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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 14-0294	Period: From 01/01/2017 To 12/31/2017	Worksheet S Parts I-III Date/Time Prepared: 5/25/2018 11:54 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 5/25/2018 Time: 11:54 am
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by CROSSROADS COMMUNITY HOSPITAL (14-0294) for the cost reporting period beginning 01/01/2017 and ending 12/31/2017 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	276,106	3,026	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
10.00	RURAL HEALTH CLINIC I	0		108,288		0	10.00
10.01	RURAL HEALTH CLINIC II	0		121,786		0	10.01
200.00	Total	0	276,106	233,100	0	0	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-0294 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-2 Part I Date/Time Prepared: 5/25/2018 11:49 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 8 DOCTORS PARK ROAD	PO Box:			1.00
2.00	City: MT VERNON	State: IL	Zip Code: 62864	County: JEFFERSON	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	CROSSROADS COMMUNITY HOSPITAL	140294	99914	1	07/01/1966	N	P	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	CROSSROADS COMMUNITY HOSPITAL	14U294	99914		04/12/1989	N	P	N	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC	CROSSROADS FAMILY MED OF MT. VERNON	148524	99914		07/19/2013	N	O	N	15.00
15.01	Hospital-Based Health Clinic - RHC II	CROSSROADS FAMILY MED OF WAYNE CITY	148523	99914		07/19/2013	N	O	N	15.01
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	01/01/2017	12/31/2017	20.00
21.00	Type of Control (see instructions)	4		21.00
	Inpatient PPS Information			
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	Y	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)	Y	Y	22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N	22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.	N	N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	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.	364	0	0	0	30	0	24.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-0294 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-2 Part I | Date/Time Prepared: 5/25/2018 11:49 am

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

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

		Beginning:	Ending:	
		1.00	2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.			36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.	1		37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)			37.01
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.	01/01/2017	12/31/2017	38.00

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

		V	XVIII	XIX	
		1.00	2.00	3.00	
	Prospective Payment System (PPS)-Capital				
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y for yes or "N" for no.	N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00
	Teaching Hospitals				
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N			56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.				57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.				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: 14-0294 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-2 Part I | Date/Time Prepared: 5/25/2018 11:49 am

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-0294 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-2 Part I | Date/Time Prepared: 5/25/2018 11:49 am

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 14-0294	Period: From 01/01/2017 To 12/31/2017	Worksheet S-2 Part I Date/Time Prepared: 5/25/2018 11:49 am

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

		V	XIX	
		1.00	2.00	
	Title V and XIX Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.06
	Rural Providers			
105.00	Does this hospital qualify as a CAH?	N		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)			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.			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.					109.00

		1.00	
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration)for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.	N	110.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-0294 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-2 Part I | Date/Time Prepared: 5/25/2018 11:49 am

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

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

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	19,311	0	0	118.01

		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	Y	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	HB0776	140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-0294 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-2 Part I Date/Time Prepared: 5/25/2018 11:49 am

	1.00	2.00	3.00	
	If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.			
141.00	Name: QUORUM GROUP CORPORATION	Contractor's Name: WISCONSIN PHYSICIAN SERVICES	Contractor's Number: 52280	141.00
142.00	Street: 1573 MALLORY LANE	PO Box: SUITE 100		142.00
143.00	City: BRENTWOOD	State: TN	Zip Code: 37027	143.00

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

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

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

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

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

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

		1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act		
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.	Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)	0	168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)		168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	9.99	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)	05/01/2017	07/29/2017	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: 14-0294 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-2 Part II | Date/Time Prepared: 5/25/2018 11:49 am

			Y/N	Date	
			1.00	2.00	
	General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.				
	COMPLETED BY ALL HOSPITALS				
	Provider Organization and Operation				
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)		N		1.00
		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N			3.00
		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	N			4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00
			Y/N	Legal Oper.	
			1.00	2.00	
	Approved Educational Activities				
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?		N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.		N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.		N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.		N		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.		N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.		N		11.00
				Y/N	
				1.00	
	Bad Debts				
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.			Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.			N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.			N	14.00
	Bed Complement				
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			N	15.00
		Part A		Part B	
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
	PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	Y	03/01/2018	Y	03/01/2018
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N	
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N	
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N	

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 14-0294 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-2 Part II Date/Time Prepared: 5/25/2018 11:49 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	Y	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.	N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.	N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.	N	27.00
	Interest Expense		
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.	N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions	N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.	N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.	N	31.00
	Purchased Services		
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.	N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.	N	33.00
	Provider-Based Physicians		
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.	Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.	N	35.00

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

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	COLT	SULLIVAN	41.00
42.00	Enter the employer/company name of the cost report preparer.	QHC		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	615.221.3649	COLT_SULLIVAN@QUORUMHEALTH.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 14-0294	Period: From 01/01/2017 To 12/31/2017	Worksheet S-2 Part II Date/Time Prepared: 5/25/2018 11:49 am

		3.00		
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	DIRECTOR		41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 14-0294 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-3 Part I | Date/Time Prepared: 5/25/2018 11:49 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	40	14,600	0.00	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)		40	14,600	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	7	2,555	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						13.00
14.00	Total (see instructions)		47	17,155	0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	88.00				0	26.00
26.01	RURAL HEALTH CLINIC II	88.01				0	26.01
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		47				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00
33.01	LTCH site neutral days and discharges						33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 14-0294 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-3 Part I | Date/Time Prepared: 5/25/2018 11:49 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)	1,418	346	2,485			1.00
2.00	HMO and other (see instructions)	173	30				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			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)	1,418	346	2,485			7.00
8.00	INTENSIVE CARE UNIT	66	18	99			8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	1,484	364	2,584	0.00	153.04	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	0	0	0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	1,777	0	5,780	0.00	7.51	26.00
26.01	RURAL HEALTH CLINIC II	1,032	0	3,225	0.00	3.38	26.01
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	163.93	27.00
28.00	Observation Bed Days		0	696			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 14-0294 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-3 Part I | Date/Time Prepared: 5/25/2018 11:49 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	467	168	899	1.00
2.00	HMO and other (see instructions)			51	0		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				0		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	467	168	899	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	0.00					26.00
26.01	RURAL HEALTH CLINIC II	0.00					26.01
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 14-0294 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-3 Part II Date/Time Prepared: 5/25/2018 11:49 am

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA							
	SALARIES							
1.00	Total salaries (see instructions)	200.00	9,787,518	0	9,787,518	340,975.30	28.70	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician and Non Physician-Part B		457,438	0	457,438	4,548.00	100.58	5.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		567,300	0	567,300	18,092.25	31.36	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		54,821	47,132	101,953	3,680.00	27.70	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		783,067	0	783,067	15,373.28	50.94	11.00
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00	12.00
13.00	Contract labor: Physician-Part A - Administrative		0	0	0	0.00	0.00	13.00
14.00	Home office and/or related orgainzation salaries and wage-related costs		0	0	0	0.00	0.00	14.00
14.01	Home office salaries		485,000	0	485,000	7,560.00	64.15	14.01
14.02	Related organization salaries		0	0	0	0.00	0.00	14.02
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
	WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		2,581,682	0	2,581,682			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		30,867	0	30,867			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		0	0	0			21.00
22.00	Physician Part A - Administrative		0	0	0			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		58,199	0	58,199			23.00
24.00	Wage-related costs (RHC/FQHC)		158,328	0	158,328			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
25.50	Home office wage-related (core)		0	0	0			25.50
25.51	Related organization wage-related (core)		0	0	0			25.51
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0			25.52
25.53	Home office & Contract Physicians Part A - Teaching - wage-related (core)		0	0	0			25.53
	OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	162,609	0	162,609	5,268.25	30.87	26.00
27.00	Administrative & General	5.00	1,513,094	-47,132	1,465,962	60,641.47	24.17	27.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 14-0294 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-3 Part II Date/Time Prepared: 5/25/2018 11:49 am

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
28.00	Administrative & General under contract (see inst.)		130,803	0	130,803	1,676.75	78.01	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	154,804	0	154,804	6,261.75	24.72	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	0	0	0	0.00	0.00	32.00
33.00	Housekeeping under contract (see instructions)		469,602	0	469,602	32,475.96	14.46	33.00
34.00	Dietary	10.00	0	0	0	0.00	0.00	34.00
35.00	Dietary under contract (see instructions)		409,983	0	409,983	24,787.33	16.54	35.00
36.00	Cafeteria	11.00	0	0	0	0.00	0.00	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	753,251	0	753,251	18,776.77	40.12	38.00
39.00	Central Services and Supply	14.00	204,193	0	204,193	10,140.46	20.14	39.00
40.00	Pharmacy	15.00	366,763	0	366,763	5,841.25	62.79	40.00
41.00	Medical Records & Medical Records Library	16.00	311,796	0	311,796	16,134.98	19.32	41.00
42.00	Social Service	17.00	0	0	0	0.00	0.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 14-0294 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-3 Part III Date/Time Prepared: 5/25/2018 11:49 am

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)		9,773,168	0	9,773,168	377,275.09	25.90	1.00
2.00	Excluded area salaries (see instructions)		54,821	47,132	101,953	3,680.00	27.70	2.00
3.00	Subtotal salaries (line 1 minus line 2)		9,718,347	-47,132	9,671,215	373,595.09	25.89	3.00
4.00	Subtotal other wages & related costs (see inst.)		1,268,067	0	1,268,067	22,933.28	55.29	4.00
5.00	Subtotal wage-related costs (see inst.)		2,581,682	0	2,581,682	0.00	26.69	5.00
6.00	Total (sum of lines 3 thru 5)		13,568,096	-47,132	13,520,964	396,528.37	34.10	6.00
7.00	Total overhead cost (see instructions)		4,476,898	-47,132	4,429,766	182,004.97	24.34	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 14-0294 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-3 Part IV Date/Time Prepared: 5/25/2018 11:49 am

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	122,267	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	1,596,179	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)	0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	0	8.02
8.03	Health Insurance (Purchased)	0	8.03
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	15,636	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	9,420	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	-142	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	10,728	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	206,604	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	0	16.00
	TAXES		
17.00	FICA-Employers Portion Only	554,273	17.00
18.00	Medicare Taxes - Employers Portion Only	129,628	18.00
19.00	Unemployment Insurance	0	19.00
20.00	State or Federal Unemployment Taxes	80,999	20.00
	OTHER		
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	103,484	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	0	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	2,829,076	24.00
	Part B - Other than Core Related Cost		
25.00	OTHER WAGE COST	0	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST | Provider CCN: 14-0294 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-3 Part V | Date/Time Prepared: 5/25/2018 11:49 am

	Cost Center Description	Contract Labor	Benefit Cost	
		1.00	2.00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	783,067	2,829,076	1.00
2.00	Hospital	783,067	2,829,076	2.00
3.00	Subprovider - IPF			3.00
4.00	Subprovider - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC	0	0	14.00
14.01	Hospital-Based Health Clinic RHC 1	0	0	14.01
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis	0	0	17.00
18.00	Other	0	0	18.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 14-0294 | Component CCN: 14-8524 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-8 | Date/Time Prepared: 5/25/2018 11:49 am

RHC I | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			3050 BROADWAY		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	MT.VERNON		IL	62864	2.00
					1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0	3.00
			Grant Award		Date	
			1.00		2.00	
	Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)					4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)					5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)					6.00
7.00	Appalachian Regional Commission					7.00
8.00	Look-Alikes					8.00
9.00	OTHER (SPECIFY)					9.00
				1.00	2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N	0	10.00

		Sunday		Monday		Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
	Facility hours of operations (1)						
11.00	CLINIC			08:00	16:30	08:00	11.00

				1.00	2.00	
12.00	Have you received an approval for an exception to the productivity standard?					12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.			N	0	13.00
				Provider name	CCN number	
				1.00	2.00	
14.00	RHC/FQHC name, CCN number					14.00

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

			County				
			4.00				
2.00	City, State, ZIP Code, County		JEFFERSON				2.00
		Tuesday	Wednesday		Thursday		
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)						
11.00	CLINIC	16:30	08:00	16:30	08:00	16:30	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-0294
Component CCN: 14-8524

Period:
From 01/01/2017
To 12/31/2017

Worksheet S-8

Date/Time Prepared:
5/25/2018 11:49 am

RHC I

Cost

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	CLINIC	08:00	16:30				11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 14-0294 | Component CCN: 14-8523 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-8 | Date/Time Prepared: 5/25/2018 11:49 am

RHC II | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			1209 W ROBINSON		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	WAYNE CITY		IL	62864	2.00
					1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0	3.00
			Grant Award		Date	
			1.00		2.00	
	Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)					4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)					5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)					6.00
7.00	Appalachian Regional Commission					7.00
8.00	Look-Alikes					8.00
9.00	OTHER (SPECIFY)					9.00
				1.00	2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N	0	10.00

		Sunday		Monday		Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
	Facility hours of operations (1)						
11.00	CLINIC			08:00	16:30	08:00	11.00

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

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

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

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

		Tuesday	Wednesday		Thursday		
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)						
11.00	CLINIC	16:30	08:00	16:30	08:00	12:00	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-0294
Component CCN: 14-8523

