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: 14-1348	Period: From 07/01/2016 To 06/30/2017	Worksheet S Parts I-III Date/Time Prepared: 11/29/2017 10:49 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 11/29/2017 Time: 10:49 am
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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

PART II - CERTIFICATION

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

CERTIFICATION BY 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 RED BUD REGIONAL HOSPITAL (14-1348) for the cost reporting period beginning 07/01/2016 and ending 06/30/2017 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.

(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	-194,799	-2,032,649	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	-155,848	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
10.00	RURAL HEALTH CLINIC I	0		126,479		0	10.00
200.00	Total	0	-350,647	-1,906,170	0	0	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1348 | Period: From 07/01/2016 To 06/30/2017 | Worksheet S-2 Part I | Date/Time Prepared: 11/29/2017 10:46 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: ST. CLEMENT BLVD	PO Box:			1.00
2.00	City: RED BUD	State: IL	Zip Code: 62278-	County: RANDOLPH	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	RED BUD REGIONAL HOSPITAL	141348	99914	1	07/01/2005	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	RED BUD HOSPITAL	14Z348	99914		08/10/2005	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	OLDER ADULT HEALTH CENTER	148514	99914		05/26/2011	N	O	N	15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	07/01/2016	06/30/2017	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	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: 14-1348 | Period: From 07/01/2016 To 06/30/2017 | Worksheet S-2 Part I Date/Time Prepared: 11/29/2017 10:46 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)	N		37.01
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.			38.00
		Y/N	Y/N	
		1.00	2.00	
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(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)(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 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
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N			60.00

		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	61.00
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)		0.00	0.00			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)		0.00	0.00			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)		0.00	0.00			61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).		0.00	0.00			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)		0.00	0.00			61.05

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1348 | Period: From 07/01/2016 To 06/30/2017 | Worksheet S-2 Part I | Date/Time Prepared: 11/29/2017 10:46 am

		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
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)		0.00	0.00			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 and enter in column 4, 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 and enter in column 4, 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 64-67. (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	
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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1348 | Period: From 07/01/2016 To 06/30/2017 | Worksheet S-2 Part I Date/Time Prepared: 11/29/2017 10:46 am

		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 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 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0	76.00

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

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		V	XIX	
		1.00	2.00	
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
	Rural Providers			
105.00	Does this hospital qualify as a critical access hospital (CAH)?	Y		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N		106.00
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II.	N		107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00

		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 Demo)for the current cost reporting period? Enter "Y" for yes or "N" for no.	N	110.00

		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:	15,177	25,000	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 state health or similar taxes? 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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1348 | Period: From 07/01/2016 To 06/30/2017 | Worksheet S-2 Part I Date/Time Prepared: 11/29/2017 10:46 am

		1.00	2.00	
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

	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	Contractor's Name: WPS	Contractor's Number: 52280	141.00
142.00	Street: 1573 MALLORY LANE SUITE 100	PO Box:		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.	N	N	145.00
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N		146.00

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 14-1348	Period: From 07/01/2016 To 06/30/2017	Worksheet S-2 Part I Date/Time Prepared: 11/29/2017 10:46 am

		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	01/01/2015	03/31/2015	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: 14-1348 | Period: From 07/01/2016 To 06/30/2017 | Worksheet S-2 Part II | Date/Time Prepared: 11/29/2017 10:46 am

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

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

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

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

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

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	Y	10/19/2017	Y	10/19/2017	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 14-1348 | Period: From 07/01/2016 To 06/30/2017 | Worksheet S-2 Part II Date/Time Prepared: 11/29/2017 10:46 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.	Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.	Y	35.00

		Y/N	Date	
		1.00	2.00	
	Home Office Costs			
36.00	Were home office costs claimed on the cost report?	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.	Y	12/31/2016	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.	DAVID	PERRY	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.	615-371-4703	DPERRY@QHR.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 14-1348	Period: From 07/01/2016 To 06/30/2017	Worksheet S-2 Part II Date/Time Prepared: 11/29/2017 10:46 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.	AVP		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: 14-1348 | Period: From 07/01/2016 To 06/30/2017 | Worksheet S-3 Part I Date/Time Prepared: 11/29/2017 10:46 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	53,496.00	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	53,496.00	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	53,496.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	88.00				0	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		25				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 14-1348 | Period: From 07/01/2016 To 06/30/2017 | Worksheet S-3 Part I | Date/Time Prepared: 11/29/2017 10:46 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)	1,597	105	2,229			1.00
2.00	HMO and other (see instructions)	232	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	2,462	0	3,096			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	269			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	4,059	105	5,594			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)	4,059	105	5,594	0.00	127.82	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	0	0	0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	5,311	0	8,651	0.00	17.72	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	145.54	27.00
28.00	Observation Bed Days		0	347			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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 14-1348 | Period: From 07/01/2016 To 06/30/2017 | Worksheet S-3 Part I Date/Time Prepared: 11/29/2017 10:46 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	470	36	705	1.00
2.00	HMO and other (see instructions)			0	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	470	36	705	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	0.00					26.00
26.25	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						33.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 14-1348 | Period: From 07/01/2016 To 06/30/2017 | Worksheet S-3 Part IV Date/Time Prepared: 11/29/2017 10:46 am

