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: 14-1320	Period: From 01/01/2017 To 12/31/2017	Worksheet S Parts I-III Date/Time Prepared: 5/29/2018 9:36 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 5/29/2018 Time: 9:36 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 PARIS COMMUNITY HOSPITAL (14-1320) 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	-352,331	130,026	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	208,692	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
10.00	RURAL HEALTH CLINIC I	0		551,341		0	10.00
10.01	RURAL HEALTH CLINIC II	0		-14,472		0	10.01
10.02	RURAL HEALTH CLINIC III	0		0		0	10.02
200.00	Total	0	-143,639	666,895	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: 14-1320 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-2 Part I Date/Time Prepared: 5/24/2018 4:41 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 721 EAST COURT STREET	PO Box:			1.00
2.00	City: PARIS	State: IL	Zip Code: 61944-	County: EDGAR	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	PARIS COMMUNITY HOSPITAL	141320	99914	1	06/30/2002	N	O	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	PARIS COMMUNITY HOSPITAL	14Z320	99914		06/30/2002	N	O	N	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC	FMC	143987	99914		09/24/1994	N	O	N	15.00
15.01	Hospital-Based Health Clinic - RHC II	HATCH	143989	99914		01/01/1995	N	O	N	15.01
15.02	Hospital-Based Health Clinic - RHC III	FMC	143431	99914		02/16/1997	N	O	N	15.02
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)	2		21.00
	Inpatient PPS Information			
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	N	N	22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	N	N	22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N	22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.	N	N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	2	N	23.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1320 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-2 Part I | Date/Time Prepared: 5/24/2018 4:41 pm

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

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

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

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

		V	XVIII	XIX	
		1.00	2.00	3.00	
	Prospective Payment System (PPS)-Capital				
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y for yes or "N" for no.	N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00
	Teaching Hospitals				
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N			56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.				57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.				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: 14-1320 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-2 Part I Date/Time Prepared: 5/24/2018 4:41 pm

		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	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: 14-1320 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-2 Part I Date/Time Prepared: 5/24/2018 4:41 pm

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

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

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

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

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		1.00	2.00	3.00	
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

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

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

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		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.	N	N	N	N	109.00

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

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

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

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	449,413	0	0	118.01

		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	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			

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 14-1320	Period: From 01/01/2017 To 12/31/2017	Worksheet S-2 Part I Date/Time Prepared: 5/24/2018 4:41 pm

		1.00	2.00	
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)	N		140.00

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

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

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

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

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

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

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

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

		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	01/01/2017	12/31/2017	170.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 14-1320	Period: From 01/01/2017 To 12/31/2017	Worksheet S-2 Part I Date/Time Prepared: 5/24/2018 4:41 pm

		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: 14-1320 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-2 Part II | Date/Time Prepared: 5/24/2018 4:41 pm

			Y/N	Date	
			1.00	2.00	
	General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.				
	COMPLETED BY ALL HOSPITALS				
	Provider Organization and Operation				
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)		N		1.00
		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N			3.00
		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	R		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00
			Y/N	Legal Oper.	
			1.00	2.00	
	Approved Educational Activities				
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?		N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.		N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.		N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.		N		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.		N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.		N		11.00
				Y/N	
				1.00	
	Bad Debts				
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.			Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.			N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.			N	14.00
	Bed Complement				
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			N	15.00
		Part A		Part B	
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
	PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	Y	03/20/2018	N	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		Y	03/20/2018 17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N	18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N	19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 14-1320 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-2 Part II Date/Time Prepared: 5/24/2018 4:41 pm

		Description		Y/N	Y/N	
		0		1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00

		1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)		
	Capital Related Cost		
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions	N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.	N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions	N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.	N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.	N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.	N	27.00
	Interest Expense		
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.	N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions	N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.	N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.	N	31.00
	Purchased Services		
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.	N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.	N	33.00
	Provider-Based Physicians		
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.	Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.	N	35.00

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

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	SHAWN	ADAMS	41.00
42.00	Enter the employer/company name of the cost report preparer.	ALLIANT MANAGEMENT SERVICES		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	5029923508	SADAMS@BLUEANDCO.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 14-1320	Period: From 01/01/2017 To 12/31/2017	Worksheet S-2 Part II Date/Time Prepared: 5/24/2018 4:41 pm

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 14-1320 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-3 Part I | Date/Time Prepared: 5/24/2018 4:41 pm

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	25	9,125	28,728.00	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)		25	9,125	28,728.00	0	7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)		25	9,125	28,728.00	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)		25				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00
33.01	LTCH site neutral days and discharges						33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 14-1320 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-3 Part I | Date/Time Prepared: 5/24/2018 4:41 pm

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	771	119	1,197			1.00
2.00	HMO and other (see instructions)	21	0				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	359	0	454			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	2,440			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,130	119	4,091			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)	1,130	119	4,091	0.00	190.56	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	9,174	0	38,240	0.00	44.82	26.00
26.01	RURAL HEALTH CLINIC II	451	0	2,083	0.00	1.91	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	237.29	27.00
28.00	Observation Bed Days		0	236			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: 14-1320 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-3 Part I | Date/Time Prepared: 5/24/2018 4:41 pm

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	290	57	406	1.00
2.00	HMO and other (see instructions)			10	0		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				0		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	290	57	406	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	0.00					26.00
26.01	RURAL HEALTH CLINIC II	0.00					26.01
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 14-1320 | Component CCN: 14-3987 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-8 | Date/Time Prepared: 5/24/2018 4:41 pm

			RHC I	Cost
			1.00	
	Clinic Address and Identification			
1.00	Street		727 EAST COURT STREET	1.00
		City	State	ZIP Code
		1.00	2.00	3.00
2.00	City, State, ZIP Code, County	PARIS	IL	61944 2.00
				1.00
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban			0 3.00

		Grant Award	Date
		1.00	2.00
	Source of Federal Funds		
4.00	Community Health Center (Section 330(d), PHS Act)		4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)		5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)		6.00
7.00	Appalachian Regional Commission		7.00
8.00	Look-Alikes		8.00
9.00	OTHER (SPECIFY)		9.00
9.01			9.01
9.02			9.02
9.03			9.03
9.04			9.04
9.05			9.05
9.06			9.06
9.07			9.07
9.08			9.08
9.09			9.09
9.10			9.10

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

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

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

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

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

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-1320
Component CCN: 14-3987

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

Worksheet S-8

Date/Time Prepared:
5/24/2018 4:41 pm

RHC I | Cost

			County				
			4.00				
2.00	City, State, ZIP Code, County		EDGAR				2.00
		Tuesday	Wednesday		Thursday		
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)						
11.00	CLINIC	17:00	08:00	19:00	08:00	19:00	11.00
		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	CLINIC	08:00	19:00	08:00	11:30		11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 14-1320 | Component CCN: 14-3989 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-8 | Date/Time Prepared: 5/24/2018 4:41 pm

RHC II | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			144 ILLINOIS		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	CHRISMAN		IL	61924	2.00
					1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0	3.00
			Grant Award		Date	
			1.00		2.00	
	Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)					4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)					5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)					6.00
7.00	Appalachian Regional Commission					7.00
8.00	Look-Alikes					8.00
9.00	OTHER (SPECIFY)					9.00
9.01						9.01
9.02						9.02
9.03						9.03
9.04						9.04
9.05						9.05
9.06						9.06
9.07						9.07
9.08						9.08
9.09						9.09
9.10						9.10
				1.00	2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N	0	10.00

		Sunday		Monday		Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
	Facility hours of operations (1)						
11.00	CLINIC			08:00	12:00	13:30	11.00

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

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

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-1320
Component CCN: 14-3989

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

Worksheet S-8

Date/Time Prepared:
5/24/2018 4:41 pm

RHC II | Cost

			County				
			4.00				
2.00	City, State, ZIP Code, County		EDGAR				2.00
		Tuesday	Wednesday		Thursday		
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)						
11.00	CLINIC	19:30			08:00	12:00	11.00
		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	CLINIC	08:00	12:00				11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 14-1320 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-10 | Date/Time Prepared: 5/24/2018 4:41 pm

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.432908	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	5,717,170	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	N	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?	N	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	20,468,392	6.00
7.00	Medicaid cost (line 1 times line 6)	8,860,931	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)	3,143,761	8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone CHIP	0	9.00
10.00	Stand-alone CHIP charges	0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	3,143,761	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)	700,200	0	700,200	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	303,122	0	303,122	21.00
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	303,122	0	303,122	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)	3,703,198	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	223,824	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	344,344	27.01
28.00	Non-Medicare bad debt expense (see instructions)	3,358,854	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	1,574,595	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	1,877,717	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	5,021,478	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-1320 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A | Date/Time Prepared: 5/24/2018 4:41 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		736,044	736,044	184,946	920,990	1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		1,250,605	1,250,605	164,645	1,415,250	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	104,084	924,662	1,028,746	1,526,762	2,555,508	4.00
5.01	00590	OTHER ADMINISTRATIVE AND GENERAL	2,235,679	5,063,874	7,299,553	-1,786,537	5,513,016	5.01
5.02	00560	ADMITTING	703,351	646,425	1,349,776	-467	1,349,309	5.02
7.00	00700	OPERATION OF PLANT	436,683	723,930	1,160,613	-237	1,160,376	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	144,654	144,654	0	144,654	8.00
9.00	00900	HOUSEKEEPING	203,092	75,306	278,398	0	278,398	9.00
10.00	01000	DIETARY	381,414	282,831	664,245	-402,283	261,962	10.00
11.00	01100	CAFETERIA	0	0	0	402,240	402,240	11.00
13.00	01300	NURSING ADMINISTRATION	1,163,805	138,708	1,302,513	0	1,302,513	13.00
15.00	01500	PHARMACY	293,698	1,351,617	1,645,315	-1,299,971	345,344	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	451,687	83,949	535,636	0	535,636	16.00
17.00	01700	SOCIAL SERVICE	56,699	7,334	64,033	0	64,033	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,978,820	533,867	2,512,687	-35,495	2,477,192	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,271,035	1,171,429	2,442,464	-931,110	1,511,354	50.00
53.00	05300	ANESTHESIOLOGY	1,099,131	163,047	1,262,178	-15,973	1,246,205	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,419,125	878,755	2,297,880	-169,601	2,128,279	54.00
60.00	06000	LABORATORY	774,052	1,161,053	1,935,105	-290,951	1,644,154	60.00
65.00	06500	RESPIRATORY THERAPY	447,776	78,314	526,090	-45,277	480,813	65.00
66.00	06600	PHYSICAL THERAPY	1,038,988	154,880	1,193,868	-789	1,193,079	66.00
69.00	06900	ELECTROCARDIOLOGY	0	44,927	44,927	82,628	127,555	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	2,226	2,226	0	2,226	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	1,375,806	1,375,806	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	124,326	124,326	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,306,976	1,306,976	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	4,457,139	2,852,733	7,309,872	0	7,309,872	88.00
88.01	08801	RURAL HEALTH CLINIC II	175,945	125,406	301,351	0	301,351	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	0	88.02
90.00	09000	CLINIC	99,318	46,990	146,308	-22,201	124,107	90.00
90.01	04951	CHEMO/PAIN	976,744	311,705	1,288,449	-24,478	1,263,971	90.01
90.02	09002	SENIOR CARE	703	472,003	472,706	-26,119	446,587	90.02
90.03	09003	SLEEP LAB	56,598	53,450	110,048	-540	109,508	90.03
91.00	09100	EMERGENCY	1,192,916	2,130,881	3,323,797	-3,166	3,320,631	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		91,097	91,097	-91,097	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	21,018,482	21,702,702	42,721,184	22,037	42,743,221	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2,971,173	1,292,215	4,263,388	-22,037	4,241,351	192.00
192.01	19202	OCCUPATIONAL MEDICINE	0	6,964	6,964	0	6,964	192.01
200.00		TOTAL (SUM OF LINES 118 through 199)	23,989,655	23,001,881	46,991,536	0	46,991,536	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-1320 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A | Date/Time Prepared: 5/24/2018 4:41 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	-97,797	823,193		1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	0	1,415,250		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-70	2,555,438		4.00
5.01	00590	OTHER ADMINISTRATIVE AND GENERAL	-398,547	5,114,469		5.01
5.02	00560	ADMITTING	0	1,349,309		5.02
7.00	00700	OPERATION OF PLANT	-18	1,160,358		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	144,654		8.00
9.00	00900	HOUSEKEEPING	0	278,398		9.00
10.00	01000	DIETARY	0	261,962		10.00
11.00	01100	CAFETERIA	-90,575	311,665		11.00
13.00	01300	NURSING ADMINISTRATION	-135	1,302,378		13.00
15.00	01500	PHARMACY	0	345,344		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-5,519	530,117		16.00
17.00	01700	SOCIAL SERVICE	0	64,033		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-782,970	1,694,222		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	1,511,354		50.00
53.00	05300	ANESTHESIOLOGY	-1,335,415	-89,210		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-610,843	1,517,436		54.00
60.00	06000	LABORATORY	-2,451	1,641,703		60.00
65.00	06500	RESPIRATORY THERAPY	-135	480,678		65.00
66.00	06600	PHYSICAL THERAPY	-571	1,192,508		66.00
69.00	06900	ELECTROCARDIOLOGY	-44,583	82,972		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	-2,226	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,375,806		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	124,326		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-28,713	1,278,263		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	-76,347	7,233,525		88.00
88.01	08801	RURAL HEALTH CLINIC II	-3,142	298,209		88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0		88.02
90.00	09000	CLINIC	-25,638	98,469		90.00
90.01	04951	CHEMO/PAIN	-143,567	1,120,404		90.01
90.02	09002	SENIOR CARE	-146,146	300,441		90.02
90.03	09003	SLEEP LAB	-30,561	78,947		90.03
91.00	09100	EMERGENCY	-1,451,424	1,869,207		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-5,277,393	37,465,828		118.00
		NONREIMBURSABLE COST CENTERS				
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	4,241,351		192.00
192.01	19202	OCCUPATIONAL MEDICINE	0	6,964		192.01
200.00		TOTAL (SUM OF LINES 118 through 199)	-5,277,393	41,714,143		200.00