Period:
From 01/01/2017
To 12/31/2017

Worksheet S-8

Date/Time Prepared:
5/25/2018 11:49 am

RHC II

Cost

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	CLINIC	08:00	16:30				11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 14-0294 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-10 | Date/Time Prepared: 5/25/2018 11:49 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)	0.145220	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	2,095,259	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?	N	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	1	5.00
6.00	Medicaid charges	52,214,504	6.00
7.00	Medicaid cost (line 1 times line 6)	7,582,590	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)	5,487,330	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)	131	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	369	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	54	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	5,487,330	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)	2,654,203	40,190	2,694,393	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	385,443	40,190	425,633	21.00
22.00	Payments received from patients for amounts previously written off as charity care	20,611	0	20,611	22.00
23.00	Cost of charity care (line 21 minus line 22)	364,832	40,190	405,022	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)	2,615,193	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	233,081	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	358,587	27.01
28.00	Non-Medicare bad debt expense (see instructions)	2,256,606	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	453,210	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	858,232	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	6,345,562	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-0294 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A | Date/Time Prepared: 5/25/2018 11:49 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		775,557	775,557	179,149	954,706	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		1,388,001	1,388,001	824,291	2,212,292	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	162,609	44,150	206,759	2,060,202	2,266,961	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,513,094	8,738,548	10,251,642	-2,338,415	7,913,227	5.00
7.00	00700	OPERATION OF PLANT	154,804	1,168,682	1,323,486	-57,575	1,265,911	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	83,504	83,504	171	83,675	8.00
9.00	00900	HOUSEKEEPING	0	512,443	512,443	0	512,443	9.00
10.00	01000	DIETARY	0	665,446	665,446	-270,430	395,016	10.00
11.00	01100	CAFETERIA	0	0	0	270,010	270,010	11.00
13.00	01300	NURSING ADMINISTRATION	753,251	225,908	979,159	-4,306	974,853	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	204,193	806,793	1,010,986	-562,282	448,704	14.00
15.00	01500	PHARMACY	366,763	672,487	1,039,250	-619,201	420,049	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	311,796	137,672	449,468	-3,959	445,509	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	964,256	1,142,288	2,106,544	-13,262	2,093,282	30.00
31.00	03100	INTENSIVE CARE UNIT	155,263	70,365	225,628	-3,060	222,568	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	836,547	5,220,359	6,056,906	-2,344,461	3,712,445	50.00
51.00	05100	RECOVERY ROOM	445,948	68,238	514,186	-514,186	0	51.00
53.00	05300	ANESTHESIOLOGY	0	637,726	637,726	0	637,726	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	499,880	927,694	1,427,574	-112,935	1,314,639	54.00
54.01	03630	ULTRA SOUND	71,701	377,091	448,792	0	448,792	54.01
56.00	05600	RADIOISOTOPE	31,890	234,378	266,268	0	266,268	56.00
57.00	05700	CT SCAN	122,860	224,044	346,904	0	346,904	57.00
58.00	05800	MRI	5,033	144,463	149,496	0	149,496	58.00
60.00	06000	LABORATORY	663,803	605,634	1,269,437	-52,227	1,217,210	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	136	50,977	51,113	-35,595	15,518	62.00
65.00	06500	RESPIRATORY THERAPY	249,058	77,544	326,602	-567	326,035	65.00
66.00	06600	PHYSICAL THERAPY	61	838,091	838,152	-114,900	723,252	66.00
67.00	06700	OCCUPATIONAL THERAPY	62	254,184	254,246	0	254,246	67.00
68.00	06800	SPEECH PATHOLOGY	0	70,885	70,885	0	70,885	68.00
69.00	06900	ELECTROCARDIOLOGY	210,597	24,502	235,099	0	235,099	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	853,706	853,706	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	2,226,710	2,226,710	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	567,826	567,826	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	101,055	40,802	141,857	-302	141,555	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	805,994	281,316	1,087,310	-67,735	1,019,575	88.00
88.01	08801	RURAL HEALTH CLINIC II	218,744	211,571	430,315	-31,899	398,416	88.01
91.00	09100	EMERGENCY	883,299	1,628,304	2,511,603	-7,187	2,504,416	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	9,732,697	28,349,647	38,082,344	-172,419	37,909,925	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	0	0	0	0	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	0	0	173,455	173,455	194.01
194.02	07954	SENIOR CIRCLE	54,821	20,508	75,329	-1,036	74,293	194.02
194.03	07953	VACANT SPACE	0	0	0	0	0	194.03
194.04	07952	GUEST MEALS	0	0	0	0	0	194.04
200.00		TOTAL (SUM OF LINES 118 through 199)	9,787,518	28,370,155	38,157,673	0	38,157,673	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-0294 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A | Date/Time Prepared: 5/25/2018 11:49 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	-155,439	799,267		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	41,223	2,253,515		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-3,479	2,263,482		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-2,623,370	5,289,857		5.00
7.00	00700	OPERATION OF PLANT	-25,436	1,240,475		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	83,675		8.00
9.00	00900	HOUSEKEEPING	0	512,443		9.00
10.00	01000	DIETARY	0	395,016		10.00
11.00	01100	CAFETERIA	-74,443	195,567		11.00
13.00	01300	NURSING ADMINISTRATION	0	974,853		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	448,704		14.00
15.00	01500	PHARMACY	0	420,049		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-54	445,455		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-749,674	1,343,608		30.00
31.00	03100	INTENSIVE CARE UNIT	0	222,568		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-73,200	3,639,245		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
53.00	05300	ANESTHESIOLOGY	-618,830	18,896		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-300,564	1,014,075		54.00
54.01	03630	ULTRA SOUND	-3,108	445,684		54.01
56.00	05600	RADIOISOTOPE	-336	265,932		56.00
57.00	05700	CT SCAN	-45,864	301,040		57.00
58.00	05800	MRI	-42	149,454		58.00
60.00	06000	LABORATORY	-4,740	1,212,470		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	15,518		62.00
65.00	06500	RESPIRATORY THERAPY	0	326,035		65.00
66.00	06600	PHYSICAL THERAPY	0	723,252		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	254,246		67.00
68.00	06800	SPEECH PATHOLOGY	0	70,885		68.00
69.00	06900	ELECTROCARDIOLOGY	0	235,099		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	853,706		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	2,226,710		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	567,826		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
76.00	03020	ACUPUNCTURE	0	0		76.00
76.01	03610	SLEEP LAB	0	141,555		76.01
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	1,019,575		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	398,416		88.01
91.00	09100	EMERGENCY	-1,313,420	1,190,996		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-5,950,776	31,959,149		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0		192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0		194.00
194.01	07951	MARKETING	0	173,455		194.01
194.02	07954	SENIOR CIRCLE	0	74,293		194.02
194.03	07953	VACANT SPACE	0	0		194.03
194.04	07952	GUEST MEALS	0	0		194.04
200.00		TOTAL (SUM OF LINES 118 through 199)	-5,950,776	32,206,897		200.00

RECLASSIFICATIONS | Provider CCN: 14-0294 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-6 | Date/Time Prepared: 5/25/2018 11:49 am

		Increases				
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - EMPLOYEE BENEFITS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	2,062,294		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
	0		0	2,062,294		
	B - OXYGEN SUPPLY					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	54,342		1.00
	0		0	54,342		
	C - RENTAL AND LEASE RECLASS					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	115,309		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	821,260		2.00
3.00	LAUNDRY & LINEN SERVICE	8.00	0	171		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15.00
16.00		0.00	0	0		16.00
17.00		0.00	0	0		17.00
18.00		0.00	0	0		18.00
	0		0	936,740		
	D - OTHER CAPITAL COSTS					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	40,842		1.00
2.00	CAP REL COSTS-BLDG & FIXT	1.00	0	22,998		2.00
3.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	3,031		3.00
	0		0	66,871		
	E - MARKETING					
1.00	MARKETING	194.01	47,132	126,323		1.00
	0		47,132	126,323		
	F - MEDICAL SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	799,364		1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	2,226,710		2.00
	0		0	3,026,074		
	G - COST OF DRUGS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	567,826		1.00
	0		0	567,826		
	H - BLOOD AND LAB					
1.00	LABORATORY	60.00	0	43,261		1.00
2.00	WHOLE BLOOD & PACKED RED BLOOD CELL	62.00	7,666	0		2.00
	0		7,666	43,261		
	I - MISCELLANEOUS DEPARTMENTS					
1.00	OPERATING ROOM	50.00	445,948	68,238		1.00
	0		445,948	68,238		
	J - DIETARY					
1.00	CAFETERIA	11.00	0	270,010		1.00
	0		0	270,010		
500.00	Grand Total: Increases		500,746	7,221,979		500.00

RECLASSIFICATIONS | Provider CCN: 14-0294 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-6 | Date/Time Prepared: 5/25/2018 11:49 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - EMPLOYEE BENEFITS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	1,962,660	0		1.00
2.00	RURAL HEALTH CLINIC	88.00	0	67,735	0		2.00
3.00	RURAL HEALTH CLINIC II	88.01	0	31,899	0		3.00
	0		0	2,062,294			
	B - OXYGEN SUPPLY						
1.00	OPERATION OF PLANT	7.00	0	54,342	0		1.00
	0		0	54,342			
	C - RENTAL AND LEASE RECLASS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	2,092	10		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	135,429	10		2.00
3.00	OPERATION OF PLANT	7.00	0	3,233	0		3.00
4.00	DIETARY	10.00	0	420	0		4.00
5.00	NURSING ADMINISTRATION	13.00	0	4,306	0		5.00
6.00	CENTRAL SERVICES & SUPPLY	14.00	0	2,291	0		6.00
7.00	PHARMACY	15.00	0	51,375	0		7.00
8.00	MEDICAL RECORDS & LIBRARY	16.00	0	3,959	0		8.00
9.00	ADULTS & PEDIATRICS	30.00	0	13,262	0		9.00
10.00	INTENSIVE CARE UNIT	31.00	0	3,060	0		10.00
11.00	OPERATING ROOM	50.00	0	392,564	0		11.00
12.00	RADIOLOGY-DIAGNOSTIC	54.00	0	112,935	0		12.00
13.00	LABORATORY	60.00	0	87,822	0		13.00
14.00	RESPIRATORY THERAPY	65.00	0	567	0		14.00
15.00	PHYSICAL THERAPY	66.00	0	114,900	0		15.00
16.00	SLEEP LAB	76.01	0	302	0		16.00
17.00	EMERGENCY	91.00	0	7,187	0		17.00
18.00	SENIOR CIRCLE	194.02	0	1,036	0		18.00
	0		0	936,740			
	D - OTHER CAPITAL COSTS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	66,871	12		1.00
2.00		0.00	0	0	13		2.00
3.00		0.00	0	0	12		3.00
	0		0	66,871			
	E - MARKETING						
1.00	ADMINISTRATIVE & GENERAL	5.00	47,132	126,323	0		1.00
	0		47,132	126,323			
	F - MEDICAL SUPPLIES						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	559,991	0		1.00
2.00	OPERATING ROOM	50.00	0	2,466,083	0		2.00
	0		0	3,026,074			
	G - COST OF DRUGS						
1.00	PHARMACY	15.00	0	567,826	0		1.00
	0		0	567,826			
	H - BLOOD AND LAB						
1.00	LABORATORY	60.00	7,666	0	0		1.00
2.00	WHOLE BLOOD & PACKED RED BLOOD CELL	62.00	0	43,261	0		2.00
	0		7,666	43,261			
	I - MISCELLANEOUS DEPARTMENTS						
1.00	RECOVERY ROOM	51.00	445,948	68,238	0		1.00
	0		445,948	68,238			
	J - DIETARY						
1.00	DIETARY	10.00	0	270,010	0		1.00
	0		0	270,010			
500.00	Grand Total: Decreases		500,746	7,221,979			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-0294 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-7 Part I | Date/Time Prepared: 5/25/2018 11:49 am

		Beginning Balances	Acquisitions: Purchases	Acquisitions: Donation	Acquisitions: Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	961,157	0	0	0	0	1.00
2.00	Land Improvements	411,367	0	0	0	0	2.00
3.00	Buildings and Fixtures	28,865,081	25,590	0	25,590	0	3.00
4.00	Building Improvements	5,824,416	13,498	0	13,498	0	4.00
5.00	Fixed Equipment	2,236,145	43,003	0	43,003	0	5.00
6.00	Movable Equipment	12,705,943	55,232	0	55,232	179,008	6.00
7.00	HIT designated Assets	4,787,566	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	55,791,675	137,323	0	137,323	179,008	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	55,791,675	137,323	0	137,323	179,008	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	961,157	0	1.00
2.00	Land Improvements	411,367	0	2.00
3.00	Buildings and Fixtures	28,890,671	0	3.00
4.00	Building Improvements	5,837,914	0	4.00
5.00	Fixed Equipment	2,279,148	0	5.00
6.00	Movable Equipment	12,582,167	0	6.00
7.00	HIT designated Assets	4,787,566	0	7.00
8.00	Subtotal (sum of lines 1-7)	55,749,990	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	55,749,990	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-0294 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-7 Part II | Date/Time Prepared: 5/25/2018 11:49 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	775,557	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	1,388,001	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	2,163,558	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	775,557		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	1,388,001		2.00
3.00	Total (sum of lines 1-2)	0	2,163,558		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-0294 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-7 Part III Date/Time Prepared: 5/25/2018 11:49 am

