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: 14-1342	Period: From 01/01/2017 To 12/31/2017	Worksheet S Parts I-III Date/Time Prepared: 5/25/2018 1:51 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 5/25/2018 Time: 1:51 pm
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 UNION COUNTY HOSPITAL DISTRICT (14-1342) 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	154,932	-379,793	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	75,972	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
10.00	RURAL HEALTH CLINIC I	0		23,810		0	10.00
200.00	Total	0	230,904	-355,983	0	0	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1342 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-2 Part I | Date/Time Prepared: 5/25/2018 11:45 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 517 NORTH MAIN STREET	PO Box:			1.00
2.00	City: ANNA	State: IL	Zip Code: 62906	County: UNION	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	UNION COUNTY HOSPITAL DISTRICT	141342	99914	1	07/01/1966	N	O	P	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	UNION COUNTY HOSP DIST SWING BEDS	14Z342	99914		08/05/1992	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	UNION COUNTY HOSP DIST RHC	143975	99914		05/22/1991	N	O	N	15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From: 1.00	To: 2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	01/01/2017	12/31/2017	20.00
21.00	Type of Control (see instructions)	4		21.00
	Inpatient PPS Information			
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	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.	3	N	23.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1342 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-2 Part I Date/Time Prepared: 5/25/2018 11:45 am

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1342 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-2 Part I | Date/Time Prepared: 5/25/2018 11:45 am

		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).						61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.06

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

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

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

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1342 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-2 Part I | Date/Time Prepared: 5/25/2018 11:45 am

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 14-1342	Period: From 01/01/2017 To 12/31/2017	Worksheet S-2 Part I Date/Time Prepared: 5/25/2018 11:45 am

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

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

		Physical	Occupational	Speech	Respiratory	
		1.00	2.00	3.00	4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1342 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-2 Part I | Date/Time Prepared: 5/25/2018 11:45 am

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

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

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	9,307	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			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	HB0776	140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1342 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-2 Part I | Date/Time Prepared: 5/25/2018 11:45 am

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

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

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

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

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

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

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

		1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act		
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.	Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)	0	168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)		168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	1.00	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)	06/13/2017	09/10/2017	170.00

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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 14-1342 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-2 Part II | Date/Time Prepared: 5/25/2018 11:45 am

			Y/N	Date	
			1.00	2.00	
	General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.				
	COMPLETED BY ALL HOSPITALS				
	Provider Organization and Operation				
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)		N		1.00
		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y			3.00
		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	N			4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00
			Y/N	Legal Oper.	
			1.00	2.00	
	Approved Educational Activities				
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?		N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.		N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.		N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.		N		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.		N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.		N		11.00
				Y/N	
				1.00	
	Bad Debts				
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.			Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.			N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.			N	14.00
	Bed Complement				
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			N	15.00
		Part A		Part B	
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
	PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	Y	03/19/2018	Y	03/19/2018
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N	
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N	
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N	

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 14-1342 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-2 Part II Date/Time Prepared: 5/25/2018 11:45 am

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

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

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

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	BRENT	WILSON	41.00
42.00	Enter the employer/company name of the cost report preparer.	QUORUM HEALTH		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	615-221-3647	BRENT	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 14-1342	Period: From 01/01/2017 To 12/31/2017	Worksheet S-2 Part II Date/Time Prepared: 5/25/2018 11:45 am

		3.00		
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	REVENUE 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: 14-1342 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-3 Part I Date/Time Prepared: 5/25/2018 11:45 am

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	25	9,125	39,672.00	0	1.00
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		25	9,125	39,672.00	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	39,672.00	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	46.00	22	8,030			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
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		47				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00
33.01	LTCH site neutral days and discharges						33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 14-1342 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-3 Part I | Date/Time Prepared: 5/25/2018 11:45 am

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	1,051	202	1,653			1.00
2.00	HMO and other (see instructions)	202	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	713	0	830			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	35			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,764	202	2,518			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)	1,764	202	2,518	0.00	128.07	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			5,093	0.00	17.01	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	956	0	8,901	0.00	8.02	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	153.10	27.00
28.00	Observation Bed Days		0	310			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: 14-1342 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-3 Part I Date/Time Prepared: 5/25/2018 11:45 am

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	272	67	459	1.00
2.00	HMO and other (see instructions)			57	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	272	67	459	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	0.00				0	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
26.25	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: 14-1342 | Component CCN: 14-3975 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-8 | Date/Time Prepared: 5/25/2018 11:45 am

RHC I | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			517 NORTH MAIN STREET		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	ANNA		IL	62906	2.00
					1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0	3.00
			Grant Award		Date	
			1.00		2.00	
	Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)					4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)					5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)					6.00
7.00	Appalachian Regional Commission					7.00
8.00	Look-Alikes					8.00
9.00	OTHER (SPECIFY)					9.00
				1.00	2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N	0	10.00

		Sunday		Monday		Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
	Facility hours of operations (1)						
11.00	CLINIC	12:00	17:00	08:00	20:00	08:00	11.00

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

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

			County				
			4.00				
2.00	City, State, ZIP Code, County		UNION				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	20:00	08:00	20:00	08:00	20:00	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-1342
Component CCN: 14-3975

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

Worksheet S-8
Date/Time Prepared:
5/25/2018 11:45 am

RHC I | Cost

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	CLINIC	08:00	20:00	08:00	20:00		11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 14-1342 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-10 | Date/Time Prepared: 5/25/2018 11:45 am

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.215687	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	1,777,070	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?	N	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	3,891,254	5.00
6.00	Medicaid charges	20,640,444	6.00
7.00	Medicaid cost (line 1 times line 6)	4,451,875	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)	0	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)	0	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)	913,248	30,856	944,104	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	196,976	30,856	227,832	21.00
22.00	Payments received from patients for amounts previously written off as charity care	12,001	0	12,001	22.00
23.00	Cost of charity care (line 21 minus line 22)	184,975	30,856	215,831	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)	1,409,781	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	916,358	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	1,409,781	27.01
28.00	Non-Medicare bad debt expense (see instructions)	0	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	493,423	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	709,254	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	709,254	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-1342 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A | Date/Time Prepared: 5/25/2018 11:45 am

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		170,609	170,609	31,462	202,071	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		1,245,041	1,245,041	423,016	1,668,057	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	103,948	26,411	130,359	1,487,926	1,618,285	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,405,288	4,654,549	6,059,837	-1,803,908	4,255,929	5.00
7.00	00700	OPERATION OF PLANT	260,091	680,525	940,616	9,058	949,674	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	27,580	2,368	29,948	0	29,948	8.00
9.00	00900	HOUSEKEEPING	240,832	71,365	312,197	25,659	337,856	9.00
10.00	01000	DIETARY	220,535	208,284	428,819	0	428,819	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	776,986	74,292	851,278	-384,682	466,596	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	83,551	166,498	250,049	-131,636	118,413	14.00
15.00	01500	PHARMACY	300,129	586,199	886,328	-512,000	374,328	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	101,988	131,996	233,984	-20,946	213,038	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	647,877	994,959	1,642,836	437,462	2,080,298	30.00
46.00	04600	OTHER LONG TERM CARE	637,675	151,562	789,237	-36,747	752,490	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	232,336	140,370	372,706	30,658	403,364	50.00
51.00	05100	RECOVERY ROOM	22,433	4,960	27,393	-27,393	0	51.00
53.00	05300	ANESTHESIOLOGY	0	275,888	275,888	0	275,888	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	351,971	209,816	561,787	450,053	1,011,840	54.00
54.01	05401	ULTRASOUND	58,386	20,380	78,766	-78,766	0	54.01
56.00	05600	RADIOISOTOPE	0	105,925	105,925	-105,925	0	56.00
57.00	05700	CT SCAN	0	75,440	75,440	-75,440	0	57.00
58.00	05800	MRI	80,295	289,120	369,415	-369,415	0	58.00
60.00	06000	LABORATORY	370,822	376,050	746,872	-29,886	716,986	60.00
65.00	06500	RESPIRATORY THERAPY	53,256	34,845	88,101	-29,912	58,189	65.00
66.00	06600	PHYSICAL THERAPY	517,352	59,284	576,636	-1,174	575,462	66.00
67.00	06700	OCCUPATIONAL THERAPY	137,111	11,415	148,526	0	148,526	67.00
68.00	06800	SPEECH PATHOLOGY	41,190	4,800	45,990	0	45,990	68.00
69.00	06900	ELECTROCARDIOLOGY	68,002	12,962	80,964	0	80,964	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	123,793	123,793	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	34,190	34,190	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	492,812	492,812	73.00
76.00	03020	SLEEP LAB	0	93,853	93,853	0	93,853	76.00
76.03	03950	WOUND CARE	11,632	23,241	34,873	0	34,873	76.03
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	622,520	271,086	893,606	-50,147	843,459	88.00
91.00	09100	EMERGENCY	918,147	1,205,217	2,123,364	-1,053	2,122,311	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	8,291,933	12,379,310	20,671,243	-112,941	20,558,302	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	38,449	38,449	0	38,449	192.00
194.00	07956	AREAS UNDER RENOVATION	0	0	0	0	0	194.00
194.01	07951	OTHER NONREIMBURSABLE - MARKETING	0	0	0	112,941	112,941	194.01
194.02	07952	OTHER NONREIMBURSABLE - SENIOR CIRC	0	2,247	2,247	0	2,247	194.02
194.03	07953	FREESTANDING HHA COSTS	0	0	0	0	0	194.03
194.04	07954	LEASED TO SPECIALTY CLINICS	0	0	0	0	0	194.04
194.05	07955	VACANT SPACE	0	0	0	0	0	194.05
200.00		TOTAL (SUM OF LINES 118 through 199)	8,291,933	12,420,006	20,711,939	0	20,711,939	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-1342 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A | Date/Time Prepared: 5/25/2018 11:45 am

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	507,468	709,539		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-704,778	963,279		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-1,196	1,617,089		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-761,823	3,494,106		5.00
7.00	00700	OPERATION OF PLANT	-1,110	948,564		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	29,948		8.00
9.00	00900	HOUSEKEEPING	0	337,856		9.00
10.00	01000	DIETARY	0	428,819		10.00
11.00	01100	CAFETERIA	-25,841	-25,841		11.00
13.00	01300	NURSING ADMINISTRATION	0	466,596		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	118,413		14.00
15.00	01500	PHARMACY	0	374,328		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-513	212,525		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-830,337	1,249,961		30.00
46.00	04600	OTHER LONG TERM CARE	0	752,490		46.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	403,364		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
53.00	05300	ANESTHESIOLOGY	0	275,888		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,011,840		54.00
54.01	05401	ULTRASOUND	0	0		54.01
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MRI	0	0		58.00
60.00	06000	LABORATORY	0	716,986		60.00
65.00	06500	RESPIRATORY THERAPY	0	58,189		65.00
66.00	06600	PHYSICAL THERAPY	0	575,462		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	148,526		67.00
68.00	06800	SPEECH PATHOLOGY	0	45,990		68.00
69.00	06900	ELECTROCARDIOLOGY	0	80,964		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	123,793		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	34,190		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	492,812		73.00
76.00	03020	SLEEP LAB	0	93,853		76.00
76.03	03950	WOUND CARE	0	34,873		76.03
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	843,459		88.00
91.00	09100	EMERGENCY	-559,578	1,562,733		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-2,377,708	18,180,594		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	38,449		192.00
194.00	07956	AREAS UNDER RENOVATION	0	0		194.00
194.01	07951	OTHER NONREIMBURSABLE - MARKETING	0	112,941		194.01
194.02	07952	OTHER NONREIMBURSABLE - SENIOR CIRC	0	2,247		194.02
194.03	07953	FREESTANDING HHA COSTS	0	0		194.03
194.04	07954	LEASED TO SPECIALTY CLINICS	0	0		194.04
194.05	07955	VACANT SPACE	0	0		194.05
200.00		TOTAL (SUM OF LINES 118 through 199)	-2,377,708	18,334,231		200.00

