITATION	0	108,149	108,149	1.825833	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	15,164,405	15,164,405			88.00
90.00	09000	CLINIC	0	2,422,763	2,422,763	1.361183	0.000000	90.00
90.02	09002	WOUND CARE	6,331	431,475	437,806	0.520872	0.000000	90.02
91.00	09100	EMERGENCY	406,992	5,710,351	6,117,343	0.610478	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	302,299	3,011,446	3,313,745	0.303490	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	3,683,955	3,683,955			101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	653,716	653,716			116.00
200.00		Subtotal (see instructions)	31,605,722	133,069,641	164,675,363			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	31,605,722	133,069,641	164,675,363			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: | Period: From 07/01/2017 To 06/30/2018 | Worksheet C Part I Date/Time Prepared: 6/12/2019 8:29 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
40.00	04000	SUBPROVIDER - IPF			40.00
43.00	04300	NURSERY			43.00
44.00	04400	SKILLED NURSING FACILITY			44.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.236226		50.00
51.00	05100	RECOVERY ROOM	0.263678		51.00
52.00	05200	LABOR ROOM & DELIVERY ROOM	0.488351		52.00
53.00	05300	ANESTHESIOLOGY	0.195267		53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0.309516		54.00
56.00	05600	RADIOISOTOPE	0.252677		56.00
57.00	05700	CT SCAN	0.068186		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.188088		58.00
60.00	06000	LABORATORY	0.161089		60.00
65.00	06500	RESPIRATORY THERAPY	0.412241		65.00
66.00	06600	PHYSICAL THERAPY	0.446798		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.341396		67.00
68.00	06800	SPEECH PATHOLOGY	0.478205		68.00
69.00	06900	ELECTROCARDIOLOGY	0.208941		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000		70.00
70.01	03610	SLEEP LAB	0.338293		70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.727622		71.00
72.00	07200	IMP. DEV CHARGED TO PATIENT	0.497188		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.325314		73.00
76.00	03480	ONCOLOGY	0.366461		76.00
76.01	03952	OCCUPATIONAL HEALTH	14.279526		76.01
76.03	03951	OP DIABETIC EDUCATION	0.499741		76.03
76.97	07697	CARDIAC REHABILITATION	1.825833		76.97
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC			88.00
90.00	09000	CLINIC	1.361183		90.00
90.02	09002	WOUND CARE	0.520872		90.02
91.00	09100	EMERGENCY	0.610478		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.303490		92.00
		OTHER REIMBURSABLE COST CENTERS			
101.00	10100	HOME HEALTH AGENCY			101.00
		SPECIAL PURPOSE COST CENTERS			
116.00	11600	HOSPICE			116.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part II Date/Time Prepared: 6/12/2019 8:29 am

Title XVIII | Hospital | Cost

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	818,810	17,499,914	0.046789	1,104,359	51,672	50.00
51.00	05100	RECOVERY ROOM	54,337	1,361,693	0.039904	125,121	4,993	51.00
52.00	05200	LABOR ROOM & DELIVERY ROOM	87,404	649,756	0.134518	1,285	173	52.00
53.00	05300	ANESTHESIOLOGY	27,460	2,346,257	0.011704	177,240	2,074	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	450,102	9,503,605	0.047361	98,108	4,646	54.00
56.00	05600	RADIOISOTOPE	64,092	1,287,357	0.049786	20,209	1,006	56.00
57.00	05700	CT SCAN	166,839	8,718,749	0.019136	84,836	1,623	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	331,599	4,260,751	0.077826	73,319	5,706	58.00
60.00	06000	LABORATORY	205,498	23,068,827	0.008908	789,437	7,032	60.00
65.00	06500	RESPIRATORY THERAPY	78,223	2,127,613	0.036766	636,901	23,416	65.00
66.00	06600	PHYSICAL THERAPY	212,501	4,921,404	0.043179	366,721	15,835	66.00
67.00	06700	OCCUPATIONAL THERAPY	41,605	1,874,522	0.022195	374,406	8,310	67.00
68.00	06800	SPEECH PATHOLOGY	14,096	444,709	0.031697	95,345	3,022	68.00
69.00	06900	ELECTROCARDIOLOGY	87,582	2,922,459	0.029969	157,872	4,731	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0	0	70.00
70.01	03610	SLEEP LAB	40,752	812,335	0.050166	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	99,043	4,490,185	0.022058	592,051	13,059	71.00
72.00	07200	IMP. DEV CHARGED TO PATIENT	161,025	9,643,039	0.016699	1,736,205	28,993	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	135,025	21,063,214	0.006410	961,522	6,163	73.00
76.00	03480	ONCOLOGY	262,384	4,547,792	0.057695	2,550	147	76.00
76.01	03952	OCCUPATIONAL HEALTH	5,167	4,386	1.178067	0	0	76.01
76.03	03951	OP DIABETIC EDUCATION	11,169	117,933	0.094706	0	0	76.03
76.97	07697	CARDIAC REHABILITATION	50,513	108,149	0.467069	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,232,555	15,164,405	0.081279	0	0	88.00
90.00	09000	CLINIC	331,398	2,422,763	0.136785	0	0	90.00
90.02	09002	WOUND CARE	26,021	437,806	0.059435	0	0	90.02
91.00	09100	EMERGENCY	254,921	6,117,343	0.041672	3,690	154	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	98,464	3,313,745	0.029714	0	0	92.00
200.00		Total (lines 50 through 199)	5,348,585	149,230,711		7,401,177	182,755	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN:

Period: From 07/01/2017 To 06/30/2018

Worksheet D Part IV Date/Time Prepared: 6/12/2019 8:29 am

Title XVIII | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	LABOR ROOM & DELIVERY ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
70.01	03610	SLEEP LAB	0	0	0	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMP. DEV CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03480	ONCOLOGY	0	0	0	0	0	76.00
76.01	03952	OCCUPATIONAL HEALTH	0	0	0	0	0	76.01
76.03	03951	OP DIABETIC EDUCATION	0	0	0	0	0	76.03
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.02	09002	WOUND CARE	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0		0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN:

Period: From 07/01/2017 To 06/30/2018

Worksheet D Part IV Date/Time Prepared: 6/12/2019 8:29 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	17,499,914	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	1,361,693	0.000000	51.00
52.00	05200	LABOR ROOM & DELIVERY ROOM	0	0	0	649,756	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	2,346,257	0.000000	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0	0	0	9,503,605	0.000000	54.00
56.00	05600	RADIOISOTOPE	0	0	0	1,287,357	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	8,718,749	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	4,260,751	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	23,068,827	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	2,127,613	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	4,921,404	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,874,522	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	444,709	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	2,922,459	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0.000000	70.00
70.01	03610	SLEEP LAB	0	0	0	812,335	0.000000	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	4,490,185	0.000000	71.00
72.00	07200	IMP. DEV CHARGED TO PATIENT	0	0	0	9,643,039	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	21,063,214	0.000000	73.00
76.00	03480	ONCOLOGY	0	0	0	4,547,792	0.000000	76.00
76.01	03952	OCCUPATIONAL HEALTH	0	0	0	4,386	0.000000	76.01
76.03	03951	OP DIABETIC EDUCATION	0	0	0	117,933	0.000000	76.03
76.97	07697	CARDIAC REHABILITATION	0	0	0	108,149	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	15,164,405	0.000000	88.00
90.00	09000	CLINIC	0	0	0	2,422,763	0.000000	90.00
90.02	09002	WOUND CARE	0	0	0	437,806	0.000000	90.02
91.00	09100	EMERGENCY	0	0	0	6,117,343	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	3,313,745	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	149,230,711		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part IV Date/Time Prepared: 6/12/2019 8:29 am

Title XVIII | Hospital | Cost

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	1,104,359	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	125,121	0	0	0	51.00
52.00	05200	LABOR ROOM & DELIVERY ROOM	0.000000	1,285	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	177,240	0	0	0	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0.000000	98,108	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0.000000	20,209	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	84,836	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	73,319	0	0	0	58.00
60.00	06000	LABORATORY	0.000000	789,437	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	636,901	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	366,721	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	374,406	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	95,345	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	157,872	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
70.01	03610	SLEEP LAB	0.000000	0	0	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	592,051	0	0	0	71.00
72.00	07200	IMP. DEV CHARGED TO PATIENT	0.000000	1,736,205	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	961,522	0	0	0	73.00
76.00	03480	ONCOLOGY	0.000000	2,550	0	0	0	76.00
76.01	03952	OCCUPATIONAL HEALTH	0.000000	0	0	0	0	76.01
76.03	03951	OP DIABETIC EDUCATION	0.000000	0	0	0	0	76.03
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.02	09002	WOUND CARE	0.000000	0	0	0	0	90.02
91.00	09100	EMERGENCY	0.000000	3,690	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		7,401,177	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN:

Period: From 07/01/2017 To 06/30/2018

Worksheet D Part IV Date/Time Prepared: 6/12/2019 8:29 am

Title XVIII | Hospital | Cost

		Cost Center Description	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. All Other Medical Education Cost		
			21.00	24.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
52.00	05200	LABOR ROOM & DELIVERY ROOM	0	0		52.00
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	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
60.00	06000	LABORATORY	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
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
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
70.01	03610	SLEEP LAB	0	0		70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMP. DEV CHARGED TO PATIENT	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
76.00	03480	ONCOLOGY	0	0		76.00
76.01	03952	OCCUPATIONAL HEALTH	0	0		76.01
76.03	03951	OP DIABETIC EDUCATION	0	0		76.03
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
90.00	09000	CLINIC	0	0		90.00
90.02	09002	WOUND CARE	0	0		90.02
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
200.00		Total (lines 50 through 199)	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part V Date/Time Prepared: 6/12/2019 8:29 am

Title XVIII | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.236226	0	3,045,000	0	0	50.00
51.00	05100	RECOVERY ROOM	0.263678	0	152,349	0	0	51.00
52.00	05200	LABOR ROOM & DELIVERY ROOM	0.488351	0	15,033	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.195267	0	341,681	0	0	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0.309516	0	2,280,929	0	0	54.00
56.00	05600	RADIOISOTOPE	0.252677	0	473,762	0	0	56.00
57.00	05700	CT SCAN	0.068186	0	2,695,291	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.188088	0	1,044,922	0	0	58.00
60.00	06000	LABORATORY	0.161089	0	5,906,760	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.412241	0	310,261	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.446798	0	1,016,634	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.341396	0	191,994	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.478205	0	49,958	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.208941	0	936,928	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
70.01	03610	SLEEP LAB	0.338293	0	182,371	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.727622	0	687,873	0	0	71.00
72.00	07200	IMP. DEV CHARGED TO PATIENT	0.497188	0	1,497,561	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.325314	0	7,332,557	4,035	0	73.00
76.00	03480	ONCOLOGY	0.366461	0	1,798,220	0	0	76.00
76.01	03952	OCCUPATIONAL HEALTH	14.279526	0	0	0	0	76.01
76.03	03951	OP DIABETIC EDUCATION	0.499741	0	29,028	0	0	76.03
76.97	07697	CARDIAC REHABILITATION	1.825833	0	58,017	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
90.00	09000	CLINIC	1.361183	0	245,093	304	0	90.00
90.02	09002	WOUND CARE	0.520872	0	181,524	0	0	90.02
91.00	09100	EMERGENCY	0.610478	0	1,811,295	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.303490	0	937,322	0	0	92.00
200.00		Subtotal (see instructions)		0	33,222,363	4,339	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	33,222,363	4,339	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part V Date/Time Prepared: 6/12/2019 8:29 am