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	162,201	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	1,334,537	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)	0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	0	8.02
8.03	Health Insurance (Purchased)	0	8.03
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	13,117	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	8,877	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	9,803	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	-64,984	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	0	16.00
	TAXES		
17.00	FICA-Employers Portion Only	561,580	17.00
18.00	Medicare Taxes - Employers Portion Only	131,337	18.00
19.00	Unemployment Insurance	0	19.00
20.00	State or Federal Unemployment Taxes	56,097	20.00
	OTHER		
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	0	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	2,212,565	24.00
	Part B - Other than Core Related Cost		
25.00	OTHER WAGE RELATED COSTS (SPECIFY)	-25,430	25.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 14-1348 | Component CCN: 14-8514 | Period: From 07/01/2016 To 06/30/2017 | Worksheet S-8 | Date/Time Prepared: 11/29/2017 10:46 am

RHC I | Cost

					1.00	
	Clinic Address and Identification					
1.00	Street			325 SPRING STREET		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	RED BUD		IL	62278	2.00
					1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0	3.00
			Grant Award		Date	
			1.00		2.00	
	Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)					4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)					5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)					6.00
7.00	Appalachian Regional Commission					7.00
8.00	Look-Alikes					8.00
9.00	OTHER (SPECIFY)					9.00
				1.00	2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N	0	10.00

		Sunday		Monday		Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
	Facility hours of operations (1)						
11.00	Clinic			08:00	05:00	08:00	11.00

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

				Provider name		CCN number	
				1.00		2.00	
14.00	RHC/FQHC name, CCN number						14.00
		Y/N	V	XVIII	XIX	Total Visits	
		1.00	2.00	3.00	4.00	5.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)						15.00

			County				
			4.00				
2.00	City, State, ZIP Code, County		RANDOLPH				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	05:00	08:00	05:00	08:00	05:00	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-1348
Component CCN: 14-8514

Period:
From 07/01/2016
To 06/30/2017

Worksheet S-8

Date/Time Prepared:
11/29/2017 10:46 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	05:00				11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 14-1348 | Period: From 07/01/2016 To 06/30/2017 | Worksheet S-10 | Date/Time Prepared: 11/29/2017 10:46 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)	0.162061	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	642,501	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 or supplemental payments from Medicaid?	N	4.00
5.00	If line 4 is no, then enter DSH or supplemental payments from Medicaid	114,486	5.00
6.00	Medicaid charges	10,583,683	6.00
7.00	Medicaid cost (line 1 times line 6)	1,715,202	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)	958,215	8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone CHIP	10,451	9.00
10.00	Stand-alone CHIP charges	180,152	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	29,196	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)	18,745	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)	976,960	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)	101,766	0	101,766	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	16,492	0	16,492	21.00
22.00	Payments received from patients for amounts previously written off as charity care	3,338	0	3,338	22.00
23.00	Cost of charity care (line 21 minus line 22)	13,154	0	13,154	23.00