RECLASSIFICATIONS | Provider CCN: 14-1342 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-6 | Date/Time Prepared: 5/25/2018 11:45 am

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - EMPLOYEE BENEFITS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	1,487,926		1.00
	0		0	1,487,926		
	B - OXYGEN					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	29,612		1.00
	0		0	29,612		
	C - RENTAL AND LEASE					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	268,732		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	268,732		
	D - OTHER CAPITAL COSTS					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	31,462		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	1,876		2.00
	0		0	33,338		
	E - MARKETING DEPT					
1.00	OTHER NONREIMBURSABLE - MARKETING	194.01	63,083	49,858		1.00
	0		63,083	49,858		
	F - MED SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	94,181		1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	34,190		2.00
3.00	OPERATING ROOM	50.00	0	3,265		3.00
	0		0	131,636		
	G - COST OF DRUGS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	492,812		1.00
	0		0	492,812		
	I - AMORT EXP					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	152,408		1.00
	0		0	152,408		
	J - OTHER RADIOLOGY COSTS					
1.00	RADIOLOGY-DIAGNOSTIC	54.00	138,681	311,372		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
	0		138,681	311,372		
	K - RECOVERY ROOM					
1.00	OPERATING ROOM	50.00	22,433	4,960		1.00
	0		22,433	4,960		
	M - RHC SALARY TO ADMIN					
1.00	ADMINISTRATIVE & GENERAL	5.00	48,973	0		1.00
	0		48,973	0		
	N - INFECTION CONTROL					
1.00	NURSING ADMINISTRATION	13.00	45,210	8,509		1.00
	0		45,210	8,509		
	O - RECLASS COSTS TO HSKP AND MAINT					
1.00	OPERATION OF PLANT	7.00	10,566	0		1.00
2.00	HOUSEKEEPING	9.00	25,659	0		2.00
	TOTALS		36,225	0		
	P - HOUSE SUPVR TO ADULT AND PED					
1.00	ADULTS & PEDIATRICS	30.00	438,401	0		1.00
	TOTALS		438,401	0		
500.00	Grand Total: Increases		793,006	2,971,163		500.00

RECLASSIFICATIONS | Provider CCN: 14-1342 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-6 | Date/Time Prepared: 5/25/2018 11:45 am

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - EMPLOYEE BENEFITS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	1,487,926	0		1.00
	0		0	1,487,926			
	B - OXYGEN						
1.00	RESPIRATORY THERAPY	65.00	0	29,612	0		1.00
	0		0	29,612			
	C - RENTAL AND LEASE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	12,549	10		1.00
2.00	OPERATION OF PLANT	7.00	0	1,508	0		2.00
3.00	PHARMACY	15.00	0	19,188	0		3.00
4.00	MEDICAL RECORDS & LIBRARY	16.00	0	20,946	0		4.00
5.00	ADULTS & PEDIATRICS	30.00	0	939	0		5.00
6.00	OTHER LONG TERM CARE	46.00	0	522	0		6.00
7.00	LABORATORY	60.00	0	29,886	0		7.00
8.00	MRI	58.00	0	179,493	0		8.00
9.00	RESPIRATORY THERAPY	65.00	0	300	0		9.00
10.00	PHYSICAL THERAPY	66.00	0	1,174	0		10.00
11.00	RURAL HEALTH CLINIC	88.00	0	1,174	0		11.00
12.00	EMERGENCY	91.00	0	1,053	0		12.00
	0		0	268,732			
	D - OTHER CAPITAL COSTS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	33,338	12		1.00
2.00		0.00	0	0	13		2.00
	0		0	33,338			
	E - MARKETING DEPT						
1.00	ADMINISTRATIVE & GENERAL	5.00	63,083	49,858	0		1.00
	0		63,083	49,858			
	F - MED SUPPLIES						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	131,636	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
	0		0	131,636			
	G - COST OF DRUGS						
1.00	PHARMACY	15.00	0	492,812	0		1.00
	0		0	492,812			
	I - AMORT EXP						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	152,408	9		1.00
	0		0	152,408			
	J - OTHER RADIOLOGY COSTS						
1.00	ULTRASOUND	54.01	58,386	20,380	0		1.00
2.00	RADIOISOTOPE	56.00	0	105,925	0		2.00
3.00	CT SCAN	57.00	0	75,440	0		3.00
4.00	MRI	58.00	80,295	109,627	0		4.00
	0		138,681	311,372			
	K - RECOVERY ROOM						
1.00	RECOVERY ROOM	51.00	22,433	4,960	0		1.00
	0		22,433	4,960			
	M - RHC SALARY TO ADMIN						
1.00	RURAL HEALTH CLINIC	88.00	48,973	0	0		1.00
	0		48,973	0			
	N - INFECTION CONTROL						
1.00	ADMINISTRATIVE & GENERAL	5.00	45,210	8,509	0		1.00
	0		45,210	8,509			
	O - RECLASS COSTS TO HSKP AND MAINT						
1.00	OTHER LONG TERM CARE	46.00	36,225	0	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		36,225	0			
	P - HOUSE SUPVR TO ADULT AND PED						
1.00	NURSING ADMINISTRATION	13.00	438,401	0	0		1.00
	TOTALS		438,401	0			
500.00	Grand Total: Decreases		793,006	2,971,163			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1342 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-7 Part I | Date/Time Prepared: 5/25/2018 11:45 am

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	0	0	0	0	0	1.00
2.00	Land Improvements	124,306	0	0	0	0	2.00
3.00	Buildings and Fixtures	6,846,397	0	0	0	0	3.00
4.00	Building Improvements	9,509,240	277,306	0	277,306	6,618	4.00
5.00	Fixed Equipment	2,311,000	11,661	0	11,661	9,362	5.00
6.00	Movable Equipment	10,099,673	489,890	0	489,890	172,313	6.00
7.00	HIT designated Assets	3,248,805	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	32,139,421	778,857	0	778,857	188,293	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	32,139,421	778,857	0	778,857	188,293	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	0	0	1.00
2.00	Land Improvements	124,306	0	2.00
3.00	Buildings and Fixtures	6,846,397	0	3.00
4.00	Building Improvements	9,779,928	0	4.00
5.00	Fixed Equipment	2,313,299	0	5.00
6.00	Movable Equipment	10,417,250	0	6.00
7.00	HIT designated Assets	3,248,805	0	7.00
8.00	Subtotal (sum of lines 1-7)	32,729,985	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	32,729,985	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1342 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-7 Part II Date/Time Prepared: 5/25/2018 11:45 am

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	170,609	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	1,245,041	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	1,415,650	0	0	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL		
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
		14.00	15.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	170,609	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	1,245,041	2.00
3.00	Total (sum of lines 1-2)	0	1,415,650	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1342 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-7 Part III Date/Time Prepared: 5/25/2018 11:45 am

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	COMPUTATION OF RATIOS: Capitalized Leases	COMPUTATION OF RATIOS: Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	ALLOCATION OF OTHER CAPITAL: Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	16,750,631	0	16,750,631	0.511782	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	15,979,354	0	15,979,354	0.488218	0	2.00
3.00	Total (sum of lines 1-2)	32,729,985	0	32,729,985	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	ALLOCATION OF OTHER CAPITAL: Other Capital-Related Costs	ALLOCATION OF OTHER CAPITAL: Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	SUMMARY OF CAPITAL: Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	678,077	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	692,671	268,732	2.00
3.00	Total (sum of lines 1-2)	0	0	0	1,370,748	268,732	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	SUMMARY OF CAPITAL: Insurance (see instructions)	SUMMARY OF CAPITAL: Taxes (see instructions)	SUMMARY OF CAPITAL: Other Capital-Related Costs (see instructions)	SUMMARY OF CAPITAL: Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	31,462	0	0	709,539	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	1,876	0	963,279	2.00
3.00	Total (sum of lines 1-2)	0	31,462	1,876	0	1,672,818	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-1342 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-8 | Date/Time Prepared: 5/25/2018 11:45 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-7,273	ADMINISTRATIVE & GENERAL	5.00	0	7.00
8.00	Television and radio service (chapter 21)	A	-545	CAP REL COSTS-MVBLE EQUIP	2.00	9	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-1,389,915			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	-72,273			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-25,841	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-513	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT	A	482,596	CAP REL COSTS-BLDG & FIXT	1.00	9	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP	A	-709,311	CAP REL COSTS-MVBLE EQUIP	2.00	9	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	FITNESS REVENUE	B	-11,113	ADMINISTRATIVE & GENERAL	5.00	0	33.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-1342 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-8 | Date/Time Prepared: 5/25/2018 11:45 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.02	IL PROVIDER TAX	B	-532,392	ADMINISTRATIVE & GENERAL	5.00	0	33.02
34.00	LOBBY EXPENSE	A	-8,938	ADMINISTRATIVE & GENERAL	5.00	0	34.00
34.01	CHARITABLE CONTRIBUTIONS	A	-1,080	ADMINISTRATIVE & GENERAL	5.00	0	34.01
35.00	PATIENT PHONES BENEFIT COST	A	-1,196	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	35.00
36.00	PATIENT PHONES DEPRECIATION COST	A	-1,066	CAP REL COSTS-MVBLE EQUIP	2.00	9	36.00
37.00	CABLE TV EXPENSE	A	-1,110	OPERATION OF PLANT	7.00	0	37.00
38.00	MARKETING EXPENSE - EXCLUDING MARKET	A	-76,619	ADMINISTRATIVE & GENERAL	5.00	0	38.00
39.00	PHYSICIAN RECRUITING	A	-10,771	ADMINISTRATIVE & GENERAL	5.00	0	39.00
40.00	LOBBYING EXPENSE IN ASSOCIATION DUES	A	-10,348	ADMINISTRATIVE & GENERAL	5.00	0	40.00
41.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	41.00
41.01	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	41.01
42.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	42.00
43.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	43.00
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-2,377,708				50.00

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 14-1342 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-8-1 | Date/Time Prepared: 5/25/2018 11:45 am

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	1.00	CAP REL COSTS-BLDG & FIXT	CAPITAL RELATED COSTS(INT &	24,872	0	1.00
2.00	2.00	CAP REL COSTS-MVBLE EQUIP	CAPITAL RELATED (MOVEABLE)	6,144	0	2.00
3.00	5.00	ADMINISTRATIVE & GENERAL	ALLOCATED COSTS	484,380	413,769	3.00
4.00	5.00	ADMINISTRATIVE & GENERAL	MALPRACTICE COSTS	9,307	183,207	4.00
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			524,703	596,976	5.00

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

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

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

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

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

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	Provider CCN: 14-1342	Period: From 01/01/2017 To 12/31/2017	Worksheet A-8-1 Date/Time Prepared: 5/25/2018 11:45 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	24,872	9		1.00
2.00	6,144	9		2.00
3.00	70,611	0		3.00
4.00	-173,900	0		4.00
5.00	-72,273			5.00