Title XVIII | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	719,308	0		50.00
51.00	05100	RECOVERY ROOM	40,171	0		51.00
52.00	05200	LABOR ROOM & DELIVERY ROOM	7,341	0		52.00
53.00	05300	ANESTHESIOLOGY	66,719	0		53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	705,984	0		54.00
56.00	05600	RADIOISOTOPE	119,709	0		56.00
57.00	05700	CT SCAN	183,781	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	196,537	0		58.00
60.00	06000	LABORATORY	951,514	0		60.00
65.00	06500	RESPIRATORY THERAPY	127,902	0		65.00
66.00	06600	PHYSICAL THERAPY	454,230	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	65,546	0		67.00
68.00	06800	SPEECH PATHOLOGY	23,890	0		68.00
69.00	06900	ELECTROCARDIOLOGY	195,763	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
70.01	03610	SLEEP LAB	61,695	0		70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	500,512	0		71.00
72.00	07200	IMP. DEV CHARGED TO PATIENT	744,569	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,385,383	1,313		73.00
76.00	03480	ONCOLOGY	658,977	0		76.00
76.01	03952	OCCUPATIONAL HEALTH	0	0		76.01
76.03	03951	OP DIABETIC EDUCATION	14,506	0		76.03
76.97	07697	CARDIAC REHABILITATION	105,929	0		76.97
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
90.00	09000	CLINIC	333,616	414		90.00
90.02	09002	WOUND CARE	94,551	0		90.02
91.00	09100	EMERGENCY	1,105,756	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	284,468	0		92.00
200.00		Subtotal (see instructions)	10,148,357	1,727		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	10,148,357	1,727		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN:
Component CCN:
Period: From 07/01/2017 To 06/30/2018
Worksheet D Part II Date/Time Prepared: 6/12/2019 8:29 am
Title XVIII
Subprovider - IPF
PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	818,810	17,499,914	0.046789	0	0	50.00
51.00	05100	RECOVERY ROOM	54,337	1,361,693	0.039904	0	0	51.00
52.00	05200	LABOR ROOM & DELIVERY ROOM	87,404	649,756	0.134518	0	0	52.00
53.00	05300	ANESTHESIOLOGY	27,460	2,346,257	0.011704	0	0	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	450,102	9,503,605	0.047361	10,598	502	54.00
56.00	05600	RADIOISOTOPE	64,092	1,287,357	0.049786	0	0	56.00
57.00	05700	CT SCAN	166,839	8,718,749	0.019136	8,487	162	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	331,599	4,260,751	0.077826	5,634	438	58.00
60.00	06000	LABORATORY	205,498	23,068,827	0.008908	76,014	677	60.00
65.00	06500	RESPIRATORY THERAPY	78,223	2,127,613	0.036766	5,613	206	65.00
66.00	06600	PHYSICAL THERAPY	212,501	4,921,404	0.043179	41,954	1,812	66.00
67.00	06700	OCCUPATIONAL THERAPY	41,605	1,874,522	0.022195	58,095	1,289	67.00
68.00	06800	SPEECH PATHOLOGY	14,096	444,709	0.031697	39,947	1,266	68.00
69.00	06900	ELECTROCARDIOLOGY	87,582	2,922,459	0.029969	9,671	290	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0	0	70.00
70.01	03610	SLEEP LAB	40,752	812,335	0.050166	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	99,043	4,490,185	0.022058	6,914	153	71.00
72.00	07200	IMP. DEV CHARGED TO PATIENT	161,025	9,643,039	0.016699	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	135,025	21,063,214	0.006410	307,304	1,970	73.00
76.00	03480	ONCOLOGY	262,384	4,547,792	0.057695	0	0	76.00
76.01	03952	OCCUPATIONAL HEALTH	5,167	4,386	1.178067	0	0	76.01
76.03	03951	OP DIABETIC EDUCATION	11,169	117,933	0.094706	0	0	76.03
76.97	07697	CARDIAC REHABILITATION	50,513	108,149	0.467069	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,232,555	15,164,405	0.081279	0	0	88.00
90.00	09000	CLINIC	331,398	2,422,763	0.136785	0	0	90.00
90.02	09002	WOUND CARE	26,021	437,806	0.059435	0	0	90.02
91.00	09100	EMERGENCY	254,921	6,117,343	0.041672	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	3,313,745	0.000000	0	0	92.00
200.00		Total (lines 50 through 199)	5,250,121	149,230,711		570,231	8,765	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN:
Component CCN:
Period: From 07/01/2017 To 06/30/2018
Worksheet D Part IV Date/Time Prepared: 6/12/2019 8:29 am
Title XVIII
Subprovider - IPF
PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	LABOR ROOM & DELIVERY ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
70.01	03610	SLEEP LAB	0	0	0	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMP. DEV CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03480	ONCOLOGY	0	0	0	0	0	76.00
76.01	03952	OCCUPATIONAL HEALTH	0	0	0	0	0	76.01
76.03	03951	OP DIABETIC EDUCATION	0	0	0	0	0	76.03
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.02	09002	WOUND CARE	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0		0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN:
Component CCN:
Period: From 07/01/2017 To 06/30/2018
Worksheet D Part IV Date/Time Prepared: 6/12/2019 8:29 am
Title XVIII
Subprovider - IPF
PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	17,499,914	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	1,361,693	0.000000	51.00
52.00	05200	LABOR ROOM & DELIVERY ROOM	0	0	0	649,756	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	2,346,257	0.000000	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0	0	0	9,503,605	0.000000	54.00
56.00	05600	RADIOISOTOPE	0	0	0	1,287,357	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	8,718,749	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	4,260,751	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	23,068,827	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	2,127,613	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	4,921,404	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,874,522	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	444,709	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	2,922,459	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0.000000	70.00
70.01	03610	SLEEP LAB	0	0	0	812,335	0.000000	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	4,490,185	0.000000	71.00
72.00	07200	IMP. DEV CHARGED TO PATIENT	0	0	0	9,643,039	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	21,063,214	0.000000	73.00
76.00	03480	ONCOLOGY	0	0	0	4,547,792	0.000000	76.00
76.01	03952	OCCUPATIONAL HEALTH	0	0	0	4,386	0.000000	76.01
76.03	03951	OP DIABETIC EDUCATION	0	0	0	117,933	0.000000	76.03
76.97	07697	CARDIAC REHABILITATION	0	0	0	108,149	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	15,164,405	0.000000	88.00
90.00	09000	CLINIC	0	0	0	2,422,763	0.000000	90.00
90.02	09002	WOUND CARE	0	0	0	437,806	0.000000	90.02
91.00	09100	EMERGENCY	0	0	0	6,117,343	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	3,313,745	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	149,230,711		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN:
Component CCN:
Period: From 07/01/2017 To 06/30/2018
Worksheet D Part IV Date/Time Prepared: 6/12/2019 8:29 am
Title XVIII
Subprovider - IPF
PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
52.00	05200	LABOR ROOM & DELIVERY ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0.000000	10,598	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	8,487	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	5,634	0	0	0	58.00
60.00	06000	LABORATORY	0.000000	76,014	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	5,613	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	41,954	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	58,095	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	39,947	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	9,671	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
70.01	03610	SLEEP LAB	0.000000	0	0	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	6,914	0	0	0	71.00
72.00	07200	IMP. DEV CHARGED TO PATIENT	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	307,304	0	0	0	73.00
76.00	03480	ONCOLOGY	0.000000	0	0	0	0	76.00
76.01	03952	OCCUPATIONAL HEALTH	0.000000	0	0	0	0	76.01
76.03	03951	OP DIABETIC EDUCATION	0.000000	0	0	0	0	76.03
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.02	09002	WOUND CARE	0.000000	0	0	0	0	90.02
91.00	09100	EMERGENCY	0.000000	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		570,231	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: Component CCN:	Period: From 07/01/2017 To 06/30/2018	Worksheet D Part IV Date/Time Prepared: 6/12/2019 8:29 am
	Title XVIII	Subprovider - IPF	PPS

		Cost Center Description	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. All Other Medical Education Cost		
			21.00	24.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
52.00	05200	LABOR ROOM & DELIVERY ROOM	0	0		52.00
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	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
60.00	06000	LABORATORY	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
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
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
70.01	03610	SLEEP LAB	0	0		70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMP. DEV CHARGED TO PATIENT	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
76.00	03480	ONCOLOGY	0	0		76.00
76.01	03952	OCCUPATIONAL HEALTH	0	0		76.01
76.03	03951	OP DIABETIC EDUCATION	0	0		76.03
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
90.00	09000	CLINIC	0	0		90.00
90.02	09002	WOUND CARE	0	0		90.02
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
200.00		Total (lines 50 through 199)	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN:
Component CCN:

Period:
From 07/01/2017
To 06/30/2018

Worksheet D
Part V
Date/Time Prepared:
6/12/2019 8:29 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.236226	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.263678	0	0	0	0	51.00
52.00	05200	LABOR ROOM & DELIVERY ROOM	0.488351	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.195267	0	0	0	0	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0.309516	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0.252677	0	0	0	0	56.00
57.00	05700	CT SCAN	0.068186	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.188088	0	0	0	0	58.00
60.00	06000	LABORATORY	0.161089	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.412241	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.446798	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.341396	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.478205	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.208941	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
70.01	03610	SLEEP LAB	0.338293	0	0	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.727622	0	0	0	0	71.00
72.00	07200	IMP. DEV CHARGED TO PATIENT	0.497188	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.325314	0	0	0	0	73.00
76.00	03480	ONCOLOGY	0.366461	0	0	0	0	76.00
76.01	03952	OCCUPATIONAL HEALTH	14.279526	0	0	0	0	76.01
76.03	03951	OP DIABETIC EDUCATION	0.499741	0	0	0	0	76.03
76.97	07697	CARDIAC REHABILITATION	1.825833	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
90.00	09000	CLINIC	1.361183	0	0	0	0	90.00
90.02	09002	WOUND CARE	0.520872	0	0	0	0	90.02
91.00	09100	EMERGENCY	0.610478	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.303490	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:
Component CCN:

Period:
From 07/01/2017
To 06/30/2018

Worksheet D
Part V
Date/Time Prepared:
6/12/2019 8:29 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
52.00	05200	LABOR ROOM & DELIVERY ROOM	0	0		52.00
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	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
60.00	06000	LABORATORY	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
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
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
70.01	03610	SLEEP LAB	0	0		70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMP. DEV CHARGED TO PATIENT	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
76.00	03480	ONCOLOGY	0	0		76.00
76.01	03952	OCCUPATIONAL HEALTH	0	0		76.01
76.03	03951	OP DIABETIC EDUCATION	0	0		76.03
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
90.00	09000	CLINIC	0	0		90.00
90.02	09002	WOUND CARE	0	0		90.02
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
200.00		Subtotal (see instructions)	0	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	0		202.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN:
Component CCN:

Period:
From 07/01/2017
To 06/30/2018

Worksheet D
Part IV
Date/Time Prepared:
6/12/2019 8:29 am

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	LABOR ROOM & DELIVERY ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
70.01	03610	SLEEP LAB	0	0	0	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMP. DEV CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03480	ONCOLOGY	0	0	0	0	0	76.00
76.01	03952	OCCUPATIONAL HEALTH	0	0	0	0	0	76.01
76.03	03951	OP DIABETIC EDUCATION	0	0	0	0	0	76.03
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.02	09002	WOUND CARE	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0		0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: Component CCN:	Period: From 07/01/2017 To 06/30/2018	Worksheet D Part IV Date/Time Prepared: 6/12/2019 8:29 am
	Title XVIII	Skilled Nursing Facility	PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	17,499,914	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	1,361,693	0.000000	51.00
52.00	05200	LABOR ROOM & DELIVERY ROOM	0	0	0	649,756	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	2,346,257	0.000000	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0	0	0	9,503,605	0.000000	54.00
56.00	05600	RADIOISOTOPE	0	0	0	1,287,357	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	8,718,749	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	4,260,751	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	23,068,827	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	2,127,613	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	4,921,404	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,874,522	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	444,709	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	2,922,459	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0.000000	70.00
70.01	03610	SLEEP LAB	0	0	0	812,335	0.000000	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	4,490,185	0.000000	71.00
72.00	07200	IMP. DEV CHARGED TO PATIENT	0	0	0	9,643,039	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	21,063,214	0.000000	73.00
76.00	03480	ONCOLOGY	0	0	0	4,547,792	0.000000	76.00
76.01	03952	OCCUPATIONAL HEALTH	0	0	0	4,386	0.000000	76.01
76.03	03951	OP DIABETIC EDUCATION	0	0	0	117,933	0.000000	76.03
76.97	07697	CARDIAC REHABILITATION	0	0	0	108,149	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	15,164,405	0.000000	88.00
90.00	09000	CLINIC	0	0	0	2,422,763	0.000000	90.00
90.02	09002	WOUND CARE	0	0	0	437,806	0.000000	90.02
91.00	09100	EMERGENCY	0	0	0	6,117,343	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	3,313,745	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	149,230,711		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: Component CCN:	Period: From 07/01/2017 To 06/30/2018	Worksheet D Part IV Date/Time Prepared: 6/12/2019 8:29 am
	Title XVIII	Skilled Nursing Facility	PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
52.00	05200	LABOR ROOM & DELIVERY ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0.000000	18,950	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	4,945	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0	58.00
60.00	06000	LABORATORY	0.000000	24,994	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	19,894	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	240,926	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	287,691	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	29,350	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	2,418	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
70.01	03610	SLEEP LAB	0.000000	0	0	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	8,079	0	0	0	71.00
72.00	07200	IMP. DEV CHARGED TO PATIENT	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	94,674	0	0	0	73.00
76.00	03480	ONCOLOGY	0.000000	0	0	0	0	76.00
76.01	03952	OCCUPATIONAL HEALTH	0.000000	0	0	0	0	76.01
76.03	03951	OP DIABETIC EDUCATION	0.000000	0	0	0	0	76.03
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.02	09002	WOUND CARE	0.000000	4,834	0	0	0	90.02
91.00	09100	EMERGENCY	0.000000	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		736,755	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: Component CCN:	Period: From 07/01/2017 To 06/30/2018	Worksheet D Part IV Date/Time Prepared: 6/12/2019 8:29 am
	Title XVIII	Skilled Nursing Facility	PPS

		Cost Center Description	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. All Other Medical Education Cost		
			21.00	24.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
52.00	05200	LABOR ROOM & DELIVERY ROOM	0	0		52.00
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	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
60.00	06000	LABORATORY	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
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
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
70.01	03610	SLEEP LAB	0	0		70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMP. DEV CHARGED TO PATIENT	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
76.00	03480	ONCOLOGY	0	0		76.00
76.01	03952	OCCUPATIONAL HEALTH	0	0		76.01
76.03	03951	OP DIABETIC EDUCATION	0	0		76.03
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
90.00	09000	CLINIC	0	0		90.00
90.02	09002	WOUND CARE	0	0		90.02
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
200.00		Total (lines 50 through 199)	0	0		200.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: | Period: From 07/01/2017 To 06/30/2018 | Worksheet D-1 | Date/Time Prepared: 6/12/2019 8:29 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)	5,358	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	4,848	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	3,909	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	257	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)	253	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	1,813	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)	196	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)	208	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	224.25	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	226.90	20.00
21.00	Total general inpatient routine service cost (see instructions)	5,738,507	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	546,220	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	5,192,287	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)	5,192,287	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)	1,071.02	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,941,759	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)	1,941,759	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: | Period: From 07/01/2017 To 06/30/2018 | Worksheet D-1 | Date/Time Prepared: 6/12/2019 8:29 am

Title XVIII | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	1,376,279	855	1,609.68	424	682,504	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	2,754,125	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	5,378,388	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	209,920	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	222,772	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	432,692	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	939	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,071.02	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,005,688	89.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN:	Period: From 07/01/2017 To 06/30/2018	Worksheet D-1 Date/Time Prepared: 6/12/2019 8:29 am
	Title XVIII	Hospital	Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	561,841	5,738,507	0.097907	1,005,688	98,464	90.00
91.00	Nursing School cost	0	5,738,507	0.000000	1,005,688	0	91.00
92.00	Allied health cost	0	5,738,507	0.000000	1,005,688	0	92.00
93.00	All other Medical Education	0	5,738,507	0.000000	1,005,688	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN:	Period: From 07/01/2017 To 06/30/2018	Worksheet D-1
	Component CCN:		Date/Time Prepared: 6/12/2019 8:29 am
	Title XVIII	Subprovider - IPF	PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	992	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	992	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)	992	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	936	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	1,255,158	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	1,255,158	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	1,255,158	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)	1,265.28	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,184,302	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)	1,184,302	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: | Component CCN: | Period: From 07/01/2017 To 06/30/2018 | Worksheet D-1 | Date/Time Prepared: 6/12/2019 8:29 am

Title XVIII | Subprovider - IPF | PPS

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	184,181	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	1,368,483	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	8,765	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	8,765	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	1,359,718	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: Component CCN:	Period: From 07/01/2017 To 06/30/2018	Worksheet D-1 Date/Time Prepared: 6/12/2019 8:29 am
	Title XVIII	Subprovider - IPF	PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	0	1,255,158	0.000000	0	0	90.00
91.00	Nursing School cost	0	1,255,158	0.000000	0	0	91.00
92.00	Allied health cost	0	1,255,158	0.000000	0	0	92.00
93.00	All other Medical Education	0	1,255,158	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN:	Period: From 07/01/2017 To 06/30/2018	Worksheet D-1
	Component CCN:		Date/Time Prepared: 6/12/2019 8:29 am
	Title XVIII	Skilled Nursing Facility	PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	13,714	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	13,714	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)	13,714	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	1,187	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	3,986,620	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	3,986,620	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	3,986,620	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)		38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: | Component CCN: | Period: From 07/01/2017 To 06/30/2018 | Worksheet D-1 | Date/Time Prepared: 6/12/2019 8:29 am