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	COMPUTATION OF RATIOS: Capitalized Leases	COMPUTATION OF RATIOS: Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	ALLOCATION OF OTHER CAPITAL: Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	36,101,110	0	36,101,110	0.647554	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	19,648,882	0	19,648,882	0.352446	0	2.00
3.00	Total (sum of lines 1-2)	55,749,992	0	55,749,992	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	ALLOCATION OF OTHER CAPITAL: Other Capital-Related Costs	ALLOCATION OF OTHER CAPITAL: Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	SUMMARY OF CAPITAL: Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	745,575	-10,148	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	1,429,224	821,260	2.00
3.00	Total (sum of lines 1-2)	0	0	0	2,174,799	811,112	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	SUMMARY OF CAPITAL: Insurance (see instructions)	SUMMARY OF CAPITAL: Taxes (see instructions)	SUMMARY OF CAPITAL: Other Capital-Related Costs (see instructions)	SUMMARY OF CAPITAL: Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	40,842	22,998	0	799,267	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	3,031	0	0	2,253,515	2.00
3.00	Total (sum of lines 1-2)	0	43,873	22,998	0	3,052,782	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-0294 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-8 | Date/Time Prepared: 5/25/2018 11:49 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-58,675	ADMINISTRATIVE & GENERAL	5.00	0	7.00
8.00	Television and radio service (chapter 21)	A	-6,542	CAP REL COSTS-MVBLE EQUIP	2.00	9	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-3,108,245			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)	B	-1,533	RADIOLOGY-DIAGNOSTIC	54.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	-396,772			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-74,443	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-54	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		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	A	-71,010	CAP REL COSTS-BLDG & FIXT	1.00	9	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP	A	51,350	CAP REL COSTS-MVBLE EQUIP	2.00	9	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-0294 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-8 | Date/Time Prepared: 5/25/2018 11:49 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	ADMIN & GENERAL ORGANIZATION COST	A	-137,792	ADMINISTRATIVE & GENERAL	5.00	0	33.00
33.01	MARKETING EXPENSE	A	-168,246	ADMINISTRATIVE & GENERAL	5.00	0	33.01
33.02	HEALTH WOMAN SPONSORSHIP	B	502	ADMINISTRATIVE & GENERAL	5.00	0	33.02
33.03	COUNTRY CLUB DUES	A	-1,047	ADMINISTRATIVE & GENERAL	5.00	0	33.03
33.04	PHYSICIAN RECRUITING	A	-270,703	ADMINISTRATIVE & GENERAL	5.00	0	33.04
33.05	LOBBYING EXPENSE	A	-14,708	ADMINISTRATIVE & GENERAL	5.00	0	33.05
33.06	PENALTIES	A	-8	ADMINISTRATIVE & GENERAL	5.00	0	33.06
33.07	SPECIAL EVENTS	A	-36,045	ADMINISTRATIVE & GENERAL	5.00	0	33.07
33.08	MEDICAL STAFF RELATIONS	A	-8,236	ADMINISTRATIVE & GENERAL	5.00	0	33.08
33.09	ILLINOIS PROVIDER TAX	A	-1,423,944	ADMINISTRATIVE & GENERAL	5.00	0	33.09
33.10	GIFT SHOP EXPENSE	A	-939	ADMINISTRATIVE & GENERAL	5.00	0	33.10
33.11	NON-ALLOWABLE LEGAL FEES	A	-48,721	ADMINISTRATIVE & GENERAL	5.00	0	33.11
33.12	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.12
33.13	TELEPHONE BENEFIT COSTS	A	-3,479	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.13
33.14	TELEPHONE DEPRECIATION COST	A	-3,585	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.14
33.15	TELEVISION EXPENSE	A	-25,436	OPERATION OF PLANT	7.00	0	33.15
33.17	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.17
33.19	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.19
33.20	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.20
33.21	RENTAL INCOME	B	-125,457	CAP REL COSTS-BLDG & FIXT	1.00	10	33.21
33.22	OTHER MISCELLANEOUS REVENUE	B	-17,008	ADMINISTRATIVE & GENERAL	5.00	0	33.22
33.23	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.23
33.24	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.24
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-5,950,776				50.00

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1.
(2) Basis for adjustment (see instructions).
A. Costs - if cost, including applicable overhead, can be determined.
B. Amount Received - if cost cannot be determined.
(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.
Note: See instructions for column 5 referencing to Worksheet A-7.

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 14-0294 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-8-1 | Date/Time Prepared: 5/25/2018 11:49 am

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	1.00	CAP REL COSTS-BLDG & FIXT	HOME OFFICE CAPITAL	41,028	0	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE NON CAPITAL	863,510	0	2.00
3.00	5.00	ADMINISTRATIVE & GENERAL	MALPRACTICE COSTS	19,311	410,701	3.00
4.00	5.00	ADMINISTRATIVE & GENERAL	MANAGEMENT FEES	0	909,920	4.00
4.01	0.00			0	0	4.01
4.02	0.00			0	0	4.02
4.03	0.00			0	0	4.03
4.04	0.00			0	0	4.04
4.05	0.00			0	0	4.05
4.06	0.00			0	0	4.06
4.07	0.00			0	0	4.07
4.08	0.00			0	0	4.08
4.10	0.00			0	0	4.10
4.11	0.00			0	0	4.11
4.12	0.00			0	0	4.12
4.15	0.00			0	0	4.15
4.18	0.00			0	0	4.18
4.20	0.00			0	0	4.20
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			923,849	1,320,621	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	B		0.00	QHC	100.00	6.00
7.00			0.00		0.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	Provider CCN: 14-0294	Period: From 01/01/2017 To 12/31/2017	Worksheet A-8-1 Date/Time Prepared: 5/25/2018 11:49 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	41,028	9		1.00
2.00	863,510	0		2.00
3.00	-391,390	0		3.00
4.00	-909,920	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
4.10	0	0		4.10
4.11	0	0		4.11
4.12	0	0		4.12
4.15	0	0		4.15
4.18	0	0		4.18
4.20	0	0		4.20
5.00	-396,772			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	HOSPITAL MGMT		6.00
7.00			7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 14-0294 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-8-2 | Date/Time Prepared: 5/25/2018 11:49 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	30.00	ADULTS & PEDIATRICS	749,674	749,674	0	0	0	1.00
2.00	50.00	OPERATING ROOM	73,200	73,200	0	0	0	2.00
3.00	53.00	ANESTHESIOLOGY	618,830	618,830	0	0	0	3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	299,031	299,031	0	0	0	4.00
5.00	54.01	ULTRA SOUND	3,108	3,108	0	0	0	5.00
6.00	56.00	RADIOISOTOPE	336	336	0	0	0	6.00
7.00	57.00	CT SCAN	45,864	45,864	0	0	0	7.00
8.00	58.00	MRI	42	42	0	0	0	8.00
9.00	60.00	LABORATORY	4,740	4,740	0	0	0	9.00
10.00	91.00	EMERGENCY	1,313,420	1,313,420	0	0	0	10.00
200.00			3,108,245	3,108,245	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	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	50.00	OPERATING ROOM	0	0	0	0	0	2.00
3.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	4.00
5.00	54.01	ULTRA SOUND	0	0	0	0	0	5.00
6.00	56.00	RADIOISOTOPE	0	0	0	0	0	6.00
7.00	57.00	CT SCAN	0	0	0	0	0	7.00
8.00	58.00	MRI	0	0	0	0	0	8.00
9.00	60.00	LABORATORY	0	0	0	0	0	9.00
10.00	91.00	EMERGENCY	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	30.00	ADULTS & PEDIATRICS	0	0	0	749,674		1.00
2.00	50.00	OPERATING ROOM	0	0	0	73,200		2.00
3.00	53.00	ANESTHESIOLOGY	0	0	0	618,830		3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	299,031		4.00
5.00	54.01	ULTRA SOUND	0	0	0	3,108		5.00
6.00	56.00	RADIOISOTOPE	0	0	0	336		6.00
7.00	57.00	CT SCAN	0	0	0	45,864		7.00
8.00	58.00	MRI	0	0	0	42		8.00
9.00	60.00	LABORATORY	0	0	0	4,740		9.00
10.00	91.00	EMERGENCY	0	0	0	1,313,420		10.00
200.00			0	0	0	3,108,245		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0294 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part I Date/Time Prepared: 5/25/2018 11:49 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	799,267	799,267				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2,253,515		2,253,515			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,263,482	5,110	14,406	2,282,998		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5,289,857	85,371	240,703	347,720	5,963,651	5.00
7.00	00700	OPERATION OF PLANT	1,240,475	156,234	440,494	36,719	1,873,922	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	83,675	3,504	9,879	0	97,058	8.00
9.00	00900	HOUSEKEEPING	512,443	26,341	74,269	0	613,053	9.00
10.00	01000	DIETARY	395,016	24,615	69,401	0	489,032	10.00
11.00	01100	CAFETERIA	195,567	0	0	0	195,567	11.00
13.00	01300	NURSING ADMINISTRATION	974,853	8,150	22,979	178,669	1,184,651	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	448,704	17,404	49,071	48,434	563,613	14.00
15.00	01500	PHARMACY	420,049	6,462	18,218	86,995	531,724	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	445,455	15,830	44,633	73,957	579,875	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,343,608	144,287	406,815	228,719	2,123,429	30.00
31.00	03100	INTENSIVE CARE UNIT	222,568	30,486	85,955	36,828	375,837	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,639,245	98,028	276,388	304,204	4,317,865	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	18,896	1,085	3,060	0	23,041	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,014,075	27,579	77,759	118,570	1,237,983	54.00
54.01	03630	ULTRA SOUND	445,684	3,231	9,109	17,007	475,031	54.01
56.00	05600	RADIOISOTOPE	265,932	2,710	7,642	7,564	283,848	56.00
57.00	05700	CT SCAN	301,040	0	0	29,142	330,182	57.00
58.00	05800	MRI	149,454	0	0	1,194	150,648	58.00
60.00	06000	LABORATORY	1,212,470	18,959	53,456	155,634	1,440,519	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	15,518	965	2,720	1,851	21,054	62.00
65.00	06500	RESPIRATORY THERAPY	326,035	8,670	24,446	59,076	418,227	65.00
66.00	06600	PHYSICAL THERAPY	723,252	3,497	9,861	14	736,624	66.00
67.00	06700	OCCUPATIONAL THERAPY	254,246	0	0	15	254,261	67.00
68.00	06800	SPEECH PATHOLOGY	70,885	0	0	0	70,885	68.00
69.00	06900	ELECTROCARDIOLOGY	235,099	0	0	49,953	285,052	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	853,706	0	0	0	853,706	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,226,710	0	0	0	2,226,710	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	567,826	0	0	0	567,826	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	141,555	0	0	23,970	165,525	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,019,575	0	0	191,179	1,210,754	88.00
88.01	08801	RURAL HEALTH CLINIC II	398,416	0	0	51,885	450,301	88.01
91.00	09100	EMERGENCY	1,190,996	39,874	112,423	209,516	1,552,809	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	31,959,149	728,392	2,053,687	2,258,815	31,664,263	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	2,444	6,890	0	9,334	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	2,374	6,693	0	9,067	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	MARKETING	173,455	1,301	3,669	11,180	189,605	194.01
194.02	07954	SENIOR CIRCLE	74,293	3,428	9,664	13,003	100,388	194.02
194.03	07953	VACANT SPACE	0	61,328	172,912	0	234,240	194.03
194.04	07952	GUEST MEALS	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	32,206,897	799,267	2,253,515	2,282,998	32,206,897	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0294 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part I | Date/Time Prepared: 5/25/2018 11:49 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	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
5.00	00500	ADMINISTRATIVE & GENERAL	5,963,651					5.00
7.00	00700	OPERATION OF PLANT	425,839	2,299,761				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	22,056	14,583	133,697			8.00
9.00	00900	HOUSEKEEPING	139,313	109,634	0	862,000		9.00
10.00	01000	DIETARY	111,130	102,449	0	40,593	743,204	10.00
11.00	01100	CAFETERIA	44,442	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	269,206	33,921	0	13,440	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	128,078	72,438	0	28,702	0	14.00
15.00	01500	PHARMACY	120,832	26,893	0	10,656	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	131,774	65,886	0	26,106	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	482,539	600,533	44,121	237,943	699,351	30.00
31.00	03100	INTENSIVE CARE UNIT	85,407	126,885	8,021	50,275	27,867	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	981,217	407,999	26,741	161,658	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	5,236	4,517	0	1,790	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	281,325	114,786	8,021	45,481	0	54.00
54.01	03630	ULTRA SOUND	107,948	13,447	0	5,328	0	54.01
56.00	05600	RADIOISOTOPE	64,503	11,280	0	4,470	0	56.00
57.00	05700	CT SCAN	75,032	0	0	0	0	57.00
58.00	05800	MRI	34,234	0	0	0	0	58.00
60.00	06000	LABORATORY	327,351	78,910	0	31,266	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	4,784	4,016	0	1,591	0	62.00
65.00	06500	RESPIRATORY THERAPY	95,040	36,087	4,011	14,298	0	65.00
66.00	06600	PHYSICAL THERAPY	167,394	14,556	0	5,768	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	57,780	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	16,108	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	64,777	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	194,000	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	506,009	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	129,036	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	37,615	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	275,138	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	102,329	0	0	0	0	88.01
91.00	09100	EMERGENCY	352,868	165,958	42,782	65,756	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	5,840,340	2,004,778	133,697	745,121	727,218	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,121	10,171	0	4,030	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2,060	9,880	0	3,915	0	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	MARKETING	43,087	5,416	0	2,146	0	194.01
194.02	07954	SENIOR CIRCLE	22,813	14,266	0	5,652	0	194.02
194.03	07953	VACANT SPACE	53,230	255,250	0	101,136	0	194.03
194.04	07952	GUEST MEALS	0	0	0	0	15,986	194.04
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)	5,963,651	2,299,761	133,697	862,000	743,204	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0294 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part I | Date/Time Prepared: 5/25/2018 11:49 am