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

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

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

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

6.00	HOSPITAL MANAGE		6.00
7.00			7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 14-1342 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-8-2 | Date/Time Prepared: 5/25/2018 11:45 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	AGGREGATE-ADULTS & PEDIATRICS	830,337	830,337	0	0	0	1.00
2.00	91.00	AGGREGATE-EMERGENCY	1,017,600	559,578	458,022	0	0	2.00
3.00	0.00	AGGREGATE-	0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			1,847,937	1,389,915	458,022		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	AGGREGATE-ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	91.00	AGGREGATE-EMERGENCY	0	0	0	0	0	2.00
3.00	0.00	AGGREGATE-	0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	30.00	AGGREGATE-ADULTS & PEDIATRICS	0	0	0	830,337		1.00
2.00	91.00	AGGREGATE-EMERGENCY	0	0	0	559,578		2.00
3.00	0.00	AGGREGATE-	0	0	0	0		3.00
4.00	0.00		0	0	0	0		4.00
5.00	0.00		0	0	0	0		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	1,389,915		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1342 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part I Date/Time Prepared: 5/25/2018 11:45 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	709,539	709,539				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	963,279		963,279			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,617,089	5,543	7,627	1,630,259		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	3,494,106	52,258	71,907	267,988	3,886,259	5.00
7.00	00700	OPERATION OF PLANT	948,564	199,889	275,041	53,889	1,477,383	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	29,948	11,967	16,466	5,491	63,872	8.00
9.00	00900	HOUSEKEEPING	337,856	9,146	12,584	53,059	412,645	9.00
10.00	01000	DIETARY	428,819	22,597	31,094	43,909	526,419	10.00
11.00	01100	CAFETERIA	-25,841	0	0	0	-25,841	11.00
13.00	01300	NURSING ADMINISTRATION	466,596	16,849	23,183	76,415	583,043	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	118,413	13,956	19,204	16,635	168,208	14.00
15.00	01500	PHARMACY	374,328	8,748	12,037	59,757	454,870	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	212,525	8,129	11,186	20,306	252,146	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,249,961	50,262	69,159	216,282	1,585,664	30.00
46.00	04600	OTHER LONG TERM CARE	752,490	42,217	58,090	119,751	972,548	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	403,364	27,863	38,339	50,726	520,292	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	275,888	0	0	0	275,888	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,011,840	44,861	61,728	97,691	1,216,120	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	716,986	12,414	17,082	73,832	820,314	60.00
65.00	06500	RESPIRATORY THERAPY	58,189	4,399	6,053	10,603	79,244	65.00
66.00	06600	PHYSICAL THERAPY	575,462	31,878	43,864	103,007	754,211	66.00
67.00	06700	OCCUPATIONAL THERAPY	148,526	7,106	9,778	27,299	192,709	67.00
68.00	06800	SPEECH PATHOLOGY	45,990	988	1,359	8,201	56,538	68.00
69.00	06900	ELECTROCARDIOLOGY	80,964	5,394	7,421	13,539	107,318	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	123,793	0	0	0	123,793	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	34,190	0	0	0	34,190	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	492,812	0	0	0	492,812	73.00
76.00	03020	SLEEP LAB	93,853	0	0	0	93,853	76.00
76.03	03950	WOUND CARE	34,873	6,843	9,416	2,316	53,448	76.03
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	843,459	19,613	26,987	114,196	1,004,255	88.00
91.00	09100	EMERGENCY	1,562,733	33,470	46,054	182,807	1,825,064	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	18,180,594	636,390	875,659	1,617,699	18,007,265	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	3,340	4,596	0	7,936	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	38,449	44,605	61,376	0	144,430	192.00
194.00	07956	AREAS UNDER RENOVATION	0	0	0	0	0	194.00
194.01	07951	OTHER NONREIMBURSABLE - MARKETING	112,941	2,778	3,823	12,560	132,102	194.01
194.02	07952	OTHER NONREIMBURSABLE - SENIOR CIRC	2,247	3,233	4,449	0	9,929	194.02
194.03	07953	FREESTANDING HHA COSTS	0	0	0	0	0	194.03
194.04	07954	LEASED TO SPECIALTY CLINICS	0	9,721	13,376	0	23,097	194.04
194.05	07955	VACANT SPACE	0	9,472	0	0	9,472	194.05
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)	18,334,231	709,539	963,279	1,630,259	18,334,231	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1342 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part I | Date/Time Prepared: 5/25/2018 11:45 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	3,886,259					5.00
7.00	00700	OPERATION OF PLANT	396,682	1,874,065				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	17,150	50,694	131,716			8.00
9.00	00900	HOUSEKEEPING	110,796	38,743	3,925	566,109		9.00
10.00	01000	DIETARY	141,345	95,729	634	30,367	794,494	10.00
11.00	01100	CAFETERIA	0	0	0	0	384,835	11.00
13.00	01300	NURSING ADMINISTRATION	156,549	71,375	0	22,642	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	45,164	59,123	0	18,755	0	14.00
15.00	01500	PHARMACY	122,134	37,057	0	11,755	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	67,702	34,438	0	10,925	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	425,756	212,922	21,044	67,543	143,446	30.00
46.00	04600	OTHER LONG TERM CARE	261,132	178,845	67,360	56,733	266,213	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	139,700	118,036	5,962	37,443	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	74,077	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	326,532	190,044	5,747	60,286	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	220,257	52,591	0	16,683	0	60.00
65.00	06500	RESPIRATORY THERAPY	21,277	18,634	0	5,911	0	65.00
66.00	06600	PHYSICAL THERAPY	202,508	129,566	9,887	42,839	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	51,743	34,499	0	9,549	0	67.00
68.00	06800	SPEECH PATHOLOGY	15,181	5,298	0	1,327	0	68.00
69.00	06900	ELECTROCARDIOLOGY	28,815	22,849	0	7,248	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	33,239	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	9,180	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	132,322	0	0	0	0	73.00
76.00	03020	SLEEP LAB	25,200	0	0	0	0	76.00
76.03	03950	WOUND CARE	14,351	28,990	0	9,196	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	269,645	83,086	991	26,356	0	88.00
91.00	09100	EMERGENCY	490,030	141,788	16,166	44,978	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	3,798,467	1,604,307	131,716	480,536	794,494	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,131	14,149	0	4,488	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	38,780	188,960	0	59,942	0	192.00
194.00	07956	AREAS UNDER RENOVATION	0	0	0	0	0	194.00
194.01	07951	OTHER NONREIMBURSABLE - MARKETING	35,470	11,770	0	3,734	0	194.01
194.02	07952	OTHER NONREIMBURSABLE - SENIOR CIRC	2,666	13,697	0	4,345	0	194.02
194.03	07953	FREESTANDING HHA COSTS	0	0	0	0	0	194.03
194.04	07954	LEASED TO SPECIALTY CLINICS	6,202	41,182	0	13,064	0	194.04
194.05	07955	VACANT SPACE	2,543	0	0	0	0	194.05
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	3,886,259	1,874,065	131,716	566,109	794,494	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1342 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part I | Date/Time Prepared: 5/25/2018 11:45 am

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	358,994					11.00
13.00	01300	NURSING ADMINISTRATION	13,593	847,202				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	7,624	0	298,874			14.00
15.00	01500	PHARMACY	10,644	0	4,564	641,024		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	9,997	0	1,675	0	376,883	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	69,549	293,567	22,290	0	18,553	30.00
46.00	04600	OTHER LONG TERM CARE	55,631	0	7,995	0	3,785	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	15,247	113,471	39,015	0	16,850	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	4,089	0	3,986	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	31,537	0	11,237	0	138,455	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	28,984	0	90,692	0	58,401	60.00
65.00	06500	RESPIRATORY THERAPY	3,632	24,131	633	0	1,354	65.00
66.00	06600	PHYSICAL THERAPY	27,474	0	5,911	0	15,923	66.00
67.00	06700	OCCUPATIONAL THERAPY	7,084	0	435	0	3,551	67.00
68.00	06800	SPEECH PATHOLOGY	1,798	0	105	0	493	68.00
69.00	06900	ELECTROCARDIOLOGY	3,668	0	390	0	7,439	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	56,861	0	5,861	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	7,720	0	593	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	641,024	40,712	73.00
76.00	03020	SLEEP LAB	0	0	0	0	2,136	76.00
76.03	03950	WOUND CARE	1,402	0	4,980	0	907	76.03
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	21,109	0	5,747	0	5,322	88.00
91.00	09100	EMERGENCY	46,713	416,033	34,177	0	52,562	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	355,686	847,202	298,516	641,024	376,883	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07956	AREAS UNDER RENOVATION	0	0	0	0	0	194.00
194.01	07951	OTHER NONREIMBURSABLE - MARKETING	3,308	0	243	0	0	194.01
194.02	07952	OTHER NONREIMBURSABLE - SENIOR CIRC	0	0	115	0	0	194.02
194.03	07953	FREESTANDING HHA COSTS	0	0	0	0	0	194.03
194.04	07954	LEASED TO SPECIALTY CLINICS	0	0	0	0	0	194.04
194.05	07955	VACANT SPACE	0	0	0	0	0	194.05
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)	358,994	847,202	298,874	641,024	376,883	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1342 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part I | Date/Time Prepared: 5/25/2018 11:45 am