RECLASSIFICATIONS | Provider CCN: 14-1320 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-6 | Date/Time Prepared: 5/24/2018 4:41 pm

		Increases				
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - RENTAL EXPENSE					
1.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	164,645		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
	0		0	164,645		
	B - CAFETERIA					
1.00	CAFETERIA	11.00	230,984	171,256		1.00
	0		230,984	171,256		
	C - EKG					
1.00	ELECTROCARDIOLOGY	69.00	61,770	0		1.00
2.00		0.00	0	0		2.00
	0		61,770	0		
	D - PROPERTY INSURANCE					
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	93,849		1.00
	0		0	93,849		
	E - OXYGEN/PATIENT SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	1,375,806		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
	0		0	1,375,806		
	F - DRUGS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	1,306,976		1.00
2.00	LABORATORY	60.00	0	402		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
	0		0	1,307,378		
	I - STRESS TEST					
1.00	ELECTROCARDIOLOGY	69.00	14,290	6,568		1.00
	0		14,290	6,568		
	J - IMPLANT EXPENSE					
1.00	IMPL. DEV. CHARGED TO PATIENT	72.00	0	124,326		1.00
	0		0	124,326		
	K - INTEREST EXPENSE					
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	91,097		1.00
	0		0	91,097		
	L - BENEFITS RECLASS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	1,526,762		1.00
	TOTALS		0	1,526,762		
500.00	Grand Total: Increases		307,044	4,861,687		500.00

RECLASSIFICATIONS | Provider CCN: 14-1320 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-6 | Date/Time Prepared: 5/24/2018 4:41 pm

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - RENTAL EXPENSE						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	47,268	10		1.00
2.00	ADMITTING	5.02	0	467	0		2.00
3.00	OPERATION OF PLANT	7.00	0	230	0		3.00
4.00	ADULTS & PEDIATRICS	30.00	0	498	0		4.00
5.00	OPERATING ROOM	50.00	0	54,307	0		5.00
6.00	ANESTHESIOLOGY	53.00	0	933	0		6.00
7.00	LABORATORY	60.00	0	37	0		7.00
8.00	RESPIRATORY THERAPY	65.00	0	12,150	0		8.00
9.00	CHEMO/PAIN	90.01	0	59	0		9.00
10.00	SENIOR CARE	90.02	0	26,119	0		10.00
11.00	SLEEP LAB	90.03	0	540	0		11.00
12.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	22,037	0		12.00
	0		0	164,645			
	B - CAFETERIA						
1.00	DIETARY	10.00	230,984	171,256	0		1.00
	0		230,984	171,256			
	C - EKG						
1.00	ADULTS & PEDIATRICS	30.00	34,657	0	0		1.00
2.00	RESPIRATORY THERAPY	65.00	27,113	0	0		2.00
	0		61,770	0			
	D - PROPERTY INSURANCE						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	93,849	12		1.00
	0		0	93,849			
	E - OXYGEN/PATIENT SUPPLIES						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	118,360	0		1.00
2.00	PHARMACY	15.00	0	5,055	0		2.00
3.00	ADULTS & PEDIATRICS	30.00	0	288	0		3.00
4.00	OPERATING ROOM	50.00	0	752,139	0		4.00
5.00	ANESTHESIOLOGY	53.00	0	15,040	0		5.00
6.00	RADIOLOGY-DIAGNOSTIC	54.00	0	165,371	0		6.00
7.00	LABORATORY	60.00	0	291,316	0		7.00
8.00	RESPIRATORY THERAPY	65.00	0	5,254	0		8.00
9.00	CHEMO/PAIN	90.01	0	20,801	0		9.00
10.00	EMERGENCY	91.00	0	2,182	0		10.00
	0		0	1,375,806			
	F - DRUGS						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	298	0		1.00
2.00	OPERATION OF PLANT	7.00	0	7	0		2.00
3.00	DIETARY	10.00	0	43	0		3.00
4.00	PHARMACY	15.00	0	1,294,916	0		4.00
5.00	ADULTS & PEDIATRICS	30.00	0	52	0		5.00
6.00	OPERATING ROOM	50.00	0	338	0		6.00
7.00	RADIOLOGY-DIAGNOSTIC	54.00	0	4,230	0		7.00
8.00	RESPIRATORY THERAPY	65.00	0	760	0		8.00
9.00	PHYSICAL THERAPY	66.00	0	789	0		9.00
10.00	CLINIC	90.00	0	1,343	0		10.00
11.00	CHEMO/PAIN	90.01	0	3,618	0		11.00
12.00	EMERGENCY	91.00	0	984	0		12.00
	0		0	1,307,378			
	I - STRESS TEST						
1.00	CLINIC	90.00	14,290	6,568	0		1.00
	0		14,290	6,568			
	J - IMPLANT EXPENSE						
1.00	OPERATING ROOM	50.00	0	124,326	0		1.00
	0		0	124,326			
	K - INTEREST EXPENSE						
1.00	INTEREST EXPENSE	113.00	0	91,097	9		1.00
	0		0	91,097			
	L - BENEFITS RECLASS						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	1,526,762	0		1.00
	TOTALS		0	1,526,762			
500.00	Grand Total: Decreases		307,044	4,861,687			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1320 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-7 Part I | Date/Time Prepared: 5/24/2018 4:41 pm

		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	403,842	0	0	0	0	1.00
2.00	Land Improvements	2,272,048	52,816	0	52,816	0	2.00
3.00	Buildings and Fixtures	23,908,133	914,053	0	914,053	0	3.00
4.00	Building Improvements	0	855,820	0	855,820	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	16,777,565	335,706	0	335,706	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	43,361,588	2,158,395	0	2,158,395	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	43,361,588	2,158,395	0	2,158,395	0	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	403,842	0	1.00
2.00	Land Improvements	2,324,864	0	2.00
3.00	Buildings and Fixtures	24,822,186	0	3.00
4.00	Building Improvements	855,820	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	17,113,271	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	45,519,983	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	45,519,983	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1320 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-7 Part II Date/Time Prepared: 5/24/2018 4:41 pm

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	NEW CAP REL COSTS-BLDG & FIXT	736,044	0	0	0	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	1,250,605	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	1,986,649	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	NEW CAP REL COSTS-BLDG & FIXT	0	736,044		1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	1,250,605		2.00
3.00	Total (sum of lines 1-2)	0	1,986,649		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1320 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-7 Part III Date/Time Prepared: 5/24/2018 4:41 pm

	Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	28,406,712	0	28,406,712	0.624049	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	17,113,271	0	17,113,271	0.375951	0	2.00
3.00	Total (sum of lines 1-2)	45,519,983	0	45,519,983	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	729,344	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	1,250,605	164,645	2.00
3.00	Total (sum of lines 1-2)	0	0	0	1,979,949	164,645	3.00

	Cost Center Description	SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	93,849	0	0	823,193	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	1,415,250	2.00
3.00	Total (sum of lines 1-2)	0	93,849	0	0	2,238,443	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-1320 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-8 | Date/Time Prepared: 5/24/2018 4:41 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)	A	-91,097	NEW CAP REL COSTS-BLDG & FIXT	1.00	9	1.00
2.00	Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)	B	-1,257	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)	B	-6,168	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-3,298,592			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	0			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-90,575	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others	B	-6,700	NEW CAP REL COSTS-BLDG & FIXT	1.00	9	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients	B	-28,713	DRUGS CHARGED TO PATIENTS	73.00	0	17.00
18.00	Sale of medical records and abstracts	B	-5,519	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 - NEW CAP REL COSTS-BLDG & FIXT		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - NEW CAP REL COSTS-MVBLE EQUIP		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-1320 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-8 | Date/Time Prepared: 5/24/2018 4:41 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	PHYSICIAN RECRUTING	A	-88,167	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	33.00
34.00	ADVERTISING	A	-70	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	34.00
35.00	ADVERTISING	A	-58,030	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	35.00
36.00	ADVERTISING	A	-135	NURSING ADMINISTRATION	13.00	0	36.00
37.00	ADVERTISING	A	-61	ANESTHESIOLOGY	53.00	0	37.00
38.00	ADVERTISING	A	-135	RESPIRATORY THERAPY	65.00	0	38.00
39.00	ADVERTISING	A	-571	PHYSICAL THERAPY	66.00	0	39.00
40.00	ADVERTISING	A	-53,025	RURAL HEALTH CLINIC	88.00	0	40.00
41.00	ADVERTISING	A	-3,142	RURAL HEALTH CLINIC II	88.01	0	41.00
42.00	ADVERTISING	A	-3,797	SENIOR CARE	90.02	0	42.00
43.00	ANESTHESIA	A	-1,099,131	ANESTHESIOLOGY	53.00	0	43.00
44.00	ANESTHESIA BENEFITS	A	-236,223	ANESTHESIOLOGY	53.00	0	44.00
45.00	OTHER REVENUE - MAINTENANCE DISCOUNT	B	-18	OPERATION OF PLANT	7.00	0	45.00
45.01	OTHER REVENUE - RHC RENTAL INCOME	B	-13,264	RURAL HEALTH CLINIC	88.00	0	45.01
45.02	OTHER REVENUE - RHC	B	-10,058	RURAL HEALTH CLINIC	88.00	0	45.02
45.03	OTHER REVENUE - MISC A & G	B	-168,357	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	45.03
45.05	LOBBYING DUES	A	-14,588	OTHER ADMINISTRATIVE AND GENERAL	5.01	11	45.05
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-5,277,393				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.