Title XVIII | Skilled Nursing Facility | PPS

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)		48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)		49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)		50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)		51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)		52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)		53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges		54.00
55.00	Target amount per discharge		55.00
56.00	Target amount (line 54 x line 55)		56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)		57.00
58.00	Bonus payment (see instructions)		58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket		59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket		60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)		61.00
62.00	Relief payment (see instructions)		62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)		63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)		64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)		65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)		66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)		67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)		68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)		69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)	3,986,620	70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)	290.70	71.00
72.00	Program routine service cost (line 9 x line 71)	345,061	72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)	0	73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)	345,061	74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)	0	75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)	0.00	76.00
77.00	Program capital-related costs (line 9 x line 76)	0	77.00
78.00	Inpatient routine service cost (line 74 minus line 77)	0	78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)	0	79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)	0	80.00
81.00	Inpatient routine service cost per diem limitation	0.00	81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)	0	82.00
83.00	Reasonable inpatient routine service costs (see instructions)	345,061	83.00
84.00	Program inpatient ancillary services (see instructions)	278,026	84.00
85.00	Utilization review - physician compensation (see instructions)	0	85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)	623,087	86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: Component CCN:	Period: From 07/01/2017 To 06/30/2018	Worksheet D-1 Date/Time Prepared: 6/12/2019 8:29 am
	Title XVIII	Skilled Nursing Facility	PPS

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

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: | Period: From 07/01/2017 To 06/30/2018 | Worksheet D-3 | Date/Time Prepared: 6/12/2019 8:29 am

Title XVIII | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		1,769,702		30.00
31.00	03100	INTENSIVE CARE UNIT		726,296		31.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.236226	1,104,359	260,878	50.00
51.00	05100	RECOVERY ROOM	0.263678	125,121	32,992	51.00
52.00	05200	LABOR ROOM & DELIVERY ROOM	0.488351	1,285	628	52.00
53.00	05300	ANESTHESIOLOGY	0.195267	177,240	34,609	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0.309516	98,108	30,366	54.00
56.00	05600	RADIOISOTOPE	0.252677	20,209	5,106	56.00
57.00	05700	CT SCAN	0.068186	84,836	5,785	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.188088	73,319	13,790	58.00
60.00	06000	LABORATORY	0.161089	789,437	127,170	60.00
65.00	06500	RESPIRATORY THERAPY	0.412241	636,901	262,557	65.00
66.00	06600	PHYSICAL THERAPY	0.446798	366,721	163,850	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.341396	374,406	127,821	67.00
68.00	06800	SPEECH PATHOLOGY	0.478205	95,345	45,594	68.00
69.00	06900	ELECTROCARDIOLOGY	0.208941	157,872	32,986	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
70.01	03610	SLEEP LAB	0.338293	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.727622	592,051	430,789	71.00
72.00	07200	IMP. DEV CHARGED TO PATIENT	0.497188	1,736,205	863,220	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.325314	961,522	312,797	73.00
76.00	03480	ONCOLOGY	0.366461	2,550	934	76.00
76.01	03952	OCCUPATIONAL HEALTH	14.279526	0	0	76.01
76.03	03951	OP DIABETIC EDUCATION	0.499741	0	0	76.03
76.97	07697	CARDIAC REHABILITATION	1.825833	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000	CLINIC	1.361183	0	0	90.00
90.02	09002	WOUND CARE	0.520872	0	0	90.02
91.00	09100	EMERGENCY	0.610478	3,690	2,253	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.303490	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		7,401,177	2,754,125	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)		7,401,177		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: | Component CCN: | Period: From 07/01/2017 To 06/30/2018 | Worksheet D-3 | Date/Time Prepared: 6/12/2019 8:29 am

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
40.00	04000	SUBPROVIDER - IPF		914,345		40.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.236226	0	0	50.00
51.00	05100	RECOVERY ROOM	0.263678	0	0	51.00
52.00	05200	LABOR ROOM & DELIVERY ROOM	0.488351	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.195267	0	0	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0.309516	10,598	3,280	54.00
56.00	05600	RADIOISOTOPE	0.252677	0	0	56.00
57.00	05700	CT SCAN	0.068186	8,487	579	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.188088	5,634	1,060	58.00
60.00	06000	LABORATORY	0.161089	76,014	12,245	60.00
65.00	06500	RESPIRATORY THERAPY	0.412241	5,613	2,314	65.00
66.00	06600	PHYSICAL THERAPY	0.446798	41,954	18,745	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.341396	58,095	19,833	67.00
68.00	06800	SPEECH PATHOLOGY	0.478205	39,947	19,103	68.00
69.00	06900	ELECTROCARDIOLOGY	0.208941	9,671	2,021	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
70.01	03610	SLEEP LAB	0.338293	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.727622	6,914	5,031	71.00
72.00	07200	IMP. DEV CHARGED TO PATIENT	0.497188	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.325314	307,304	99,970	73.00
76.00	03480	ONCOLOGY	0.366461	0	0	76.00
76.01	03952	OCCUPATIONAL HEALTH	14.279526	0	0	76.01
76.03	03951	OP DIABETIC EDUCATION	0.499741	0	0	76.03
76.97	07697	CARDIAC REHABILITATION	1.825833	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000	CLINIC	1.361183	0	0	90.00
90.02	09002	WOUND CARE	0.520872	0	0	90.02
91.00	09100	EMERGENCY	0.610478	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.303490	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		570,231	184,181	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)		570,231		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: | Component CCN: | Period: From 07/01/2017 To 06/30/2018 | Worksheet D-3 | Date/Time Prepared: 6/12/2019 8:29 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
40.00	04000	SUBPROVIDER - IPF		0		40.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.236226	12,534	2,961	50.00
51.00	05100	RECOVERY ROOM	0.263678	0	0	51.00
52.00	05200	LABOR ROOM & DELIVERY ROOM	0.488351	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.195267	1,148	224	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0.309516	8,839	2,736	54.00
56.00	05600	RADIOISOTOPE	0.252677	0	0	56.00
57.00	05700	CT SCAN	0.068186	16,476	1,123	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.188088	0	0	58.00
60.00	06000	LABORATORY	0.161089	55,872	9,000	60.00
65.00	06500	RESPIRATORY THERAPY	0.412241	89,615	36,943	65.00
66.00	06600	PHYSICAL THERAPY	0.446798	76,153	34,025	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.341396	92,758	31,667	67.00
68.00	06800	SPEECH PATHOLOGY	0.478205	25,250	12,075	68.00
69.00	06900	ELECTROCARDIOLOGY	0.208941	4,663	974	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
70.01	03610	SLEEP LAB	0.338293	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.727622	8,993	6,544	71.00
72.00	07200	IMP. DEV CHARGED TO PATIENT	0.497188	8	4	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.325314	99,936	32,511	73.00
76.00	03480	ONCOLOGY	0.366461	0	0	76.00
76.01	03952	OCCUPATIONAL HEALTH	14.279526	0	0	76.01
76.03	03951	OP DIABETIC EDUCATION	0.499741	0	0	76.03
76.97	07697	CARDIAC REHABILITATION	1.825833	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000	CLINIC	1.361183	0	0	90.00
90.02	09002	WOUND CARE	0.520872	0	0	90.02
91.00	09100	EMERGENCY	0.610478	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.303490	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		492,245	170,787	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)		492,245		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CCN:	Period: From 07/01/2017 To 06/30/2018	Worksheet D-3
	Component CCN:		Date/Time Prepared: 6/12/2019 8:29 am
	Title XVIII	Skilled Nursing Facility	PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.236226	0	0	50.00
51.00	05100	RECOVERY ROOM	0.263678	0	0	51.00
52.00	05200	LABOR ROOM & DELIVERY ROOM	0.488351	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.195267	0	0	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0.309516	18,950	5,865	54.00
56.00	05600	RADIOISOTOPE	0.252677	0	0	56.00
57.00	05700	CT SCAN	0.068186	4,945	337	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.188088	0	0	58.00
60.00	06000	LABORATORY	0.161089	24,994	4,026	60.00
65.00	06500	RESPIRATORY THERAPY	0.412241	19,894	8,201	65.00
66.00	06600	PHYSICAL THERAPY	0.446798	240,926	107,645	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.341396	287,691	98,217	67.00
68.00	06800	SPEECH PATHOLOGY	0.478205	29,350	14,035	68.00
69.00	06900	ELECTROCARDIOLOGY	0.208941	2,418	505	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
70.01	03610	SLEEP LAB	0.338293	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.727622	8,079	5,878	71.00
72.00	07200	IMP. DEV CHARGED TO PATIENT	0.497188	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.325314	94,674	30,799	73.00
76.00	03480	ONCOLOGY	0.366461	0	0	76.00
76.01	03952	OCCUPATIONAL HEALTH	14.279526	0	0	76.01
76.03	03951	OP DIABETIC EDUCATION	0.499741	0	0	76.03
76.97	07697	CARDIAC REHABILITATION	1.825833	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000	CLINIC	1.361183	0	0	90.00
90.02	09002	WOUND CARE	0.520872	4,834	2,518	90.02
91.00	09100	EMERGENCY	0.610478	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.303490	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		736,755	278,026	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)		736,755		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN:	Period: From 07/01/2017 To 06/30/2018	Worksheet E Part B Date/Time Prepared: 6/12/2019 8:29 am
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	10,150,084	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)	10,150,084	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)	10,251,585	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)	175,104	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	5,450,483	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	4,625,998	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	4,625,998	30.00
31.00	Primary payer payments	4,596	31.00
32.00	Subtotal (line 30 minus line 31)	4,621,402	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)	1,310,405	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	851,763	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	1,101,737	36.00
37.00	Subtotal (see instructions)	5,473,165	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)	5,473,165	40.00
40.01	Sequestration adjustment (see instructions)	109,463	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
41.00	Interim payments	5,473,479	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	-109,777	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN:	Period: From 07/01/2017 To 06/30/2018	Worksheet E Part B Date/Time Prepared: 6/12/2019 8:29 am
	Title XVIII	Hospital	Cost

		Overrides	
		1.00	
	WORKSHEET OVERRIDE VALUES		
112.00	Override of Ancillary service charges (line 12)	0	112.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: | Period: From 07/01/2017 To 06/30/2018 | Worksheet E-1 Part I Date/Time Prepared: 6/12/2019 8:29 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		4,210,208		5,301,966	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	03/01/2018	66,944	06/01/2018	199,165	3.01
3.02		06/01/2018	273,691		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0	03/01/2018	27,652	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)		340,635		171,513	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		4,550,843		5,473,479	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		52,779		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		109,777	6.02
7.00	Total Medicare program liability (see instructions)		4,603,622		5,363,702	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: | Component CCN: | Period: From 07/01/2017 To 06/30/2018 | Worksheet E-1 Part I Date/Time Prepared: 6/12/2019 8:29 am

Title XVIII | Subprovider - IPF | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		776,590		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		776,590		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		10,072		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		786,662		0	7.00

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: | Component CCN: | Period: From 07/01/2017 To 06/30/2018 | Worksheet E-1 Part I | Date/Time Prepared: 6/12/2019 8:29 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		603,483		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	06/01/2018	11,000		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	03/01/2018	32,971		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)		-21,971		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)		581,512		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		6,795		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		588,307		0	7.00

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider CCN:	Period: From 07/01/2017 To 06/30/2018	Worksheet E-1 Part I Date/Time Prepared: 6/12/2019 8:29 am
	Component CCN:		
	Title XVIII	Skilled Nursing Facility	PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		376,547		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		376,547		0	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		376,547		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:	Period: From 07/01/2017 To 06/30/2018	Worksheet E-1 Part II Date/Time Prepared: 6/12/2019 8:29 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
		Overrides	
		1.00	
	CONTRACTOR OVERRIDES		
108.00	Override of HIT payment		108.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS	Provider CCN:	Period: From 07/01/2017	Worksheet E-2
	Component CCN:	To 06/30/2018	Date/Time Prepared: 6/12/2019 8:29 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)	437,019	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)	172,495	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	404	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)	609,514	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	609,514	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	1,914	0	11.00
12.00	Subtotal (line 10 minus line 11)	607,600	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	7,496	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)	600,104	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)	322	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	209	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	322	0	18.00
19.00	Total (see instructions)	600,313	0	19.00
19.01	Sequestration adjustment (see instructions)	12,006	0	19.01
19.02	Demonstration payment adjustment amount after sequestration)	0	0	19.02
20.00	Interim payments	581,512	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)	6,795	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:	Period: From 07/01/2017 To 06/30/2018	Worksheet E-3 Part V Date/Time Prepared: 6/12/2019 8:29 am
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	5,378,388	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)	5,378,388	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	5,432,172	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)	5,432,172	19.00
20.00	Deductibles (exclude professional component)	802,580	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	4,629,592	22.00
23.00	Coinsurance	5,025	23.00
24.00	Subtotal (line 22 minus line 23)	4,624,567	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	112,317	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	73,006	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	86,278	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	4,697,573	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)	4,697,573	30.00
30.01	Sequestration adjustment (see instructions)	93,951	30.01
30.02	Demonstration payment adjustment amount after sequestration	0	30.02
31.00	Interim payments	4,550,843	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)	52,779	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: Component CCN:	Period: From 07/01/2017 To 06/30/2018	Worksheet E-3 Part II Date/Time Prepared: 6/12/2019 8:29 am
	Title XVIII	Subprovider - IPF	PPS

		1.00	
	PART II - MEDICARE PART A SERVICES - IPF PPS		
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)	835,786	1.00
2.00	Net IPF PPS Outlier Payments	3,888	2.00
3.00	Net IPF PPS ECT Payments	0	3.00
4.00	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004. (see instructions)	0.00	4.00
4.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)	0.00	4.01
5.00	New Teaching program adjustment. (see instructions)	0.00	5.00
6.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instuctions)	0.00	6.00
7.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instuctions)	0.00	7.00
8.00	Intern and resident count for IPF PPS medical education adjustment (see instructions)	0.00	8.00
9.00	Average Daily Census (see instructions)	2.717808	9.00
10.00	Teaching Adjustment Factor {((1 + (line 8/line 9)) raised to the power of .5150 -1}.	0.000000	10.00
11.00	Teaching Adjustment (line 1 multiplied by line 10).	0	11.00
12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)	839,674	12.00
13.00	Nursing and Allied Health Managed Care payment (see instruction)	0	13.00
14.00	Organ acquisition (DO NOT USE THIS LINE)		14.00
15.00	Cost of physicians' services in a teaching hospital (see instructions)	0	15.00
16.00	Subtotal (see instructions)	839,674	16.00
17.00	Primary payer payments	0	17.00
18.00	Subtotal (line 16 less line 17).	839,674	18.00
19.00	Deductibles	31,737	19.00
20.00	Subtotal (line 18 minus line 19)	807,937	20.00
21.00	Coinsurance	15,499	21.00
22.00	Subtotal (line 20 minus line 21)	792,438	22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	15,812	23.00
24.00	Adjusted reimbursable bad debts (see instructions)	10,278	24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	10,446	25.00
26.00	Subtotal (sum of lines 22 and 24)	802,716	26.00
27.00	Direct graduate medical education payments (from Wkst. E-4, line 49)	0	27.00
28.00	Other pass through costs (see instructions)	0	28.00
29.00	Outlier payments reconciliation	0	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	30.50
30.99	Demonstration payment adjustment amount before sequestration	0	30.99
31.00	Total amount payable to the provider (see instructions)	802,716	31.00
31.01	Sequestration adjustment (see instructions)	16,054	31.01
31.02	Demonstration payment adjustment amount after sequestration	0	31.02
32.00	Interim payments	776,590	32.00
33.00	Tentative settlement (for contractor use only)	0	33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 31.02, 32 and 33)	10,072	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	35.00
	TO BE COMPLETED BY CONTRACTOR		
50.00	Original outlier amount from Worksheet E-3, Part II, line 2	3,888	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)	0	51.00
52.00	The rate used to calculate the Time Value of Money	0.00	52.00
53.00	Time Value of Money (see instructions)	0	53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: Component CCN:	Period: From 07/01/2017 To 06/30/2018	Worksheet E-3 Part VI Date/Time Prepared: 6/12/2019 8:29 am
	Title XVIII	Skilled Nursing Facility	PPS