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	2,860,334	0	2,860,334		30.00
46.00	04600	OTHER LONG TERM CARE	1,870,242	0	1,870,242		46.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	1,006,016	0	1,006,016		50.00
51.00	05100	RECOVERY ROOM	0	0	0		51.00
53.00	05300	ANESTHESIOLOGY	358,040	0	358,040		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,979,958	0	1,979,958		54.00
54.01	05401	ULTRASOUND	0	0	0		54.01
56.00	05600	RADIOISOTOPE	0	0	0		56.00
57.00	05700	CT SCAN	0	0	0		57.00
58.00	05800	MRI	0	0	0		58.00
60.00	06000	LABORATORY	1,287,922	0	1,287,922		60.00
65.00	06500	RESPIRATORY THERAPY	154,816	0	154,816		65.00
66.00	06600	PHYSICAL THERAPY	1,188,319	0	1,188,319		66.00
67.00	06700	OCCUPATIONAL THERAPY	299,570	0	299,570		67.00
68.00	06800	SPEECH PATHOLOGY	80,740	0	80,740		68.00
69.00	06900	ELECTROCARDIOLOGY	177,727	0	177,727		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	219,754	0	219,754		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	51,683	0	51,683		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,306,870	0	1,306,870		73.00
76.00	03020	SLEEP LAB	121,189	0	121,189		76.00
76.03	03950	WOUND CARE	113,274	0	113,274		76.03
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	1,416,511	0	1,416,511		88.00
91.00	09100	EMERGENCY	3,067,511	0	3,067,511		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0			92.00
		SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	17,560,476	0	17,560,476		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	28,704	0	28,704		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	432,112	0	432,112		192.00
194.00	07956	AREAS UNDER RENOVATION	0	0	0		194.00
194.01	07951	OTHER NONREIMBURSABLE - MARKETING	186,627	0	186,627		194.01
194.02	07952	OTHER NONREIMBURSABLE - SENIOR CIRC	30,752	0	30,752		194.02
194.03	07953	FREESTANDING HHA COSTS	0	0	0		194.03
194.04	07954	LEASED TO SPECIALTY CLINICS	83,545	0	83,545		194.04
194.05	07955	VACANT SPACE	12,015	0	12,015		194.05
200.00		Cross Foot Adjustments	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	18,334,231	0	18,334,231		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1342 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part II Date/Time Prepared: 5/25/2018 11:45 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	5,543	7,627	13,170	13,170	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	52,258	71,907	124,165	2,169	5.00
7.00	00700	OPERATION OF PLANT	0	199,889	275,041	474,930	435	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	11,967	16,466	28,433	44	8.00
9.00	00900	HOUSEKEEPING	0	9,146	12,584	21,730	429	9.00
10.00	01000	DIETARY	0	22,597	31,094	53,691	355	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	16,849	23,183	40,032	617	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	13,956	19,204	33,160	134	14.00
15.00	01500	PHARMACY	0	8,748	12,037	20,785	483	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	8,129	11,186	19,315	164	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	50,262	69,159	119,421	1,747	30.00
46.00	04600	OTHER LONG TERM CARE	0	42,217	58,090	100,307	967	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	27,863	38,339	66,202	410	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	44,861	61,728	106,589	789	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	12,414	17,082	29,496	596	60.00
65.00	06500	RESPIRATORY THERAPY	0	4,399	6,053	10,452	86	65.00
66.00	06600	PHYSICAL THERAPY	0	31,878	43,864	75,742	832	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	7,106	9,778	16,884	220	67.00
68.00	06800	SPEECH PATHOLOGY	0	988	1,359	2,347	66	68.00
69.00	06900	ELECTROCARDIOLOGY	0	5,394	7,421	12,815	109	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	SLEEP LAB	0	0	0	0	0	76.00
76.03	03950	WOUND CARE	0	6,843	9,416	16,259	19	76.03
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	19,613	26,987	46,600	922	88.00
91.00	09100	EMERGENCY	0	33,470	46,054	79,524	1,476	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	636,390	875,659	1,512,049	13,069	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	3,340	4,596	7,936	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	44,605	61,376	105,981	0	192.00
194.00	07956	AREAS UNDER RENOVATION	0	0	0	0	0	194.00
194.01	07951	OTHER NONREIMBURSABLE - MARKETING	0	2,778	3,823	6,601	101	194.01
194.02	07952	OTHER NONREIMBURSABLE - SENIOR CIRC	0	3,233	4,449	7,682	0	194.02
194.03	07953	FREESTANDING HHA COSTS	0	0	0	0	0	194.03
194.04	07954	LEASED TO SPECIALTY CLINICS	0	9,721	13,376	23,097	0	194.04
194.05	07955	VACANT SPACE	0	9,472	0	9,472	0	194.05
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	709,539	963,279	1,672,818	13,170	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1342 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part II Date/Time Prepared: 5/25/2018 11:45 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	126,334					5.00
7.00	00700	OPERATION OF PLANT	12,895	488,260				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	557	13,208	42,242			8.00
9.00	00900	HOUSEKEEPING	3,602	10,094	1,259	37,114		9.00
10.00	01000	DIETARY	4,595	24,941	203	1,991	85,776	10.00
11.00	01100	CAFETERIA	0	0	0	0	41,548	11.00
13.00	01300	NURSING ADMINISTRATION	5,089	18,596	0	1,484	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,468	15,404	0	1,230	0	14.00
15.00	01500	PHARMACY	3,970	9,655	0	771	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,201	8,972	0	716	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	13,840	55,472	6,749	4,427	15,487	30.00
46.00	04600	OTHER LONG TERM CARE	8,488	46,595	21,603	3,719	28,741	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,541	30,753	1,912	2,455	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	2,408	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	10,614	49,513	1,843	3,952	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	7,160	13,702	0	1,094	0	60.00
65.00	06500	RESPIRATORY THERAPY	692	4,855	0	388	0	65.00
66.00	06600	PHYSICAL THERAPY	6,583	33,756	3,171	2,809	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,682	8,988	0	626	0	67.00
68.00	06800	SPEECH PATHOLOGY	493	1,380	0	87	0	68.00
69.00	06900	ELECTROCARDIOLOGY	937	5,953	0	475	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,080	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	298	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,301	0	0	0	0	73.00
76.00	03020	SLEEP LAB	819	0	0	0	0	76.00
76.03	03950	WOUND CARE	466	7,553	0	603	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	8,765	21,647	318	1,728	0	88.00
91.00	09100	EMERGENCY	15,935	36,941	5,184	2,949	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	123,479	417,978	42,242	31,504	85,776	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	69	3,686	0	294	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,261	49,231	0	3,930	0	192.00
194.00	07956	AREAS UNDER RENOVATION	0	0	0	0	0	194.00
194.01	07951	OTHER NONREIMBURSABLE - MARKETING	1,153	3,067	0	245	0	194.01
194.02	07952	OTHER NONREIMBURSABLE - SENIOR CIRC	87	3,569	0	285	0	194.02
194.03	07953	FREESTANDING HHA COSTS	0	0	0	0	0	194.03
194.04	07954	LEASED TO SPECIALTY CLINICS	202	10,729	0	856	0	194.04
194.05	07955	VACANT SPACE	83	0	0	0	0	194.05
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)	126,334	488,260	42,242	37,114	85,776	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1342 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part II Date/Time Prepared: 5/25/2018 11:45 am

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	38,758					11.00
13.00	01300	NURSING ADMINISTRATION	1,468	67,286				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	823	0	52,219			14.00
15.00	01500	PHARMACY	1,149	0	797	37,610		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,079	0	293	0	32,740	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,510	23,316	3,895	0	1,611	30.00
46.00	04600	OTHER LONG TERM CARE	6,006	0	1,397	0	329	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,646	9,012	6,817	0	1,463	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	714	0	346	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,405	0	1,963	0	12,033	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	3,129	0	15,846	0	5,072	60.00
65.00	06500	RESPIRATORY THERAPY	392	1,917	111	0	118	65.00
66.00	06600	PHYSICAL THERAPY	2,966	0	1,033	0	1,383	66.00
67.00	06700	OCCUPATIONAL THERAPY	765	0	76	0	308	67.00
68.00	06800	SPEECH PATHOLOGY	194	0	18	0	43	68.00
69.00	06900	ELECTROCARDIOLOGY	396	0	68	0	646	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	9,935	0	509	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	1,349	0	52	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	37,610	3,536	73.00
76.00	03020	SLEEP LAB	0	0	0	0	185	76.00
76.03	03950	WOUND CARE	151	0	870	0	79	76.03
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	2,279	0	1,004	0	462	88.00
91.00	09100	EMERGENCY	5,043	33,041	5,971	0	4,565	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	38,401	67,286	52,157	37,610	32,740	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07956	AREAS UNDER RENOVATION	0	0	0	0	0	194.00
194.01	07951	OTHER NONREIMBURSABLE - MARKETING	357	0	42	0	0	194.01
194.02	07952	OTHER NONREIMBURSABLE - SENIOR CIRC	0	0	20	0	0	194.02
194.03	07953	FREESTANDING HHA COSTS	0	0	0	0	0	194.03
194.04	07954	LEASED TO SPECIALTY CLINICS	0	0	0	0	0	194.04
194.05	07955	VACANT SPACE	0	0	0	0	0	194.05
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	2,790	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	41,548	67,286	52,219	37,610	32,740	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1342 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part II | Date/Time Prepared: 5/25/2018 11:45 am

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	253,475	0	253,475		30.00
46.00	04600	OTHER LONG TERM CARE	218,152	0	218,152		46.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	125,211	0	125,211		50.00
51.00	05100	RECOVERY ROOM	0	0	0		51.00
53.00	05300	ANESTHESIOLOGY	3,468	0	3,468		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	190,701	0	190,701		54.00
54.01	05401	ULTRASOUND	0	0	0		54.01
56.00	05600	RADIOISOTOPE	0	0	0		56.00
57.00	05700	CT SCAN	0	0	0		57.00
58.00	05800	MRI	0	0	0		58.00
60.00	06000	LABORATORY	76,095	0	76,095		60.00
65.00	06500	RESPIRATORY THERAPY	19,011	0	19,011		65.00
66.00	06600	PHYSICAL THERAPY	128,275	0	128,275		66.00
67.00	06700	OCCUPATIONAL THERAPY	29,549	0	29,549		67.00
68.00	06800	SPEECH PATHOLOGY	4,628	0	4,628		68.00
69.00	06900	ELECTROCARDIOLOGY	21,399	0	21,399		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	11,524	0	11,524		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,699	0	1,699		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	45,447	0	45,447		73.00
76.00	03020	SLEEP LAB	1,004	0	1,004		76.00
76.03	03950	WOUND CARE	26,000	0	26,000		76.03
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	83,725	0	83,725		88.00
91.00	09100	EMERGENCY	190,629	0	190,629		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0			92.00
		SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,429,992	0	1,429,992		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	11,985	0	11,985		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	160,403	0	160,403		192.00
194.00	07956	AREAS UNDER RENOVATION	0	0	0		194.00
194.01	07951	OTHER NONREIMBURSABLE - MARKETING	11,566	0	11,566		194.01
194.02	07952	OTHER NONREIMBURSABLE - SENIOR CIRC	11,643	0	11,643		194.02
194.03	07953	FREESTANDING HHA COSTS	0	0	0		194.03
194.04	07954	LEASED TO SPECIALTY CLINICS	34,884	0	34,884		194.04
194.05	07955	VACANT SPACE	9,555	0	9,555		194.05
200.00		Cross Foot Adjustments	0	0	0		200.00
201.00		Negative Cost Centers	2,790	0	2,790		201.00
202.00		TOTAL (sum lines 118 through 201)	1,672,818	0	1,672,818		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1342 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B-1 | Date/Time Prepared: 5/25/2018 11:45 am

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	99,849					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		98,516				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	780	780	8,187,985			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	7,354	7,354	1,345,968	-3,886,259	14,473,813	5.00
7.00	00700	OPERATION OF PLANT	28,129	28,129	270,657	0	1,477,383	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,684	1,684	27,580	0	63,872	8.00
9.00	00900	HOUSEKEEPING	1,287	1,287	266,491	0	412,645	9.00
10.00	01000	DIETARY	3,180	3,180	220,535	0	526,419	10.00
11.00	01100	CAFETERIA	0	0	0	25,841	0	11.00
13.00	01300	NURSING ADMINISTRATION	2,371	2,371	383,795	0	583,043	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,964	1,964	83,551	0	168,208	14.00
15.00	01500	PHARMACY	1,231	1,231	300,129	0	454,870	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,144	1,144	101,988	0	252,146	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,073	7,073	1,086,278	0	1,585,664	30.00
46.00	04600	OTHER LONG TERM CARE	5,941	5,941	601,450	0	972,548	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,921	3,921	254,769	0	520,292	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	275,888	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,313	6,313	490,652	0	1,216,120	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	1,747	1,747	370,822	0	820,314	60.00
65.00	06500	RESPIRATORY THERAPY	619	619	53,256	0	79,244	65.00
66.00	06600	PHYSICAL THERAPY	4,486	4,486	517,352	0	754,211	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,000	1,000	137,111	0	192,709	67.00
68.00	06800	SPEECH PATHOLOGY	139	139	41,190	0	56,538	68.00
69.00	06900	ELECTROCARDIOLOGY	759	759	68,002	0	107,318	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	123,793	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	34,190	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	492,812	73.00
76.00	03020	SLEEP LAB	0	0	0	0	93,853	76.00
76.03	03950	WOUND CARE	963	963	11,632	0	53,448	76.03
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	2,760	2,760	573,547	0	1,004,255	88.00
91.00	09100	EMERGENCY	4,710	4,710	918,147	0	1,825,064	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	89,555	89,555	8,124,902	-3,860,418	14,146,847	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	470	470	0	0	7,936	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	6,277	6,277	0	0	144,430	192.00
194.00	07956	AREAS UNDER RENOVATION	0	0	0	0	0	194.00
194.01	07951	OTHER NONREIMBURSABLE - MARKETING	391	391	63,083	0	132,102	194.01
194.02	07952	OTHER NONREIMBURSABLE - SENIOR CIRC	455	455	0	0	9,929	194.02
194.03	07953	FREESTANDING HHA COSTS	0	0	0	0	0	194.03
194.04	07954	LEASED TO SPECIALTY CLINICS	1,368	1,368	0	0	23,097	194.04
194.05	07955	VACANT SPACE	1,333	0	0	0	9,472	194.05
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)	709,539	963,279	1,630,259		3,886,259	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	7.106120	9.777894	0.199104		0.268503	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			13,170		126,334	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.001608		0.008728	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: 14-1342 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B-1 | Date/Time Prepared: 5/25/2018 11:45 am