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 14-1320 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-8-2 | Date/Time Prepared: 5/24/2018 4:41 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.01	OTHER ADMINISTRATIVE AND GENERAL	61,980	61,980	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	782,970	782,970	0	0	0	2.00
3.00	54.00	RADIOLOGY-DIAGNOSTIC	610,843	610,843	0	0	0	3.00
4.00	60.00	LABORATORY	72,451	2,451	70,000	0	0	4.00
5.00	69.00	ELECTROCARDIOLOGY	44,583	44,583	0	0	0	5.00
6.00	70.00	ELECTROENCEPHALOGRAPHY	2,226	2,226	0	0	0	6.00
7.00	90.00	CLINIC	25,638	25,638	0	0	0	7.00
8.00	90.01	CHEMO/PAIN	171,567	143,567	28,000	0	0	8.00
9.00	90.02	SENIOR CARE	142,349	142,349	0	0	0	9.00
10.00	90.03	SLEEP LAB	40,561	30,561	10,000	0	0	10.00
11.00	91.00	EMERGENCY	1,869,910	1,451,424	418,486	0	0	11.00
200.00			3,825,078	3,298,592	526,486		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	5.01	OTHER ADMINISTRATIVE AND GENERAL	0	0	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	2.00
3.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	3.00
4.00	60.00	LABORATORY	0	0	0	0	0	4.00
5.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	5.00
6.00	70.00	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	6.00
7.00	90.00	CLINIC	0	0	0	0	0	7.00
8.00	90.01	CHEMO/PAIN	0	0	0	0	0	8.00
9.00	90.02	SENIOR CARE	0	0	0	0	0	9.00
10.00	90.03	SLEEP LAB	0	0	0	0	0	10.00
11.00	91.00	EMERGENCY	0	0	0	0	0	11.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	5.01	OTHER ADMINISTRATIVE AND GENERAL	0	0	0	61,980		1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	782,970		2.00
3.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	610,843		3.00
4.00	60.00	LABORATORY	0	0	0	2,451		4.00
5.00	69.00	ELECTROCARDIOLOGY	0	0	0	44,583		5.00
6.00	70.00	ELECTROENCEPHALOGRAPHY	0	0	0	2,226		6.00
7.00	90.00	CLINIC	0	0	0	25,638		7.00
8.00	90.01	CHEMO/PAIN	0	0	0	143,567		8.00
9.00	90.02	SENIOR CARE	0	0	0	142,349		9.00
10.00	90.03	SLEEP LAB	0	0	0	30,561		10.00
11.00	91.00	EMERGENCY	0	0	0	1,451,424		11.00
200.00			0	0	0	3,298,592		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1320 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part I Date/Time Prepared: 5/24/2018 4:41 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS NEW BLDG & FIXT	CAPITAL RELATED COSTS NEW MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	823,193	823,193				1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	1,415,250		1,415,250			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,555,438	7,535	12,954	2,575,927		4.00
5.01	00590	OTHER ADMINISTRATIVE AND GENERAL	5,114,469	166,088	285,544	353,712	5,919,813	5.01
5.02	00560	ADMITTING	1,349,309	26,743	45,976	111,280	1,533,308	5.02
7.00	00700	OPERATION OF PLANT	1,160,358	96,412	165,753	69,089	1,491,612	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	144,654	7,893	13,569	0	166,116	8.00
9.00	00900	HOUSEKEEPING	278,398	5,552	9,545	32,132	325,627	9.00
10.00	01000	DIETARY	261,962	24,938	42,874	60,345	390,119	10.00
11.00	01100	CAFETERIA	311,665	11,347	19,509	0	342,521	11.00
13.00	01300	NURSING ADMINISTRATION	1,302,378	11,217	19,285	184,130	1,517,010	13.00
15.00	01500	PHARMACY	345,344	7,080	12,172	46,467	411,063	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	530,117	18,135	31,177	71,463	650,892	16.00
17.00	01700	SOCIAL SERVICE	64,033	1,268	2,180	8,971	76,452	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,694,222	113,847	195,728	313,077	2,316,874	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,511,354	82,544	141,912	201,096	1,936,906	50.00
53.00	05300	ANESTHESIOLOGY	-89,210	967	1,663	173,898	87,318	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,517,436	59,866	102,923	224,525	1,904,750	54.00
60.00	06000	LABORATORY	1,641,703	24,946	42,888	122,466	1,832,003	60.00
65.00	06500	RESPIRATORY THERAPY	480,678	3,097	5,324	70,844	559,943	65.00
66.00	06600	PHYSICAL THERAPY	1,192,508	35,790	61,530	164,382	1,454,210	66.00
69.00	06900	ELECTROCARDIOLOGY	82,972	4,259	7,323	0	94,554	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,375,806	0	0	0	1,375,806	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	124,326	0	0	0	124,326	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,278,263	0	0	0	1,278,263	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	7,233,525	0	0	0	7,233,525	88.00
88.01	08801	RURAL HEALTH CLINIC II	298,209	0	0	0	298,209	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	0	88.02
90.00	09000	CLINIC	98,469	4,999	8,594	15,713	127,775	90.00
90.01	04951	CHEMO/PAIN	1,120,404	12,550	21,577	154,535	1,309,066	90.01
90.02	09002	SENIOR CARE	300,441	0	0	111	300,552	90.02
90.03	09003	SLEEP LAB	78,947	1,057	1,817	8,955	90,776	90.03
91.00	09100	EMERGENCY	1,869,207	41,894	72,025	188,736	2,171,862	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	37,465,828	770,024	1,323,842	2,575,927	37,321,251	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	4,241,351	35,733	61,432	0	4,338,516	192.00
192.01	19202	OCCUPATIONAL MEDICINE	6,964	17,436	29,976	0	54,376	192.01
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	41,714,143	823,193	1,415,250	2,575,927	41,714,143	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1320 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part I | Date/Time Prepared: 5/24/2018 4:41 pm

		Cost Center Description	OTHER ADMINISTRATIVE AND GENERAL	ADMITTING	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.01	5.02	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	OTHER ADMINISTRATIVE AND GENERAL	5,919,813					5.01
5.02	00560	ADMITTING	253,585	1,786,893				5.02
7.00	00700	OPERATION OF PLANT	246,689	0	1,738,301			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	27,473	0	26,063	219,652		8.00
9.00	00900	HOUSEKEEPING	53,853	0	18,333	0	397,813	9.00
10.00	01000	DIETARY	64,519	0	82,349	0	19,340	10.00
11.00	01100	CAFETERIA	56,647	0	37,471	0	8,800	11.00
13.00	01300	NURSING ADMINISTRATION	250,889	0	37,041	0	8,699	13.00
15.00	01500	PHARMACY	67,983	0	23,379	0	5,491	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	107,647	0	59,883	0	14,064	16.00
17.00	01700	SOCIAL SERVICE	12,644	0	4,187	0	983	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	383,174	236,055	375,940	219,652	88,289	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	320,333	307,769	272,574	0	64,014	50.00
53.00	05300	ANESTHESIOLOGY	14,441	12,990	3,194	0	750	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	315,015	198,591	197,687	0	46,427	54.00
60.00	06000	LABORATORY	302,984	227,845	82,376	0	19,346	60.00
65.00	06500	RESPIRATORY THERAPY	92,606	58,044	10,227	0	2,402	65.00
66.00	06600	PHYSICAL THERAPY	240,503	152,437	118,183	0	27,755	66.00
69.00	06900	ELECTROCARDIOLOGY	15,638	11,165	14,065	0	3,303	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	763	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	227,536	14,576	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	20,562	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	211,404	169,010	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,196,314	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	49,319	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	0	88.02
90.00	09000	CLINIC	21,132	13,338	16,507	0	3,877	90.00
90.01	04951	CHEMO/PAIN	216,499	101,929	41,443	0	9,733	90.01
90.02	09002	SENIOR CARE	49,706	39,393	0	0	0	90.02
90.03	09003	SLEEP LAB	15,013	8,496	3,489	0	819	90.03
91.00	09100	EMERGENCY	359,191	234,492	138,340	0	32,489	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	5,193,299	1,786,893	1,562,731	219,652	356,581	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	717,521	0	117,995	0	27,711	192.00
192.01	19202	OCCUPATIONAL MEDICINE	8,993	0	57,575	0	13,521	192.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	5,919,813	1,786,893	1,738,301	219,652	397,813	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1320 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part I | Date/Time Prepared: 5/24/2018 4:41 pm

		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	PHARMACY	MEDICAL RECORDS & LIBRARY	
			10.00	11.00	13.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	OTHER ADMINISTRATIVE AND GENERAL						5.01
5.02	00560	ADMITTING						5.02
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	556,327					10.00
11.00	01100	CAFETERIA	0	445,439				11.00
13.00	01300	NURSING ADMINISTRATION	0	42,075	1,855,714			13.00
15.00	01500	PHARMACY	0	10,618	0	518,534		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	16,330	0	0	848,816	16.00
17.00	01700	SOCIAL SERVICE	0	2,050	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	556,327	71,535	583,228	0	17,500	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	45,952	511,001	0	122,902	50.00
53.00	05300	ANESTHESIOLOGY	0	39,737	0	0	5,662	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	51,306	0	0	231,262	54.00
60.00	06000	LABORATORY	0	27,984	0	0	149,102	60.00
65.00	06500	RESPIRATORY THERAPY	0	16,188	0	0	5,341	65.00
66.00	06600	PHYSICAL THERAPY	0	37,563	0	0	95,504	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	14,640	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	155	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	41,655	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	5,797	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	518,534	64,780	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	0	88.02
90.00	09000	CLINIC	0	3,591	0	0	2,616	90.00
90.01	04951	CHEMO/PAIN	0	35,312	290,360	0	12,192	90.01
90.02	09002	SENIOR CARE	0	25	293	0	9,711	90.02
90.03	09003	SLEEP LAB	0	2,046	0	0	3,023	90.03
91.00	09100	EMERGENCY	0	43,127	470,832	0	66,974	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	556,327	445,439	1,855,714	518,534	848,816	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19202	OCCUPATIONAL MEDICINE	0	0	0	0	0	192.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	556,327	445,439	1,855,714	518,534	848,816	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1320 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part I | Date/Time Prepared: 5/24/2018 4:41 pm