		1.00	
	PART VI - CALCULATION OF REIMBURSEMENT SETTLEMEMENT - ALL OTHER HEALTH SERVICES FOR TITLE XVIII PART A PPS SNF SERVICES		
	PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCTIONS)		
1.00	Resource Utilization Group Payment (RUGS)	485,107	1.00
2.00	Routine service other pass through costs	0	2.00
3.00	Ancillary service other pass through costs	0	3.00
4.00	Subtotal (sum of lines 1 through 3)	485,107	4.00
	COMPUTATION OF NET COST OF COVERED SERVICES		
5.00	Medical and other services (Do not use this line as vaccine costs are included in line 1 of W/S E, Part B. This line is now shaded.)		5.00
6.00	Deductible	0	6.00
7.00	Coinsurance	100,875	7.00
8.00	Allowable bad debts (see instructions)	0	8.00
9.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)	0	9.00
10.00	Adjusted reimbursable bad debts (see instructions)	0	10.00
11.00	Utilization review	0	11.00
12.00	Subtotal (sum of lines 4, 5 minus lines 6 and 7, plus lines 10 and 11)(see instructions)	384,232	12.00
13.00	Inpatient primary payer payments	0	13.00
14.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	14.00
14.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	14.50
14.99	Demonstration payment adjustment amount before sequestration	0	14.99
15.00	Subtotal (see instructions	384,232	15.00
15.01	Sequestration adjustment (see instructions)	7,685	15.01
15.02	Demonstration payment adjustment amount after sequestration	0	15.02
16.00	Interim payments	376,547	16.00
17.00	Tentative settlement (for contractor use only)	0	17.00
18.00	Balance due provider/program (line 15 minus lines 15.01, 15.02, 16, and 17)	0	18.00
19.00	Protested amounts (nonallowable cost report items) in accordance with CMS 19 Pub. 15-2, chapter 1, §115.2	0	19.00

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

Provider CCN:

Period: From 07/01/2017 To 06/30/2018

Worksheet G

Date/Time Prepared: 6/12/2019 8:29 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	3,761,182	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	22,665,360	0	0	0	4.00
5.00	Other receivable	2,143,131	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-13,030,595	0	0	0	6.00
7.00	Inventory	1,181,473	0	0	0	7.00
8.00	Prepaid expenses	1,268,604	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	17,989,155	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	1,090,847	0	0	0	12.00
13.00	Land improvements	1,752,347	0	0	0	13.00
14.00	Accumulated depreciation	-1,573,712	0	0	0	14.00
15.00	Buildings	26,758,949	0	0	0	15.00
16.00	Accumulated depreciation	-19,585,265	0	0	0	16.00
17.00	Leasehold improvements	25,013,285	0	0	0	17.00
18.00	Accumulated depreciation	-10,847,034	0	0	0	18.00
19.00	Fixed equipment	5,819,720	0	0	0	19.00
20.00	Accumulated depreciation	-4,872,152	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	20,128,140	0	0	0	23.00
24.00	Accumulated depreciation	-17,092,892	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	4,761,231	0	0	0	27.00
28.00	Accumulated depreciation	-3,242,176	0	0	0	28.00
29.00	Minor equipment-nondepreciable	121,318	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	28,232,606	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	5,329,866	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	-5,935,688	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	-605,822	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	45,615,939	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	4,141,341	0	0	0	37.00
38.00	Salaries, wages, and fees payable	3,338,191	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	30,000	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	2,619,559	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	10,129,091	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	228,059	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	8,157,316	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	8,385,375	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	18,514,466	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	27,101,473				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)	27,101,473	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	45,615,939	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: | Period: From 07/01/2017 To 06/30/2018 | Worksheet G-1 | Date/Time Prepared: 6/12/2019 8:29 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		24,693,223		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		1,849,999				2.00
3.00	Total (sum of line 1 and line 2)		26,543,222		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00	SPECIFIC PURPOSE FUND	209,627		0		0	5.00
6.00	DONOR CREATED - ENDOWMENT FUND BALAN	4,220,847		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)		4,430,474		0		10.00
11.00	Subtotal (line 3 plus line 10)		30,973,696		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00	CHANGES IN FUND BALANCE	3,872,223		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)		3,872,223		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		27,101,473		0		19.00

		Endowment Fund	Plant Fund			
		6.00	7.00	8.00		
1.00	Fund balances at beginning of period	0		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)					2.00
3.00	Total (sum of line 1 and line 2)	0		0		3.00
4.00	Additions (credit adjustments) (specify)		0			4.00
5.00	SPECIFIC PURPOSE FUND		0			5.00
6.00	DONOR CREATED - ENDOWMENT FUND BALAN		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	CHANGES IN FUND BALANCE		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: | Period: From 07/01/2017 To 06/30/2018 | Worksheet G-2 Parts I & II Date/Time Prepared: 6/12/2019 8:29 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	4,624,753		4,624,753	1.00
2.00	SUBPROVIDER - IPF	966,141		966,141	2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	196,924		196,924	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY	4,326,791		4,326,791	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)	10,114,609		10,114,609	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	1,294,671		1,294,671	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)	1,294,671		1,294,671	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	11,409,280		11,409,280	17.00
18.00	Ancillary services	25,280,718	0	25,280,718	18.00
19.00	Outpatient services	0	132,184,039	132,184,039	19.00
20.00	RURAL HEALTH CLINIC	0	15,164,405	15,164,405	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		3,683,955	3,683,955	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	0	653,716	653,716	26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	36,689,998	151,686,115	188,376,113	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		92,888,123		29.00
30.00	WELLNESS EXPENSE ON AUDIT NOT CR	96,190			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)		96,190		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)		92,984,313		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN:	Period: From 07/01/2017 To 06/30/2018	Worksheet G-3 Date/Time Prepared: 6/12/2019 8:29 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	188,376,113	1.00
2.00	Less contractual allowances and discounts on patients' accounts	103,175,513	2.00
3.00	Net patient revenues (line 1 minus line 2)	85,200,600	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	92,984,313	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-7,783,713	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	1,097,616	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	1,757	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	404,797	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	3,390	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	18,687	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	243,168	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER INCOME	7,864,297	24.00
25.00	Total other income (sum of lines 6-24)	9,633,712	25.00
26.00	Total (line 5 plus line 25)	1,849,999	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	1,849,999	29.00

ANALYSIS OF HOSPITAL-BASED HOME HEALTH AGENCY COSTS

Provider CCN:
HHA CCN:

Period:
From 07/01/2017
To 06/30/2018

Worksheet H
Date/Time Prepared:
6/12/2019 8:29 am

Home Health Agency I | PPS

		Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased Services	Other Costs	Total (sum of cols. 1 thru 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures			0		0	0	1.00
2.00	Capital Related - Movable Equipment			0		0	0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0	0	0	3.00
4.00	Transportation	0	0	0	0	0	0	4.00
5.00	Administrative and General	507,945	117,106	0	1,772	147,348	774,171	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	910,345	205,620	106,939	0	0	1,222,904	6.00
7.00	Physical Therapy	186,127	42,041	26,758	0	0	254,926	7.00
8.00	Occupational Therapy	101,547	22,936	13,680	0	0	138,163	8.00
9.00	Speech Pathology	150,885	34,081	8,940	0	0	193,906	9.00
10.00	Medical Social Services	37,108	8,382	2,094	0	0	47,584	10.00
11.00	Home Health Aide	56,347	12,727	12,148	0	0	81,222	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	29,616	6,689	0	436,634	0	472,939	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	1,979,920	449,582	170,559	438,406	147,348	3,185,815	24.00

		Reclassification	Reclassified Trial Balance (col. 6 + col.7)	Adjustments	Net Expenses for Allocation (col. 8 + col. 9)			
		7.00	8.00	9.00	10.00			
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0	0	0			1.00
2.00	Capital Related - Movable Equipment	0	0	0	0			2.00
3.00	Plant Operation & Maintenance	0	0	0	0			3.00
4.00	Transportation	0	0	0	0			4.00
5.00	Administrative and General	-41,348	732,823	0	732,823			5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	1,222,904	0	1,222,904			6.00
7.00	Physical Therapy	0	254,926	0	254,926			7.00
8.00	Occupational Therapy	0	138,163	0	138,163			8.00
9.00	Speech Pathology	0	193,906	0	193,906			9.00
10.00	Medical Social Services	0	47,584	0	47,584			10.00
11.00	Home Health Aide	0	81,222	0	81,222			11.00
12.00	Supplies (see instructions)	0	0	0	0			12.00
13.00	Drugs	0	0	0	0			13.00
14.00	DME	0	0	0	0			14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0			15.00
16.00	Respiratory Therapy	0	0	0	0			16.00
17.00	Private Duty Nursing	0	0	0	0			17.00
18.00	Clinic	0	0	0	0			18.00
19.00	Health Promotion Activities	0	0	0	0			19.00
20.00	Day Care Program	0	0	0	0			20.00
21.00	Home Delivered Meals Program	0	0	0	0			21.00
22.00	Homemaker Service	0	472,939	0	472,939			22.00
23.00	All Others (specify)	0	0	0	0			23.00
23.50	Telemedicine	0	0	0	0			23.50
24.00	Total (sum of lines 1-23)	-41,348	3,144,467	0	3,144,467			24.00

Column, 6 line 24 should agree with the Worksheet A, column 3, line 101, or subscript as applicable.
6/12/2019 8:29 am S:\HFS\Hospitals\Sample\Sample CA Hospital.mcrx

COST ALLOCATION - HHA GENERAL SERVICE COST | Provider CCN: | HHA CCN: | Period: From 07/01/2017 To 06/30/2018 | Worksheet H-1 Part I Date/Time Prepared: 6/12/2019 8:29 am

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		Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Capital Related Costs: Bldgs & Fixtures	Capital Related Costs: Movable Equipment	Plant Operation & Maintenance	Transportation	Subtotal (cols. 0-4)	
		0	1.00	2.00	3.00	4.00	4A.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0				0	1.00
2.00	Capital Related - Movable Equipment	0		0			0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0		0	3.00
4.00	Transportation	0	0	0	0	0		4.00
5.00	Administrative and General	732,823	0	0	0	0	732,823	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	1,222,904	0	0	0	0	1,222,904	6.00
7.00	Physical Therapy	254,926	0	0	0	0	254,926	7.00
8.00	Occupational Therapy	138,163	0	0	0	0	138,163	8.00
9.00	Speech Pathology	193,906	0	0	0	0	193,906	9.00
10.00	Medical Social Services	47,584	0	0	0	0	47,584	10.00
11.00	Home Health Aide	81,222	0	0	0	0	81,222	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0		0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	472,939	0	0	0	0	472,939	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	3,144,467	0	0	0	0	3,144,467	24.00

		Administrative & General	Total (cols. 4A + 5)		
		5.00	6.00		
	GENERAL SERVICE COST CENTERS				
1.00	Capital Related - Bldg. & Fixtures				1.00
2.00	Capital Related - Movable Equipment				2.00
3.00	Plant Operation & Maintenance				3.00
4.00	Transportation				4.00
5.00	Administrative and General	732,823			5.00
	HHA REIMBURSABLE SERVICES				
6.00	Skilled Nursing Care	371,602	1,594,506		6.00
7.00	Physical Therapy	77,464	332,390		7.00
8.00	Occupational Therapy	41,983	180,146		8.00
9.00	Speech Pathology	58,922	252,828		9.00
10.00	Medical Social Services	14,459	62,043		10.00
11.00	Home Health Aide	24,681	105,903		11.00
12.00	Supplies (see instructions)	0	0		12.00
13.00	Drugs	0	0		13.00
14.00	DME	0	0		14.00
	HHA NONREIMBURSABLE SERVICES				
15.00	Home Dialysis Aide Services	0	0		15.00
16.00	Respiratory Therapy	0	0		16.00
17.00	Private Duty Nursing	0	0		17.00
18.00	Clinic	0	0		18.00
19.00	Health Promotion Activities	0	0		19.00
20.00	Day Care Program	0	0		20.00
21.00	Home Delivered Meals Program	0	0		21.00
22.00	Homemaker Service	143,712	616,651		22.00
23.00	All Others (specify)	0	0		23.00
23.50	Telemedicine	0	0		23.50
24.00	Total (sum of lines 1-23)		3,144,467		24.00

COST ALLOCATION - HHA STATISTICAL BASIS | Provider CCN: | HHA CCN: | Period: From 07/01/2017 To 06/30/2018 | Worksheet H-1 Part II Date/Time Prepared: 6/12/2019 8:29 am

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		Capital Related Costs						
		Bldgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)	Plant Operation & Maintenance (SQUARE FEET)	Transportation (MILEAGE)	Reconciliation	Administrative & General (ACCUM. COST)	
		1.00	2.00	3.00	4.00	5A.00	5.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0				0		1.00
2.00	Capital Related - Movable Equipment		0			0		2.00
3.00	Plant Operation & Maintenance	0	0	0		0		3.00
4.00	Transportation (see instructions)	0	0	0	0			4.00
5.00	Administrative and General	0	0	0	0	-732,823	2,411,644	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	0	1,222,904	6.00
7.00	Physical Therapy	0	0	0	0	0	254,926	7.00
8.00	Occupational Therapy	0	0	0	0	0	138,163	8.00
9.00	Speech Pathology	0	0	0	0	0	193,906	9.00
10.00	Medical Social Services	0	0	0	0	0	47,584	10.00
11.00	Home Health Aide	0	0	0	0	0	81,222	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	0	12.00
13.00	Drugs	0	0	0		0	0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	472,939	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	0	0	0	0	-732,823	2,411,644	24.00
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0	0		732,823	25.00
26.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000		0.303869	26.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN:
HHA CCN:

Period:
From 07/01/2017
To 06/30/2018

Worksheet H-2
Part I
Date/Time Prepared:
6/12/2019 8:29 am

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	Cost Center Description	HHA Trial Balance (1)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	NONPATIENT TELEPHONES	PURCHASING RECEIVING AND STORES	
		0	1.00	2.00	4.00	5.01	5.02	
1.00	Administrative and General	0	0	151	26,945	6,668	4,948	1.00
2.00	Skilled Nursing Care	1,594,506	0	0	48,292	0	0	2.00
3.00	Physical Therapy	332,390	0	0	9,874	0	0	3.00
4.00	Occupational Therapy	180,146	0	0	5,387	0	0	4.00
5.00	Speech Pathology	252,828	0	0	8,004	0	0	5.00
6.00	Medical Social Services	62,043	0	0	1,969	0	0	6.00
7.00	Home Health Aide	105,903	0	0	2,989	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	616,651	0	0	1,571	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	3,144,467	0	151	105,031	6,668	4,948	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

	Cost Center Description	ADMITTING	CASHIERING/ACCOUNTS RECEIVABLE	Subtotal	OTHER ADMINISTRATIVE AND GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
		5.03	5.04	5A.04	5.05	7.00	8.00	
1.00	Administrative and General	0	33,005	71,717	6,216	0	0	1.00
2.00	Skilled Nursing Care	0	0	1,642,798	142,394	0	0	2.00
3.00	Physical Therapy	0	0	342,264	29,666	0	0	3.00
4.00	Occupational Therapy	0	0	185,533	16,081	0	0	4.00
5.00	Speech Pathology	0	0	260,832	22,608	0	0	5.00
6.00	Medical Social Services	0	0	64,012	5,548	0	0	6.00
7.00	Home Health Aide	0	0	108,892	9,438	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	618,222	53,586	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	0	33,005	3,294,270	285,537	0	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.			0.000000				21.00

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN:
HHA CCN:

Period:
From 07/01/2017
To 06/30/2018

Worksheet H-2
Part I
Date/Time Prepared:
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	Cost Center Description	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
		9.00	10.00	11.00	13.00	14.00	15.00	
1.00	Administrative and General	0	0	0	0	0	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	6,452	0	8.00
9.00	Drugs	0	0	0	0	0	565	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	0	0	0	0	6,452	565	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

	Cost Center Description	MEDICAL RECORDS & LIBRARY	OTHER GENERAL SERVICE INSERVICE EDUCATION	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	
		16.00	18.00	19.00	24.00	25.00	26.00	
1.00	Administrative and General	0	7,376	0	85,309	0	85,309	1.00
2.00	Skilled Nursing Care	0	11,578	0	1,796,770	0	1,796,770	2.00
3.00	Physical Therapy	0	2,365	0	374,295	0	374,295	3.00
4.00	Occupational Therapy	0	1,166	0	202,780	0	202,780	4.00
5.00	Speech Pathology	0	843	0	284,283	0	284,283	5.00
6.00	Medical Social Services	0	662	0	70,222	0	70,222	6.00
7.00	Home Health Aide	0	1,844	0	120,174	0	120,174	7.00
8.00	Supplies (see instructions)	0	0	0	6,452	0	6,452	8.00
9.00	Drugs	0	0	0	565	0	565	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	463	0	672,271	0	672,271	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	0	26,297	0	3,613,121	0	3,613,121	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN:

HHA CCN:

Period:
From 07/01/2017
To 06/30/2018

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Part I
Date/Time Prepared:
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	Cost Center Description	Allocated HHA A&G (see Part II)	Total HHA Costs				
		27.00	28.00				
1.00	Administrative and General						1.00
2.00	Skilled Nursing Care	43,448	1,840,218				2.00
3.00	Physical Therapy	9,051	383,346				3.00
4.00	Occupational Therapy	4,904	207,684				4.00
5.00	Speech Pathology	6,875	291,158				5.00
6.00	Medical Social Services	1,698	71,920				6.00
7.00	Home Health Aide	2,906	123,080				7.00
8.00	Supplies (see instructions)	156	6,608				8.00
9.00	Drugs	14	579				9.00
10.00	DME	0	0				10.00
11.00	Home Dialysis Aide Services	0	0				11.00
12.00	Respiratory Therapy	0	0				12.00
13.00	Private Duty Nursing	0	0				13.00
14.00	Clinic	0	0				14.00
15.00	Health Promotion Activities	0	0				15.00
16.00	Day Care Program	0	0				16.00
17.00	Home Delivered Meals Program	0	0				17.00
18.00	Homemaker Service	16,257	688,528				18.00
19.00	All Others (specify)	0	0				19.00
19.50	Telemedicine	0	0				19.50
20.00	Total (sum of lines 1-19) (2)	85,309	3,613,121				20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.	0.024182					21.00

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN:
HHA CCN:

Period:
From 07/01/2017
To 06/30/2018

Worksheet H-2
Part II
Date/Time Prepared:
6/12/2019 8:29 am

Home Health Agency I

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	Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	NONPATIENT TELEPHONES (EXTENSION)	PURCHASING RECEIVING AND STORES (SUPPLIES EXPENSE)	ADMITTING (GROSS CHARGES)	
		1.00	2.00	4.00	5.01	5.02	5.03	
1.00	Administrative and General	0	4,067	507,945	24	47,691	0	1.00
2.00	Skilled Nursing Care	0	0	910,345	0	0	0	2.00
3.00	Physical Therapy	0	0	186,127	0	0	0	3.00
4.00	Occupational Therapy	0	0	101,547	0	0	0	4.00
5.00	Speech Pathology	0	0	150,885	0	0	0	5.00
6.00	Medical Social Services	0	0	37,108	0	0	0	6.00
7.00	Home Health Aide	0	0	56,347	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	29,616	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	0	4,067	1,979,920	24	47,691	0	20.00
21.00	Total cost to be allocated	0	151	105,031	6,668	4,948	0	21.00
22.00	Unit cost multiplier	0.000000	0.037128	0.053048	277.833333	0.103751	0.000000	22.00

	Cost Center Description	CASHIERING/ACCOUNTS RECEIVABLE (GROSS CHARGES)	Reconciliation	OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	
		5.04	5A.05	5.05	7.00	8.00	9.00	
1.00	Administrative and General	3,683,955	0	71,717	0	0	0	1.00
2.00	Skilled Nursing Care	0	0	1,642,798	0	0	0	2.00
3.00	Physical Therapy	0	0	342,264	0	0	0	3.00
4.00	Occupational Therapy	0	0	185,533	0	0	0	4.00
5.00	Speech Pathology	0	0	260,832	0	0	0	5.00
6.00	Medical Social Services	0	0	64,012	0	0	0	6.00
7.00	Home Health Aide	0	0	108,892	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	618,222	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	3,683,955		3,294,270	0	0	0	20.00
21.00	Total cost to be allocated	33,005		285,537	0	0	0	21.00
22.00	Unit cost multiplier	0.008959		0.086677	0.000000	0.000000	0.000000	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN:
HHA CCN:

Period:
From 07/01/2017
To 06/30/2018

Worksheet H-2
Part II
Date/Time Prepared:
6/12/2019 8:29 am

Home Health Agency I

PPS

	Cost Center Description	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	
		10.00	11.00	13.00	14.00	15.00	16.00	
1.00	Administrative and General	0	0	0	0	0	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	33,606	0	0	8.00
9.00	Drugs	0	0	0	0	1,835	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	0	0	0	33,606	1,835	0	20.00
21.00	Total cost to be allocated	0	0	0	6,452	565	0	21.00
22.00	Unit cost multiplier	0.000000	0.000000	0.000000	0.191990	0.307902	0.000000	22.00

	Cost Center Description	OTHER GENERAL SERVICE INSERVICE EDUCATION (FTE'S)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	
		18.00	19.00	
1.00	Administrative and General	892	0	1.00
2.00	Skilled Nursing Care	1,400	0	2.00
3.00	Physical Therapy	286	0	3.00
4.00	Occupational Therapy	141	0	4.00
5.00	Speech Pathology	102	0	5.00
6.00	Medical Social Services	80	0	6.00
7.00	Home Health Aide	223	0	7.00
8.00	Supplies (see instructions)	0	0	8.00
9.00	Drugs	0	0	9.00
10.00	DME	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	11.00
12.00	Respiratory Therapy	0	0	12.00
13.00	Private Duty Nursing	0	0	13.00
14.00	Clinic	0	0	14.00
15.00	Health Promotion Activities	0	0	15.00
16.00	Day Care Program	0	0	16.00
17.00	Home Delivered Meals Program	0	0	17.00
18.00	Homemaker Service	56	0	18.00
19.00	All Others (specify)	0	0	19.00
19.50	Telemedicine	0	0	19.50
20.00	Total (sum of lines 1-19)	3,180	0	20.00
21.00	Total cost to be allocated	26,297	0	21.00
22.00	Unit cost multiplier	8.269497	0.000000	22.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN:
HHA CCN:

Period: From 07/01/2017 To 06/30/2018

Worksheet H-3 Part I Date/Time Prepared: 6/12/2019 8:29 am

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	Cost Center Description	From, Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Visits	Average Cost Per Visit (col. 3 ÷ col. 4)	
		0	1.00	2.00	3.00	4.00	5.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	2.00	1,840,218		1,840,218	10,467	175.81	1.00
2.00	Physical Therapy	3.00	383,346	0	383,346	2,619	146.37	2.00
3.00	Occupational Therapy	4.00	207,684	0	207,684	1,339	155.10	3.00
4.00	Speech Pathology	5.00	291,158	0	291,158	875	332.75	4.00
5.00	Medical Social Services	6.00	71,920		71,920	205	350.83	5.00
6.00	Home Health Aide	7.00	123,080		123,080	1,189	103.52	6.00
7.00	Total (sum of lines 1-6)		2,917,406	0	2,917,406	16,694		7.00

	Cost Center Description	Cost Limits	CBSA No. (1)	Part A	Program Visits Part B Not Subject to Deductibles & Coinsurance	Part B Subject to Deductibles		
		0	1.00	2.00	3.00	4.00	5.00	
	Limitation Cost Computation							
8.00	Skilled Nursing Care		99901	0	5,332			8.00
8.01	Skilled Nursing Care		99902	0	3			8.01
9.00	Physical Therapy		99901	0	1,460			9.00
9.01	Physical Therapy		99902	0	4			9.01
10.00	Occupational Therapy		99901	0	560			10.00
10.01	Occupational Therapy		99902	0	1			10.01
11.00	Speech Pathology		99901	0	406			11.00
11.01	Speech Pathology		99902	0	0			11.01
12.00	Medical Social Services		99901	0	87			12.00
12.01	Medical Social Services		99902	0	0			12.01
13.00	Home Health Aide		99901	0	556			13.00
13.01	Home Health Aide		99902	0	0			13.01
14.00	Total (sum of lines 8-13)			0	8,409			14.00

	Cost Center Description	From Wkst. H-2 Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Charges (from HHA Records)	Ratio (col. 3 ÷ col. 4)	
		0	1.00	2.00	3.00	4.00	5.00	
	Supplies and Drugs Cost Computations							
15.00	Cost of Medical Supplies	8.00	6,608	0	6,608	0	0.000000	15.00
16.00	Cost of Drugs	9.00	579	0	579	0	0.000000	16.00

	Cost Center Description	Program Visits Part A	Program Visits Part B Not Subject to Deductibles & Coinsurance	Program Visits Part B Subject to Deductibles & Coinsurance	Cost of Services Part A	Part B Not Subject to Deductibles & Coinsurance	Part B Subject to Deductibles & Coinsurance	
		6.00	7.00	8.00	9.00	10.00	11.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	0	5,335		0	937,946		1.00
2.00	Physical Therapy	0	1,464		0	214,286		2.00
3.00	Occupational Therapy	0	561		0	87,011		3.00
4.00	Speech Pathology	0	406		0	135,097		4.00
5.00	Medical Social Services	0	87		0	30,522		5.00
6.00	Home Health Aide	0	556		0	57,557		6.00
7.00	Total (sum of lines 1-6)	0	8,409		0	1,462,419		7.00

APPORTIONMENT OF PATIENT SERVICE COSTS | Provider CCN: | HHA CCN: | Period: From 07/01/2017 To 06/30/2018 | Worksheet H-3 Part I Date/Time Prepared: 6/12/2019 8:29 am

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	Cost Center Description							
		6.00	7.00	8.00	9.00	10.00	11.00	
	Limitation Cost Computation							
8.00	Skilled Nursing Care							8.00
8.01	Skilled Nursing Care							8.01
9.00	Physical Therapy							9.00
9.01	Physical Therapy							9.01
10.00	Occupational Therapy							10.00
10.01	Occupational Therapy							10.01
11.00	Speech Pathology							11.00
11.01	Speech Pathology							11.01
12.00	Medical Social Services							12.00
12.01	Medical Social Services							12.01
13.00	Home Health Aide							13.00
13.01	Home Health Aide							13.01
14.00	Total (sum of lines 8-13)							14.00

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

	Cost Center Description	Total Program Cost (sum of cols. 9-10)						
		12.00						
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	937,946						1.00
2.00	Physical Therapy	214,286						2.00
3.00	Occupational Therapy	87,011						3.00
4.00	Speech Pathology	135,097						4.00
5.00	Medical Social Services	30,522						5.00
6.00	Home Health Aide	57,557						6.00
7.00	Total (sum of lines 1-6)	1,462,419						7.00

	Cost Center Description							
		12.00						
	Limitation Cost Computation							
8.00	Skilled Nursing Care							8.00
8.01	Skilled Nursing Care							8.01
9.00	Physical Therapy							9.00
9.01	Physical Therapy							9.01
10.00	Occupational Therapy							10.00
10.01	Occupational Therapy							10.01
11.00	Speech Pathology							11.00
11.01	Speech Pathology							11.01
12.00	Medical Social Services							12.00
12.01	Medical Social Services							12.01
13.00	Home Health Aide							13.00
13.01	Home Health Aide							13.01
14.00	Total (sum of lines 8-13)							14.00

APPORTIONMENT OF PATIENT SERVICE COSTS	Provider CCN: HHA CCN:	Period: From 07/01/2017 To 06/30/2018	Worksheet H-3 Part II Date/Time Prepared: 6/12/2019 8:29 am
	Title XVIII	Home Health Agency I	PPS