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (LBS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTES)	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	62,254					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,684	55,299				8.00
9.00	00900	HOUSEKEEPING	1,287	1,648	59,282			9.00
10.00	01000	DIETARY	3,180	266	3,180	45,223		10.00
11.00	01100	CAFETERIA	0	0	0	21,905	9,983	11.00
13.00	01300	NURSING ADMINISTRATION	2,371	0	2,371	0	378	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,964	0	1,964	0	212	14.00
15.00	01500	PHARMACY	1,231	0	1,231	0	296	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,144	0	1,144	0	278	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,073	8,835	7,073	8,165	1,934	30.00
46.00	04600	OTHER LONG TERM CARE	5,941	28,280	5,941	15,153	1,547	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,921	2,503	3,921	0	424	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,313	2,413	6,313	0	877	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	1,747	0	1,747	0	806	60.00
65.00	06500	RESPIRATORY THERAPY	619	0	619	0	101	65.00
66.00	06600	PHYSICAL THERAPY	4,304	4,151	4,486	0	764	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,146	0	1,000	0	197	67.00
68.00	06800	SPEECH PATHOLOGY	176	0	139	0	50	68.00
69.00	06900	ELECTROCARDIOLOGY	759	0	759	0	102	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	SLEEP LAB	0	0	0	0	0	76.00
76.03	03950	WOUND CARE	963	0	963	0	39	76.03
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	2,760	416	2,760	0	587	88.00
91.00	09100	EMERGENCY	4,710	6,787	4,710	0	1,299	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	53,293	55,299	50,321	45,223	9,891	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	470	0	470	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	6,277	0	6,277	0	0	192.00
194.00	07956	AREAS UNDER RENOVATION	0	0	0	0	0	194.00
194.01	07951	OTHER NONREIMBURSABLE - MARKETING	391	0	391	0	92	194.01
194.02	07952	OTHER NONREIMBURSABLE - SENIOR CIRC	455	0	455	0	0	194.02
194.03	07953	FREESTANDING HHA COSTS	0	0	0	0	0	194.03
194.04	07954	LEASED TO SPECIALTY CLINICS	1,368	0	1,368	0	0	194.04
194.05	07955	VACANT SPACE	0	0	0	0	0	194.05
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)	1,874,065	131,716	566,109	794,494	358,994	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	30.103527	2.381888	9.549425	17.568361	35.960533	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	488,260	42,242	37,114	85,776	41,548	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	7.843030	0.763884	0.626059	1.896734	3.882400	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: 14-1342 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B-1 | Date/Time Prepared: 5/25/2018 11:45 am

		Cost Center Description	NURSING ADMINISTRATION (NURSING WAGES)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)		
			13.00	14.00	15.00	16.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	1,869,701					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	494,509				14.00
15.00	01500	PHARMACY	0	7,552	492,812			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	2,771	0	81,416,417		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	647,877	36,881	0	4,008,094		30.00
46.00	04600	OTHER LONG TERM CARE	0	13,228	0	817,688		46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	250,421	64,554	0	3,640,056		50.00
51.00	05100	RECOVERY ROOM	0	0	0	0		51.00
53.00	05300	ANESTHESIOLOGY	0	6,765	0	861,184		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	18,593	0	29,908,760		54.00
54.01	05401	ULTRASOUND	0	0	0	0		54.01
56.00	05600	RADIOISOTOPE	0	0	0	0		56.00
57.00	05700	CT SCAN	0	0	0	0		57.00
58.00	05800	MRI	0	0	0	0		58.00
60.00	06000	LABORATORY	0	150,059	0	12,616,438		60.00
65.00	06500	RESPIRATORY THERAPY	53,256	1,047	0	292,515		65.00
66.00	06600	PHYSICAL THERAPY	0	9,780	0	3,439,744		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	719	0	767,181		67.00
68.00	06800	SPEECH PATHOLOGY	0	173	0	106,407		68.00
69.00	06900	ELECTROCARDIOLOGY	0	646	0	1,607,068		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	94,080	0	1,266,127		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	12,773	0	128,126		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	492,812	8,795,092		73.00
76.00	03020	SLEEP LAB	0	0	0	461,395		76.00
76.03	03950	WOUND CARE	0	8,239	0	195,934		76.03
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	9,509	0	1,149,685		88.00
91.00	09100	EMERGENCY	918,147	56,548	0	11,354,923		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,869,701	493,917	492,812	81,416,417		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192.00
194.00	07956	AREAS UNDER RENOVATION	0	0	0	0		194.00
194.01	07951	OTHER NONREIMBURSABLE - MARKETING	0	402	0	0		194.01
194.02	07952	OTHER NONREIMBURSABLE - SENIOR CIRC	0	190	0	0		194.02
194.03	07953	FREESTANDING HHA COSTS	0	0	0	0		194.03
194.04	07954	LEASED TO SPECIALTY CLINICS	0	0	0	0		194.04
194.05	07955	VACANT SPACE	0	0	0	0		194.05
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)	847,202	298,874	641,024	376,883		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.453122	0.604385	1.300748	0.004629		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	67,286	52,219	37,610	32,740		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.035988	0.105598	0.076317	0.000402		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: 14-1342 | Period: From 01/01/2017 To 12/31/2017 | Worksheet C Part I Date/Time Prepared: 5/25/2018 11:45 am

Title XVIII | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,860,334		2,860,334	0	0	30.00
46.00	04600	OTHER LONG TERM CARE	1,870,242		1,870,242	0	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,006,016		1,006,016	0	0	50.00
51.00	05100	RECOVERY ROOM	0		0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	358,040		358,040	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,979,958		1,979,958	0	0	54.00
54.01	05401	ULTRASOUND	0		0	0	0	54.01
56.00	05600	RADIOISOTOPE	0		0	0	0	56.00
57.00	05700	CT SCAN	0		0	0	0	57.00
58.00	05800	MRI	0		0	0	0	58.00
60.00	06000	LABORATORY	1,287,922		1,287,922	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	154,816	0	154,816	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,188,319	0	1,188,319	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	299,570	0	299,570	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	80,740	0	80,740	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	177,727		177,727	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	219,754		219,754	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	51,683		51,683	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,306,870		1,306,870	0	0	73.00
76.00	03020	SLEEP LAB	121,189		121,189	0	0	76.00
76.03	03950	WOUND CARE	113,274		113,274	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,416,511		1,416,511	0	0	88.00
91.00	09100	EMERGENCY	3,067,511		3,067,511	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	316,901		316,901		0	92.00
200.00		Subtotal (see instructions)	17,877,377	0	17,877,377	0	0	200.00
201.00		Less Observation Beds	316,901		316,901		0	201.00
202.00		Total (see instructions)	17,560,476	0	17,560,476	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1342 | Period: From 01/01/2017 To 12/31/2017 | Worksheet C Part I Date/Time Prepared: 5/25/2018 11:45 am

Title XVIII | Hospital | Cost

		Cost Center Description	Charges: Inpatient	Charges: Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,222,279		3,222,279			30.00
46.00	04600	OTHER LONG TERM CARE	817,688		817,688			46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	59,960	3,580,096	3,640,056	0.276374	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0.000000	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	20,381	840,803	861,184	0.415753	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	901,872	29,006,888	29,908,760	0.066200	0.000000	54.00
54.01	05401	ULTRASOUND	0	0	0	0.000000	0.000000	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0.000000	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	0.000000	0.000000	57.00
58.00	05800	MRI	0	0	0	0.000000	0.000000	58.00
60.00	06000	LABORATORY	1,536,992	11,079,446	12,616,438	0.102083	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	203,468	89,047	292,515	0.529258	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	510,108	2,929,636	3,439,744	0.345467	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	435,607	331,574	767,181	0.390482	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	41,505	64,902	106,407	0.758785	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	25,564	1,581,504	1,607,068	0.110591	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	825,572	440,555	1,266,127	0.173564	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	76	128,050	128,126	0.403376	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,882,202	5,912,890	8,795,092	0.148591	0.000000	73.00
76.00	03020	SLEEP LAB	0	461,395	461,395	0.262658	0.000000	76.00
76.03	03950	WOUND CARE	0	195,934	195,934	0.578123	0.000000	76.03
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	1,149,685	1,149,685			88.00
91.00	09100	EMERGENCY	33,118	11,321,805	11,354,923	0.270148	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	4,478	781,337	785,815	0.403277	0.000000	92.00
200.00		Subtotal (see instructions)	11,520,870	69,895,547	81,416,417			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	11,520,870	69,895,547	81,416,417			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1342 | Period: From 01/01/2017 To 12/31/2017 | Worksheet C Part I Date/Time Prepared: 5/25/2018 11:45 am

Title XVIII | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
46.00	04600	OTHER LONG TERM CARE		46.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.000000	50.00
51.00	05100	RECOVERY ROOM	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	54.00
54.01	05401	ULTRASOUND	0.000000	54.01
56.00	05600	RADIOISOTOPE	0.000000	56.00
57.00	05700	CT SCAN	0.000000	57.00
58.00	05800	MRI	0.000000	58.00
60.00	06000	LABORATORY	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	73.00
76.00	03020	SLEEP LAB	0.000000	76.00
76.03	03950	WOUND CARE	0.000000	76.03
		OUTPATIENT SERVICE COST CENTERS		
88.00	08800	RURAL HEALTH CLINIC		88.00
91.00	09100	EMERGENCY	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	92.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1342 | Period: From 01/01/2017 To 12/31/2017 | Worksheet C Part I Date/Time Prepared: 5/25/2018 11:45 am