		Cost Center Description	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			17.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	OTHER ADMINISTRATIVE AND GENERAL						5.01
5.02	00560	ADMITTING						5.02
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE	96,316					17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	96,316	4,944,890	0	4,944,890		30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	3,581,451	0	3,581,451		50.00
53.00	05300	ANESTHESIOLOGY	0	164,092	0	164,092		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,945,038	0	2,945,038		54.00
60.00	06000	LABORATORY	0	2,641,640	0	2,641,640		60.00
65.00	06500	RESPIRATORY THERAPY	0	744,751	0	744,751		65.00
66.00	06600	PHYSICAL THERAPY	0	2,126,155	0	2,126,155		66.00
69.00	06900	ELECTROCARDIOLOGY	0	153,365	0	153,365		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	918	0	918		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,659,573	0	1,659,573		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	150,685	0	150,685		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,241,991	0	2,241,991		73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	8,429,839	0	8,429,839		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	347,528	0	347,528		88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0		88.02
90.00	09000	CLINIC	0	188,836	0	188,836		90.00
90.01	04951	CHEMO/PAIN	0	2,016,534	0	2,016,534		90.01
90.02	09002	SENIOR CARE	0	399,680	0	399,680		90.02
90.03	09003	SLEEP LAB	0	123,662	0	123,662		90.03
91.00	09100	EMERGENCY	0	3,517,307	0	3,517,307		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0			92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	96,316	36,377,935	0	36,377,935		118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	5,201,743	0	5,201,743		192.00
192.01	19202	OCCUPATIONAL MEDICINE	0	134,465	0	134,465		192.01
200.00		Cross Foot Adjustments		0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	96,316	41,714,143	0	41,714,143		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1320 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part II Date/Time Prepared: 5/24/2018 4:41 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS NEW BLDG & FIXT	CAPITAL RELATED COSTS NEW MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	7,535	12,954	20,489	20,489	4.00
5.01	00590	OTHER ADMINISTRATIVE AND GENERAL	0	166,088	285,544	451,632	2,821	5.01
5.02	00560	ADMITTING	0	26,743	45,976	72,719	885	5.02
7.00	00700	OPERATION OF PLANT	0	96,412	165,753	262,165	549	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	7,893	13,569	21,462	0	8.00
9.00	00900	HOUSEKEEPING	0	5,552	9,545	15,097	255	9.00
10.00	01000	DIETARY	0	24,938	42,874	67,812	480	10.00
11.00	01100	CAFETERIA	0	11,347	19,509	30,856	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	11,217	19,285	30,502	1,464	13.00
15.00	01500	PHARMACY	0	7,080	12,172	19,252	369	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	18,135	31,177	49,312	568	16.00
17.00	01700	SOCIAL SERVICE	0	1,268	2,180	3,448	71	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	113,847	195,728	309,575	2,489	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	82,544	141,912	224,456	1,599	50.00
53.00	05300	ANESTHESIOLOGY	0	967	1,663	2,630	1,383	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	59,866	102,923	162,789	1,785	54.00
60.00	06000	LABORATORY	0	24,946	42,888	67,834	974	60.00
65.00	06500	RESPIRATORY THERAPY	0	3,097	5,324	8,421	563	65.00
66.00	06600	PHYSICAL THERAPY	0	35,790	61,530	97,320	1,307	66.00
69.00	06900	ELECTROCARDIOLOGY	0	4,259	7,323	11,582	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	0	88.02
90.00	09000	CLINIC	0	4,999	8,594	13,593	125	90.00
90.01	04951	CHEMO/PAIN	0	12,550	21,577	34,127	1,229	90.01
90.02	09002	SENIOR CARE	0	0	0	0	1	90.02
90.03	09003	SLEEP LAB	0	1,057	1,817	2,874	71	90.03
91.00	09100	EMERGENCY	0	41,894	72,025	113,919	1,501	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	770,024	1,323,842	2,093,866	20,489	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	35,733	61,432	97,165	0	192.00
192.01	19202	OCCUPATIONAL MEDICINE	0	17,436	29,976	47,412	0	192.01
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	823,193	1,415,250	2,238,443	20,489	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1320 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part II | Date/Time Prepared: 5/24/2018 4:41 pm

		Cost Center Description	OTHER ADMINISTRATIVE AND GENERAL	ADMITTING	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.01	5.02	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	OTHER ADMINISTRATIVE AND GENERAL	454,453					5.01
5.02	00560	ADMITTING	19,467	93,071				5.02
7.00	00700	OPERATION OF PLANT	18,938	0	281,652			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,109	0	4,223	27,794		8.00
9.00	00900	HOUSEKEEPING	4,134	0	2,970	0	22,456	9.00
10.00	01000	DIETARY	4,953	0	13,343	0	1,092	10.00
11.00	01100	CAFETERIA	4,349	0	6,071	0	497	11.00
13.00	01300	NURSING ADMINISTRATION	19,260	0	6,002	0	491	13.00
15.00	01500	PHARMACY	5,219	0	3,788	0	310	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	8,264	0	9,703	0	794	16.00
17.00	01700	SOCIAL SERVICE	971	0	678	0	56	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	29,415	12,296	60,912	27,794	4,984	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	24,591	16,026	44,164	0	3,613	50.00
53.00	05300	ANESTHESIOLOGY	1,109	677	518	0	42	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	24,183	10,344	32,031	0	2,621	54.00
60.00	06000	LABORATORY	23,259	11,868	13,347	0	1,092	60.00
65.00	06500	RESPIRATORY THERAPY	7,109	3,023	1,657	0	136	65.00
66.00	06600	PHYSICAL THERAPY	18,463	7,940	19,149	0	1,567	66.00
69.00	06900	ELECTROCARDIOLOGY	1,200	582	2,279	0	186	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	40	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	17,467	759	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1,578	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	16,229	8,803	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	91,844	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	3,786	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	0	88.02
90.00	09000	CLINIC	1,622	695	2,675	0	219	90.00
90.01	04951	CHEMO/PAIN	16,620	5,309	6,715	0	549	90.01
90.02	09002	SENIOR CARE	3,816	2,052	0	0	0	90.02
90.03	09003	SLEEP LAB	1,152	443	565	0	46	90.03
91.00	09100	EMERGENCY	27,574	12,214	22,415	0	1,834	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	398,681	93,071	253,205	27,794	20,129	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	55,082	0	19,118	0	1,564	192.00
192.01	19202	OCCUPATIONAL MEDICINE	690	0	9,329	0	763	192.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	454,453	93,071	281,652	27,794	22,456	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1320 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part II | Date/Time Prepared: 5/24/2018 4:41 pm

		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	PHARMACY	MEDICAL RECORDS & LIBRARY	
			10.00	11.00	13.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	OTHER ADMINISTRATIVE AND GENERAL						5.01
5.02	00560	ADMITTING						5.02
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	87,680					10.00
11.00	01100	CAFETERIA	0	41,773				11.00
13.00	01300	NURSING ADMINISTRATION	0	3,945	61,664			13.00
15.00	01500	PHARMACY	0	996	0	29,934		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,531	0	0	70,172	16.00
17.00	01700	SOCIAL SERVICE	0	192	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	87,680	6,713	19,379	0	1,447	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	4,309	16,980	0	10,159	50.00
53.00	05300	ANESTHESIOLOGY	0	3,726	0	0	468	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	4,811	0	0	19,125	54.00
60.00	06000	LABORATORY	0	2,624	0	0	12,325	60.00
65.00	06500	RESPIRATORY THERAPY	0	1,518	0	0	441	65.00
66.00	06600	PHYSICAL THERAPY	0	3,522	0	0	7,894	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	1,210	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	13	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	3,443	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	479	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	29,934	5,355	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	0	88.02
90.00	09000	CLINIC	0	337	0	0	216	90.00
90.01	04951	CHEMO/PAIN	0	3,311	9,649	0	1,008	90.01
90.02	09002	SENIOR CARE	0	2	10	0	803	90.02
90.03	09003	SLEEP LAB	0	192	0	0	250	90.03
91.00	09100	EMERGENCY	0	4,044	15,646	0	5,536	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	87,680	41,773	61,664	29,934	70,172	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19202	OCCUPATIONAL MEDICINE	0	0	0	0	0	192.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	87,680	41,773	61,664	29,934	70,172	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1320 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part II | Date/Time Prepared: 5/24/2018 4:41 pm

		Cost Center Description	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			17.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	OTHER ADMINISTRATIVE AND GENERAL						5.01
5.02	00560	ADMITTING						5.02
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE	5,416					17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,416	568,100	0	568,100		30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	345,897	0	345,897		50.00
53.00	05300	ANESTHESIOLOGY	0	10,553	0	10,553		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	257,689	0	257,689		54.00
60.00	06000	LABORATORY	0	133,323	0	133,323		60.00
65.00	06500	RESPIRATORY THERAPY	0	22,868	0	22,868		65.00
66.00	06600	PHYSICAL THERAPY	0	157,162	0	157,162		66.00
69.00	06900	ELECTROCARDIOLOGY	0	17,039	0	17,039		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	53	0	53		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	21,669	0	21,669		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	2,057	0	2,057		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	60,321	0	60,321		73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	91,844	0	91,844		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	3,786	0	3,786		88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0		88.02
90.00	09000	CLINIC	0	19,482	0	19,482		90.00
90.01	04951	CHEMO/PAIN	0	78,517	0	78,517		90.01
90.02	09002	SENIOR CARE	0	6,684	0	6,684		90.02
90.03	09003	SLEEP LAB	0	5,593	0	5,593		90.03
91.00	09100	EMERGENCY	0	204,683	0	204,683		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0			92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	5,416	2,007,320	0	2,007,320		118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	172,929	0	172,929		192.00
192.01	19202	OCCUPATIONAL MEDICINE	0	58,194	0	58,194		192.01
200.00		Cross Foot Adjustments		0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	5,416	2,238,443	0	2,238,443		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1320 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B-1 | Date/Time Prepared: 5/24/2018 4:41 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A.01	5.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	101,273					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		101,273				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	927	927	16,281,314			4.00
5.01	00590	OTHER ADMINISTRATIVE AND GENERAL	20,433	20,433	2,235,679	-5,919,813	35,794,330	5.01
5.02	00560	ADMITTING	3,290	3,290	703,351	0	1,533,308	5.02
7.00	00700	OPERATION OF PLANT	11,861	11,861	436,683	0	1,491,612	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	971	971	0	0	166,116	8.00
9.00	00900	HOUSEKEEPING	683	683	203,092	0	325,627	9.00
10.00	01000	DIETARY	3,068	3,068	381,414	0	390,119	10.00
11.00	01100	CAFETERIA	1,396	1,396	0	0	342,521	11.00
13.00	01300	NURSING ADMINISTRATION	1,380	1,380	1,163,805	0	1,517,010	13.00
15.00	01500	PHARMACY	871	871	293,698	0	411,063	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,231	2,231	451,687	0	650,892	16.00
17.00	01700	SOCIAL SERVICE	156	156	56,699	0	76,452	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	14,006	14,006	1,978,820	0	2,316,874	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	10,155	10,155	1,271,035	0	1,936,906	50.00
53.00	05300	ANESTHESIOLOGY	119	119	1,099,131	0	87,318	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,365	7,365	1,419,125	0	1,904,750	54.00
60.00	06000	LABORATORY	3,069	3,069	774,052	0	1,832,003	60.00
65.00	06500	RESPIRATORY THERAPY	381	381	447,776	0	559,943	65.00
66.00	06600	PHYSICAL THERAPY	4,403	4,403	1,038,988	0	1,454,210	66.00
69.00	06900	ELECTROCARDIOLOGY	524	524	0	0	94,554	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	1,375,806	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	124,326	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	1,278,263	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	7,233,525	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	298,209	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	0	88.02
90.00	09000	CLINIC	615	615	99,318	0	127,775	90.00
90.01	04951	CHEMO/PAIN	1,544	1,544	976,744	0	1,309,066	90.01
90.02	09002	SENIOR CARE	0	0	703	0	300,552	90.02
90.03	09003	SLEEP LAB	130	130	56,598	0	90,776	90.03
91.00	09100	EMERGENCY	5,154	5,154	1,192,916	0	2,171,862	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	94,732	94,732	16,281,314	-5,919,813	31,401,438	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	4,396	4,396	0	0	4,338,516	192.00
192.01	19202	OCCUPATIONAL MEDICINE	2,145	2,145	0	0	54,376	192.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	823,193	1,415,250	2,575,927		5,919,813	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	8.128455	13.974603	0.158214		0.165384	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			20,489		454,453	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.001258		0.012696	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: 14-1320 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B-1 | Date/Time Prepared: 5/24/2018 4:41 pm