	Cost Center Description	From Wkst. C, Part I, col. 9, line	Cost to Charge Ratio	Total HHA Charge (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)	Transfer to Part I as Indicated		
		0	1.00	2.00	3.00	4.00		
	PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS							
1.00	Physical Therapy	66.00	0.446798	0	0	col. 2, line 2.00		1.00
2.00	Occupational Therapy	67.00	0.341396	0	0	col. 2, line 3.00		2.00
3.00	Speech Pathology	68.00	0.478205	0	0	col. 2, line 4.00		3.00
4.00	Cost of Medical Supplies	71.00	0.727622	0	0	col. 2, line 15.00		4.00
5.00	Cost of Drugs	73.00	0.325314	0	0	col. 2, line 16.00		5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT	Provider CCN: HHA CCN:	Period: From 07/01/2017 To 06/30/2018	Worksheet H-4 Part I-II Date/Time Prepared: 6/12/2019 8:29 am
	Title XVIII	Home Health Agency I	PPS

		Part A	Part B		
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
		1.00	2.00	3.00	
	PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES				
	Reasonable Cost of Part A & Part B Services				
1.00	Reasonable cost of services (see instructions)	0	0	0	1.00
2.00	Total charges	0	0	0	2.00
	Customary Charges				
3.00	Amount actually collected from patients liable for payment for services on a charge basis (from your records)	0	0	0	3.00
4.00	Amount that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(b)	0	0	0	4.00
5.00	Ratio of line 3 to line 4 (not to exceed 1.000000)	0.000000	0.000000	0.000000	5.00
6.00	Total customary charges (see instructions)	0	0	0	6.00
7.00	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)	0	0	0	7.00
8.00	Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6)	0	0	0	8.00
9.00	Primary payer amounts	0	0	0	9.00

		Part A Services	Part B Services	
		1.00	2.00	
	PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT			
10.00	Total reasonable cost (see instructions)	0	0	10.00
11.00	Total PPS Reimbursement - Full Episodes without Outliers	0	1,085,028	11.00
12.00	Total PPS Reimbursement - Full Episodes with Outliers	0	70,955	12.00
13.00	Total PPS Reimbursement - LUPA Episodes	0	14,896	13.00
14.00	Total PPS Reimbursement - PEP Episodes	0	6,740	14.00
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers	0	22,947	15.00
16.00	Total PPS Outlier Reimbursement - PEP Episodes	0	0	16.00
17.00	Total Other Payments	0	0	17.00
18.00	DME Payments	0	0	18.00
19.00	Oxygen Payments	0	0	19.00
20.00	Prosthetic and Orthotic Payments	0	0	20.00
21.00	Part B deductibles billed to Medicare patients (exclude coinsurance)		0	21.00
22.00	Subtotal (sum of lines 10 thru 20 minus line 21)	0	1,200,566	22.00
23.00	Excess reasonable cost (from line 8)	0	0	23.00
24.00	Subtotal (line 22 minus line 23)	0	1,200,566	24.00
25.00	Coinsurance billed to program patients (from your records)		0	25.00
26.00	Net cost (line 24 minus line 25)	0	1,200,566	26.00
27.00	Reimbursable bad debts (from your records)			27.00
28.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)			28.00
29.00	Total costs - current cost reporting period (line 26 plus line 27)	0	1,200,566	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	0	30.50
30.99	Demonstration payment adjustment amount before sequestration	0	0	30.99
31.00	Subtotal (see instructions)	0	1,200,566	31.00
31.01	Sequestration adjustment (see instructions)	0	24,011	31.01
31.02	Demonstration payment adjustment amount after sequestration	0	0	31.02
32.00	Interim payments (see instructions)	0	1,176,555	32.00
33.00	Tentative settlement (for contractor use only)	0	0	33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 32, and 33)	0	0	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	35.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED HHAs FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: HHA CCN:	Period: From 07/01/2017 To 06/30/2018	Worksheet H-5 Date/Time Prepared: 6/12/2019 8:29 am
		Home Health Agency I	PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		0		1,176,555	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01			0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50			0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate, line 32)		0		1,176,555	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01			0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50			0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		0		1,176,555	7.00

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

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS

Provider CCN:

Hospice CCN:

Period: From 07/01/2017 To 06/30/2018

Worksheet O

Date/Time Prepared: 6/12/2019 8:29 am

Hospice I

		SALARIES	OTHER	SUBTOTAL (col. 1 plus col. 2)	RECLASSIFI-CATIONS	SUBTOTAL	
		1.00	2.00	3.00	4.00	5.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT*		0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP*		380	380	0	380	2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT*	0	55,408	55,408	-1,237	54,171	3.00
4.00	ADMINISTRATIVE & GENERAL*	70,010	21,559	91,569	6,000	97,569	4.00
5.00	PLANT OPERATION & MAINTENANCE*	0	0	0	0	0	5.00
6.00	LAUNDRY & LINEN SERVICE*	0	0	0	0	0	6.00
7.00	HOUSEKEEPING*	0	0	0	0	0	7.00
8.00	DIETARY*	0	0	0	0	0	8.00
9.00	NURSING ADMINISTRATION*	0	0	0	0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES*	0	0	0	0	0	10.00
11.00	MEDICAL RECORDS*	0	0	0	0	0	11.00
12.00	STAFF TRANSPORTATION*	0	0	0	0	0	12.00
13.00	VOLUNTEER SERVICE COORDINATION*	0	0	0	0	0	13.00
14.00	PHARMACY*	0	48,941	48,941	0	48,941	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES*	22,088	156	22,244	0	22,244	15.00
16.00	OTHER GENERAL SERVICE*	0	0	0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES						17.00
	DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED**		2,400	2,400	0	2,400	25.00
26.00	PHYSICIAN SERVICES**	0	0	0	0	0	26.00
27.00	NURSE PRACTITIONER**	0	0	0	0	0	27.00
28.00	REGISTERED NURSE**	105,974	11,514	117,488	0	117,488	28.00
29.00	LPN/LVN**	1,733	188	1,921	0	1,921	29.00
30.00	PHYSICAL THERAPY**	0	0	0	0	0	30.00
31.00	OCCUPATIONAL THERAPY**	0	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY**	0	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES**	12,438	1,351	13,789	0	13,789	33.00
34.00	SPIRITUAL COUNSELING**	28,352	3,080	31,432	0	31,432	34.00
35.00	DIETARY COUNSELING**	0	0	0	0	0	35.00
36.00	COUNSELING - OTHER**	0	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES**	13,866	1,506	15,372	0	15,372	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN**	0	7,611	7,611	0	7,611	38.00
39.00	PATIENT TRANSPORTATION**	0	0	0	0	0	39.00
40.00	IMAGING SERVICES**	0	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS**	0	0	0	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE**	0	14,629	14,629	0	14,629	42.00
42.50	DRUGS CHARGED TO PATIENTS**	0	0	0	0	0	42.50
43.00	OUTPATIENT SERVICES**	0	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY**	0	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY**	0	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)**	0	0	0	0	0	46.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM *	0	0	0	0	0	60.00
61.00	VOLUNTEER PROGRAM *	0	0	0	0	0	61.00
62.00	FUNDRAISING*	0	0	0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS*	0	0	0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM*	0	0	0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES*	0	0	0	0	0	65.00
66.00	RESIDENTIAL CARE*	0	0	0	0	0	66.00
67.00	ADVERTISING*	0	0	0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING*	0	0	0	0	0	68.00
69.00	THRIFT STORE*	0	0	0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD*	0	0	0	0	0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)*	0	0	0	0	0	71.00
100.00	TOTAL	254,461	168,723	423,184	4,763	427,947	100.00

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

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS

Provider CCN:

Hospice CCN:

Period: From 07/01/2017 To 06/30/2018

Worksheet O

Date/Time Prepared: 6/12/2019 8:29 am

Hospice I

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)		
		6.00	7.00		
	GENERAL SERVICE COST CENTERS				
1.00	CAP REL COSTS-BLDG & FIXT*	0	0		1.00
2.00	CAP REL COSTS-MVBLE EQUIP*	0	380		2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT*	0	54,171		3.00
4.00	ADMINISTRATIVE & GENERAL*	0	97,569		4.00
5.00	PLANT OPERATION & MAINTENANCE*	0	0		5.00
6.00	LAUNDRY & LINEN SERVICE*	0	0		6.00
7.00	HOUSEKEEPING*	0	0		7.00
8.00	DIETARY*	0	0		8.00
9.00	NURSING ADMINISTRATION*	0	0		9.00
10.00	ROUTINE MEDICAL SUPPLIES*	0	0		10.00
11.00	MEDICAL RECORDS*	0	0		11.00
12.00	STAFF TRANSPORTATION*	0	0		12.00
13.00	VOLUNTEER SERVICE COORDINATION*	0	0		13.00
14.00	PHARMACY*	0	48,941		14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES*	0	22,244		15.00
16.00	OTHER GENERAL SERVICE*	0	0		16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES				17.00
	DIRECT PATIENT CARE SERVICE COST CENTERS				
25.00	INPATIENT CARE-CONTRACTED**	0	2,400		25.00
26.00	PHYSICIAN SERVICES**	0	0		26.00
27.00	NURSE PRACTITIONER**	0	0		27.00
28.00	REGISTERED NURSE**	0	117,488		28.00
29.00	LPN/LVN**	0	1,921		29.00
30.00	PHYSICAL THERAPY**	0	0		30.00
31.00	OCCUPATIONAL THERAPY**	0	0		31.00
32.00	SPEECH/LANGUAGE PATHOLOGY**	0	0		32.00
33.00	MEDICAL SOCIAL SERVICES**	0	13,789		33.00
34.00	SPIRITUAL COUNSELING**	0	31,432		34.00
35.00	DIETARY COUNSELING**	0	0		35.00
36.00	COUNSELING - OTHER**	0	0		36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES**	0	15,372		37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN**	0	7,611		38.00
39.00	PATIENT TRANSPORTATION**	0	0		39.00
40.00	IMAGING SERVICES**	0	0		40.00
41.00	LABS & DIAGNOSTICS**	0	0		41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE**	0	14,629		42.00
42.50	DRUGS CHARGED TO PATIENTS**	0	0		42.50
43.00	OUTPATIENT SERVICES**	0	0		43.00
44.00	PALLIATIVE RADIATION THERAPY**	0	0		44.00
45.00	PALLIATIVE CHEMOTHERAPY**	0	0		45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)**	0	0		46.00
	NONREIMBURSABLE COST CENTERS				
60.00	BEREAVEMENT PROGRAM *	0	0		60.00
61.00	VOLUNTEER PROGRAM *	0	0		61.00
62.00	FUNDRAISING*	0	0		62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS*	0	0		63.00
64.00	PALLIATIVE CARE PROGRAM*	0	0		64.00
65.00	OTHER PHYSICIAN SERVICES*	0	0		65.00
66.00	RESIDENTIAL CARE*	0	0		66.00
67.00	ADVERTISING*	0	0		67.00
68.00	TELEHEALTH/TELEMONITORING*	0	0		68.00
69.00	THRIFT STORE*	0	0		69.00
70.00	NURSING FACILITY ROOM & BOARD*	0	0		70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)*	0	0		71.00
100.00	TOTAL	0	427,947		100.00

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

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

Provider CCN:

Hospice CCN:

Period: From 07/01/2017 To 06/30/2018

Worksheet O-2

Date/Time Prepared: 6/12/2019 8:29 am

Hospice I

		SALARIES	OTHER	SUBTOTAL (col. 1 + col. 2)	RECLASSIFI-CATIONS	SUBTOTAL	
		1.00	2.00	3.00	4.00	5.00	
	DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED						25.00
26.00	PHYSICIAN SERVICES	0	0	0	0	0	26.00
27.00	NURSE PRACTITIONER	0	0	0	0	0	27.00
28.00	REGISTERED NURSE	105,305	11,441	116,746	0	116,746	28.00
29.00	LPN/LVN	1,722	187	1,909	0	1,909	29.00
30.00	PHYSICAL THERAPY	0	0	0	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	12,359	1,342	13,701	0	13,701	33.00
34.00	SPIRITUAL COUNSELING	28,173	3,061	31,234	0	31,234	34.00
35.00	DIETARY COUNSELING	0	0	0	0	0	35.00
36.00	COUNSELING - OTHER	0	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	13,778	1,496	15,274	0	15,274	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	7,611	7,611	0	7,611	38.00
39.00	PATIENT TRANSPORTATION	0	0	0	0	0	39.00
40.00	IMAGING SERVICES	0	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	0	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	14,537	14,537	0	14,537	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	42.50
43.00	OUTPATIENT SERVICES	0	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	0	0	0	46.00
100.00	TOTAL *	161,337	39,675	201,012	0	201,012	100.00

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

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)		
		6.00	7.00		
	DIRECT PATIENT CARE SERVICE COST CENTERS				
25.00	INPATIENT CARE-CONTRACTED				25.00
26.00	PHYSICIAN SERVICES	0	0		26.00
27.00	NURSE PRACTITIONER	0	0		27.00
28.00	REGISTERED NURSE	0	116,746		28.00
29.00	LPN/LVN	0	1,909		29.00
30.00	PHYSICAL THERAPY	0	0		30.00
31.00	OCCUPATIONAL THERAPY	0	0		31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0		32.00
33.00	MEDICAL SOCIAL SERVICES	0	13,701		33.00
34.00	SPIRITUAL COUNSELING	0	31,234		34.00
35.00	DIETARY COUNSELING	0	0		35.00
36.00	COUNSELING - OTHER	0	0		36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	15,274		37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	7,611		38.00
39.00	PATIENT TRANSPORTATION	0	0		39.00
40.00	IMAGING SERVICES	0	0		40.00
41.00	LABS & DIAGNOSTICS	0	0		41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	14,537		42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0		42.50
43.00	OUTPATIENT SERVICES	0	0		43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0		44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0		45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0		46.00
100.00	TOTAL *	0	201,012		100.00

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

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS FOR HOSPICE INPATIENT RESPITE CARE

Provider CCN:

Hospice CCN:

Period: From 07/01/2017 To 06/30/2018

Worksheet O-3

Date/Time Prepared: 6/12/2019 8:29 am

Hospice I

		SALARIES	OTHER	SUBTOTAL (col. 1 + col. 2)	RECLASSIFI-CATIONS	SUBTOTAL	
		1.00	2.00	3.00	4.00	5.00	
	DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED		2,400	2,400	0	2,400	25.00
26.00	PHYSICIAN SERVICES	0	0	0	0	0	26.00
27.00	NURSE PRACTITIONER	0	0	0	0	0	27.00
28.00	REGISTERED NURSE	669	73	742	0	742	28.00
29.00	LPN/LVN	11	1	12	0	12	29.00
30.00	PHYSICAL THERAPY	0	0	0	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	79	9	88	0	88	33.00
34.00	SPIRITUAL COUNSELING	179	19	198	0	198	34.00
35.00	DIETARY COUNSELING	0	0	0	0	0	35.00
36.00	COUNSELING - OTHER	0	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	88	10	98	0	98	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	0	0	0	38.00
39.00	PATIENT TRANSPORTATION	0	0	0	0	0	39.00
40.00	IMAGING SERVICES	0	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	0	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	92	92	0	92	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	42.50
43.00	OUTPATIENT SERVICES	0	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	0	0	0	46.00
100.00	TOTAL *	1,026	2,604	3,630	0	3,630	100.00

* Transfer the amount in column 7 to Wkst. O-5, column 1, line 52.