Title XIX | Hospital | PPS

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	Costs RCE Disallowance	Costs Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,860,334		2,860,334	0	2,860,334	30.00
46.00	04600	OTHER LONG TERM CARE	1,870,242		1,870,242	0	1,870,242	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,006,016		1,006,016	0	1,006,016	50.00
51.00	05100	RECOVERY ROOM	0		0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	358,040		358,040	0	358,040	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,979,958		1,979,958	0	1,979,958	54.00
54.01	05401	ULTRASOUND	0		0	0	0	54.01
56.00	05600	RADIOISOTOPE	0		0	0	0	56.00
57.00	05700	CT SCAN	0		0	0	0	57.00
58.00	05800	MRI	0		0	0	0	58.00
60.00	06000	LABORATORY	1,287,922		1,287,922	0	1,287,922	60.00
65.00	06500	RESPIRATORY THERAPY	154,816	0	154,816	0	154,816	65.00
66.00	06600	PHYSICAL THERAPY	1,188,319	0	1,188,319	0	1,188,319	66.00
67.00	06700	OCCUPATIONAL THERAPY	299,570	0	299,570	0	299,570	67.00
68.00	06800	SPEECH PATHOLOGY	80,740	0	80,740	0	80,740	68.00
69.00	06900	ELECTROCARDIOLOGY	177,727		177,727	0	177,727	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	219,754		219,754	0	219,754	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	51,683		51,683	0	51,683	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,306,870		1,306,870	0	1,306,870	73.00
76.00	03020	SLEEP LAB	121,189		121,189	0	121,189	76.00
76.03	03950	WOUND CARE	113,274		113,274	0	113,274	76.03
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,416,511		1,416,511	0	1,416,511	88.00
91.00	09100	EMERGENCY	3,067,511		3,067,511	0	3,067,511	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	316,901		316,901		316,901	92.00
200.00		Subtotal (see instructions)	17,877,377	0	17,877,377	0	17,877,377	200.00
201.00		Less Observation Beds	316,901		316,901		316,901	201.00
202.00		Total (see instructions)	17,560,476	0	17,560,476	0	17,560,476	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1342 | Period: From 01/01/2017 To 12/31/2017 | Worksheet C Part I Date/Time Prepared: 5/25/2018 11:45 am

Title XIX | Hospital | PPS

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,222,279		3,222,279			30.00
46.00	04600	OTHER LONG TERM CARE	817,688		817,688			46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	59,960	3,580,096	3,640,056	0.276374	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0.000000	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	20,381	840,803	861,184	0.415753	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	901,872	29,006,888	29,908,760	0.066200	0.000000	54.00
54.01	05401	ULTRASOUND	0	0	0	0.000000	0.000000	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0.000000	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	0.000000	0.000000	57.00
58.00	05800	MRI	0	0	0	0.000000	0.000000	58.00
60.00	06000	LABORATORY	1,536,992	11,079,446	12,616,438	0.102083	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	203,468	89,047	292,515	0.529258	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	510,108	2,929,636	3,439,744	0.345467	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	435,607	331,574	767,181	0.390482	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	41,505	64,902	106,407	0.758785	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	25,564	1,581,504	1,607,068	0.110591	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	825,572	440,555	1,266,127	0.173564	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	76	128,050	128,126	0.403376	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,882,202	5,912,890	8,795,092	0.148591	0.000000	73.00
76.00	03020	SLEEP LAB	0	461,395	461,395	0.262658	0.000000	76.00
76.03	03950	WOUND CARE	0	195,934	195,934	0.578123	0.000000	76.03
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	1,149,685	1,149,685	1.232086	0.000000	88.00
91.00	09100	EMERGENCY	33,118	11,321,805	11,354,923	0.270148	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	4,478	781,337	785,815	0.403277	0.000000	92.00
200.00		Subtotal (see instructions)	11,520,870	69,895,547	81,416,417			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	11,520,870	69,895,547	81,416,417			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1342 | Period: From 01/01/2017 To 12/31/2017 | Worksheet C Part I Date/Time Prepared: 5/25/2018 11:45 am

Title XIX | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
46.00	04600	OTHER LONG TERM CARE		46.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.276374	50.00
51.00	05100	RECOVERY ROOM	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	0.415753	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.066200	54.00
54.01	05401	ULTRASOUND	0.000000	54.01
56.00	05600	RADIOISOTOPE	0.000000	56.00
57.00	05700	CT SCAN	0.000000	57.00
58.00	05800	MRI	0.000000	58.00
60.00	06000	LABORATORY	0.102083	60.00
65.00	06500	RESPIRATORY THERAPY	0.529258	65.00
66.00	06600	PHYSICAL THERAPY	0.345467	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.390482	67.00
68.00	06800	SPEECH PATHOLOGY	0.758785	68.00
69.00	06900	ELECTROCARDIOLOGY	0.110591	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.173564	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.403376	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.148591	73.00
76.00	03020	SLEEP LAB	0.262658	76.00
76.03	03950	WOUND CARE	0.578123	76.03
		OUTPATIENT SERVICE COST CENTERS		
88.00	08800	RURAL HEALTH CLINIC	1.232086	88.00
91.00	09100	EMERGENCY	0.270148	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.403277	92.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

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

Provider CCN: 14-1342 | Period: From 01/01/2017 To 12/31/2017 | Worksheet C Part II | Date/Time Prepared: 5/25/2018 11:45 am

Title XIX | Hospital | PPS

		Cost Center Description	Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,006,016	125,211	880,805	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	358,040	3,468	354,572	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,979,958	190,701	1,789,257	0	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	1,287,922	76,095	1,211,827	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	154,816	19,011	135,805	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,188,319	128,275	1,060,044	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	299,570	29,549	270,021	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	80,740	4,628	76,112	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	177,727	21,399	156,328	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	219,754	11,524	208,230	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	51,683	1,699	49,984	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,306,870	45,447	1,261,423	0	0	73.00
76.00	03020	SLEEP LAB	121,189	1,004	120,185	0	0	76.00
76.03	03950	WOUND CARE	113,274	26,000	87,274	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,416,511	83,725	1,332,786	0	0	88.00
91.00	09100	EMERGENCY	3,067,511	190,629	2,876,882	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	316,901	28,083	288,818	0	0	92.00
200.00		Subtotal (sum of lines 50 thru 199)	13,146,801	986,448	12,160,353	0	0	200.00
201.00		Less Observation Beds	316,901	28,083	288,818	0	0	201.00
202.00		Total (line 200 minus line 201)	12,829,900	958,365	11,871,535	0	0	202.00

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

Provider CCN: 14-1342 | Period: From 01/01/2017 To 12/31/2017 | Worksheet C Part II Date/Time Prepared: 5/25/2018 11:45 am

Title XIX | Hospital | PPS

		Cost Center Description	Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)		
			6.00	7.00	8.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	1,006,016	3,640,056	0.276374		50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000		51.00
53.00	05300	ANESTHESIOLOGY	358,040	861,184	0.415753		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,979,958	29,908,760	0.066200		54.00
54.01	05401	ULTRASOUND	0	0	0.000000		54.01
56.00	05600	RADIOISOTOPE	0	0	0.000000		56.00
57.00	05700	CT SCAN	0	0	0.000000		57.00
58.00	05800	MRI	0	0	0.000000		58.00
60.00	06000	LABORATORY	1,287,922	12,616,438	0.102083		60.00
65.00	06500	RESPIRATORY THERAPY	154,816	292,515	0.529258		65.00
66.00	06600	PHYSICAL THERAPY	1,188,319	3,439,744	0.345467		66.00
67.00	06700	OCCUPATIONAL THERAPY	299,570	767,181	0.390482		67.00
68.00	06800	SPEECH PATHOLOGY	80,740	106,407	0.758785		68.00
69.00	06900	ELECTROCARDIOLOGY	177,727	1,607,068	0.110591		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	219,754	1,266,127	0.173564		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	51,683	128,126	0.403376		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,306,870	8,795,092	0.148591		73.00
76.00	03020	SLEEP LAB	121,189	461,395	0.262658		76.00
76.03	03950	WOUND CARE	113,274	195,934	0.578123		76.03
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	1,416,511	1,149,685	1.232086		88.00
91.00	09100	EMERGENCY	3,067,511	11,354,923	0.270148		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	316,901	785,815	0.403277		92.00
200.00		Subtotal (sum of lines 50 thru 199)	13,146,801	77,376,450			200.00
201.00		Less Observation Beds	316,901	0			201.00
202.00		Total (line 200 minus line 201)	12,829,900	77,376,450			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 14-1342 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part II Date/Time Prepared: 5/25/2018 11:45 am

Title XVIII | Hospital | Cost

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	125,211	3,640,056	0.034398	20,163	694	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0	0	51.00
53.00	05300	ANESTHESIOLOGY	3,468	861,184	0.004027	2,025	8	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	190,701	29,908,760	0.006376	506,213	3,228	54.00
54.01	05401	ULTRASOUND	0	0	0.000000	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0.000000	0	0	56.00
57.00	05700	CT SCAN	0	0	0.000000	0	0	57.00
58.00	05800	MRI	0	0	0.000000	0	0	58.00
60.00	06000	LABORATORY	76,095	12,616,438	0.006031	827,303	4,989	60.00
65.00	06500	RESPIRATORY THERAPY	19,011	292,515	0.064992	131,030	8,516	65.00
66.00	06600	PHYSICAL THERAPY	128,275	3,439,744	0.037292	42,446	1,583	66.00
67.00	06700	OCCUPATIONAL THERAPY	29,549	767,181	0.038516	25,981	1,001	67.00
68.00	06800	SPEECH PATHOLOGY	4,628	106,407	0.043493	23,272	1,012	68.00
69.00	06900	ELECTROCARDIOLOGY	21,399	1,607,068	0.013316	16,154	215	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	11,524	1,266,127	0.009102	490,960	4,469	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,699	128,126	0.013260	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	45,447	8,795,092	0.005167	1,564,058	8,081	73.00
76.00	03020	SLEEP LAB	1,004	461,395	0.002176	0	0	76.00
76.03	03950	WOUND CARE	26,000	195,934	0.132698	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	83,725	1,149,685	0.072824	0	0	88.00
91.00	09100	EMERGENCY	190,629	11,354,923	0.016788	14,391	242	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	28,083	785,815	0.035737	2,550	91	92.00
200.00		Total (lines 50 through 199)	986,448	77,376,450		3,666,546	34,129	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 14-1342 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part IV Date/Time Prepared: 5/25/2018 11:45 am

Title XVIII | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	SLEEP LAB	0	0	0	0	0	76.00
76.03	03950	WOUND CARE	0	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
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: 14-1342 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part IV Date/Time Prepared: 5/25/2018 11:45 am

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	3,640,056	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	861,184	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	29,908,760	0.000000	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0.000000	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	0	0.000000	57.00
58.00	05800	MRI	0	0	0	0	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	12,616,438	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	292,515	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	3,439,744	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	767,181	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	106,407	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	1,607,068	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	1,266,127	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	128,126	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	8,795,092	0.000000	73.00
76.00	03020	SLEEP LAB	0	0	0	461,395	0.000000	76.00
76.03	03950	WOUND CARE	0	0	0	195,934	0.000000	76.03
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	1,149,685	0.000000	88.00
91.00	09100	EMERGENCY	0	0	0	11,354,923	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	785,815	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	77,376,450		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 14-1342 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part IV Date/Time Prepared: 5/25/2018 11:45 am

Title XVIII | Hospital | Cost

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	20,163	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.000000	2,025	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	506,213	0	0	0	54.00
54.01	05401	ULTRASOUND	0.000000	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MRI	0.000000	0	0	0	0	58.00
60.00	06000	LABORATORY	0.000000	827,303	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	131,030	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	42,446	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	25,981	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	23,272	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	16,154	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	490,960	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	1,564,058	0	0	0	73.00
76.00	03020	SLEEP LAB	0.000000	0	0	0	0	76.00
76.03	03950	WOUND CARE	0.000000	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
91.00	09100	EMERGENCY	0.000000	14,391	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	2,550	0	0	0	92.00
200.00		Total (lines 50 through 199)		3,666,546	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-1342 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part V Date/Time Prepared: 5/25/2018 11:45 am