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	240,009					11.00
13.00	01300	NURSING ADMINISTRATION	18,312	1,519,530				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	9,896	0	802,727			14.00
15.00	01500	PHARMACY	5,699	99,376	2,472	797,652		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	15,737	0	880	0	820,258	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	33,421	261,268	12,521	0	24,579	30.00
31.00	03100	INTENSIVE CARE UNIT	4,218	42,069	942	0	1,402	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	42,120	347,496	239,508	0	152,882	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	2,862	0	77,205	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	17,765	135,444	4,221	0	33,724	54.00
54.01	03630	ULTRA SOUND	2,738	19,428	813	0	11,243	54.01
56.00	05600	RADIOISOTOPE	1,136	8,641	47	0	7,894	56.00
57.00	05700	CT SCAN	4,827	33,289	5,166	0	117,748	57.00
58.00	05800	MRI	243	1,364	476	0	12,155	58.00
60.00	06000	LABORATORY	29,162	177,782	28,455	0	135,499	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	345	2,114	0	0	1,611	62.00
65.00	06500	RESPIRATORY THERAPY	9,673	67,483	5,171	0	9,620	65.00
66.00	06600	PHYSICAL THERAPY	0	0	1,749	0	18,888	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	650	0	7,721	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	17	0	1,008	68.00
69.00	06900	ELECTROCARDIOLOGY	9,329	57,062	174	0	19,954	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	124,990	0	3,451	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	348,174	0	65,782	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	797,652	29,095	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	3,792	27,381	2,448	0	4,812	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	3,867	0	3,801	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	2,329	0	2,107	88.01
91.00	09100	EMERGENCY	28,006	239,333	10,381	0	78,077	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	236,419	1,519,530	798,313	797,652	820,258	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	0	0	0	0	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	MARKETING	1,562	0	3,108	0	0	194.01
194.02	07954	SENIOR CIRCLE	2,028	0	1,306	0	0	194.02
194.03	07953	VACANT SPACE	0	0	0	0	0	194.03
194.04	07952	GUEST MEALS	0	0	0	0	0	194.04
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)	240,009	1,519,530	802,727	797,652	820,258	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0294 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part I Date/Time Prepared: 5/25/2018 11:49 am

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	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
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
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
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	4,519,705	0	4,519,705		30.00
31.00	03100	INTENSIVE CARE UNIT	722,923	0	722,923		31.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	6,677,486	0	6,677,486		50.00
51.00	05100	RECOVERY ROOM	0	0	0		51.00
53.00	05300	ANESTHESIOLOGY	114,651	0	114,651		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,878,750	0	1,878,750		54.00
54.01	03630	ULTRA SOUND	635,976	0	635,976		54.01
56.00	05600	RADIOISOTOPE	381,819	0	381,819		56.00
57.00	05700	CT SCAN	566,244	0	566,244		57.00
58.00	05800	MRI	199,120	0	199,120		58.00
60.00	06000	LABORATORY	2,248,944	0	2,248,944		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	35,515	0	35,515		62.00
65.00	06500	RESPIRATORY THERAPY	659,610	0	659,610		65.00
66.00	06600	PHYSICAL THERAPY	944,979	0	944,979		66.00
67.00	06700	OCCUPATIONAL THERAPY	320,412	0	320,412		67.00
68.00	06800	SPEECH PATHOLOGY	88,018	0	88,018		68.00
69.00	06900	ELECTROCARDIOLOGY	436,348	0	436,348		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,176,147	0	1,176,147		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,146,675	0	3,146,675		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,523,609	0	1,523,609		73.00
74.00	07400	RENAL DIALYSIS	0	0	0		74.00
76.00	03020	ACUPUNCTURE	0	0	0		76.00
76.01	03610	SLEEP LAB	241,573	0	241,573		76.01
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	1,493,560	0	1,493,560		88.00
88.01	08801	RURAL HEALTH CLINIC II	557,066	0	557,066		88.01
91.00	09100	EMERGENCY	2,535,970	0	2,535,970		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0			92.00
		SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	31,105,100	0	31,105,100		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	25,656	0	25,656		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	24,922	0	24,922		192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0		194.00
194.01	07951	MARKETING	244,924	0	244,924		194.01
194.02	07954	SENIOR CIRCLE	146,453	0	146,453		194.02
194.03	07953	VACANT SPACE	643,856	0	643,856		194.03
194.04	07952	GUEST MEALS	15,986	0	15,986		194.04
200.00		Cross Foot Adjustments	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	32,206,897	0	32,206,897		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0294 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part II Date/Time Prepared: 5/25/2018 11:49 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	5,110	14,406	19,516	19,516	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	85,371	240,703	326,074	2,968	5.00
7.00	00700	OPERATION OF PLANT	0	156,234	440,494	596,728	314	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	3,504	9,879	13,383	0	8.00
9.00	00900	HOUSEKEEPING	0	26,341	74,269	100,610	0	9.00
10.00	01000	DIETARY	0	24,615	69,401	94,016	0	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	8,150	22,979	31,129	1,528	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	17,404	49,071	66,475	414	14.00
15.00	01500	PHARMACY	0	6,462	18,218	24,680	744	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	15,830	44,633	60,463	632	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	144,287	406,815	551,102	1,956	30.00
31.00	03100	INTENSIVE CARE UNIT	0	30,486	85,955	116,441	315	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	98,028	276,388	374,416	2,601	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	1,085	3,060	4,145	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	27,579	77,759	105,338	1,014	54.00
54.01	03630	ULTRA SOUND	0	3,231	9,109	12,340	145	54.01
56.00	05600	RADIOISOTOPE	0	2,710	7,642	10,352	65	56.00
57.00	05700	CT SCAN	0	0	0	0	249	57.00
58.00	05800	MRI	0	0	0	0	10	58.00
60.00	06000	LABORATORY	0	18,959	53,456	72,415	1,331	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	965	2,720	3,685	16	62.00
65.00	06500	RESPIRATORY THERAPY	0	8,670	24,446	33,116	505	65.00
66.00	06600	PHYSICAL THERAPY	0	3,497	9,861	13,358	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	427	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	205	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	1,635	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	444	88.01
91.00	09100	EMERGENCY	0	39,874	112,423	152,297	1,791	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	728,392	2,053,687	2,782,079	19,309	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	2,444	6,890	9,334	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	2,374	6,693	9,067	0	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	1,301	3,669	4,970	96	194.01
194.02	07954	SENIOR CIRCLE	0	3,428	9,664	13,092	111	194.02
194.03	07953	VACANT SPACE	0	61,328	172,912	234,240	0	194.03
194.04	07952	GUEST MEALS	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	799,267	2,253,515	3,052,782	19,516	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0294 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part II | Date/Time Prepared: 5/25/2018 11:49 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	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
5.00	00500	ADMINISTRATIVE & GENERAL	329,042					5.00
7.00	00700	OPERATION OF PLANT	23,495	620,537				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,217	3,935	18,535			8.00
9.00	00900	HOUSEKEEPING	7,686	29,582	0	137,878		9.00
10.00	01000	DIETARY	6,131	27,643	0	6,493	134,283	10.00
11.00	01100	CAFETERIA	2,452	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	14,853	9,153	0	2,150	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	7,067	19,546	0	4,591	0	14.00
15.00	01500	PHARMACY	6,667	7,257	0	1,704	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	7,270	17,778	0	4,176	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	26,624	162,041	6,117	38,059	126,360	30.00
31.00	03100	INTENSIVE CARE UNIT	4,712	34,237	1,112	8,042	5,035	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	54,142	110,089	3,707	25,857	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	289	1,219	0	286	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	15,522	30,972	1,112	7,275	0	54.00
54.01	03630	ULTRA SOUND	5,956	3,628	0	852	0	54.01
56.00	05600	RADIOISOTOPE	3,559	3,044	0	715	0	56.00
57.00	05700	CT SCAN	4,140	0	0	0	0	57.00
58.00	05800	MRI	1,889	0	0	0	0	58.00
60.00	06000	LABORATORY	18,061	21,292	0	5,001	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	264	1,083	0	254	0	62.00
65.00	06500	RESPIRATORY THERAPY	5,244	9,737	556	2,287	0	65.00
66.00	06600	PHYSICAL THERAPY	9,236	3,928	0	923	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	3,188	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	889	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	3,574	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	10,704	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	27,918	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	7,119	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	2,075	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	15,180	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	5,646	0	0	0	0	88.01
91.00	09100	EMERGENCY	19,469	44,780	5,931	10,518	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	322,238	540,944	18,535	119,183	131,395	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	117	2,744	0	645	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	114	2,666	0	626	0	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	MARKETING	2,377	1,461	0	343	0	194.01
194.02	07954	SENIOR CIRCLE	1,259	3,849	0	904	0	194.02
194.03	07953	VACANT SPACE	2,937	68,873	0	16,177	0	194.03
194.04	07952	GUEST MEALS	0	0	0	0	2,888	194.04
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)	329,042	620,537	18,535	137,878	134,283	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0294 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part II | Date/Time Prepared: 5/25/2018 11:49 am

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	2,452					11.00
13.00	01300	NURSING ADMINISTRATION	187	59,000				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	101	0	98,194			14.00
15.00	01500	PHARMACY	58	3,859	302	45,271		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	161	0	108	0	90,588	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	341	10,145	1,532	0	2,715	30.00
31.00	03100	INTENSIVE CARE UNIT	43	1,634	115	0	155	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	431	13,490	29,298	0	16,880	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	350	0	8,527	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	181	5,259	516	0	3,725	54.00
54.01	03630	ULTRA SOUND	28	754	99	0	1,242	54.01
56.00	05600	RADIOISOTOPE	12	336	6	0	872	56.00
57.00	05700	CT SCAN	49	1,293	632	0	13,005	57.00
58.00	05800	MRI	2	53	58	0	1,342	58.00
60.00	06000	LABORATORY	298	6,903	3,481	0	14,965	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	4	82	0	0	178	62.00
65.00	06500	RESPIRATORY THERAPY	99	2,620	633	0	1,062	65.00
66.00	06600	PHYSICAL THERAPY	0	0	214	0	2,086	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	79	0	853	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	2	0	111	68.00
69.00	06900	ELECTROCARDIOLOGY	95	2,216	21	0	2,204	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	15,289	0	381	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	42,591	0	7,265	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	45,271	3,213	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	39	1,063	300	0	531	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	473	0	420	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	285	0	233	88.01
91.00	09100	EMERGENCY	286	9,293	1,270	0	8,623	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,415	59,000	97,654	45,271	90,588	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	0	0	0	0	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	MARKETING	16	0	380	0	0	194.01
194.02	07954	SENIOR CIRCLE	21	0	160	0	0	194.02
194.03	07953	VACANT SPACE	0	0	0	0	0	194.03
194.04	07952	GUEST MEALS	0	0	0	0	0	194.04
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)	2,452	59,000	98,194	45,271	90,588	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0294 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part II | Date/Time Prepared: 5/25/2018 11:49 am

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	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
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
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
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	926,992	0	926,992		30.00
31.00	03100	INTENSIVE CARE UNIT	171,841	0	171,841		31.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	630,911	0	630,911		50.00
51.00	05100	RECOVERY ROOM	0	0	0		51.00
53.00	05300	ANESTHESIOLOGY	14,816	0	14,816		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	170,914	0	170,914		54.00
54.01	03630	ULTRA SOUND	25,044	0	25,044		54.01
56.00	05600	RADIOISOTOPE	18,961	0	18,961		56.00
57.00	05700	CT SCAN	19,368	0	19,368		57.00
58.00	05800	MRI	3,354	0	3,354		58.00
60.00	06000	LABORATORY	143,747	0	143,747		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	5,566	0	5,566		62.00
65.00	06500	RESPIRATORY THERAPY	55,859	0	55,859		65.00
66.00	06600	PHYSICAL THERAPY	29,745	0	29,745		66.00
67.00	06700	OCCUPATIONAL THERAPY	4,120	0	4,120		67.00
68.00	06800	SPEECH PATHOLOGY	1,002	0	1,002		68.00
69.00	06900	ELECTROCARDIOLOGY	8,537	0	8,537		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	26,374	0	26,374		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	77,774	0	77,774		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	55,603	0	55,603		73.00
74.00	07400	RENAL DIALYSIS	0	0	0		74.00
76.00	03020	ACUPUNCTURE	0	0	0		76.00
76.01	03610	SLEEP LAB	4,213	0	4,213		76.01
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	17,708	0	17,708		88.00
88.01	08801	RURAL HEALTH CLINIC II	6,608	0	6,608		88.01
91.00	09100	EMERGENCY	254,258	0	254,258		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0			92.00
		SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,673,315	0	2,673,315		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	12,840	0	12,840		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	12,473	0	12,473		192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0		194.00
194.01	07951	MARKETING	9,643	0	9,643		194.01
194.02	07954	SENIOR CIRCLE	19,396	0	19,396		194.02
194.03	07953	VACANT SPACE	322,227	0	322,227		194.03
194.04	07952	GUEST MEALS	2,888	0	2,888		194.04
200.00		Cross Foot Adjustments	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	3,052,782	0	3,052,782		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0294 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B-1 | Date/Time Prepared: 5/25/2018 11:49 am