		Cost Center Description	ADMITTING (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (PATIENT DAYS)	
			5.02	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	OTHER ADMINISTRATIVE AND GENERAL						5.01
5.02	00560	ADMITTING	15,154,060					5.02
7.00	00700	OPERATION OF PLANT	0	64,762				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	971	100			8.00
9.00	00900	HOUSEKEEPING	0	683	0	63,108		9.00
10.00	01000	DIETARY	0	3,068	0	3,068	100	10.00
11.00	01100	CAFETERIA	0	1,396	0	1,396	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	1,380	0	1,380	0	13.00
15.00	01500	PHARMACY	0	871	0	871	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	2,231	0	2,231	0	16.00
17.00	01700	SOCIAL SERVICE	0	156	0	156	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,001,912	14,006	100	14,006	100	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,610,076	10,155	0	10,155	0	50.00
53.00	05300	ANESTHESIOLOGY	110,164	119	0	119	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,684,186	7,365	0	7,365	0	54.00
60.00	06000	LABORATORY	1,932,283	3,069	0	3,069	0	60.00
65.00	06500	RESPIRATORY THERAPY	492,250	381	0	381	0	65.00
66.00	06600	PHYSICAL THERAPY	1,292,769	4,403	0	4,403	0	66.00
69.00	06900	ELECTROCARDIOLOGY	94,686	524	0	524	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	6,474	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	123,614	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,433,317	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	0	88.02
90.00	09000	CLINIC	113,113	615	0	615	0	90.00
90.01	04951	CHEMO/PAIN	864,429	1,544	0	1,544	0	90.01
90.02	09002	SENIOR CARE	334,076	0	0	0	0	90.02
90.03	09003	SLEEP LAB	72,056	130	0	130	0	90.03
91.00	09100	EMERGENCY	1,988,655	5,154	0	5,154	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	15,154,060	58,221	100	56,567	100	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	4,396	0	4,396	0	192.00
192.01	19202	OCCUPATIONAL MEDICINE	0	2,145	0	2,145	0	192.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,786,893	1,738,301	219,652	397,813	556,327	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.117915	26.841373	2,196.520000	6.303686	5,563.270000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	93,071	281,652	27,794	22,456	87,680	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.006142	4.349032	277.940000	0.355834	876.800000	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: 14-1320 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B-1 | Date/Time Prepared: 5/24/2018 4:41 pm

		Cost Center Description	CAFETERIA (GROSS SALARIES)	NURSING ADMINISTRATION (NRSNG SALARIES)	PHARMACY (COST REQU.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (PAT DAYS)	
			11.00	13.00	15.00	16.00	17.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	OTHER ADMINISTRATIVE AND GENERAL						5.01
5.02	00560	ADMITTING						5.02
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	12,321,095					11.00
13.00	01300	NURSING ADMINISTRATION	1,163,805	4,450,738				13.00
15.00	01500	PHARMACY	293,698	0	100			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	451,687	0	0	70,092,972		16.00
17.00	01700	SOCIAL SERVICE	56,699	0	0	0	100	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,978,820	1,398,811	0	1,445,106	100	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,271,035	1,225,583	0	10,148,804	0	50.00
53.00	05300	ANESTHESIOLOGY	1,099,131	0	0	467,555	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,419,125	0	0	19,097,620	0	54.00
60.00	06000	LABORATORY	774,052	0	0	12,312,323	0	60.00
65.00	06500	RESPIRATORY THERAPY	447,776	0	0	441,042	0	65.00
66.00	06600	PHYSICAL THERAPY	1,038,988	0	0	7,886,379	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	1,208,904	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	12,789	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	3,439,734	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	478,672	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	100	5,349,268	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	0	88.02
90.00	09000	CLINIC	99,318	0	0	216,015	0	90.00
90.01	04951	CHEMO/PAIN	976,744	696,398	0	1,006,769	0	90.01
90.02	09002	SENIOR CARE	703	703	0	801,930	0	90.02
90.03	09003	SLEEP LAB	56,598	0	0	249,626	0	90.03
91.00	09100	EMERGENCY	1,192,916	1,129,243	0	5,530,436	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	12,321,095	4,450,738	100	70,092,972	100	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19202	OCCUPATIONAL MEDICINE	0	0	0	0	0	192.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	445,439	1,855,714	518,534	848,816	96,316	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.036153	0.416945	5,185.340000	0.012110	963.160000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	41,773	61,664	29,934	70,172	5,416	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.003390	0.013855	299.340000	0.001001	54.160000	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: 14-1320 | Period: From 01/01/2017 To 12/31/2017 | Worksheet C Part I Date/Time Prepared: 5/24/2018 4:41 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,944,890		4,944,890	0	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,581,451		3,581,451	0	0	50.00
53.00	05300	ANESTHESIOLOGY	164,092		164,092	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,945,038		2,945,038	0	0	54.00
60.00	06000	LABORATORY	2,641,640		2,641,640	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	744,751	0	744,751	0	0	65.00
66.00	06600	PHYSICAL THERAPY	2,126,155	0	2,126,155	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	153,365		153,365	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	918		918	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,659,573		1,659,573	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	150,685		150,685	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,241,991		2,241,991	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	8,429,839		8,429,839	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	347,528		347,528	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0		0	0	0	88.02
90.00	09000	CLINIC	188,836		188,836	0	0	90.00
90.01	04951	CHEMO/PAIN	2,016,534		2,016,534	0	0	90.01
90.02	09002	SENIOR CARE	399,680		399,680	0	0	90.02
90.03	09003	SLEEP LAB	123,662		123,662	0	0	90.03
91.00	09100	EMERGENCY	3,517,307		3,517,307	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	569,614		569,614		0	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	36,947,549	0	36,947,549	0	0	200.00
201.00		Less Observation Beds	569,614		569,614		0	201.00
202.00		Total (see instructions)	36,377,935	0	36,377,935	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1320 | Period: From 01/01/2017 To 12/31/2017 | Worksheet C Part I Date/Time Prepared: 5/24/2018 4:41 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,655,397		1,655,397			30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	459,951	9,688,853	10,148,804	0.352894	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	58,689	408,866	467,555	0.350958	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	421,543	18,676,077	19,097,620	0.154210	0.000000	54.00
60.00	06000	LABORATORY	587,072	11,725,251	12,312,323	0.214553	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	162,264	278,778	441,042	1.688617	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	551,897	7,334,482	7,886,379	0.269598	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	12,724	1,196,180	1,208,904	0.126863	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	12,789	12,789	0.071780	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	419,202	3,020,532	3,439,734	0.482471	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	59,769	418,903	478,672	0.314798	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	716,473	4,632,795	5,349,268	0.419121	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	13,203,661	13,203,661			88.00
88.01	08801	RURAL HEALTH CLINIC II	0	314,262	314,262			88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0			88.02
90.00	09000	CLINIC	0	216,015	216,015	0.874180	0.000000	90.00
90.01	04951	CHEMO/PAIN	0	1,006,769	1,006,769	2.002976	0.000000	90.01
90.02	09002	SENIOR CARE	0	801,930	801,930	0.498398	0.000000	90.02
90.03	09003	SLEEP LAB	0	249,626	249,626	0.495389	0.000000	90.03
91.00	09100	EMERGENCY	19,403	5,511,033	5,530,436	0.635991	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2,390	207,901	210,291	2.708694	0.000000	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	5,126,774	78,904,703	84,031,477			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	5,126,774	78,904,703	84,031,477			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1320 | Period: From 01/01/2017 To 12/31/2017 | Worksheet C Part I Date/Time Prepared: 5/24/2018 4:41 pm

Title XVIII | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	54.00
60.00	06000	LABORATORY	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS		
88.00	08800	RURAL HEALTH CLINIC		88.00
88.01	08801	RURAL HEALTH CLINIC II		88.01
88.02	08802	RURAL HEALTH CLINIC III		88.02
90.00	09000	CLINIC	0.000000	90.00
90.01	04951	CHEMO/PAIN	0.000000	90.01
90.02	09002	SENIOR CARE	0.000000	90.02
90.03	09003	SLEEP LAB	0.000000	90.03
91.00	09100	EMERGENCY	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	92.00
		SPECIAL PURPOSE COST CENTERS		
113.00	11300	INTEREST EXPENSE		113.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1320 | Period: From 01/01/2017 To 12/31/2017 | Worksheet C Part I Date/Time Prepared: 5/24/2018 4:41 pm

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,944,890		4,944,890	0	4,944,890	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,581,451		3,581,451	0	3,581,451	50.00
53.00	05300	ANESTHESIOLOGY	164,092		164,092	0	164,092	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,945,038		2,945,038	0	2,945,038	54.00
60.00	06000	LABORATORY	2,641,640		2,641,640	0	2,641,640	60.00
65.00	06500	RESPIRATORY THERAPY	744,751	0	744,751	0	744,751	65.00
66.00	06600	PHYSICAL THERAPY	2,126,155	0	2,126,155	0	2,126,155	66.00
69.00	06900	ELECTROCARDIOLOGY	153,365		153,365	0	153,365	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	918		918	0	918	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,659,573		1,659,573	0	1,659,573	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	150,685		150,685	0	150,685	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,241,991		2,241,991	0	2,241,991	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	8,429,839		8,429,839	0	8,429,839	88.00
88.01	08801	RURAL HEALTH CLINIC II	347,528		347,528	0	347,528	88.01
88.02	08802	RURAL HEALTH CLINIC III	0		0	0	0	88.02
90.00	09000	CLINIC	188,836		188,836	0	188,836	90.00
90.01	04951	CHEMO/PAIN	2,016,534		2,016,534	0	2,016,534	90.01
90.02	09002	SENIOR CARE	399,680		399,680	0	399,680	90.02
90.03	09003	SLEEP LAB	123,662		123,662	0	123,662	90.03
91.00	09100	EMERGENCY	3,517,307		3,517,307	0	3,517,307	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	569,614		569,614		569,614	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	36,947,549	0	36,947,549	0	36,947,549	200.00
201.00		Less Observation Beds	569,614		569,614		569,614	201.00
202.00		Total (see instructions)	36,377,935	0	36,377,935	0	36,377,935	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1320 | Period: From 01/01/2017 To 12/31/2017 | Worksheet C Part I Date/Time Prepared: 5/24/2018 4:41 pm