Title XVIII | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.276374	0	997,347	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.415753	0	71,988	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.066200	0	9,716,403	0	0	54.00
54.01	05401	ULTRASOUND	0.000000	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MRI	0.000000	0	0	0	0	58.00
60.00	06000	LABORATORY	0.102083	0	3,723,201	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.529258	0	34,865	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.345467	0	988,147	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.390482	0	130,727	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.758785	0	26,701	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.110591	0	655,483	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.173564	0	170,374	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.403376	0	49,496	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.148591	0	1,688,367	14,684	0	73.00
76.00	03020	SLEEP LAB	0.262658	0	35,482	0	0	76.00
76.03	03950	WOUND CARE	0.578123	0	108,646	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
91.00	09100	EMERGENCY	0.270148	0	3,576,068	6,965	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.403277	0	417,402	0	0	92.00
200.00		Subtotal (see instructions)		0	22,390,697	21,649	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	22,390,697	21,649	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-1342 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part V Date/Time Prepared: 5/25/2018 11:45 am

Title XVIII | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	275,641	0		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
53.00	05300	ANESTHESIOLOGY	29,929	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	643,226	0		54.00
54.01	05401	ULTRASOUND	0	0		54.01
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MRI	0	0		58.00
60.00	06000	LABORATORY	380,076	0		60.00
65.00	06500	RESPIRATORY THERAPY	18,453	0		65.00
66.00	06600	PHYSICAL THERAPY	341,372	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	51,047	0		67.00
68.00	06800	SPEECH PATHOLOGY	20,260	0		68.00
69.00	06900	ELECTROCARDIOLOGY	72,491	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	29,571	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	19,965	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	250,876	2,182		73.00
76.00	03020	SLEEP LAB	9,320	0		76.00
76.03	03950	WOUND CARE	62,811	0		76.03
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
91.00	09100	EMERGENCY	966,068	1,882		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	168,329	0		92.00
200.00		Subtotal (see instructions)	3,339,435	4,064		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	3,339,435	4,064		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1342 | Component CCN: 14-Z342 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part V | Date/Time Prepared: 5/25/2018 11:45 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.276374	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.415753	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.066200	0	0	0	0	54.00
54.01	05401	ULTRASOUND	0.000000	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MRI	0.000000	0	0	0	0	58.00
60.00	06000	LABORATORY	0.102083	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.529258	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.345467	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.390482	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.758785	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.110591	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.173564	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.403376	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.148591	0	0	0	0	73.00
76.00	03020	SLEEP LAB	0.262658	0	0	0	0	76.00
76.03	03950	WOUND CARE	0.578123	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
91.00	09100	EMERGENCY	0.270148	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.403277	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: 14-1342 | Component CCN: 14-Z342 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part V | Date/Time Prepared: 5/25/2018 11:45 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
			6.00	7.00	
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
54.01	05401	ULTRASOUND	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	56.00
57.00	05700	CT SCAN	0	0	57.00
58.00	05800	MRI	0	0	58.00
60.00	06000	LABORATORY	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
76.00	03020	SLEEP LAB	0	0	76.00
76.03	03950	WOUND CARE	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	0	0	88.00
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	92.00
200.00		Subtotal (see instructions)	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	0	0	202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 14-1342 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part I Date/Time Prepared: 5/25/2018 11:45 am

Title XIX | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	253,475	75,326	178,149	1,963	90.75	30.00
200.00	Total (lines 30 through 199)	253,475		178,149	1,963		200.00

	Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)	
		6.00	7.00	
	INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	ADULTS & PEDIATRICS	202	18,332	30.00
200.00	Total (lines 30 through 199)	202	18,332	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 14-1342 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part II Date/Time Prepared: 5/25/2018 11:45 am

Title XIX | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	125,211	3,640,056	0.034398	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0	0	51.00
53.00	05300	ANESTHESIOLOGY	3,468	861,184	0.004027	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	190,701	29,908,760	0.006376	0	0	54.00
54.01	05401	ULTRASOUND	0	0	0.000000	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0.000000	0	0	56.00
57.00	05700	CT SCAN	0	0	0.000000	0	0	57.00
58.00	05800	MRI	0	0	0.000000	0	0	58.00
60.00	06000	LABORATORY	76,095	12,616,438	0.006031	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	19,011	292,515	0.064992	0	0	65.00
66.00	06600	PHYSICAL THERAPY	128,275	3,439,744	0.037292	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	29,549	767,181	0.038516	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	4,628	106,407	0.043493	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	21,399	1,607,068	0.013316	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	11,524	1,266,127	0.009102	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,699	128,126	0.013260	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	45,447	8,795,092	0.005167	0	0	73.00
76.00	03020	SLEEP LAB	1,004	461,395	0.002176	0	0	76.00
76.03	03950	WOUND CARE	26,000	195,934	0.132698	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	83,725	1,149,685	0.072824	0	0	88.00
91.00	09100	EMERGENCY	190,629	11,354,923	0.016788	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	28,134	785,815	0.035802	0	0	92.00
200.00		Total (lines 50 through 199)	986,499	77,376,450		0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 14-1342 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part III Date/Time Prepared: 5/25/2018 11:45 am

Title XIX | Hospital | PPS

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

		Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
			4.00	5.00	6.00	7.00	8.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	1,963	0.00	202	30.00
200.00		Total (lines 30 through 199)		0	1,963		202	200.00

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

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 14-1342 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part IV Date/Time Prepared: 5/25/2018 11:45 am

Title XIX | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	SLEEP LAB	0	0	0	0	0	76.00
76.03	03950	WOUND CARE	0	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
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: 14-1342 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part IV Date/Time Prepared: 5/25/2018 11:45 am

Title XIX | Hospital | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	3,640,056	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	861,184	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	29,908,760	0.000000	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0.000000	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	0	0.000000	57.00
58.00	05800	MRI	0	0	0	0	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	12,616,438	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	292,515	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	3,439,744	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	767,181	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	106,407	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	1,607,068	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	1,266,127	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	128,126	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	8,795,092	0.000000	73.00
76.00	03020	SLEEP LAB	0	0	0	461,395	0.000000	76.00
76.03	03950	WOUND CARE	0	0	0	195,934	0.000000	76.03
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	1,149,685	0.000000	88.00
91.00	09100	EMERGENCY	0	0	0	11,354,923	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	785,815	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	77,376,450		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1342 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part IV | Date/Time Prepared: 5/25/2018 11:45 am

Title XIX | Hospital | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	0	0	0	0	54.00
54.01	05401	ULTRASOUND	0.000000	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MRI	0.000000	0	0	0	0	58.00
60.00	06000	LABORATORY	0.000000	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	0	0	0	0	73.00
76.00	03020	SLEEP LAB	0.000000	0	0	0	0	76.00
76.03	03950	WOUND CARE	0.000000	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
91.00	09100	EMERGENCY	0.000000	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		0	0	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1342 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-1 | Date/Time Prepared: 5/25/2018 11:45 am

Title XVIII | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	2,828	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,963	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.	338	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	1,315	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	830	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	35	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	1,051	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)	713	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	147.52	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	2,860,334	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)	5,163	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)	853,639	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	2,006,695	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	2,430,111	28.00
29.00	Private room charges (excluding swing-bed charges)	533,985	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	1,896,126	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.825763	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	1,579.84	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	1,441.92	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	137.92	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	113.89	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	38,495	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	1,968,200	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,002.65	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,053,785	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)	1,053,785	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1342 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-1 | Date/Time Prepared: 5/25/2018 11:45 am

Title XVIII | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						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)	560,516	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	1,614,301	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)	714,889	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)	714,889	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)	310	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,022.26	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	316,901	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1342 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-1 | Date/Time Prepared: 5/25/2018 11:45 am

Title XVIII | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	253,475	2,860,334	0.088617	316,901	28,083	90.00
91.00	Nursing School cost	0	2,860,334	0.000000	316,901	0	91.00
92.00	Allied health cost	0	2,860,334	0.000000	316,901	0	92.00
93.00	All other Medical Education	0	2,860,334	0.000000	316,901	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1342 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-1 | Date/Time Prepared: 5/25/2018 11:45 am

Title XIX | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	2,828	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,963	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)	1,653	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	830	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	35	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)	202	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	2,860,334	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	850,011	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	2,010,323	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	2,010,323	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,024.11	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	206,870	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)	206,870	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1342 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-1 | Date/Time Prepared: 5/25/2018 11:45 am

Title XIX | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						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)	0	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	206,870	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)	18,332	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)	18,332	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	188,538	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)	310	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,024.11	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	317,474	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1342 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-1 | Date/Time Prepared: 5/25/2018 11:45 am

Title XIX | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	253,475	2,860,334	0.088617	317,474	28,134	90.00
91.00	Nursing School cost	0	2,860,334	0.000000	317,474	0	91.00
92.00	Allied health cost	0	2,860,334	0.000000	317,474	0	92.00
93.00	All other Medical Education	0	2,860,334	0.000000	317,474	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 14-1342 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-3 | Date/Time Prepared: 5/25/2018 11:45 am

Title XVIII | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		1,529,093		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.276374	20,163	5,573	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.415753	2,025	842	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.066200	506,213	33,511	54.00
54.01	05401	ULTRASOUND	0.000000	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	57.00
58.00	05800	MRI	0.000000	0	0	58.00
60.00	06000	LABORATORY	0.102083	827,303	84,454	60.00
65.00	06500	RESPIRATORY THERAPY	0.529258	131,030	69,349	65.00
66.00	06600	PHYSICAL THERAPY	0.345467	42,446	14,664	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.390482	25,981	10,145	67.00
68.00	06800	SPEECH PATHOLOGY	0.758785	23,272	17,658	68.00
69.00	06900	ELECTROCARDIOLOGY	0.110591	16,154	1,786	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.173564	490,960	85,213	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.403376	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.148591	1,564,058	232,405	73.00
76.00	03020	SLEEP LAB	0.262658	0	0	76.00
76.03	03950	WOUND CARE	0.578123	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
91.00	09100	EMERGENCY	0.270148	14,391	3,888	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.403277	2,550	1,028	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		3,666,546	560,516	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)		3,666,546		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 14-1342 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-3

Component CCN: 14-Z342 | Date/Time Prepared: 5/25/2018 11:45 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.276374	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.415753	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.066200	48,411	3,205	54.00
54.01	05401	ULTRASOUND	0.000000	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	57.00
58.00	05800	MRI	0.000000	0	0	58.00
60.00	06000	LABORATORY	0.102083	202,572	20,679	60.00
65.00	06500	RESPIRATORY THERAPY	0.529258	29,994	15,875	65.00
66.00	06600	PHYSICAL THERAPY	0.345467	374,298	129,308	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.390482	342,510	133,744	67.00
68.00	06800	SPEECH PATHOLOGY	0.758785	7,429	5,637	68.00
69.00	06900	ELECTROCARDIOLOGY	0.110591	1,342	148	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.173564	138,349	24,012	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.403376	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.148591	377,659	56,117	73.00
76.00	03020	SLEEP LAB	0.262658	0	0	76.00
76.03	03950	WOUND CARE	0.578123	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
91.00	09100	EMERGENCY	0.270148	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.403277	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		1,522,564	388,725	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)		1,522,564		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-1342	Period: From 01/01/2017 To 12/31/2017	Worksheet E Part B Date/Time Prepared: 5/25/2018 11:45 am
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	3,343,499	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)	3,343,499	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)	3,376,934	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)	66,763	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	3,697,870	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)	-387,699	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)	-387,699	30.00
31.00	Primary payer payments	63	31.00
32.00	Subtotal (line 30 minus line 31)	-387,762	32.00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
33.00	Composite rate ESRD (from Wkst. I-5, line 11)	0	33.00
34.00	Allowable bad debts (see instructions)	1,312,027	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	852,818	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	1,282,986	36.00
37.00	Subtotal (see instructions)	465,056	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)	465,056	40.00
40.01	Sequestration adjustment (see instructions)	9,301	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
41.00	Interim payments	835,548	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	-379,793	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: 14-1342 | Period: From 01/01/2017 To 12/31/2017 | Worksheet E-1 Part I | Date/Time Prepared: 5/25/2018 11:45 am