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)		
		6.00	7.00		
	DIRECT PATIENT CARE SERVICE COST CENTERS				
25.00	INPATIENT CARE-CONTRACTED	0	2,400		25.00
26.00	PHYSICIAN SERVICES	0	0		26.00
27.00	NURSE PRACTITIONER	0	0		27.00
28.00	REGISTERED NURSE	0	742		28.00
29.00	LPN/LVN	0	12		29.00
30.00	PHYSICAL THERAPY	0	0		30.00
31.00	OCCUPATIONAL THERAPY	0	0		31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0		32.00
33.00	MEDICAL SOCIAL SERVICES	0	88		33.00
34.00	SPIRITUAL COUNSELING	0	198		34.00
35.00	DIETARY COUNSELING	0	0		35.00
36.00	COUNSELING - OTHER	0	0		36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	98		37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0		38.00
39.00	PATIENT TRANSPORTATION	0	0		39.00
40.00	IMAGING SERVICES	0	0		40.00
41.00	LABS & DIAGNOSTICS	0	0		41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	92		42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0		42.50
43.00	OUTPATIENT SERVICES	0	0		43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0		44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0		45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0		46.00
100.00	TOTAL *	0	3,630		100.00

* Transfer the amount in column 7 to Wkst. O-5, column 1, line 52.

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

Provider CCN:

Hospice CCN:

Period: From 07/01/2017 To 06/30/2018

Worksheet O-5

Date/Time Prepared: 6/12/2019 8:29 am

Hospice I

	Descriptions	HOSPICE DIRECT EXPENSES (see instructions)	GENERAL SERVICE EXPENSES FROM WKST B PART I (see instructions)	TOTAL EXPENSES (sum of cols. 1 + 2)	
		1.00	2.00	3.00	
	GENERAL SERVICE COST CENTERS				
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	380	0	380	2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	54,171	13,338	67,509	3.00
4.00	ADMINISTRATIVE & GENERAL	97,569	47,035	144,604	4.00
5.00	PLANT OPERATION & MAINTENANCE	0	0	0	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0	6.00
7.00	HOUSEKEEPING	0	0	0	7.00
8.00	DIETARY	0	0	0	8.00
9.00	NURSING ADMINISTRATION	0	0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	2,809	2,809	10.00
11.00	MEDICAL RECORDS	0	0	0	11.00
12.00	STAFF TRANSPORTATION	0		0	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0		0	13.00
14.00	PHARMACY	48,941	15,081	64,022	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	22,244		22,244	15.00
16.00	OTHER GENERAL SERVICE	0	3,548	3,548	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES		0	0	17.00
	LEVEL OF CARE				
50.00	HOSPICE CONTINUOUS HOME CARE	0		0	50.00
51.00	HOSPICE ROUTINE HOME CARE	201,012		201,012	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	3,630		3,630	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0		0	53.00
	NONREIMBURSABLE COST CENTERS				
60.00	BEREAVEMENT PROGRAM	0		0	60.00
61.00	VOLUNTEER PROGRAM	0		0	61.00
62.00	FUNDRAISING	0		0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0		0	63.00
64.00	PALLIATIVE CARE PROGRAM	0		0	64.00
65.00	OTHER PHYSICIAN SERVICES	0		0	65.00
66.00	RESIDENTIAL CARE	0		0	66.00
67.00	ADVERTISING	0		0	67.00
68.00	TELEHEALTH/TELEMONITORING	0		0	68.00
69.00	THRIFT STORE	0		0	69.00
70.00	NURSING FACILITY ROOM & BOARD	0		0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0		0	71.00
99.00	NEGATIVE COST CENTER	0		0	99.00
100.00	TOTAL	427,947	81,811	509,758	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS | Provider CCN: | Hospice CCN: | Period: From 07/01/2017 To 06/30/2018 | Worksheet O-6 Part I Date/Time Prepared: 6/12/2019 8:29 am

Hospice I

	Descriptions	TOTAL EXPENSES	CAP REL BLDG & FIX	CAP REL MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	SUBTOTAL	
		0	1.00	2.00	3.00	3A	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	380		380			2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	67,509	0	0	67,509		3.00
4.00	ADMINISTRATIVE & GENERAL	144,604	0	0	20,564	165,168	4.00
5.00	PLANT OPERATION & MAINTENANCE	0	0	0	0	0	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0	0	0	6.00
7.00	HOUSEKEEPING	0	0	0	0	0	7.00
8.00	DIETARY	0	0	0	0	0	8.00
9.00	NURSING ADMINISTRATION	0	0	0	0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES	2,809	0	0	0	2,809	10.00
11.00	MEDICAL RECORDS	0	0	0	0	0	11.00
12.00	STAFF TRANSPORTATION	0	0	0	0	0	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0	0	0	0	0	13.00
14.00	PHARMACY	64,022	0	0	0	64,022	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	22,244	0	0	0	22,244	15.00
16.00	OTHER GENERAL SERVICE	3,548	0	0	0	3,548	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES		0	0		0	17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0			0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	201,012			46,648	247,660	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	3,630	0	0	297	3,927	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	0	0	0	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0	0	0	0	0	60.00
61.00	VOLUNTEER PROGRAM	0	0	0	0	0	61.00
62.00	FUNDRAISING	0	0	0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0	0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0	0	0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES	0	0	0	0	0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0	0	0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING	0	0	0	0	0	68.00
69.00	THRIFT STORE	0	0	0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD	0				0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER	0	0	0	0		99.00
100.00	TOTAL	509,758	0	0	67,509	509,378	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS | Provider CCN: | Hospice CCN: | Period: From 07/01/2017 To 06/30/2018 | Worksheet O-6 Part I Date/Time Prepared: 6/12/2019 8:29 am

Hospice I

	Descriptions	ADMINISTRATIVE & GENERAL	PLANT OPERATION & MAINTENANCE	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		4.00	5.00	6.00	7.00	8.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL	165,168					4.00
5.00	PLANT OPERATION & MAINTENANCE	0	0				5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0			6.00
7.00	HOUSEKEEPING	0	0		0		7.00
8.00	DIETARY	0	0		0	0	8.00
9.00	NURSING ADMINISTRATION	0	0		0		9.00
10.00	ROUTINE MEDICAL SUPPLIES	1,348	0		0		10.00
11.00	MEDICAL RECORDS	0	0		0		11.00
12.00	STAFF TRANSPORTATION	0	0		0		12.00
13.00	VOLUNTEER SERVICE COORDINATION	0	0		0		13.00
14.00	PHARMACY	30,721	0		0		14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	10,674	0		0		15.00
16.00	OTHER GENERAL SERVICE	1,702	0		0		16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0	0		0		17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0					50.00
51.00	HOSPICE ROUTINE HOME CARE	118,839					51.00
52.00	HOSPICE INPATIENT RESPITE CARE	1,884	0	0	0	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	0	0	0	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0	0		0		60.00
61.00	VOLUNTEER PROGRAM	0	0		0		61.00
62.00	FUNDRAISING	0	0		0		62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0		0		63.00
64.00	PALLIATIVE CARE PROGRAM	0	0		0		64.00
65.00	OTHER PHYSICIAN SERVICES	0	0		0		65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0	0		0		67.00
68.00	TELEHEALTH/TELEMONITORING	0	0		0		68.00
69.00	THRIFT STORE	0	0		0		69.00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER	0	0	0	0	0	99.00
100.00	TOTAL	165,168	0	0	0	0	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS | Provider CCN: | Hospice CCN: | Period: From 07/01/2017 To 06/30/2018 | Worksheet O-6 Part I Date/Time Prepared: 6/12/2019 8:29 am

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	Descriptions	NURSING ADMINISTRATION	ROUTINE MEDICAL SUPPLIES	MEDICAL RECORDS	STAFF TRANSPORTATION	VOLUNTEER SERVICE COORDINATION	
		9.00	10.00	11.00	12.00	13.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5.00
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPING						7.00
8.00	DIETARY						8.00
9.00	NURSING ADMINISTRATION	0					9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	4,157				10.00
11.00	MEDICAL RECORDS	0		0			11.00
12.00	STAFF TRANSPORTATION	0			0		12.00
13.00	VOLUNTEER SERVICE COORDINATION	0			0	0	13.00
14.00	PHARMACY	0			0	0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0			0	0	15.00
16.00	OTHER GENERAL SERVICE	0			0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES						17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0	0	0	0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	0	4,131	0	0	0	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	26	0	0	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	0	0	0	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0			0	0	60.00
61.00	VOLUNTEER PROGRAM	0			0	0	61.00
62.00	FUNDRAISING	0			0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0			0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0			0	0	64.00
65.00	OTHER PHYSICIAN SERVICES	0			0	0	65.00
66.00	RESIDENTIAL CARE	0			0	0	66.00
67.00	ADVERTISING	0			0	0	67.00
68.00	TELEHEALTH/TELEMONITORING	0			0	0	68.00
69.00	THRIFT STORE	0			0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0			0	0	71.00
99.00	NEGATIVE COST CENTER	0	0	0	0	0	99.00
100.00	TOTAL	0	4,157	0	0	0	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS | Provider CCN: | Hospice CCN: | Period: From 07/01/2017 To 06/30/2018 | Worksheet O-6 Part I Date/Time Prepared: 6/12/2019 8:29 am

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	Descriptions	PHARMACY	PHYSICIAN ADMINISTRATIVE SERVICES	OTHER GENERAL SERVICE	PATIENT/ RESIDENTIAL CARE SERVICES	TOTAL	
		14.00	15.00	16.00	17.00	18.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5.00
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPING						7.00
8.00	DIETARY						8.00
9.00	NURSING ADMINISTRATION						9.00
10.00	ROUTINE MEDICAL SUPPLIES						10.00
11.00	MEDICAL RECORDS						11.00
12.00	STAFF TRANSPORTATION						12.00
13.00	VOLUNTEER SERVICE COORDINATION						13.00
14.00	PHARMACY	94,743					14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	32,918				15.00
16.00	OTHER GENERAL SERVICE	0		5,250			16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES				0		17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0	0	0		0	50.00
51.00	HOSPICE ROUTINE HOME CARE	94,743	32,710	5,213		503,296	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	208	37	0	6,082	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	0	0	0	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0		0		0	60.00
61.00	VOLUNTEER PROGRAM	0		0		0	61.00
62.00	FUNDRAISING	0		0		0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0		0		0	63.00
64.00	PALLIATIVE CARE PROGRAM	0		0		0	64.00
65.00	OTHER PHYSICIAN SERVICES	0		0		0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0		0		0	67.00
68.00	TELEHEALTH/TELEMONITORING	0		0		0	68.00
69.00	THRIFT STORE	0		0		0	69.00
70.00	NURSING FACILITY ROOM & BOARD					0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER	0	0	0	0	0	99.00
100.00	TOTAL	94,743	32,918	5,250	0	509,378	100.00

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

Provider CCN:

Hospice CCN:

Period:
From 07/01/2017
To 06/30/2018

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Part II
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	Cost Center Descriptions	CAP REL BLDG & FIX (SQUARE FEET)	CAP REL MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	RECONCILIATION	ADMINISTRATIVE & GENERAL (ACCUMULATED COSTS)	
		1.00	2.00	3.00	4A	4.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0					1.00
2.00	CAP REL COSTS-MVBLE EQUIP		0				2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	0	0	233,484			3.00
4.00	ADMINISTRATIVE & GENERAL	0	0	71,121	-165,168	344,210	4.00
5.00	PLANT OPERATION & MAINTENANCE	0	0	0	0	0	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0	0	0	6.00
7.00	HOUSEKEEPING	0	0	0	0	0	7.00
8.00	DIETARY	0	0	0	0	0	8.00
9.00	NURSING ADMINISTRATION	0	0	0	0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	0	0	0	2,809	10.00
11.00	MEDICAL RECORDS	0	0	0	0	0	11.00
12.00	STAFF TRANSPORTATION	0	0	0	0	0	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0	0	0	0	0	13.00
14.00	PHARMACY	0	0	0	0	64,022	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0	0	0	22,244	15.00
16.00	OTHER GENERAL SERVICE	0	0	0	0	3,548	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0	0		0	0	17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE			0	0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE			161,337	0	247,660	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0	1,026	0	3,927	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	0	0	0	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0	0	0	0	0	60.00
61.00	VOLUNTEER PROGRAM	0	0	0	0	0	61.00
62.00	FUNDRAISING	0	0	0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0	0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0	0	0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES	0	0	0	0	0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0	0	0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING	0	0	0	0	0	68.00
69.00	THRIFT STORE	0	0	0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD				0		70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER						99.00
100.00	COST TO BE ALLOCATED (per Wkst. O-6, Part I)	0	380	67,509		165,168	100.00
101.00	UNIT COST MULTIPLIER	0.000000	0.000000	0.289138		0.479847	101.00

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

Provider CCN:

Hospice CCN:

Period:
From 07/01/2017
To 06/30/2018

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

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

Provider CCN:

Hospice CCN:

Period:
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	Cost Center Descriptions	ROUTINE MEDICAL SUPPLIES (PATIENT DAYS)	MEDICAL RECORDS (PATIENT DAYS)	STAFF TRANSPORTATION (MILEAGE)	VOLUNTEER SERVICE COORDINATION (HOURS OF SERVICE)	PHARMACY (CHARGES)	
		10.00	11.00	12.00	13.00	14.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5.00
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPING						7.00
8.00	DIETARY						8.00
9.00	NURSING ADMINISTRATION						9.00
10.00	ROUTINE MEDICAL SUPPLIES	4,434					10.00
11.00	MEDICAL RECORDS		0				11.00
12.00	STAFF TRANSPORTATION			0			12.00
13.00	VOLUNTEER SERVICE COORDINATION			0	0		13.00
14.00	PHARMACY			0	0	48,941	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES			0	0	0	15.00
16.00	OTHER GENERAL SERVICE			0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES						17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0	0	0	0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	4,406	0	0	0	48,941	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	28	0	0	0	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	0	0	0	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM			0	0	0	60.00
61.00	VOLUNTEER PROGRAM			0	0	0	61.00
62.00	FUNDRAISING			0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS			0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM			0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES			0	0	0	65.00
66.00	RESIDENTIAL CARE			0	0	0	66.00
67.00	ADVERTISING			0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING			0	0	0	68.00
69.00	THRIFT STORE			0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)			0	0	0	71.00
99.00	NEGATIVE COST CENTER						99.00
100.00	COST TO BE ALLOCATED (per Wkst. O-6, Part I)	4,157	0	0	0	94,743	100.00
101.00	UNIT COST MULTIPLIER	0.937528	0.000000	0.000000	0.000000	1.935862	101.00