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,655,397		1,655,397			30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	459,951	9,688,853	10,148,804	0.352894	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	58,689	408,866	467,555	0.350958	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	421,543	18,676,077	19,097,620	0.154210	0.000000	54.00
60.00	06000	LABORATORY	587,072	11,725,251	12,312,323	0.214553	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	162,264	278,778	441,042	1.688617	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	551,897	7,334,482	7,886,379	0.269598	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	12,724	1,196,180	1,208,904	0.126863	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	12,789	12,789	0.071780	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	419,202	3,020,532	3,439,734	0.482471	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	59,769	418,903	478,672	0.314798	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	716,473	4,632,795	5,349,268	0.419121	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	13,203,661	13,203,661	0.638447	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	314,262	314,262	1.105854	0.000000	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0.000000	0.000000	88.02
90.00	09000	CLINIC	0	216,015	216,015	0.874180	0.000000	90.00
90.01	04951	CHEMO/PAIN	0	1,006,769	1,006,769	2.002976	0.000000	90.01
90.02	09002	SENIOR CARE	0	801,930	801,930	0.498398	0.000000	90.02
90.03	09003	SLEEP LAB	0	249,626	249,626	0.495389	0.000000	90.03
91.00	09100	EMERGENCY	19,403	5,511,033	5,530,436	0.635991	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2,390	207,901	210,291	2.708694	0.000000	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	5,126,774	78,904,703	84,031,477			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	5,126,774	78,904,703	84,031,477			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1320 | Period: From 01/01/2017 To 12/31/2017 | Worksheet C Part I Date/Time Prepared: 5/24/2018 4:41 pm

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	54.00
60.00	06000	LABORATORY	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS		
88.00	08800	RURAL HEALTH CLINIC	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000	88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000	88.02
90.00	09000	CLINIC	0.000000	90.00
90.01	04951	CHEMO/PAIN	0.000000	90.01
90.02	09002	SENIOR CARE	0.000000	90.02
90.03	09003	SLEEP LAB	0.000000	90.03
91.00	09100	EMERGENCY	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	92.00
		SPECIAL PURPOSE COST CENTERS		
113.00	11300	INTEREST EXPENSE		113.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 14-1320 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part II Date/Time Prepared: 5/24/2018 4:41 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	345,897	10,148,804	0.034083	132,838	4,528	50.00
53.00	05300	ANESTHESIOLOGY	10,553	467,555	0.022571	24,504	553	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	257,689	19,097,620	0.013493	266,075	3,590	54.00
60.00	06000	LABORATORY	133,323	12,312,323	0.010828	338,180	3,662	60.00
65.00	06500	RESPIRATORY THERAPY	22,868	441,042	0.051850	96,860	5,022	65.00
66.00	06600	PHYSICAL THERAPY	157,162	7,886,379	0.019928	93,097	1,855	66.00
69.00	06900	ELECTROCARDIOLOGY	17,039	1,208,904	0.014095	8,997	127	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	53	12,789	0.004144	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	21,669	3,439,734	0.006300	171,767	1,082	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	2,057	478,672	0.004297	28,536	123	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	60,321	5,349,268	0.011276	348,404	3,929	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	91,844	13,203,661	0.006956	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	3,786	314,262	0.012047	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0.000000	0	0	88.02
90.00	09000	CLINIC	19,482	216,015	0.090188	0	0	90.00
90.01	04951	CHEMO/PAIN	78,517	1,006,769	0.077989	0	0	90.01
90.02	09002	SENIOR CARE	6,684	801,930	0.008335	0	0	90.02
90.03	09003	SLEEP LAB	5,593	249,626	0.022406	0	0	90.03
91.00	09100	EMERGENCY	204,683	5,530,436	0.037010	8,099	300	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	65,441	210,291	0.311193	0	0	92.00
200.00		Total (lines 50 through 199)	1,504,661	82,376,080		1,517,357	24,771	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 14-1320 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part IV Date/Time Prepared: 5/24/2018 4:41 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	0	88.02
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	04951	CHEMO/PAIN	0	0	0	0	0	90.01
90.02	09002	SENIOR CARE	0	0	0	0	0	90.02
90.03	09003	SLEEP LAB	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0		0	92.00
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: 14-1320 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part IV Date/Time Prepared: 5/24/2018 4:41 pm

Title XVIII | Hospital | Cost

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	10,148,804	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	467,555	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	19,097,620	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	12,312,323	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	441,042	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	7,886,379	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	1,208,904	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	12,789	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	3,439,734	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	478,672	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	5,349,268	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	13,203,661	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	314,262	0.000000	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	0.000000	88.02
90.00	09000	CLINIC	0	0	0	216,015	0.000000	90.00
90.01	04951	CHEMO/PAIN	0	0	0	1,006,769	0.000000	90.01
90.02	09002	SENIOR CARE	0	0	0	801,930	0.000000	90.02
90.03	09003	SLEEP LAB	0	0	0	249,626	0.000000	90.03
91.00	09100	EMERGENCY	0	0	0	5,530,436	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	210,291	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	82,376,080		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 14-1320 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part IV Date/Time Prepared: 5/24/2018 4:41 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	132,838	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	24,504	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	266,075	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	338,180	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	96,860	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	93,097	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	8,997	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	171,767	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000	28,536	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	348,404	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000	0	0	0	0	88.02
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	04951	CHEMO/PAIN	0.000000	0	0	0	0	90.01
90.02	09002	SENIOR CARE	0.000000	0	0	0	0	90.02
90.03	09003	SLEEP LAB	0.000000	0	0	0	0	90.03
91.00	09100	EMERGENCY	0.000000	8,099	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		1,517,357	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-1320 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part V Date/Time Prepared: 5/24/2018 4:41 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.352894	0	1,718,334	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.350958	0	276,668	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.154210	0	6,068,205	0	0	54.00
60.00	06000	LABORATORY	0.214553	0	4,770,755	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	1.688617	0	93,901	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.269598	0	2,642,848	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.126863	0	402,922	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.071780	0	6,530	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.482471	0	726,645	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.314798	0	159,776	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.419121	0	1,254,948	84	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000				0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000				0	88.02
90.00	09000	CLINIC	0.874180	0	92,299	0	0	90.00
90.01	04951	CHEMO/PAIN	2.002976	0	278,278	0	0	90.01
90.02	09002	SENIOR CARE	0.498398	0	784,658	0	0	90.02
90.03	09003	SLEEP LAB	0.495389	0	86,263	0	0	90.03
91.00	09100	EMERGENCY	0.635991	0	1,518,059	30	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2.708694	0	82,062	0	0	92.00
200.00		Subtotal (see instructions)		0	20,963,151	114	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	20,963,151	114	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-1320 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part V Date/Time Prepared: 5/24/2018 4:41 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	606,390	0		50.00
53.00	05300	ANESTHESIOLOGY	97,099	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	935,778	0		54.00
60.00	06000	LABORATORY	1,023,580	0		60.00
65.00	06500	RESPIRATORY THERAPY	158,563	0		65.00
66.00	06600	PHYSICAL THERAPY	712,507	0		66.00
69.00	06900	ELECTROCARDIOLOGY	51,116	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	469	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	350,585	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	50,297	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	525,975	35		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0		88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0		88.02
90.00	09000	CLINIC	80,686	0		90.00
90.01	04951	CHEMO/PAIN	557,384	0		90.01
90.02	09002	SENIOR CARE	391,072	0		90.02
90.03	09003	SLEEP LAB	42,734	0		90.03
91.00	09100	EMERGENCY	965,472	19		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	222,281	0		92.00
200.00		Subtotal (see instructions)	6,771,988	54		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	6,771,988	54		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1320 | Component CCN: 14-Z320 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part V | Date/Time Prepared: 5/24/2018 4:41 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.352894	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.350958	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.154210	0	0	0	0	54.00
60.00	06000	LABORATORY	0.214553	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	1.688617	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.269598	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.126863	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.071780	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.482471	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.314798	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.419121	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000				0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000				0	88.02
90.00	09000	CLINIC	0.874180	0	0	0	0	90.00
90.01	04951	CHEMO/PAIN	2.002976	0	0	0	0	90.01
90.02	09002	SENIOR CARE	0.498398	0	0	0	0	90.02
90.03	09003	SLEEP LAB	0.495389	0	0	0	0	90.03
91.00	09100	EMERGENCY	0.635991	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2.708694	0	0	0	0	92.00
200.00		Subtotal (see instructions)		0	0	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-1320 | Component CCN: 14-Z320 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part V | Date/Time Prepared: 5/24/2018 4:41 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
60.00	06000	LABORATORY	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0		88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0		88.02
90.00	09000	CLINIC	0	0		90.00
90.01	04951	CHEMO/PAIN	0	0		90.01
90.02	09002	SENIOR CARE	0	0		90.02
90.03	09003	SLEEP LAB	0	0		90.03
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
200.00		Subtotal (see instructions)	0	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	0		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-1320 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part V Date/Time Prepared: 5/24/2018 4:41 pm

Title XIX | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.352894	0	0	861,748	0	50.00
53.00	05300	ANESTHESIOLOGY	0.350958	0	0	128,252	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.154210	0	0	3,508,747	0	54.00
60.00	06000	LABORATORY	0.214553	0	0	1,651,563	0	60.00
65.00	06500	RESPIRATORY THERAPY	1.688617	0	0	49,400	0	65.00
66.00	06600	PHYSICAL THERAPY	0.269598	0	0	885,257	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.126863	0	0	124,865	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.071780	0	0	3,045	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.482471	0	0	388,102	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.314798	0	0	35,982	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.419121	0	0	567,550	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.638447				0	88.00
88.01	08801	RURAL HEALTH CLINIC II	1.105854				0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000				0	88.02
90.00	09000	CLINIC	0.874180	0	0	4,686	0	90.00
90.01	04951	CHEMO/PAIN	2.002976	0	0	128,939	0	90.01
90.02	09002	SENIOR CARE	0.498398	0	0	0	0	90.02
90.03	09003	SLEEP LAB	0.495389	0	0	68,843	0	90.03
91.00	09100	EMERGENCY	0.635991	0	0	1,394,971	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2.708694	0	0	29,605	0	92.00
200.00		Subtotal (see instructions)		0	0	9,831,555	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	0	9,831,555	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-1320 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part V Date/Time Prepared: 5/24/2018 4:41 pm

Title XIX | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	304,106		50.00
53.00	05300	ANESTHESIOLOGY	0	45,011		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	541,084		54.00
60.00	06000	LABORATORY	0	354,348		60.00
65.00	06500	RESPIRATORY THERAPY	0	83,418		65.00
66.00	06600	PHYSICAL THERAPY	0	238,664		66.00
69.00	06900	ELECTROCARDIOLOGY	0	15,841		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	219		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	187,248		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	11,327		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	237,872		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0		88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0		88.02
90.00	09000	CLINIC	0	4,096		90.00
90.01	04951	CHEMO/PAIN	0	258,262		90.01
90.02	09002	SENIOR CARE	0	0		90.02
90.03	09003	SLEEP LAB	0	34,104		90.03
91.00	09100	EMERGENCY	0	887,189		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	80,191		92.00
200.00		Subtotal (see instructions)	0	3,282,980		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	3,282,980		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1320 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-1 | Date/Time Prepared: 5/24/2018 4:41 pm

Title XVIII | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	4,327	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,433	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	1,197	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	454	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	2,440	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)	771	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)	359	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	160.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	160.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	4,944,890	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)	390,400	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)	1,486,179	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	3,458,711	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	3,458,711	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)	2,413.61	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,860,893	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	1,860,893	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1320 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-1 | Date/Time Prepared: 5/24/2018 4:41 pm

Title XVIII | Hospital | Cost

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	601,896	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	2,462,789	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	866,486	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)	866,486	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)	236	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	2,413.62	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	569,614	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1320 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-1 | Date/Time Prepared: 5/24/2018 4:41 pm