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	125,922					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		125,922				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	805	805	9,624,909			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	13,450	13,450	1,465,962	-5,963,651	26,243,246	5.00
7.00	00700	OPERATION OF PLANT	24,614	24,614	154,804	0	1,873,922	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	552	552	0	0	97,058	8.00
9.00	00900	HOUSEKEEPING	4,150	4,150	0	0	613,053	9.00
10.00	01000	DIETARY	3,878	3,878	0	0	489,032	10.00
11.00	01100	CAFETERIA	0	0	0	0	195,567	11.00
13.00	01300	NURSING ADMINISTRATION	1,284	1,284	753,251	0	1,184,651	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,742	2,742	204,193	0	563,613	14.00
15.00	01500	PHARMACY	1,018	1,018	366,763	0	531,724	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,494	2,494	311,796	0	579,875	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	22,732	22,732	964,256	0	2,123,429	30.00
31.00	03100	INTENSIVE CARE UNIT	4,803	4,803	155,263	0	375,837	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	15,444	15,444	1,282,495	0	4,317,865	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	171	171	0	0	23,041	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,345	4,345	499,880	0	1,237,983	54.00
54.01	03630	ULTRA SOUND	509	509	71,701	0	475,031	54.01
56.00	05600	RADIOISOTOPE	427	427	31,890	0	283,848	56.00
57.00	05700	CT SCAN	0	0	122,860	0	330,182	57.00
58.00	05800	MRI	0	0	5,033	0	150,648	58.00
60.00	06000	LABORATORY	2,987	2,987	656,137	0	1,440,519	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	152	152	7,802	0	21,054	62.00
65.00	06500	RESPIRATORY THERAPY	1,366	1,366	249,058	0	418,227	65.00
66.00	06600	PHYSICAL THERAPY	551	551	61	0	736,624	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	62	0	254,261	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	70,885	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	210,597	0	285,052	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	853,706	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	2,226,710	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	567,826	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	101,055	0	165,525	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	805,994	0	1,210,754	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	218,744	0	450,301	88.01
91.00	09100	EMERGENCY	6,282	6,282	883,299	0	1,552,809	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	114,756	114,756	9,522,956	-5,963,651	25,700,612	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	385	385	0	0	9,334	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	374	374	0	0	9,067	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	MARKETING	205	205	47,132	0	189,605	194.01
194.02	07954	SENIOR CIRCLE	540	540	54,821	0	100,388	194.02
194.03	07953	VACANT SPACE	9,662	9,662	0	0	234,240	194.03
194.04	07952	GUEST MEALS	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	799,267	2,253,515	2,282,998		5,963,651	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	6.347318	17.896118	0.237197		0.227245	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			19,516		329,042	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.002028		0.012538	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0294 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B-1 | Date/Time Prepared: 5/25/2018 11:49 am

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTES)	
			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
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	87,053					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	552	141,262				8.00
9.00	00900	HOUSEKEEPING	4,150	0	82,351			9.00
10.00	01000	DIETARY	3,878	0	3,878	32,777		10.00
11.00	01100	CAFETERIA	0	0	0	0	11,835	11.00
13.00	01300	NURSING ADMINISTRATION	1,284	0	1,284	0	903	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,742	0	2,742	0	488	14.00
15.00	01500	PHARMACY	1,018	0	1,018	0	281	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,494	0	2,494	0	776	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	22,732	46,617	22,732	30,843	1,648	30.00
31.00	03100	INTENSIVE CARE UNIT	4,803	8,475	4,803	1,229	208	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	15,444	28,254	15,444	0	2,077	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	171	0	171	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,345	8,475	4,345	0	876	54.00
54.01	03630	ULTRA SOUND	509	0	509	0	135	54.01
56.00	05600	RADIOISOTOPE	427	0	427	0	56	56.00
57.00	05700	CT SCAN	0	0	0	0	238	57.00
58.00	05800	MRI	0	0	0	0	12	58.00
60.00	06000	LABORATORY	2,987	0	2,987	0	1,438	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	152	0	152	0	17	62.00
65.00	06500	RESPIRATORY THERAPY	1,366	4,238	1,366	0	477	65.00
66.00	06600	PHYSICAL THERAPY	551	0	551	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	460	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	187	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
91.00	09100	EMERGENCY	6,282	45,203	6,282	0	1,381	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	75,887	141,262	71,185	32,072	11,658	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	385	0	385	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	374	0	374	0	0	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	MARKETING	205	0	205	0	77	194.01
194.02	07954	SENIOR CIRCLE	540	0	540	0	100	194.02
194.03	07953	VACANT SPACE	9,662	0	9,662	0	0	194.03
194.04	07952	GUEST MEALS	0	0	0	705	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	2,299,761	133,697	862,000	743,204	240,009	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	26.417941	0.946447	10.467390	22.674558	20.279594	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	620,537	18,535	137,878	134,283	2,452	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	7.128267	0.131210	1.674272	4.096867	0.207182	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0294 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B-1 | Date/Time Prepared: 5/25/2018 11:49 am

		Cost Center Description	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)		
			13.00	14.00	15.00	16.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	5,608,089					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	5,133,771				14.00
15.00	01500	PHARMACY	366,763	15,807	567,826			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	5,625	0	214,193,350		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	964,256	80,077	0	6,417,399		30.00
31.00	03100	INTENSIVE CARE UNIT	155,263	6,024	0	366,090		31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,282,495	1,531,754	0	39,943,603		50.00
51.00	05100	RECOVERY ROOM	0	0	0	0		51.00
53.00	05300	ANESTHESIOLOGY	0	18,306	0	20,158,043		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	499,880	26,997	0	8,805,136		54.00
54.01	03630	ULTRA SOUND	71,701	5,199	0	2,935,561		54.01
56.00	05600	RADIOISOTOPE	31,890	301	0	2,061,083		56.00
57.00	05700	CT SCAN	122,860	33,038	0	30,743,519		57.00
58.00	05800	MRI	5,033	3,045	0	3,173,596		58.00
60.00	06000	LABORATORY	656,137	181,981	0	35,378,352		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	7,802	0	0	420,666		62.00
65.00	06500	RESPIRATORY THERAPY	249,058	33,070	0	2,511,803		65.00
66.00	06600	PHYSICAL THERAPY	0	11,188	0	4,931,529		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	4,154	0	2,016,027		67.00
68.00	06800	SPEECH PATHOLOGY	0	107	0	263,241		68.00
69.00	06900	ELECTROCARDIOLOGY	210,597	1,114	0	5,209,840		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	799,364	0	900,979		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	2,226,710	0	17,175,561		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	567,826	7,596,730		73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0		74.00
76.00	03020	ACUPUNCTURE	0	0	0	0		76.00
76.01	03610	SLEEP LAB	101,055	15,659	0	1,256,378		76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	24,732	0	992,524		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	14,898	0	550,044		88.01
91.00	09100	EMERGENCY	883,299	66,389	0	20,385,646		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	5,608,089	5,105,539	567,826	214,193,350		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0		194.00
194.01	07951	MARKETING	0	19,878	0	0		194.01
194.02	07954	SENIOR CIRCLE	0	8,354	0	0		194.02
194.03	07953	VACANT SPACE	0	0	0	0		194.03
194.04	07952	GUEST MEALS	0	0	0	0		194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,519,530	802,727	797,652	820,258		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.270953	0.156362	1.404747	0.003830		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	59,000	98,194	45,271	90,588		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.010521	0.019127	0.079727	0.000423		205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0294 | Period: From 01/01/2017 To 12/31/2017 | Worksheet C Part I Date/Time Prepared: 5/25/2018 11:49 am

Title XVIII | Hospital | PPS

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	Costs RCE Disallowance	Costs Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,519,705		4,519,705	0	4,519,705	30.00
31.00	03100	INTENSIVE CARE UNIT	722,923		722,923	0	722,923	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,677,486		6,677,486	0	6,677,486	50.00
51.00	05100	RECOVERY ROOM	0		0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	114,651		114,651	0	114,651	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,878,750		1,878,750	0	1,878,750	54.00
54.01	03630	ULTRA SOUND	635,976		635,976	0	635,976	54.01
56.00	05600	RADIOISOTOPE	381,819		381,819	0	381,819	56.00
57.00	05700	CT SCAN	566,244		566,244	0	566,244	57.00
58.00	05800	MRI	199,120		199,120	0	199,120	58.00
60.00	06000	LABORATORY	2,248,944		2,248,944	0	2,248,944	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	35,515		35,515	0	35,515	62.00
65.00	06500	RESPIRATORY THERAPY	659,610	0	659,610	0	659,610	65.00
66.00	06600	PHYSICAL THERAPY	944,979	0	944,979	0	944,979	66.00
67.00	06700	OCCUPATIONAL THERAPY	320,412	0	320,412	0	320,412	67.00
68.00	06800	SPEECH PATHOLOGY	88,018	0	88,018	0	88,018	68.00
69.00	06900	ELECTROCARDIOLOGY	436,348		436,348	0	436,348	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,176,147		1,176,147	0	1,176,147	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,146,675		3,146,675	0	3,146,675	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,523,609		1,523,609	0	1,523,609	73.00
74.00	07400	RENAL DIALYSIS	0		0	0	0	74.00
76.00	03020	ACUPUNCTURE	0		0	0	0	76.00
76.01	03610	SLEEP LAB	241,573		241,573	0	241,573	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,493,560		1,493,560	0	1,493,560	88.00
88.01	08801	RURAL HEALTH CLINIC II	557,066		557,066	0	557,066	88.01
91.00	09100	EMERGENCY	2,535,970		2,535,970	0	2,535,970	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	988,905		988,905		988,905	92.00
200.00		Subtotal (see instructions)	32,094,005	0	32,094,005	0	32,094,005	200.00
201.00		Less Observation Beds	988,905		988,905		988,905	201.00
202.00		Total (see instructions)	31,105,100	0	31,105,100	0	31,105,100	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0294 | Period: From 01/01/2017 To 12/31/2017 | Worksheet C Part I Date/Time Prepared: 5/25/2018 11:49 am

Title XVIII | Hospital | PPS

		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	5,272,882		5,272,882			30.00
31.00	03100	INTENSIVE CARE UNIT	366,090		366,090			31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	12,608,890	27,334,713	39,943,603	0.167173	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0.000000	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	6,131,946	14,026,097	20,158,043	0.005688	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,307,832	7,497,304	8,805,136	0.213370	0.000000	54.00
54.01	03630	ULTRA SOUND	176,140	2,759,421	2,935,561	0.216645	0.000000	54.01
56.00	05600	RADIOISOTOPE	145,552	1,915,531	2,061,083	0.185252	0.000000	56.00
57.00	05700	CT SCAN	4,554,961	26,188,558	30,743,519	0.018418	0.000000	57.00
58.00	05800	MRI	120,792	3,052,804	3,173,596	0.062743	0.000000	58.00
60.00	06000	LABORATORY	5,026,081	30,352,271	35,378,352	0.063568	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	240,551	180,115	420,666	0.084426	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	1,547,854	963,949	2,511,803	0.262604	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	913,040	4,018,489	4,931,529	0.191620	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	454,645	1,561,382	2,016,027	0.158932	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	28,278	234,963	263,241	0.334363	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	969,443	4,240,397	5,209,840	0.083755	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	816,993	83,986	900,979	1.305410	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	11,550,794	5,624,767	17,175,561	0.183207	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,692,057	3,904,673	7,596,730	0.200561	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0.000000	0.000000	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0.000000	0.000000	76.00
76.01	03610	SLEEP LAB	0	1,256,378	1,256,378	0.192277	0.000000	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	992,524	992,524			88.00
88.01	08801	RURAL HEALTH CLINIC II	0	550,044	550,044			88.01
91.00	09100	EMERGENCY	2,183,531	18,202,115	20,385,646	0.124400	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	238,210	906,307	1,144,517	0.864037	0.000000	92.00
200.00		Subtotal (see instructions)	58,346,562	155,846,788	214,193,350			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	58,346,562	155,846,788	214,193,350			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0294 | Period: From 01/01/2017 To 12/31/2017 | Worksheet C Part I Date/Time Prepared: 5/25/2018 11:49 am

Title XVIII | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.167173		50.00
51.00	05100	RECOVERY ROOM	0.000000		51.00
53.00	05300	ANESTHESIOLOGY	0.005688		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.213370		54.00
54.01	03630	ULTRA SOUND	0.216645		54.01
56.00	05600	RADIOISOTOPE	0.185252		56.00
57.00	05700	CT SCAN	0.018418		57.00
58.00	05800	MRI	0.062743		58.00
60.00	06000	LABORATORY	0.063568		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.084426		62.00
65.00	06500	RESPIRATORY THERAPY	0.262604		65.00
66.00	06600	PHYSICAL THERAPY	0.191620		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.158932		67.00
68.00	06800	SPEECH PATHOLOGY	0.334363		68.00
69.00	06900	ELECTROCARDIOLOGY	0.083755		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1.305410		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.183207		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.200561		73.00
74.00	07400	RENAL DIALYSIS	0.000000		74.00
76.00	03020	ACUPUNCTURE	0.000000		76.00
76.01	03610	SLEEP LAB	0.192277		76.01
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC			88.00
88.01	08801	RURAL HEALTH CLINIC II			88.01
91.00	09100	EMERGENCY	0.124400		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.864037		92.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0294 | Period: From 01/01/2017 To 12/31/2017 | Worksheet C Part I Date/Time Prepared: 5/25/2018 11:49 am