		1.00	
24.00	Does the amount in 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?		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)	1,420,016	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	239,664	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	368,713	27.01
28.00	Non-Medicare bad debt expense (line 26 minus line 27.01)	1,051,303	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	299,424	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	312,578	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	1,289,538	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-1348 | Period: From 07/01/2016 To 06/30/2017 | Worksheet A | Date/Time Prepared: 11/29/2017 10:46 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		360,674	360,674	9,967	370,641	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		1,201,297	1,201,297	507,688	1,708,985	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	114,193	63,403	177,596	1,313,876	1,491,472	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,076,602	4,423,323	5,499,925	-1,439,979	4,059,946	5.00
7.00	00700	OPERATION OF PLANT	192,300	955,920	1,148,220	-37,226	1,110,994	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	87,230	87,230	0	87,230	8.00
9.00	00900	HOUSEKEEPING	158,149	51,215	209,364	-420	208,944	9.00
10.00	01000	DIETARY	0	777,336	777,336	-218,373	558,963	10.00
11.00	01100	CAFETERIA	0	0	0	218,373	218,373	11.00
13.00	01300	NURSING ADMINISTRATION	584,051	98,584	682,635	-27,897	654,738	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	35,612	243,082	278,694	-187,723	90,971	14.00
15.00	01500	PHARMACY	323,617	488,615	812,232	-439,329	372,903	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	255,193	96,408	351,601	-5,376	346,225	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,493,646	306,178	1,799,824	-10,401	1,789,423	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	342,738	147,382	490,120	-8,956	481,164	50.00
53.00	05300	ANESTHESIOLOGY	0	17,234	17,234	431,722	448,956	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	554,314	785,116	1,339,430	-349,442	989,988	54.00
60.00	06000	LABORATORY	446,942	522,777	969,719	-61,735	907,984	60.00
65.00	06500	RESPIRATORY THERAPY	116,234	42,994	159,228	-23,182	136,046	65.00
66.00	06600	PHYSICAL THERAPY	449,995	53,979	503,974	-24	503,950	66.00
67.00	06700	OCCUPATIONAL THERAPY	167,948	13,655	181,603	0	181,603	67.00
68.00	06800	SPEECH PATHOLOGY	50,829	4,310	55,139	0	55,139	68.00
69.00	06900	ELECTROCARDIOLOGY	26,451	8,099	34,550	0	34,550	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	98,816	98,816	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	97,235	97,235	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	421,965	421,965	73.00
76.00	03610	SLEEP LAB	53,010	7,557	60,567	0	60,567	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,665,159	358,559	2,023,718	4,404	2,028,122	88.00
91.00	09100	EMERGENCY	1,486,698	971,945	2,458,643	-563,728	1,894,915	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	9,593,681	12,086,872	21,680,553	-269,745	21,410,808	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	-13,991	-13,991	0	-13,991	192.00
194.00	07950	HOME HEALTH	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	0	0	72,258	72,258	194.01
194.02	07952	SENIOR CIRCLE	43,159	9,111	52,270	0	52,270	194.02
194.03	07953	RED BUD SPECIALTY CLINIC	0	0	0	0	0	194.03
194.04	07954	WATERLOO SPECIALTY CLINIC	0	-57	-57	0	-57	194.04
194.05	07955	FREE STANDING NURSING HOME	0	0	0	197,487	197,487	194.05
194.06	07956	CLINIC CORPORATION	0	0	0	0	0	194.06
194.07	07957	VACANT SPACE	0	0	0	0	0	194.07
200.00		TOTAL (SUM OF LINES 118-199)	9,636,840	12,081,935	21,718,775	0	21,718,775	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-1348 | Period: From 07/01/2016 To 06/30/2017 | Worksheet A | Date/Time Prepared: 11/29/2017 10:46 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	179,984	550,625		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-167,700	1,541,285		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	1,491,472		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-670,771	3,389,175		5.00
7.00	00700	OPERATION OF PLANT	0	1,110,994		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	87,230		8.00
9.00	00900	HOUSEKEEPING	0	208,944		9.00
10.00	01000	DIETARY	406,065	965,028		10.00
11.00	01100	CAFETERIA	-1,481	216,892		11.00
13.00	01300	NURSING ADMINISTRATION	0	654,738		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	90,971		14.00
15.00	01500	PHARMACY	0	372,903		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	346,225		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-192,746	1,596,677		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	481,164		50.00
53.00	05300	ANESTHESIOLOGY	-486,917	-37,961		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	989,988		54.00
60.00	06000	LABORATORY	-72,112	835,872		60.00
65.00	06500	RESPIRATORY THERAPY	0	136,046		65.00
66.00	06600	PHYSICAL THERAPY	0	503,950		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	181,603		67.00
68.00	06800	SPEECH PATHOLOGY	0	55,139		68.00
69.00	06900	ELECTROCARDIOLOGY	0	34,550		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	98,816		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	97,235		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-349	421,616		73.00
76.00	03610	SLEEP LAB	0	60,567		76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	-564,944	1,463,178		88.00
91.00	09100	EMERGENCY	-321,198	1,573,717		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1-117)	-1,892,169	19,518,639		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	-13,991		192.00
194.00	07950	HOME HEALTH	0	0		194.00
194.01	07951	MARKETING	0	72,258		194.01
194.02	07952	SENIOR CIRCLE	0	52,270		194.02
194.03	07953	RED BUD SPECIALTY CLINIC	0	0		194.03
194.04	07954	WATERLOO SPECIALTY CLINIC	64,500	64,443		194.04
194.05	07955	FREE STANDING NURSING HOME	0	197,487		194.05
194.06	07956	CLINIC CORPORATION	0	0		194.06
194.07	07957	VACANT SPACE	0	0		194.07
200.00		TOTAL (SUM OF LINES 118-199)	-1,827,669	19,891,106		200.00