Title XVIII | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	568,100	4,944,890	0.114886	569,614	65,441	90.00
91.00	Nursing School cost	0	4,944,890	0.000000	569,614	0	91.00
92.00	Allied health cost	0	4,944,890	0.000000	569,614	0	92.00
93.00	All other Medical Education	0	4,944,890	0.000000	569,614	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1320 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-1 | Date/Time Prepared: 5/24/2018 4:41 pm

Title XIX | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	4,327	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,433	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	1,197	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	454	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	2,440	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)	119	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	160.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	160.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	4,944,890	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)	390,400	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)	1,486,179	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	3,458,711	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	3,458,711	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)	2,413.61	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	287,220	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)	287,220	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1320 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-1 | Date/Time Prepared: 5/24/2018 4:41 pm

Title XIX | Hospital | Cost

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	84,336	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	371,556	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	236	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	2,413.62	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	569,614	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1320 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-1 | Date/Time Prepared: 5/24/2018 4:41 pm

Title XIX | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	568,100	4,944,890	0.114886	569,614	65,441	90.00
91.00	Nursing School cost	0	4,944,890	0.000000	569,614	0	91.00
92.00	Allied health cost	0	4,944,890	0.000000	569,614	0	92.00
93.00	All other Medical Education	0	4,944,890	0.000000	569,614	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 14-1320 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-3 | Date/Time Prepared: 5/24/2018 4:41 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		680,001		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.352894	132,838	46,878	50.00
53.00	05300	ANESTHESIOLOGY	0.350958	24,504	8,600	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.154210	266,075	41,031	54.00
60.00	06000	LABORATORY	0.214553	338,180	72,558	60.00
65.00	06500	RESPIRATORY THERAPY	1.688617	96,860	163,559	65.00
66.00	06600	PHYSICAL THERAPY	0.269598	93,097	25,099	66.00
69.00	06900	ELECTROCARDIOLOGY	0.126863	8,997	1,141	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.071780	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.482471	171,767	82,873	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.314798	28,536	8,983	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.419121	348,404	146,023	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000		0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000		0	88.02
90.00	09000	CLINIC	0.874180	0	0	90.00
90.01	04951	CHEMO/PAIN	2.002976	0	0	90.01
90.02	09002	SENIOR CARE	0.498398	0	0	90.02
90.03	09003	SLEEP LAB	0.495389	0	0	90.03
91.00	09100	EMERGENCY	0.635991	8,099	5,151	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2.708694	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		1,517,357	601,896	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		1,517,357		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 14-1320 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-3

Component CCN: 14-Z320 | Date/Time Prepared: 5/24/2018 4:41 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.352894	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.350958	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.154210	15,043	2,320	54.00
60.00	06000	LABORATORY	0.214553	29,524	6,334	60.00
65.00	06500	RESPIRATORY THERAPY	1.688617	19,304	32,597	65.00
66.00	06600	PHYSICAL THERAPY	0.269598	213,577	57,580	66.00
69.00	06900	ELECTROCARDIOLOGY	0.126863	196	25	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.071780	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.482471	25,064	12,093	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.314798	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.419121	63,214	26,494	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000		0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000		0	88.02
90.00	09000	CLINIC	0.874180	0	0	90.00
90.01	04951	CHEMO/PAIN	2.002976	0	0	90.01
90.02	09002	SENIOR CARE	0.498398	0	0	90.02
90.03	09003	SLEEP LAB	0.495389	0	0	90.03
91.00	09100	EMERGENCY	0.635991	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2.708694	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		365,922	137,443	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)		365,922		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 14-1320 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-3 | Date/Time Prepared: 5/24/2018 4:41 pm

Title XIX | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		82,510		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.352894	25,355	8,948	50.00
53.00	05300	ANESTHESIOLOGY	0.350958	3,755	1,318	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.154210	30,376	4,684	54.00
60.00	06000	LABORATORY	0.214553	48,257	10,354	60.00
65.00	06500	RESPIRATORY THERAPY	1.688617	7,731	13,055	65.00
66.00	06600	PHYSICAL THERAPY	0.269598	1,809	488	66.00
69.00	06900	ELECTROCARDIOLOGY	0.126863	392	50	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.071780	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.482471	21,996	10,612	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.314798	1,673	527	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.419121	62,855	26,344	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.638447	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	1.105854	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000	0	0	88.02
90.00	09000	CLINIC	0.874180	0	0	90.00
90.01	04951	CHEMO/PAIN	2.002976	0	0	90.01
90.02	09002	SENIOR CARE	0.498398	0	0	90.02
90.03	09003	SLEEP LAB	0.495389	0	0	90.03
91.00	09100	EMERGENCY	0.635991	2,331	1,482	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2.708694	2,390	6,474	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		208,920	84,336	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)		208,920		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 14-1320 | Period: From 01/01/2017 To 12/31/2017 | Worksheet E Part B Date/Time Prepared: 5/24/2018 4:41 pm

Title XVIII | Hospital | Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	6,772,042	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	OPPS payments	0	3.00
4.00	Outlier payment (see instructions)	0	4.00
4.01	Outlier reconciliation amount (see instructions)	0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	6,772,042	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	0	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (see instructions)	6,839,762	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	0	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	43,168	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	3,196,809	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	3,599,785	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	3,599,785	30.00
31.00	Primary payer payments	1,380	31.00
32.00	Subtotal (line 30 minus line 31)	3,598,405	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)	223,704	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	145,408	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	221,108	36.00
37.00	Subtotal (see instructions)	3,743,813	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)	3,743,813	40.00
40.01	Sequestration adjustment (see instructions)	74,876	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
41.00	Interim payments	3,538,911	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	130,026	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: 14-1320 | Period: From 01/01/2017 To 12/31/2017 | Worksheet E-1 Part I Date/Time Prepared: 5/24/2018 4:41 pm

Title XVIII | Hospital | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		2,569,279		3,414,023	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	08/24/2017	85,419	3.01
3.02			0	12/07/2017	39,469	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	08/24/2017	33,783		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)		-33,783		124,888	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		2,535,496		3,538,911	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		130,026	6.01
6.02	SETTLEMENT TO PROGRAM		352,331		0	6.02
7.00	Total Medicare program liability (see instructions)		2,183,165		3,668,937	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: 14-1320 | Component CCN: 14-Z320 | Period: From 01/01/2017 To 12/31/2017 | Worksheet E-1 Part I | Date/Time Prepared: 5/24/2018 4:41 pm

Title XVIII | Swing Beds - SNF | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		770,742		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	08/24/2017	9,418		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)		9,418		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)		780,160		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		208,692		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		988,852		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: 14-1320	Period: From 01/01/2017 To 12/31/2017	Worksheet E-1 Part II Date/Time Prepared: 5/24/2018 4:41 pm
	Title XVIII	Hospital	Cost

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

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

Provider CCN: 14-1320 | Component CCN: 14-Z320 | Period: From 01/01/2017 To 12/31/2017 | Worksheet E-2 | Date/Time Prepared: 5/24/2018 4:41 pm

Title XVIII | Swing Beds - SNF | Cost

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	875,151	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)	138,817	0	3.00
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)		0.00	4.00
5.00	Program days	359	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)		0	6.00
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	1,013,968	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	1,013,968	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0	0	11.00
12.00	Subtotal (line 10 minus line 11)	1,013,968	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	4,935	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)	1,009,033	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)	1,009,033	0	19.00
19.01	Sequestration adjustment (see instructions)	20,181	0	19.01
19.02	Demonstration payment adjustment amount after sequestration)	0	0	19.02
20.00	Interim payments	780,160	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)	208,692	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	23.00
	Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment			
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
	Cost Reimbursement			
201.00	Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital))			201.00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))			202.00
203.00	Total (sum of lines 201 and 202)			203.00
204.00	Medicare swing-bed SNF discharges (see instructions)			204.00
	Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)			
205.00	Medicare swing-bed SNF target amount			205.00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)			206.00
	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement			
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)			208.00
209.00	Adjustment to Medicare swing-bed SNF PPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
	Comparision of PPS versus Cost Reimbursement			
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see instructions)			215.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-1320	Period: From 01/01/2017 To 12/31/2017	Worksheet E-3 Part V Date/Time Prepared: 5/24/2018 4:41 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	2,462,789	1.00
2.00	Nursing and Allied Health Managed Care payment (see instructions)	0	2.00
3.00	Organ acquisition	0	3.00
4.00	Subtotal (sum of lines 1 through 3)	2,462,789	4.00
5.00	Primary payer payments	3,632	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	2,483,785	6.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
7.00	Routine service charges	0	7.00
8.00	Ancillary service charges	0	8.00
9.00	Organ acquisition charges, net of revenue	0	9.00
10.00	Total reasonable charges	0	10.00
	Customary charges		
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)	0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)	0.000000	13.00
14.00	Total customary charges (see instructions)	0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)	0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)	0	16.00
17.00	Cost of physicians' services in a teaching hospital (see instructions)	0	17.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)	0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)	2,483,785	19.00
20.00	Deductibles (exclude professional component)	279,753	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	2,204,032	22.00
23.00	Coinsurance	1,316	23.00
24.00	Subtotal (line 22 minus line 23)	2,202,716	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	38,466	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	25,003	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	2,227,719	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	29.50
29.99	Demonstration payment adjustment amount before sequestration	0	29.99
30.00	Subtotal (see instructions)	2,227,719	30.00
30.01	Sequestration adjustment (see instructions)	44,554	30.01
30.02	Demonstration payment adjustment amount after sequestration	0	30.02
31.00	Interim payments	2,535,496	31.00
32.00	Tentative settlement (for contractor use only)	0	32.00
33.00	Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32)	-352,331	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	34.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 14-1320 | Period: From 01/01/2017 To 12/31/2017 | Worksheet G | Date/Time Prepared: 5/24/2018 4:41 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	10,698,282	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	20,550,309	0	0	0	4.00
5.00	Other receivable	2,022,850	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-13,484,370	0	0	0	6.00
7.00	Inventory	1,277,683	0	0	0	7.00
8.00	Prepaid expenses	392,805	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	100,498	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	21,558,057	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	403,842	0	0	0	12.00
13.00	Land improvements	2,324,864	0	0	0	13.00
14.00	Accumulated depreciation	-1,629,428	0	0	0	14.00
15.00	Buildings	24,822,186	0	0	0	15.00
16.00	Accumulated depreciation	-15,854,327	0	0	0	16.00
17.00	Leasehold improvements	855,820	0	0	0	17.00
18.00	Accumulated depreciation	-62,286	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	17,113,271	0	0	0	23.00
24.00	Accumulated depreciation	-12,963,510	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	15,010,432	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	23,902,985	0	0	0	33.00
34.00	Other assets	0	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	23,902,985	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	60,471,474	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	1,126,947	0	0	0	37.00
38.00	Salaries, wages, and fees payable	217,655	0	0	0	38.00
39.00	Payroll taxes payable	2,236,905	0	0	0	39.00
40.00	Notes and loans payable (short term)	2,277,863	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	624,142	0	0	0	43.00
44.00	Other current liabilities	0	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	6,483,512	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	756,662	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	756,662	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	7,240,174	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	53,231,300				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)	53,231,300	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	60,471,474	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 14-1320 | Period: From 01/01/2017 To 12/31/2017 | Worksheet G-1 | Date/Time Prepared: 5/24/2018 4:41 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		49,821,085		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		3,410,215				2.00
3.00	Total (sum of line 1 and line 2)		53,231,300		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)		53,231,300		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		53,231,300		0		19.00