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,519,705		4,519,705	0	4,519,705	30.00
31.00	03100	INTENSIVE CARE UNIT	722,923		722,923	0	722,923	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,677,486		6,677,486	0	6,677,486	50.00
51.00	05100	RECOVERY ROOM	0		0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	114,651		114,651	0	114,651	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,878,750		1,878,750	0	1,878,750	54.00
54.01	03630	ULTRA SOUND	635,976		635,976	0	635,976	54.01
56.00	05600	RADIOISOTOPE	381,819		381,819	0	381,819	56.00
57.00	05700	CT SCAN	566,244		566,244	0	566,244	57.00
58.00	05800	MRI	199,120		199,120	0	199,120	58.00
60.00	06000	LABORATORY	2,248,944		2,248,944	0	2,248,944	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	35,515		35,515	0	35,515	62.00
65.00	06500	RESPIRATORY THERAPY	659,610	0	659,610	0	659,610	65.00
66.00	06600	PHYSICAL THERAPY	944,979	0	944,979	0	944,979	66.00
67.00	06700	OCCUPATIONAL THERAPY	320,412	0	320,412	0	320,412	67.00
68.00	06800	SPEECH PATHOLOGY	88,018	0	88,018	0	88,018	68.00
69.00	06900	ELECTROCARDIOLOGY	436,348		436,348	0	436,348	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,176,147		1,176,147	0	1,176,147	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,146,675		3,146,675	0	3,146,675	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,523,609		1,523,609	0	1,523,609	73.00
74.00	07400	RENAL DIALYSIS	0		0	0	0	74.00
76.00	03020	ACUPUNCTURE	0		0	0	0	76.00
76.01	03610	SLEEP LAB	241,573		241,573	0	241,573	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,493,560		1,493,560	0	1,493,560	88.00
88.01	08801	RURAL HEALTH CLINIC II	557,066		557,066	0	557,066	88.01
91.00	09100	EMERGENCY	2,535,970		2,535,970	0	2,535,970	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	988,905		988,905		988,905	92.00
200.00		Subtotal (see instructions)	32,094,005	0	32,094,005	0	32,094,005	200.00
201.00		Less Observation Beds	988,905		988,905		988,905	201.00
202.00		Total (see instructions)	31,105,100	0	31,105,100	0	31,105,100	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0294 | Period: From 01/01/2017 To 12/31/2017 | Worksheet C Part I Date/Time Prepared: 5/25/2018 11:49 am

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,272,882		5,272,882			30.00
31.00	03100	INTENSIVE CARE UNIT	366,090		366,090			31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	12,608,890	27,334,713	39,943,603	0.167173	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0.000000	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	6,131,946	14,026,097	20,158,043	0.005688	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,307,832	7,497,304	8,805,136	0.213370	0.000000	54.00
54.01	03630	ULTRA SOUND	176,140	2,759,421	2,935,561	0.216645	0.000000	54.01
56.00	05600	RADIOISOTOPE	145,552	1,915,531	2,061,083	0.185252	0.000000	56.00
57.00	05700	CT SCAN	4,554,961	26,188,558	30,743,519	0.018418	0.000000	57.00
58.00	05800	MRI	120,792	3,052,804	3,173,596	0.062743	0.000000	58.00
60.00	06000	LABORATORY	5,026,081	30,352,271	35,378,352	0.063568	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	240,551	180,115	420,666	0.084426	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	1,547,854	963,949	2,511,803	0.262604	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	913,040	4,018,489	4,931,529	0.191620	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	454,645	1,561,382	2,016,027	0.158932	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	28,278	234,963	263,241	0.334363	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	969,443	4,240,397	5,209,840	0.083755	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	816,993	83,986	900,979	1.305410	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	11,550,794	5,624,767	17,175,561	0.183207	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,692,057	3,904,673	7,596,730	0.200561	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0.000000	0.000000	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0.000000	0.000000	76.00
76.01	03610	SLEEP LAB	0	1,256,378	1,256,378	0.192277	0.000000	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	992,524	992,524	1.504810	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	550,044	550,044	1.012766	0.000000	88.01
91.00	09100	EMERGENCY	2,183,531	18,202,115	20,385,646	0.124400	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	238,210	906,307	1,144,517	0.864037	0.000000	92.00
200.00		Subtotal (see instructions)	58,346,562	155,846,788	214,193,350			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	58,346,562	155,846,788	214,193,350			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0294 | Period: From 01/01/2017 To 12/31/2017 | Worksheet C Part I Date/Time Prepared: 5/25/2018 11:49 am

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
51.00	05100	RECOVERY ROOM	0.000000		51.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
54.01	03630	ULTRA SOUND	0.000000		54.01
56.00	05600	RADIOISOTOPE	0.000000		56.00
57.00	05700	CT SCAN	0.000000		57.00
58.00	05800	MRI	0.000000		58.00
60.00	06000	LABORATORY	0.000000		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000		62.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
74.00	07400	RENAL DIALYSIS	0.000000		74.00
76.00	03020	ACUPUNCTURE	0.000000		76.00
76.01	03610	SLEEP LAB	0.000000		76.01
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	0.000000		88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000		88.01
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 14-0294 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part I Date/Time Prepared: 5/25/2018 11:49 am

Title XVIII | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	926,992	0	926,992	3,181	291.42	30.00
31.00	INTENSIVE CARE UNIT	171,841		171,841	99	1,735.77	31.00
200.00	Total (lines 30 through 199)	1,098,833		1,098,833	3,280		200.00

	Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)	
		6.00	7.00	
	INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	ADULTS & PEDIATRICS	1,418	413,234	30.00
31.00	INTENSIVE CARE UNIT	66	114,561	31.00
200.00	Total (lines 30 through 199)	1,484	527,795	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 14-0294 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part II Date/Time Prepared: 5/25/2018 11:49 am

Title XVIII | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	630,911	39,943,603	0.015795	5,004,802	79,051	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0	0	51.00
53.00	05300	ANESTHESIOLOGY	14,816	20,158,043	0.000735	2,375,483	1,746	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	170,914	8,805,136	0.019411	778,739	15,116	54.00
54.01	03630	ULTRA SOUND	25,044	2,935,561	0.008531	92,114	786	54.01
56.00	05600	RADIOISOTOPE	18,961	2,061,083	0.009200	94,636	871	56.00
57.00	05700	CT SCAN	19,368	30,743,519	0.000630	2,650,395	1,670	57.00
58.00	05800	MRI	3,354	3,173,596	0.001057	80,821	85	58.00
60.00	06000	LABORATORY	143,747	35,378,352	0.004063	2,919,771	11,863	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	5,566	420,666	0.013231	129,377	1,712	62.00
65.00	06500	RESPIRATORY THERAPY	55,859	2,511,803	0.022239	946,162	21,042	65.00
66.00	06600	PHYSICAL THERAPY	29,745	4,931,529	0.006032	553,756	3,340	66.00
67.00	06700	OCCUPATIONAL THERAPY	4,120	2,016,027	0.002044	257,296	526	67.00
68.00	06800	SPEECH PATHOLOGY	1,002	263,241	0.003806	22,460	85	68.00
69.00	06900	ELECTROCARDIOLOGY	8,537	5,209,840	0.001639	646,408	1,059	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	26,374	900,979	0.029273	535,736	15,683	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	77,774	17,175,561	0.004528	4,779,601	21,642	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	55,603	7,596,730	0.007319	1,927,754	14,109	73.00
74.00	07400	RENAL DIALYSIS	0	0	0.000000	0	0	74.00
76.00	03020	ACUPUNCTURE	0	0	0.000000	0	0	76.00
76.01	03610	SLEEP LAB	4,213	1,256,378	0.003353	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	17,708	992,524	0.017841	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	6,608	550,044	0.012014	0	0	88.01
91.00	09100	EMERGENCY	254,258	20,385,646	0.012472	1,263,278	15,756	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	202,824	1,144,517	0.177214	137,039	24,285	92.00
200.00		Total (lines 50 through 199)	1,777,306	208,554,378		25,195,628	230,427	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 14-0294 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part III Date/Time Prepared: 5/25/2018 11:49 am

Title XVIII | Hospital | PPS

		Cost Center Description	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
			1A	1.00	2A	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
200.00		Total (lines 30 through 199)	0	0	0	0	0	200.00

		Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
			4.00	5.00	6.00	7.00	8.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	3,181	0.00	1,418	30.00
31.00	03100	INTENSIVE CARE UNIT		0	99	0.00	66	31.00
200.00		Total (lines 30 through 199)		0	3,280		1,484	200.00

		Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8)		
			9.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	0		30.00
31.00	03100	INTENSIVE CARE UNIT	0		31.00
200.00		Total (lines 30 through 199)	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0294 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part IV | Date/Time Prepared: 5/25/2018 11:49 am

Title XVIII | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	0	54.01
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	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
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: 14-0294 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part IV Date/Time Prepared: 5/25/2018 11:49 am

Title XVIII | Hospital | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	39,943,603	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	20,158,043	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	8,805,136	0.000000	54.00
54.01	03630	ULTRA SOUND	0	0	0	2,935,561	0.000000	54.01
56.00	05600	RADIOISOTOPE	0	0	0	2,061,083	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	30,743,519	0.000000	57.00
58.00	05800	MRI	0	0	0	3,173,596	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	35,378,352	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	420,666	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	2,511,803	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	4,931,529	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	2,016,027	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	263,241	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	5,209,840	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	900,979	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	17,175,561	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	7,596,730	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0.000000	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0.000000	76.00
76.01	03610	SLEEP LAB	0	0	0	1,256,378	0.000000	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	992,524	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	550,044	0.000000	88.01
91.00	09100	EMERGENCY	0	0	0	20,385,646	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	1,144,517	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	208,554,378		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0294 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part IV Date/Time Prepared: 5/25/2018 11:49 am

Title XVIII | Hospital | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	5,004,802	0	7,961,863	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.000000	2,375,483	0	3,873,185	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	778,739	0	2,237,947	0	54.00
54.01	03630	ULTRA SOUND	0.000000	92,114	0	893,213	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	94,636	0	842,930	0	56.00
57.00	05700	CT SCAN	0.000000	2,650,395	0	8,626,655	0	57.00
58.00	05800	MRI	0.000000	80,821	0	1,000,819	0	58.00
60.00	06000	LABORATORY	0.000000	2,919,771	0	3,440,656	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000	129,377	0	111,871	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.000000	946,162	0	390,935	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	553,756	0	37,805	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	257,296	0	11,019	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	22,460	0	1,354	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	646,408	0	1,675,685	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	535,736	0	46,841	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	4,779,601	0	2,329,763	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	1,927,754	0	1,238,859	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	74.00
76.00	03020	ACUPUNCTURE	0.000000	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0.000000	0	0	140,205	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000	0	0	0	0	88.01
91.00	09100	EMERGENCY	0.000000	1,263,278	0	3,836,157	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	137,039	0	344,042	0	92.00
200.00		Total (lines 50 through 199)		25,195,628	0	39,041,804	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-0294 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part V Date/Time Prepared: 5/25/2018 11:49 am

Title XVIII | Hospital | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.167173	7,961,863	0	0	1,331,009	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.005688	3,873,185	0	0	22,031	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.213370	2,237,947	0	0	477,511	54.00
54.01	03630	ULTRA SOUND	0.216645	893,213	0	0	193,510	54.01
56.00	05600	RADIOISOTOPE	0.185252	842,930	0	0	156,154	56.00
57.00	05700	CT SCAN	0.018418	8,626,655	0	0	158,886	57.00
58.00	05800	MRI	0.062743	1,000,819	0	0	62,794	58.00
60.00	06000	LABORATORY	0.063568	3,440,656	0	0	218,716	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.084426	111,871	0	0	9,445	62.00
65.00	06500	RESPIRATORY THERAPY	0.262604	390,935	0	0	102,661	65.00
66.00	06600	PHYSICAL THERAPY	0.191620	37,805	0	0	7,244	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.158932	11,019	0	0	1,751	67.00
68.00	06800	SPEECH PATHOLOGY	0.334363	1,354	0	0	453	68.00
69.00	06900	ELECTROCARDIOLOGY	0.083755	1,675,685	0	0	140,347	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1.305410	46,841	0	0	61,147	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.183207	2,329,763	0	0	426,829	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.200561	1,238,859	0	13,327	248,467	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	74.00
76.00	03020	ACUPUNCTURE	0.000000	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0.192277	140,205	0	0	26,958	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000				0	88.01
91.00	09100	EMERGENCY	0.124400	3,836,157	0	272	477,218	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.864037	344,042	0	0	297,265	92.00
200.00		Subtotal (see instructions)		39,041,804	0	13,599	4,420,396	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		39,041,804	0	13,599	4,420,396	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-0294 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part V Date/Time Prepared: 5/25/2018 11:49 am