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

Provider CCN:

Hospice CCN:

Period:
From 07/01/2017
To 06/30/2018

Worksheet O-6
Part II
Date/Time Prepared:
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	Cost Center Descriptions	PHYSICIAN ADMINISTRATIVE SERVICES (PATIENT DAYS)	OTHER GENERAL SERVICE (SPECIFY BASIS)	PATIENT/ RESIDENTIAL CARE SERVICES (IN-FACILITY DAYS)		
		15.00	16.00	17.00		
	GENERAL SERVICE COST CENTERS					
1.00	CAP REL COSTS-BLDG & FIXT					1.00
2.00	CAP REL COSTS-MVBLE EQUIP					2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT					3.00
4.00	ADMINISTRATIVE & GENERAL					4.00
5.00	PLANT OPERATION & MAINTENANCE					5.00
6.00	LAUNDRY & LINEN SERVICE					6.00
7.00	HOUSEKEEPING					7.00
8.00	DIETARY					8.00
9.00	NURSING ADMINISTRATION					9.00
10.00	ROUTINE MEDICAL SUPPLIES					10.00
11.00	MEDICAL RECORDS					11.00
12.00	STAFF TRANSPORTATION					12.00
13.00	VOLUNTEER SERVICE COORDINATION					13.00
14.00	PHARMACY					14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	4,434				15.00
16.00	OTHER GENERAL SERVICE		429			16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES			0		17.00
	LEVEL OF CARE					
50.00	HOSPICE CONTINUOUS HOME CARE	0	0			50.00
51.00	HOSPICE ROUTINE HOME CARE	4,406	426			51.00
52.00	HOSPICE INPATIENT RESPITE CARE	28	3	0		52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	0		53.00
	NONREIMBURSABLE COST CENTERS					
60.00	BEREAVEMENT PROGRAM		0			60.00
61.00	VOLUNTEER PROGRAM		0			61.00
62.00	FUNDRAISING		0			62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS		0			63.00
64.00	PALLIATIVE CARE PROGRAM		0			64.00
65.00	OTHER PHYSICIAN SERVICES		0			65.00
66.00	RESIDENTIAL CARE	0	0	0		66.00
67.00	ADVERTISING		0			67.00
68.00	TELEHEALTH/TELEMONITORING		0			68.00
69.00	THRIFT STORE		0			69.00
70.00	NURSING FACILITY ROOM & BOARD					70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0		71.00
99.00	NEGATIVE COST CENTER					99.00
100.00	COST TO BE ALLOCATED (per Wkst. O-6, Part I)	32,918	5,250	0		100.00
101.00	UNIT COST MULTIPLIER	7.423996	12.237762	0.000000		101.00

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

Provider CCN:
Hospice CCN:

Period:
From 07/01/2017
To 06/30/2018

Worksheet O-7
Date/Time Prepared:
6/12/2019 8:29 am

Hospice I

	Cost Center Descriptions	From Wkst. C, Part I, Col. 9 line	Cost to Charge Ratio	Charges by LOC (from Provider Records) HCHC	HRHC	HIRC	
		0	1.00	2.00	3.00	4.00	
	ANCILLARY SERVICE COST CENTERS						
1.00	PHYSICAL THERAPY	66.00	0.446798	0	0	0	1.00
2.00	OCCUPATIONAL THERAPY	67.00	0.341396	0	0	0	2.00
3.00	SPEECH PATHOLOGY	68.00	0.478205	0	0	0	3.00
4.00	DRUGS CHARGED TO PATIENTS	73.00	0.325314	0	0	0	4.00
5.00	DURABLE MEDICAL EQUIP-RENTED	96.00					5.00
6.00	LABORATORY	60.00	0.161089	0	0	0	6.00
7.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0.727622	0	0	0	7.00
8.00	OTHER OUTPATIENT SERVICE COST CENTER	93.00					8.00
9.00	RADIOLOGY-THERAPEUTIC	55.00					9.00
10.00	ONCOLOGY	76.00	0.366461	0	0	0	10.00
10.01	OCCUPATIONAL HEALTH	76.01	14.279526	0	0	0	10.01
10.03	OP DIABETIC EDUCATION	76.03	0.499741	0	0	0	10.03
10.97	CARDIAC REHABILITATION	76.97	1.825833	0	0	0	10.97
11.00	Totals (sum of lines 1-11)						11.00

	Cost Center Descriptions	Charges by LOC (from Provider Records) HGIP	Shared Service Costs by LOC HCHC (col. 1 x col. 2)	HRHC (col. 1 x col. 3)	HIRC (col. 1 x col. 4)	HGIP (col. 1 x col. 5)	
		5.00	6.00	7.00	8.00	9.00	
	ANCILLARY SERVICE COST CENTERS						
1.00	PHYSICAL THERAPY	0	0	0	0	0	1.00
2.00	OCCUPATIONAL THERAPY	0	0	0	0	0	2.00
3.00	SPEECH PATHOLOGY	0	0	0	0	0	3.00
4.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	4.00
5.00	DURABLE MEDICAL EQUIP-RENTED						5.00
6.00	LABORATORY	0	0	0	0	0	6.00
7.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	7.00
8.00	OTHER OUTPATIENT SERVICE COST CENTER						8.00
9.00	RADIOLOGY-THERAPEUTIC						9.00
10.00	ONCOLOGY	0	0	0	0	0	10.00
10.01	OCCUPATIONAL HEALTH	0	0	0	0	0	10.01
10.03	OP DIABETIC EDUCATION	0	0	0	0	0	10.03
10.97	CARDIAC REHABILITATION	0	0	0	0	0	10.97
11.00	Totals (sum of lines 1-11)		0	0	0	0	11.00

CALCULATION OF HOSPITAL-BASED HOSPICE PER DIEM COST	Provider CCN: Hospice CCN:	Period: From 07/01/2017 To 06/30/2018	Worksheet O-8 Date/Time Prepared: 6/12/2019 8:29 am

Hospice I

		TITLE XVIII MEDICARE	TITLE XIX MEDICAID	TOTAL	
		1.00	2.00	3.00	
	HOSPICE CONTINUOUS HOME CARE				
1.00	Total cost (Wkst. O-6, Part I, col. 18, line 50 plus Wkst. O-7, col. 6, line 11)			0	1.00
2.00	Total unduplicated days (Wkst. S-9, col. 4, line 10)			0	2.00
3.00	Total average cost per diem (line 1 divided by line 2)			0.00	3.00
4.00	Unduplicated program days (Wkst. S-9 col. as appropriate, line 10)	0	0		4.00
5.00	Program cost (line 3 times line 4)	0	0		5.00
	HOSPICE ROUTINE HOME CARE				
6.00	Total cost (Wkst. O-6, Part I, col. 18, line 51 plus Wkst. O-7, col. 7, line 11)			503,296	6.00
7.00	Total unduplicated days (Wkst. S-9, col. 4, line 11)			4,406	7.00
8.00	Total average cost per diem (line 6 divided by line 7)			114.23	8.00
9.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 11)	4,122	0		9.00
10.00	Program cost (line 8 times line 9)	470,856	0		10.00
	HOSPICE INPATIENT RESPITE CARE				
11.00	Total cost (Wkst. O-6, Part I, col. 18, line 52 plus Wkst. O-7, col. 8, line 11)			6,082	11.00
12.00	Total unduplicated days (Wkst. S-9, col. 4, line 12)			28	12.00
13.00	Total average cost per diem (line 11 divided by line 12)			217.21	13.00
14.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 12)	28	0		14.00
15.00	Program cost (line 13 times line 14)	6,082	0		15.00
	HOSPICE GENERAL INPATIENT CARE				
16.00	Total cost (Wkst. O-6, Part I, col. 18, line 53 plus Wkst. O-7, col. 9, line 11)			0	16.00
17.00	Total unduplicated days (Wkst. S-9, col. 4, line 13)			0	17.00
18.00	Total average cost per diem (line 16 divided by line 17)			0.00	18.00
19.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 13)	0	0		19.00
20.00	Program cost (line 18 times line 19)	0	0		20.00
	TOTAL HOSPICE CARE				
21.00	Total cost (sum of line 1 + line 6 + line 11 + line 16)			509,378	21.00
22.00	Total unduplicated days (Wkst. S-9, col. 4, line 14)			4,434	22.00
23.00	Average cost per diem (line 21 divided by line 22)			114.88	23.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS | Provider CCN: | Component CCN: | Period: From 07/01/2017 To 06/30/2018 | Worksheet M-1 | Date/Time Prepared: 6/12/2019 8:29 am

RHC I | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	5,842,958	751,740	6,594,698	-1,299,394	5,295,304	1.00
2.00	Physician Assistant	1,979,339	553,047	2,532,386	-33,645	2,498,741	2.00
3.00	Nurse Practitioner	630,366	176,130	806,496	0	806,496	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	1,089,999	304,556	1,394,555	0	1,394,555	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	141,122	39,431	180,553	0	180,553	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	9,683,784	1,824,904	11,508,688	-1,333,039	10,175,649	10.00
11.00	Physician Services Under Agreement	0	1,140,817	1,140,817	0	1,140,817	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	27,000	27,000	0	27,000	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	1,167,817	1,167,817	0	1,167,817	14.00
15.00	Medical Supplies	0	1,152,776	1,152,776	0	1,152,776	15.00
16.00	Transportation (Health Care Staff)	0	25,397	25,397	0	25,397	16.00
17.00	Depreciation-Medical Equipment	0	185,514	185,514	0	185,514	17.00
18.00	Professional Liability Insurance	0	328,755	328,755	-56,312	272,443	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	1,692,442	1,692,442	-56,312	1,636,130	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	9,683,784	4,685,163	14,368,947	-1,389,351	12,979,596	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	95,344	26,640	121,984	0	121,984	24.00
25.00	Optometry	0	0	0	0	0	25.00
25.01	Telehealth	0	0	0	0	0	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	95,344	26,640	121,984	0	121,984	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	83,275	1,076,164	1,159,439	-212,340	947,099	29.00
30.00	Administrative Costs	1,762,308	1,545,302	3,307,610	-978	3,306,632	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	1,845,583	2,621,466	4,467,049	-213,318	4,253,731	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	11,624,711	7,333,269	18,957,980	-1,602,669	17,355,311	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN:

Component CCN:

Period: From 07/01/2017 To 06/30/2018

Worksheet M-1

Date/Time Prepared: 6/12/2019 8:29 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	-825,612	4,469,692		1.00
2.00	Physician Assistant	-396,327	2,102,414		2.00
3.00	Nurse Practitioner	0	806,496		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	1,394,555		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	180,553		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	0		9.00
10.00	Subtotal (sum of lines 1 through 9)	-1,221,939	8,953,710		10.00
11.00	Physician Services Under Agreement	0	1,140,817		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	27,000		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	1,167,817		14.00
15.00	Medical Supplies	0	1,152,776		15.00
16.00	Transportation (Health Care Staff)	0	25,397		16.00
17.00	Depreciation-Medical Equipment	0	185,514		17.00
18.00	Professional Liability Insurance	0	272,443		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	1,636,130		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-1,221,939	11,757,657		22.00
	COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	121,984		24.00
25.00	Optometry	0	0		25.00
25.01	Telehealth	0	0		25.01
25.02	Chronic Care Management	0	0		25.02
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs				27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	121,984		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	-39,936	907,163		29.00
30.00	Administrative Costs	-244,950	3,061,682		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-284,886	3,968,845		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-1,506,825	15,848,486		32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN:

Component CCN:

Period: From 07/01/2017 To 06/30/2018

Worksheet M-2

Date/Time Prepared: 6/12/2019 8:29 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	10.23	34,229	4,200	42,966		1.00
2.00	Physician Assistant	12.73	34,569	2,100	26,733		2.00
3.00	Nurse Practitioner	4.16	12,271	2,100	8,736		3.00
4.00	Subtotal (sum of lines 1 through 3)	27.12	81,069		78,435	81,069	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	1.76	1,923			1,923	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)	28.88	82,992			82,992	8.00
9.00	Physician Services Under Agreements		844			844	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)					11,757,657	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					121,984	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					11,879,641	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					0.989732	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					3,968,845	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					3,396,982	15.00
16.00	Total overhead (sum of lines 14 and 15)					7,365,827	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					7,365,827	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					7,290,195	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					19,047,852	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: Component CCN:	Period: From 07/01/2017 To 06/30/2018	Worksheet M-3 Date/Time Prepared: 6/12/2019 8:29 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)	19,047,852	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)	803,362	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)	18,244,490	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)	82,992	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)	844	5.00
6.00	Total adjusted visits (line 4 plus line 5)	83,836	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)	217.62	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)	217.62	217.62	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	18,820	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	4,095,608	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	101	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	21,980	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	21,980	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	4,117,588	16.00
16.01	Total program charges (see instructions)(from contractor's records)		2,771,204	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		339,463	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		504,392	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.)		2,713,290	16.04
16.05	Total program cost (see instructions)	0	3,217,682	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		221,584	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		442,093	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		3,217,682	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		194,054	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		3,411,736	22.00
23.00	Allowable bad debts (see instructions)		89,056	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		57,886	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		60,067	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)		3,469,622	26.00
26.01	Sequestration adjustment (see instructions)		69,392	26.01
26.02	Demonstration payment adjustment amount after sequestration		0	26.02
27.00	Interim payments		3,292,314	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)		107,916	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: Component CCN:	Period: From 07/01/2017 To 06/30/2018	Worksheet M-4 Date/Time Prepared: 6/12/2019 8:29 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)	8,953,710	8,953,710	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.003082	0.007690	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	27,595	68,854	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	276,238	123,204	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	303,833	192,058	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	11,757,657	11,757,657	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	7,290,195	7,290,195	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.025841	0.016335	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	188,386	119,085	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	492,219	311,143	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	2,043	5,098	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	240.93	61.03	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	485	1,265	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	116,851	77,203	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)		803,362	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)		194,054	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: / Component CCN:	Period: From 07/01/2017 To 06/30/2018	Worksheet M-5 / Date/Time Prepared: 6/12/2019 8:29 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		3,191,489	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		06/20/2018	112,391	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
	Provider to Program			
3.50		03/20/2018	7,327	3.50
3.51		03/20/2018	4,239	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)		100,825	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		3,292,314	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		107,916	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		3,400,230	7.00

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