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

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 14-1320 | Period: From 01/01/2017 To 12/31/2017 | Worksheet G-2 Parts I & II | Date/Time Prepared: 5/24/2018 4:41 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	2,690,168		2,690,168	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	2,690,168		2,690,168	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	2,690,168		2,690,168	17.00
18.00	Ancillary services	3,725,887	64,283,443	68,009,330	18.00
19.00	Outpatient services	20,078	9,352,031	9,372,109	19.00
20.00	RURAL HEALTH CLINIC	0	13,203,661	13,203,661	20.00
20.01	RURAL HEALTH CLINIC II	0	314,262	314,262	20.01
20.02	RURAL HEALTH CLINIC III	0	0	0	20.02
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	OTHER OUTPATIENT	0	241,794	241,794	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	6,436,133	87,395,191	93,831,324	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		46,991,536		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)		46,991,536		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 14-1320 | Period: From 01/01/2017 To 12/31/2017 | Worksheet G-3 | Date/Time Prepared: 5/24/2018 4:41 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	93,831,324	1.00
2.00	Less contractual allowances and discounts on patients' accounts	50,600,552	2.00
3.00	Net patient revenues (line 1 minus line 2)	43,230,772	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	46,991,536	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-3,760,764	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	586,319	6.00
7.00	Income from investments	439,818	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	1,275	10.00
11.00	Rebates and refunds of expenses	390,025	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	90,575	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	5,519	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	19,964	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER OPERATING INCOME	5,637,484	24.00
25.00	Total other income (sum of lines 6-24)	7,170,979	25.00
26.00	Total (line 5 plus line 25)	3,410,215	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)	3,410,215	29.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1320 | Component CCN: 14-3987 | Period: From 01/01/2017 To 12/31/2017 | Worksheet M-1 | Date/Time Prepared: 5/24/2018 4:41 pm

RHC I | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	1,437,305	0	1,437,305	0	1,437,305	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	825,896	0	825,896	0	825,896	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	1,035,933	0	1,035,933	0	1,035,933	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	175	0	175	0	175	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)	3,299,309	0	3,299,309	0	3,299,309	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	124,957	124,957	0	124,957	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	77,292	77,292	0	77,292	18.00
19.00	Other Health Care Costs	0	238,690	238,690	0	238,690	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	440,939	440,939	0	440,939	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	3,299,309	440,939	3,740,248	0	3,740,248	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	80,651	80,651	0	80,651	26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	80,651	80,651	0	80,651	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	352,820	352,820	0	352,820	29.00
30.00	Administrative Costs	1,157,830	1,978,323	3,136,153	0	3,136,153	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	1,157,830	2,331,143	3,488,973	0	3,488,973	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	4,457,139	2,852,733	7,309,872	0	7,309,872	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1320 | Component CCN: 14-3987 | Period: From 01/01/2017 To 12/31/2017 | Worksheet M-1 | Date/Time Prepared: 5/24/2018 4:41 pm

RHC I | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	1,437,305		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	825,896		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	1,035,933		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	175		8.00
9.00	Other Facility Health Care Staff Costs	0	0		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	3,299,309		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	124,957		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	77,292		18.00
19.00	Other Health Care Costs	0	238,690		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	440,939		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	3,740,248		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	-53,025	27,626		26.00
27.00	Nonallowable GME costs				27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	-53,025	27,626		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	352,820		29.00
30.00	Administrative Costs	-23,322	3,112,831		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-23,322	3,465,651		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-76,347	7,233,525		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1320 | Component CCN: 14-3989 | Period: From 01/01/2017 To 12/31/2017 | Worksheet M-1 | Date/Time Prepared: 5/24/2018 4:41 pm

RHC II | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	10,154	0	10,154	0	10,154	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	100,567	0	100,567	0	100,567	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	33,384	0	33,384	0	33,384	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	144,105	0	144,105	0	144,105	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	28,030	28,030	0	28,030	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	28,030	28,030	0	28,030	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	144,105	28,030	172,135	0	172,135	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	4,737	4,737	0	4,737	26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	4,737	4,737	0	4,737	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	19,217	19,217	0	19,217	29.00
30.00	Administrative Costs	31,840	73,422	105,262	0	105,262	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	31,840	92,639	124,479	0	124,479	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	175,945	125,406	301,351	0	301,351	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1320 | Component CCN: 14-3989 | Period: From 01/01/2017 To 12/31/2017 | Worksheet M-1 | Date/Time Prepared: 5/24/2018 4:41 pm

RHC II | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	10,154		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	100,567		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	33,384		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	0		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	144,105		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	28,030		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	28,030		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	172,135		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	-3,142	1,595		26.00
27.00	Nonallowable GME costs				27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	-3,142	1,595		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	19,217		29.00
30.00	Administrative Costs	0	105,262		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	124,479		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-3,142	298,209		32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1320 | Component CCN: 14-3987 | Period: From 01/01/2017 To 12/31/2017 | Worksheet M-2 | Date/Time Prepared: 5/24/2018 4:41 pm

RHC I | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	3.43	23,336	4,200	14,406		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	2.57	14,904	2,100	5,397		3.00
4.00	Subtotal (sum of lines 1 through 3)	6.00	38,240		19,803	38,240	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)	6.00	38,240			38,240	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)					3,740,248	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					27,626	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					3,767,874	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					0.992668	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					3,465,651	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					1,196,314	15.00
16.00	Total overhead (sum of lines 14 and 15)					4,661,965	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					4,661,965	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					4,627,783	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					8,368,031	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1320 | Component CCN: 14-3989 | Period: From 01/01/2017 To 12/31/2017 | Worksheet M-2 | Date/Time Prepared: 5/24/2018 4:41 pm

RHC II | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	0.00	0	4,200	0		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	0.78	2,083	2,100	1,638		3.00
4.00	Subtotal (sum of lines 1 through 3)	0.78	2,083		1,638	2,083	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)	0.78	2,083			2,083	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)					172,135	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					1,595	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					173,730	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					0.990819	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					124,479	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					49,319	15.00
16.00	Total overhead (sum of lines 14 and 15)					173,798	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					173,798	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					172,202	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					344,337	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 14-1320 Component CCN: 14-3987	Period: From 01/01/2017 To 12/31/2017	Worksheet M-3 Date/Time Prepared: 5/24/2018 4:41 pm
	Title XVIII	RHC I	Cost

				1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES				
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			8,368,031	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			184,100	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			8,183,931	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			38,240	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)			38,240	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			214.01	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)	81.32	82.30		8.00
9.00	Rate for Program covered visits (see instructions)	214.01	214.01		9.00
	CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	0	9,174		10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	1,963,328		11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0		12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0		13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0		14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)				15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *	0	1,963,328		16.00
16.01	Total program charges (see instructions)(from contractor's records)		1,366,307		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		59,379		16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		85,324		16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)		1,366,916		16.04
16.05	Total program cost (see instructions)	0	1,452,240		16.05
17.00	Primary payer amounts		105		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		169,359		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		227,514		19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		1,452,135		20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		182,727		21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		1,634,862		22.00
23.00	Allowable bad debts (see instructions)		80,765		23.00
23.01	Adjusted reimbursable bad debts (see instructions)		52,497		23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		53,394		24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0		25.50
25.99	Demonstration payment adjustment amount before sequestration		0		25.99
26.00	Net reimbursable amount (see instructions)		1,687,359		26.00
26.01	Sequestration adjustment (see instructions)		33,747		26.01
26.02	Demonstration payment adjustment amount after sequestration		0		26.02
27.00	Interim payments		1,102,271		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)		551,341		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: 14-1320 Component CCN: 14-3989	Period: From 01/01/2017 To 12/31/2017	Worksheet M-3 Date/Time Prepared: 5/24/2018 4:41 pm
	Title XVIII	RHC II	Cost

				1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES				
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			344,337	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			13,185	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			331,152	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			2,083	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)			0	5.00
6.00	Total adjusted visits (line 4 plus line 5)			2,083	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			158.98	7.00
		Calculation of Limit (1)			
		Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)		
		1.00	2.00		
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	81.32	82.30		8.00
9.00	Rate for Program covered visits (see instructions)	158.98	158.98		9.00
	CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	0	451		10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	71,700		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	71,700		16.00
16.01	Total program charges (see instructions)(from contractor's records)		60,842		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		1,793		16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		2,113		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.)		48,133		16.04
16.05	Total program cost (see instructions)	0	50,246		16.05
17.00	Primary payer amounts		0		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		9,421		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		9,926		19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		50,246		20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		13,185		21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		63,431		22.00
23.00	Allowable bad debts (see instructions)		1,409		23.00
23.01	Adjusted reimbursable bad debts (see instructions)		916		23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		983		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)		64,347		26.00
26.01	Sequestration adjustment (see instructions)		1,287		26.01
26.02	Demonstration payment adjustment amount after sequestration		0		26.02
27.00	Interim payments		77,532		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)		-14,472		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: 14-1320 | Component CCN: 14-3987 | Period: From 01/01/2017 To 12/31/2017 | Worksheet M-4 | Date/Time Prepared: 5/24/2018 4:41 pm

Title XVIII | RHC I | Cost

		Pneumococcal	Influenza	
		1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	3,299,309	3,299,309	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.004220	0.006664	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	13,923	21,987	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	37,986	8,393	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	51,909	30,380	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	3,740,248	3,740,248	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	4,627,783	4,627,783	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.013878	0.008122	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	64,224	37,587	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	116,133	67,967	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	316	499	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	367.51	136.21	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	313	497	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	115,031	67,696	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)		184,100	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)		182,727	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA VACCINE COST	Provider CCN: 14-1320 Component CCN: 14-3989	Period: From 01/01/2017 To 12/31/2017	Worksheet M-4 Date/Time Prepared: 5/24/2018 4:41 pm
	Title XVIII	RHC II	Cost

		Pneumococcal	Influenza	
		1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	144,105	144,105	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.003596	0.006062	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	518	874	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	4,207	992	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	4,725	1,866	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	172,135	172,135	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	172,202	172,202	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.027449	0.010840	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	4,727	1,867	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	9,452	3,733	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	35	59	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	270.06	63.27	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	35	59	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	9,452	3,733	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)		13,185	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)		13,185	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 14-1320 Component CCN: 14-3987	Period: From 01/01/2017 To 12/31/2017	Worksheet M-5 Date/Time Prepared: 5/24/2018 4:41 pm
		RHC I	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		1,035,352	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		12/07/2017	13,543	3.01
3.02		08/24/2017	53,376	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)		66,919	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		1,102,271	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		551,341	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		1,653,612	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: 14-1320 | Component CCN: 14-3989 | Period: From 01/01/2017 To 12/31/2017 | Worksheet M-5 | Date/Time Prepared: 5/24/2018 4:41 pm

RHC II | Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		62,608	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		08/24/2017	14,924	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)		14,924	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		77,532	4.00
	TO BE COMPLETED BY CONTRACTOR			
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			5.00
	Program to Provider			
5.01			0	5.01
5.02			0	5.02
5.03			0	5.03
	Provider to Program			
5.50			0	5.50
5.51			0	5.51
5.52			0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00
6.01	SETTLEMENT TO PROVIDER		0	6.01
6.02	SETTLEMENT TO PROGRAM		14,472	6.02
7.00	Total Medicare program liability (see instructions)		63,060	7.00

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