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		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
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
54.01	03630	ULTRA SOUND	0	0		54.01
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MRI	0	0		58.00
60.00	06000	LABORATORY	0	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		62.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,673		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
76.00	03020	ACUPUNCTURE	0	0		76.00
76.01	03610	SLEEP LAB	0	0		76.01
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0		88.01
91.00	09100	EMERGENCY	0	34		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
200.00		Subtotal (see instructions)	0	2,707		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	2,707		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-0294 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-1 | Date/Time Prepared: 5/25/2018 11:49 am

Title XVIII | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	3,181	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	3,181	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	2,485	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)	1,418	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	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	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)	4,519,705	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)	4,519,705	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	4,519,705	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)	1,420.84	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	2,014,751	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	2,014,751	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-0294 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-1 | Date/Time Prepared: 5/25/2018 11:49 am

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	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	722,923	99	7,302.25	66	481,949	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)	3,998,563	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	6,495,263	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)	527,795	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	230,427	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	758,222	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	5,737,041	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)	696	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,420.84	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	988,905	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-0294 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-1 | Date/Time Prepared: 5/25/2018 11:49 am

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	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	926,992	4,519,705	0.205100	988,905	202,824	90.00
91.00	Nursing School cost	0	4,519,705	0.000000	988,905	0	91.00
92.00	Allied health cost	0	4,519,705	0.000000	988,905	0	92.00
93.00	All other Medical Education	0	4,519,705	0.000000	988,905	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 14-0294 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-3 | Date/Time Prepared: 5/25/2018 11:49 am

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		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		3,015,468		30.00
31.00	03100	INTENSIVE CARE UNIT		243,602		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.167173	5,004,802	836,668	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.005688	2,375,483	13,512	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.213370	778,739	166,160	54.00
54.01	03630	ULTRA SOUND	0.216645	92,114	19,956	54.01
56.00	05600	RADIOISOTOPE	0.185252	94,636	17,532	56.00
57.00	05700	CT SCAN	0.018418	2,650,395	48,815	57.00
58.00	05800	MRI	0.062743	80,821	5,071	58.00
60.00	06000	LABORATORY	0.063568	2,919,771	185,604	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.084426	129,377	10,923	62.00
65.00	06500	RESPIRATORY THERAPY	0.262604	946,162	248,466	65.00
66.00	06600	PHYSICAL THERAPY	0.191620	553,756	106,111	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.158932	257,296	40,893	67.00
68.00	06800	SPEECH PATHOLOGY	0.334363	22,460	7,510	68.00
69.00	06900	ELECTROCARDIOLOGY	0.083755	646,408	54,140	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1.305410	535,736	699,355	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.183207	4,779,601	875,656	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.200561	1,927,754	386,632	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	74.00
76.00	03020	ACUPUNCTURE	0.000000	0	0	76.00
76.01	03610	SLEEP LAB	0.192277	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000		0	88.01
91.00	09100	EMERGENCY	0.124400	1,263,278	157,152	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.864037	137,039	118,407	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		25,195,628	3,998,563	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		25,195,628		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0294	Period: From 01/01/2017 To 12/31/2017	Worksheet E Part A Date/Time Prepared: 5/25/2018 11:49 am
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		1.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS		
1.00	DRG Amounts Other than Outlier Payments	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)	2,386,968	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	1,065,789	1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)	0	1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)	0	1.04
2.00	Outlier payments for discharges. (see instructions)	121,904	2.00
2.01	Outlier reconciliation amount	0	2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)	0	2.02
3.00	Managed Care Simulated Payments	333,237	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)	45.09	4.00
	Indirect Medical Education Adjustment		
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)	0.00	5.00
6.00	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)	0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)	0.00	7.00
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.	0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).	0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.	0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)	0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see instructions)	0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records	0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.	0.00	11.00
12.00	Current year allowable FTE (see instructions)	0.00	12.00
13.00	Total allowable FTE count for the prior year.	0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.	0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.	0.00	15.00
16.00	Adjustment for residents in initial years of the program	0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure	0.00	17.00
18.00	Adjusted rolling average FTE count	0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).	0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)	0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)	0.000000	21.00
22.00	IME payment adjustment (see instructions)	0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)	0	22.01
	Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA		
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C).	0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)	0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)	0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)	0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)	0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)	0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)	0	28.01
29.00	Total IME payment (sum of lines 22 and 28)	0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)	0	29.01
	Disproportionate Share Adjustment		
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	5.86	30.00
31.00	Percentage of Medicaid patient days (see instructions)	15.25	31.00
32.00	Sum of lines 30 and 31	21.11	32.00
33.00	Allowable disproportionate share percentage (see instructions)	6.63	33.00
34.00	Disproportionate share adjustment (see instructions)	57,230	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0294	Period: From 01/01/2017 To 12/31/2017	Worksheet E Part A Date/Time Prepared: 5/25/2018 11:49 am
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		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	Uncompensated Care Adjustment			
35.00	Total uncompensated care amount (see instructions)	5,977,483,147	6,766,695,164	35.00
35.01	Factor 3 (see instructions)	0.000018796	0.000017815	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	112,355	120,549	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	84,035	30,385	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	114,420		36.00
	Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)			
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)	0		40.00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0		41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0		41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)	0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)	0.00		45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)	0		46.00
47.00	Subtotal (see instructions)	3,746,311		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)	5,118,972		48.00

		Amount	
		1.00	
49.00	Total payment for inpatient operating costs (see instructions)	4,775,807	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)	323,210	50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)	0	51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).	0	52.00
53.00	Nursing and Allied Health Managed Care payment	0	53.00
54.00	Special add-on payments for new technologies	0	54.00
54.01	Islet isolation add-on payment	0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)	0	55.00
56.00	Cost of physicians' services in a teaching hospital (see intructions)	0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).	0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)	0	58.00
59.00	Total (sum of amounts on lines 49 through 58)	5,099,017	59.00
60.00	Primary payer payments	0	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)	5,099,017	61.00
62.00	Deductibles billed to program beneficiaries	484,232	62.00
63.00	Coinsurance billed to program beneficiaries	8,554	63.00
64.00	Allowable bad debts (see instructions)	166,065	64.00
65.00	Adjusted reimbursable bad debts (see instructions)	107,942	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	150,450	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	4,714,173	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)	0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96).(For SCH see instructions)	0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	70.00
70.50	Rural Community Hospital Demonstration Project (§410A Demonstration) adjustment (see instructions)	0	70.50
70.87	Demonstration payment adjustment amount before sequestration	0	70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)	0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)		70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)	-2,290	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)	-10,243	70.91
70.92	Bundled Model 1 discount amount (see instructions)	0	70.92
70.93	HVBP payment adjustment amount (see instructions)	-7,590	70.93
70.94	HRR adjustment amount (see instructions)	-34,314	70.94
70.95	Recovery of accelerated depreciation	0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0294	Period: From 01/01/2017 To 12/31/2017	Worksheet E Part A Date/Time Prepared: 5/25/2018 11:49 am
	Title XVIII	Hospital	PPS

		FFY (yyyy)	Amount	
		0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0	70.97
70.98	Low Volume Payment-3		0	70.98
70.99	HAC adjustment amount (see instructions)		0	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		4,659,736	71.00
71.01	Sequestration adjustment (see instructions)		93,195	71.01
71.02	Demonstration payment adjustment amount after sequestration		0	71.02
72.00	Interim payments		4,290,435	72.00
73.00	Tentative settlement (for contractor use only)		0	73.00
74.00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 73)		276,106	74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		218,378	75.00
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)			
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2 (see instructions)		0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00
95.00	Time value of money for operating expenses (see instructions)		0	95.00
96.00	Time value of money for capital related expenses (see instructions)		0	96.00

		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	HSP Bonus Payment Amount			
100.00	HSP bonus amount (see instructions)	770,007	259,489	100.00
	HVBP Adjustment for HSP Bonus Payment			
101.00	HVBP adjustment factor (see instructions)	0.9976610800	0.9981162138	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)	-1,801	-489	102.00
	HRR Adjustment for HSP Bonus Payment			
103.00	HRR adjustment factor (see instructions)	0.9900	0.9902	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)	-7,700	-2,543	104.00
	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 inpatient service costs (from Wkst. D-1, Pt. II, line 49)			201.00
202.00	Medicare discharges (see instructions)			202.00
203.00	Case-mix adjustment factor (see instructions)			203.00
	Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)			
204.00	Medicare target amount			204.00
205.00	Case-mix adjusted target amount (line 203 times line 204)			205.00
206.00	Medicare inpatient routine cost cap (line 202 times line 205)			206.00
	Adjustment to Medicare Part A Inpatient Reimbursement			
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)			208.00
209.00	Adjustment to Medicare IPPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
211.00	Total adjustment to Medicare IPPS payments (see instructions)			211.00
	Comparision of PPS versus Cost Reimbursement			
212.00	Total adjustment to Medicare Part A IPPS payments (from line 211)			212.00
213.00	Low-volume adjustment (see instructions)			213.00
218.00	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)			218.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0294	Period: From 01/01/2017 To 12/31/2017	Worksheet E Part B Date/Time Prepared: 5/25/2018 11:49 am
	Title XVIII	Hospital	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	2,707	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	4,420,396	2.00
3.00	OPPS payments	3,308,033	3.00
4.00	Outlier payment (see instructions)	8,609	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)	2,707	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	13,599	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)	13,599	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)	13,599	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	10,892	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)	2,707	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)	3,316,642	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	638,546	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	2,680,803	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	2,680,803	30.00
31.00	Primary payer payments	822	31.00
32.00	Subtotal (line 30 minus line 31)	2,679,981	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)	192,522	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	125,139	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	173,374	36.00
37.00	Subtotal (see instructions)	2,805,120	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		39.50
39.97	Demonstration payment adjustment amount before sequestration	0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	2,805,120	40.00
40.01	Sequestration adjustment (see instructions)	56,102	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
41.00	Interim payments	2,745,992	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	3,026	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED | Provider CCN: 14-0294 | Period: From 01/01/2017 To 12/31/2017 | Worksheet E-1 Part I | Date/Time Prepared: 5/25/2018 11:49 am

Title XVIII | Hospital | 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		4,290,435		2,745,992	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)		4,290,435		2,745,992	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		276,106		3,026	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		4,566,541		2,749,018	7.00

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-0294 | Component CCN: 14-U294 | Period: From 01/01/2017 To 12/31/2017 | Worksheet E-1 Part I | Date/Time Prepared: 5/25/2018 11:49 am

Title XVIII | Swing Beds - SNF | 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		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)		0		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)		0		0	7.00

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

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 14-0294	Period: From 01/01/2017 To 12/31/2017	Worksheet E-1 Part II Date/Time Prepared: 5/25/2018 11:49 am
	Title XVIII	Hospital	PPS

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

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS | Provider CCN: 14-0294 | Component CCN: 14-U294 | Period: From 01/01/2017 To 12/31/2017 | Worksheet E-2 | Date/Time Prepared: 5/25/2018 11:49 am

Title XVIII | Swing Beds - SNF | PPS

		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)	0	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)			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	0	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)	0	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	0	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0	0	11.00
12.00	Subtotal (line 10 minus line 11)	0	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	0	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)	0	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)			16.50
16.55	Rural community hospital demonstration project (§410A Demonstration) payment adjustment (see instructions)	0		16.55
16.99	Demonstration payment adjustment amount before sequestration	0	0	16.99
17.00	Allowable bad debts (see instructions)	0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (see instructions)	0	0	19.00
19.01	Sequestration adjustment (see instructions)	0	0	19.01
19.02	Demonstration payment adjustment amount after sequestration)	0	0	19.02
20.00	Interim payments	0	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)	0	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

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 14-0294 | Period: From 01/01/2017 To 12/31/2017 | Worksheet G | Date/Time Prepared: 5/25/2018 11:49 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	-467,077	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	-3,012,510	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-1,391,925	0	0	0	6.00
7.00	Inventory	1,629,965	0	0	0	7.00
8.00	Prepaid expenses	455,983	0	0	0	8.00
9.00	Other current assets	99,312	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)	-2,686,252	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	961,157	0	0	0	12.00
13.00	Land improvements	411,367	0	0	0	13.00
14.00	Accumulated depreciation	-212,470	0	0	0	14.00
15.00	Buildings	28,891,444	0	0	0	15.00
16.00	Accumulated depreciation	-10,034,081	0	0	0	16.00
17.00	Leasehold improvements	5,847,084	0	0	0	17.00
18.00	Accumulated depreciation	-2,804,196	0	0	0	18.00
19.00	Fixed equipment	2,279,148	0	0	0	19.00
20.00	Accumulated depreciation	-1,309,309	0	0	0	20.00
21.00	Automobiles and trucks	28,013	0	0	0	21.00
22.00	Accumulated depreciation	-26,157	0	0	0	22.00
23.00	Major movable equipment	9,896,605	0	0	0	23.00
24.00	Accumulated depreciation	-8,421,559	0	0	0	24.00
25.00	Minor equipment depreciable	3,305,345	0	0	0	25.00
26.00	Accumulated depreciation	-2,772,660	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	26,039,731	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	-12,232,783	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	-12,232,783	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	11,120,696	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	1,330,860	0	0	0	37.00
38.00	Salaries, wages, and fees payable	769,172	0	0	0	38.00
39.00	Payroll taxes payable	101,201	0	0	0	39.00
40.00	Notes and loans payable (short term)	24,000	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	-20,374,972	0	0	0	43.00
44.00	Other current liabilities	337,440	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	-17,812,299	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	30,000	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	30,000	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	-17,782,299	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	28,902,995				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)	28,902,995	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	11,120,696	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 14-0294 | Period: From 01/01/2017 To 12/31/2017 | Worksheet G-1 | Date/Time Prepared: 5/25/2018 11:49 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		26,475,721		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		2,427,278				2.00
3.00	Total (sum of line 1 and line 2)		28,902,999		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		28,902,999		0		11.00
12.00	ROUNDING	4		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		4		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		28,902,995		0		19.00