Title XVIII | Hospital | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,251,455		835,548	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,251,455		835,548	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		154,932		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		379,793	6.02
7.00	Total Medicare program liability (see instructions)		1,406,387		455,755	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: 14-1342 | Component CCN: 14-Z342 | Period: From 01/01/2017 To 12/31/2017 | Worksheet E-1 Part I | Date/Time Prepared: 5/25/2018 11:45 am

Title XVIII | Swing Beds - SNF | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		947,630		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	08/03/2017	61,500		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)		61,500		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)		1,009,130		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		75,972		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,085,102		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: 14-1342	Period: From 01/01/2017 To 12/31/2017	Worksheet E-1 Part II Date/Time Prepared: 5/25/2018 11:45 am
	Title XVIII	Hospital	Cost

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

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS | Provider CCN: 14-1342 | Component CCN: 14-Z342 | Period: From 01/01/2017 To 12/31/2017 | Worksheet E-2 | Date/Time Prepared: 5/25/2018 11:45 am

Title XVIII | Swing Beds - SNF | Cost

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	722,038	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)	392,612	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	713	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)	1,114,650	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	1,114,650	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)	1,114,650	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	7,403	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)	1,107,247	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)	1,107,247	0	19.00
19.01	Sequestration adjustment (see instructions)	22,145	0	19.01
19.02	Demonstration payment adjustment amount after sequestration)	0	0	19.02
20.00	Interim payments	1,009,130	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)	75,972	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: 14-1342	Period: From 01/01/2017 To 12/31/2017	Worksheet E-3 Part V Date/Time Prepared: 5/25/2018 11:45 am
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	1,614,301	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)	1,614,301	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	1,630,444	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)	1,630,444	19.00
20.00	Deductibles (exclude professional component)	257,908	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	1,372,536	22.00
23.00	Coinsurance	987	23.00
24.00	Subtotal (line 22 minus line 23)	1,371,549	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	97,754	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	63,540	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	95,798	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	1,435,089	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)	1,435,089	30.00
30.01	Sequestration adjustment (see instructions)	28,702	30.01
30.02	Demonstration payment adjustment amount after sequestration	0	30.02
31.00	Interim payments	1,251,455	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)	154,932	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: 14-1342 | Period: From 01/01/2017 To 12/31/2017 | Worksheet G | Date/Time Prepared: 5/25/2018 11:45 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	-729,445	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	6,422,284	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-896,247	0	0	0	6.00
7.00	Inventory	396,225	0	0	0	7.00
8.00	Prepaid expenses	237,988	0	0	0	8.00
9.00	Other current assets	15,117	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	5,445,922	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	0	0	0	0	12.00
13.00	Land improvements	76,833	0	0	0	13.00
14.00	Accumulated depreciation	-27,423	0	0	0	14.00
15.00	Buildings	3,304,483	0	0	0	15.00
16.00	Accumulated depreciation	-1,801,392	0	0	0	16.00
17.00	Leasehold improvements	9,344,407	0	0	0	17.00
18.00	Accumulated depreciation	-3,646,402	0	0	0	18.00
19.00	Fixed equipment	1,517,477	0	0	0	19.00
20.00	Accumulated depreciation	-652,964	0	0	0	20.00
21.00	Automobiles and trucks	57,058	0	0	0	21.00
22.00	Accumulated depreciation	-57,058	0	0	0	22.00
23.00	Major movable equipment	4,730,903	0	0	0	23.00
24.00	Accumulated depreciation	-3,660,760	0	0	0	24.00
25.00	Minor equipment depreciable	3,291,308	0	0	0	25.00
26.00	Accumulated depreciation	-2,984,690	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)	9,491,780	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	1,597,101	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	1,597,101	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	16,534,803	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	1,015,250	0	0	0	37.00
38.00	Salaries, wages, and fees payable	767,573	0	0	0	38.00
39.00	Payroll taxes payable	78,522	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	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	-7,905,578	0	0	0	43.00
44.00	Other current liabilities	92,526	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	-5,951,707	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	0	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	-5,951,707	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	22,486,510				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)	22,486,510	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	16,534,803	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 14-1342 | Period: From 01/01/2017 To 12/31/2017 | Worksheet G-1 | Date/Time Prepared: 5/25/2018 11:45 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		19,814,522		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		2,671,984				2.00
3.00	Total (sum of line 1 and line 2)		22,486,506		0		3.00
4.00	ROUNDING	4		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)		4		0		10.00
11.00	Subtotal (line 3 plus line 10)		22,486,510		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)		22,486,510		0		19.00

		Endowment Fund	Plant Fund			
		6.00	7.00	8.00		
1.00	Fund balances at beginning of period	0		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)					2.00
3.00	Total (sum of line 1 and line 2)	0		0		3.00
4.00	ROUNDING		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: 14-1342 | Period: From 01/01/2017 To 12/31/2017 | Worksheet G-2 Parts I & II Date/Time Prepared: 5/25/2018 11:45 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	3,222,279		3,222,279	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	817,688		817,688	9.00
10.00	Total general inpatient care services (sum of lines 1-9)	4,039,967		4,039,967	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)	4,039,967		4,039,967	17.00
18.00	Ancillary services	7,467,589	0	7,467,589	18.00
19.00	Outpatient services	0	68,759,176	68,759,176	19.00
20.00	RURAL HEALTH CLINIC	0	1,149,685	1,149,685	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	11,507,556	69,908,861	81,416,417	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		20,711,939		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)		20,711,939		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 14-1342	Period: From 01/01/2017 To 12/31/2017	Worksheet G-3 Date/Time Prepared: 5/25/2018 11:45 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	81,416,417	1.00
2.00	Less contractual allowances and discounts on patients' accounts	58,131,281	2.00
3.00	Net patient revenues (line 1 minus line 2)	23,285,136	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	20,711,939	4.00
5.00	Net income from service to patients (line 3 minus line 4)	2,573,197	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	MISCELLANEOUS REVENUE	98,796	24.00
25.00	Total other income (sum of lines 6-24)	98,796	25.00
26.00	Total (line 5 plus line 25)	2,671,993	26.00
27.00	MISCELLANEOUS EXP	9	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	9	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	2,671,984	29.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1342 | Component CCN: 14-3975 | Period: From 01/01/2017 To 12/31/2017 | Worksheet M-1 | Date/Time Prepared: 5/25/2018 11:45 am

RHC I | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	195,595	0	195,595	0	195,595	1.00
2.00	Physician Assistant	179,828	0	179,828	0	179,828	2.00
3.00	Nurse Practitioner	42,175	0	42,175	0	42,175	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	155,949	0	155,949	0	155,949	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)	573,547	0	573,547	0	573,547	10.00
11.00	Physician Services Under Agreement	0	1,104	1,104	0	1,104	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	1,104	1,104	0	1,104	14.00
15.00	Medical Supplies	0	9,509	9,509	0	9,509	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	9,509	9,509	0	9,509	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	573,547	10,613	584,160	0	584,160	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
25.01	Telehealth	0	0	0	0	0	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	1,174	1,174	-1,174	0	29.00
30.00	Administrative Costs	48,973	259,299	308,272	-48,973	259,299	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	48,973	260,473	309,446	-50,147	259,299	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	622,520	271,086	893,606	-50,147	843,459	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1342 | Component CCN: 14-3975 | Period: From 01/01/2017 To 12/31/2017 | Worksheet M-1 | Date/Time Prepared: 5/25/2018 11:45 am

RHC I | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	195,595		1.00
2.00	Physician Assistant	0	179,828		2.00
3.00	Nurse Practitioner	0	42,175		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	155,949		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	573,547		10.00
11.00	Physician Services Under Agreement	0	1,104		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	1,104		14.00
15.00	Medical Supplies	0	9,509		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	9,509		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	584,160		22.00
	COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
25.01	Telehealth	0	0		25.01
25.02	Chronic Care Management	0	0		25.02
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs				27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	0		29.00
30.00	Administrative Costs	0	259,299		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	259,299		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	843,459		32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1342 | Component CCN: 14-3975 | Period: From 01/01/2017 To 12/31/2017 | Worksheet M-2 | Date/Time Prepared: 5/25/2018 11:45 am

RHC I | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	0.80	1,691	4,200	3,360		1.00
2.00	Physician Assistant	1.53	5,766	2,100	3,213		2.00
3.00	Nurse Practitioner	0.43	1,442	2,100	903		3.00
4.00	Subtotal (sum of lines 1 through 3)	2.76	8,899		7,476	8,899	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)	2.76	8,899			8,899	8.00
9.00	Physician Services Under Agreements		2			2	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)					584,160	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					584,160	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					1.000000	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					259,299	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					573,052	15.00
16.00	Total overhead (sum of lines 14 and 15)					832,351	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					832,351	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					832,351	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					1,416,511	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1342 | Component CCN: 14-3975 | Period: From 01/01/2017 To 12/31/2017 | Worksheet M-3 | Date/Time Prepared: 5/25/2018 11:45 am

Title XVIII | RHC I | Cost

		1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES		
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)	1,416,511	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)	0	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)	1,416,511	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)	8,899	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)	2	5.00
6.00	Total adjusted visits (line 4 plus line 5)	8,901	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)	159.14	7.00

		Calculation of Limit (1)		
		Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	0.00	0.00	8.00
9.00	Rate for Program covered visits (see instructions)	159.14	159.14	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	956	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	152,138	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	152,138	16.00
16.01	Total program charges (see instructions)(from contractor's records)		141,601	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		0	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		0	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.)		106,174	16.04
16.05	Total program cost (see instructions)	0	106,174	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		19,421	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		24,436	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		106,174	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		0	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		106,174	22.00
23.00	Allowable bad debts (see instructions)		0	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		0	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	25.50
25.99	Demonstration payment adjustment amount before sequestration		0	25.99
26.00	Net reimbursable amount (see instructions)		106,174	26.00
26.01	Sequestration adjustment (see instructions)		2,123	26.01
26.02	Demonstration payment adjustment amount after sequestration		0	26.02
27.00	Interim payments		80,241	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)		23,810	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0	30.00

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

Provider CCN: 14-1342 | Component CCN: 14-3975 | Period: From 01/01/2017 To 12/31/2017 | Worksheet M-5 | Date/Time Prepared: 5/25/2018 11:45 am

RHC I | Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		80,241	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00
	Program to Provider			
3.01			0	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
	Provider to Program			
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		80,241	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		23,810	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		104,051	7.00

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