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

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 14-0294 | Period: From 01/01/2017 To 12/31/2017 | Worksheet G-2 Parts I & II | Date/Time Prepared: 5/25/2018 11:49 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	5,272,882		5,272,882	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	5,272,882		5,272,882	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	366,090		366,090	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)	366,090		366,090	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	5,638,972		5,638,972	17.00
18.00	Ancillary services	50,285,849	135,195,798	185,481,647	18.00
19.00	Outpatient services	2,421,741	19,108,422	21,530,163	19.00
20.00	RURAL HEALTH CLINIC	0	428,898	428,898	20.00
20.01	RURAL HEALTH CLINIC II	0	550,044	550,044	20.01
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PHYSICIAN PROFESSIONAL FEES	0	563,626	563,626	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	58,346,562	155,846,788	214,193,350	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		38,157,673		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		38,157,673		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 14-0294 | Period: From 01/01/2017 To 12/31/2017 | Worksheet G-3 | Date/Time Prepared: 5/25/2018 11:49 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	214,193,350	1.00
2.00	Less contractual allowances and discounts on patients' accounts	173,826,475	2.00
3.00	Net patient revenues (line 1 minus line 2)	40,366,875	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	38,157,673	4.00
5.00	Net income from service to patients (line 3 minus line 4)	2,209,202	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER OPERATING REVENUE	218,076	24.00
25.00	Total other income (sum of lines 6-24)	218,076	25.00
26.00	Total (line 5 plus line 25)	2,427,278	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)	2,427,278	29.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 14-0294	Period: From 01/01/2017 To 12/31/2017	Worksheet L Parts I-III Date/Time Prepared: 5/25/2018 11:49 am
	Title XVIII	Hospital	PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	276,166	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	47,044	2.00
2.01	Model 4 BPCI Capital DRG outlier payments	0	2.01
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)	7.08	3.00
4.00	Number of interns & residents (see instructions)	0.00	4.00
5.00	Indirect medical education percentage (see instructions)	0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)	0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)	0.00	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)	0.00	8.00
9.00	Sum of lines 7 and 8	0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)	0.00	10.00
11.00	Disproportionate share adjustment (see instructions)	0	11.00
12.00	Total prospective capital payments (see instructions)	323,210	12.00
		1.00	
	PART II - PAYMENT UNDER REASONABLE COST		
1.00	Program inpatient routine capital cost (see instructions)	0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)	0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)	0	3.00
4.00	Capital cost payment factor (see instructions)	0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)	0	5.00
		1.00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS		
1.00	Program inpatient capital costs (see instructions)	0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)	0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)	0	3.00
4.00	Applicable exception percentage (see instructions)	0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)	0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)	0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)	0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)	0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)	0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)	0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)	0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)	0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)	0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)	0	14.00
15.00	Current year allowable operating and capital payment (see instructions)	0	15.00
16.00	Current year operating and capital costs (see instructions)	0	16.00
17.00	Current year exception offset amount (see instructions)	0	17.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-0294 | Component CCN: 14-8524 | Period: From 01/01/2017 To 12/31/2017 | Worksheet M-1 | Date/Time Prepared: 5/25/2018 11:49 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	457,438	0	457,438	0	457,438	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	75,005	0	75,005	0	75,005	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	43,767	0	43,767	0	43,767	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	6,040	6,040	0	6,040	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)	576,210	6,040	582,250	0	582,250	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	24,732	24,732	0	24,732	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	24,732	24,732	0	24,732	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	576,210	30,772	606,982	0	606,982	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
25.01	Telehealth	0	0	0	0	0	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	25,545	25,545	0	25,545	29.00
30.00	Administrative Costs	229,784	224,999	454,783	-67,735	387,048	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	229,784	250,544	480,328	-67,735	412,593	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	805,994	281,316	1,087,310	-67,735	1,019,575	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-0294 | Period: From 01/01/2017 To 12/31/2017 | Worksheet M-1

Component CCN: 14-8524 | Date/Time Prepared: 5/25/2018 11:49 am

RHC I | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	457,438		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	75,005		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	43,767		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	6,040		8.00
9.00	Other Facility Health Care Staff Costs	0	0		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	582,250		10.00
11.00	Physician Services Under Agreement	0	0		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	0		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0		14.00
15.00	Medical Supplies	0	24,732		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	24,732		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	606,982		22.00
	COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
25.01	Telehealth	0	0		25.01
25.02	Chronic Care Management	0	0		25.02
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs				27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	25,545		29.00
30.00	Administrative Costs	0	387,048		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	412,593		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	1,019,575		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-0294 | Component CCN: 14-8523 | Period: From 01/01/2017 To 12/31/2017 | Worksheet M-1 | Date/Time Prepared: 5/25/2018 11:49 am

RHC II | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	0	0	0	0	0	1.00
2.00	Physician Assistant	100,002	0	100,002	0	100,002	2.00
3.00	Nurse Practitioner	0	0	0	0	0	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	45,631	0	45,631	0	45,631	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	34,291	34,291	0	34,291	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)	145,633	34,291	179,924	0	179,924	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	14,898	14,898	0	14,898	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	14,898	14,898	0	14,898	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	145,633	49,189	194,822	0	194,822	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
25.01	Telehealth	0	0	0	0	0	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	40,227	40,227	0	40,227	29.00
30.00	Administrative Costs	73,111	122,155	195,266	-31,899	163,367	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	73,111	162,382	235,493	-31,899	203,594	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	218,744	211,571	430,315	-31,899	398,416	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-0294 | Component CCN: 14-8523 | Period: From 01/01/2017 To 12/31/2017 | Worksheet M-1 | Date/Time Prepared: 5/25/2018 11:49 am

RHC II | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	0		1.00
2.00	Physician Assistant	0	100,002		2.00
3.00	Nurse Practitioner	0	0		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	45,631		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	34,291		8.00
9.00	Other Facility Health Care Staff Costs	0	0		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	179,924		10.00
11.00	Physician Services Under Agreement	0	0		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	0		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0		14.00
15.00	Medical Supplies	0	14,898		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	14,898		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	194,822		22.00
	COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
25.01	Telehealth	0	0		25.01
25.02	Chronic Care Management	0	0		25.02
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs				27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	40,227		29.00
30.00	Administrative Costs	0	163,367		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	203,594		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	398,416		32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-0294 | Component CCN: 14-8524 | Period: From 01/01/2017 To 12/31/2017 | Worksheet M-2 | Date/Time Prepared: 5/25/2018 11:49 am

RHC I | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	2.15	3,005	4,200	9,030		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	1.00	2,775	2,100	2,100		3.00
4.00	Subtotal (sum of lines 1 through 3)	3.15	5,780		11,130	11,130	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	3.15	5,780			11,130	8.00
9.00	Physician Services Under Agreements		0			0	9.00
						1.00	

	DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES		
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)	606,982	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)	0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)	606,982	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)	1.000000	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)	412,593	14.00
15.00	Parent provider overhead allocated to facility (see instructions)	473,985	15.00
16.00	Total overhead (sum of lines 14 and 15)	886,578	16.00
17.00	Allowable GME overhead (see instructions)	0	17.00
18.00	Enter the amount from line 16	886,578	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)	886,578	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)	1,493,560	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-0294 | Component CCN: 14-8523 | Period: From 01/01/2017 To 12/31/2017 | Worksheet M-2 | Date/Time Prepared: 5/25/2018 11:49 am

RHC II | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	0.00	0	4,200	0		1.00
2.00	Physician Assistant	0.90	3,225	2,100	1,890		2.00
3.00	Nurse Practitioner	0.00	0	2,100	0		3.00
4.00	Subtotal (sum of lines 1 through 3)	0.90	3,225		1,890	3,225	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	0.90	3,225			3,225	8.00
9.00	Physician Services Under Agreements		0			0	9.00
						1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)					194,822	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					194,822	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					1.000000	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					203,594	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					158,650	15.00
16.00	Total overhead (sum of lines 14 and 15)					362,244	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					362,244	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					362,244	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					557,066	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 14-0294 Component CCN: 14-8524	Period: From 01/01/2017 To 12/31/2017	Worksheet M-3 Date/Time Prepared: 5/25/2018 11:49 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)		1,493,560	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)		66,187	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		1,427,373	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		11,130	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)		0	5.00
6.00	Total adjusted visits (line 4 plus line 5)		11,130	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		128.25	7.00
		Calculation of Limit (1)		
		Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	0.00	0.00	8.00
9.00	Rate for Program covered visits (see instructions)	128.25	128.25	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	1,329	448	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	170,444	57,456	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)			15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *	0	227,900	16.00
16.01	Total program charges (see instructions)(from contractor's records)		297,677	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		31,669	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		24,246	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.)		136,561	16.04
16.05	Total program cost (see instructions)	0	160,807	16.05
17.00	Primary payer amounts		180	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		32,953	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		46,611	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		160,627	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		66,187	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		226,814	22.00
23.00	Allowable bad debts (see instructions)		0	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		0	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	25.50
25.99	Demonstration payment adjustment amount before sequestration		0	25.99
26.00	Net reimbursable amount (see instructions)		226,814	26.00
26.01	Sequestration adjustment (see instructions)		4,536	26.01
26.02	Demonstration payment adjustment amount after sequestration		0	26.02
27.00	Interim payments		113,990	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)		108,288	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0	30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 14-0294 Component CCN: 14-8523	Period: From 01/01/2017 To 12/31/2017	Worksheet M-3 Date/Time Prepared: 5/25/2018 11:49 am
	Title XVIII	RHC II	Cost

			1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES			
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)		557,066	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)		92,085	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		464,981	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		3,225	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)		0	5.00
6.00	Total adjusted visits (line 4 plus line 5)		3,225	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		144.18	7.00

		Calculation of Limit (1)		
		Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	0.00	0.00	8.00
9.00	Rate for Program covered visits (see instructions)	144.18	144.18	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	793	239	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	114,335	34,459	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)			15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *	0	148,794	16.00
16.01	Total program charges (see instructions)(from contractor's records)		149,722	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		11,268	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		11,198	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.)		93,274	16.04
16.05	Total program cost (see instructions)	0	104,472	16.05
17.00	Primary payer amounts		139	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		21,004	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		23,490	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		104,333	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		92,085	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		196,418	22.00
23.00	Allowable bad debts (see instructions)		0	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		0	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	25.50
25.99	Demonstration payment adjustment amount before sequestration		0	25.99
26.00	Net reimbursable amount (see instructions)		196,418	26.00
26.01	Sequestration adjustment (see instructions)		3,928	26.01
26.02	Demonstration payment adjustment amount after sequestration		0	26.02
27.00	Interim payments		70,704	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)		121,786	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0	30.00

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

Provider CCN: 14-0294 | Component CCN: 14-8524 | Period: From 01/01/2017 To 12/31/2017 | Worksheet M-4 | Date/Time Prepared: 5/25/2018 11:49 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)	582,250	582,250	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.001568	0.004524	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	913	2,634	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	22,256	1,095	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	23,169	3,729	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	606,982	606,982	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	886,578	886,578	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.038171	0.006144	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	33,842	5,447	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	57,011	9,176	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	26	75	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	2,192.73	122.35	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	26	75	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	57,011	9,176	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)		66,187	15.00
16.00	Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3, line 21)		66,187	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA VACCINE COST	Provider CCN: 14-0294 Component CCN: 14-8523	Period: From 01/01/2017 To 12/31/2017	Worksheet M-4 Date/Time Prepared: 5/25/2018 11:49 am
	Title XVIII	RHC II	Cost

		Pneumococcal	Influenza	
		1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	179,924	179,924	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.003309	0.010327	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	595	1,858	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	28,248	1,504	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	28,843	3,362	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	194,822	194,822	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	362,244	362,244	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.148048	0.017257	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	53,629	6,251	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	82,472	9,613	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	33	103	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	2,499.15	93.33	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	33	103	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	82,472	9,613	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)		92,085	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)		92,085	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 14-0294 Component CCN: 14-8524	Period: From 01/01/2017 To 12/31/2017	Worksheet M-5 Date/Time Prepared: 5/25/2018 11:49 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		113,990	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00
	Program to Provider			
3.01			0	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
	Provider to Program			
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		113,990	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		108,288	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		222,278	7.00

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

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES

Provider CCN: 14-0294 | Component CCN: 14-8523 | Period: From 01/01/2017 To 12/31/2017 | Worksheet M-5 | Date/Time Prepared: 5/25/2018 11:49 am

RHC II | Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		70,704	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00
	Program to Provider			
3.01			0	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
	Provider to Program			
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		70,704	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		121,786	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		192,490	7.00

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