RECLASSIFICATIONS | Provider CCN: 14-1348 | Period: From 07/01/2016 To 06/30/2017 | Worksheet A-6 | Date/Time Prepared: 11/29/2017 10:46 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	1,370,076		1.00
2.00	RURAL HEALTH CLINIC	88.00	0	44,482		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
	0		0	1,414,558		
	B - OXYGEN COSTS					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	10,273		1.00
	0		0	10,273		
	C - RENTAL EXPENSE					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	499,858		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
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15.00
16.00		0.00	0	0		16.00
17.00		0.00	0	0		17.00
	0		0	499,858		
	D - OTHER CAPITAL COSTS					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	9,967		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	7,830		2.00
	TOTALS		0	17,797		
	E - MARKETING COSTS					
1.00	MARKETING	194.01	117	72,141		1.00
	0		117	72,141		
	F - MEDICAL SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	88,543		1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	97,235		2.00
	0		0	185,778		
	G - RECLASS COST OF DRUGS/IV SOLUTIONS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	421,965		1.00
	0		0	421,965		
	H - CAFETERIA COSTS					
1.00	CAFETERIA	11.00	0	218,373		1.00
	0		0	218,373		
	I - ALLOCATE NUSRSING HOME COSTS					
1.00	FREE STANDING NURSING HOME	194.05	188,631	8,856		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
	0		188,631	8,856		
	K - RECLASS ANESTHESIA COSTS					
1.00	ANESTHESIOLOGY	53.00	387,146	44,730		1.00
	0		387,146	44,730		
	L - RECLASS MALPRACTICE EXPENSE					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	39,864		1.00
2.00		0.00	0	0		2.00
	0		0	39,864		
500.00	Grand Total: Increases		575,894	2,934,193		500.00

RECLASSIFICATIONS | Provider CCN: 14-1348 | Period: From 07/01/2016 To 06/30/2017 | Worksheet A-6 | Date/Time Prepared: 11/29/2017 10:46 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	1,264,710	0		1.00
2.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	15,712	0		2.00
3.00	EMERGENCY	91.00	0	131,800	0		3.00
4.00	ADULTS & PEDIATRICS	30.00	0	2,336	0		4.00
	0		0	1,414,558			
	B - OXYGEN COSTS						
1.00	RESPIRATORY THERAPY	65.00	0	10,273	0		1.00
	0		0	10,273			
	C - RENTAL EXPENSE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	37,482	10		1.00
2.00	ADULTS & PEDIATRICS	30.00	0	8,065	0		2.00
3.00	OPERATING ROOM	50.00	0	1,107	0		3.00
4.00	ANESTHESIOLOGY	53.00	0	154	0		4.00
5.00	CENTRAL SERVICES & SUPPLY	14.00	0	9,794	0		5.00
6.00	LABORATORY	60.00	0	61,735	0		6.00
7.00	PHARMACY	15.00	0	17,364	0		7.00
8.00	RESPIRATORY THERAPY	65.00	0	12,909	0		8.00
9.00	PHYSICAL THERAPY	66.00	0	24	0		9.00
10.00	EMERGENCY	91.00	0	52	0		10.00
11.00	HOUSEKEEPING	9.00	0	420	0		11.00
12.00	OPERATION OF PLANT	7.00	0	938	0		12.00
13.00	NURSING ADMINISTRATION	13.00	0	28	0		13.00
14.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	56	0		14.00
15.00	MEDICAL RECORDS & LIBRARY	16.00	0	74	0		15.00
16.00	RADIOLOGY-DIAGNOSTIC	54.00	0	349,442	0		16.00
17.00	RURAL HEALTH CLINIC	88.00	0	214	0		17.00
	0		0	499,858			
	D - OTHER CAPITAL COSTS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	17,797	12		1.00
2.00		0.00	0	0	13		2.00
	TOTALS		0	17,797			
	E - MARKETING COSTS						
1.00	ADMINISTRATIVE & GENERAL	5.00	117	72,141	0		1.00
	0		117	72,141			
	F - MEDICAL SUPPLIES						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	177,929	0		1.00
2.00	OPERATING ROOM	50.00	0	7,849	0		2.00
	0		0	185,778			
	G - RECLASS COST OF DRUGS/IV SOLUTIONS						
1.00	PHARMACY	15.00	0	421,965	0		1.00
	0		0	421,965			
	H - CAFETERIA COSTS						
1.00	DIETARY	10.00	0	218,373	0		1.00
	0		0	218,373			
	I - ALLOCATE NUSRSING HOME COSTS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	37,550	2,882	0		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	84,871	2,725	0		2.00
3.00	OPERATION OF PLANT	7.00	33,581	2,707	0		3.00
5.00	NURSING ADMINISTRATION	13.00	27,327	542	0		5.00
6.00	MEDICAL RECORDS & LIBRARY	16.00	5,302	0	0		6.00
	0		188,631	8,856			
	K - RECLASS ANESTHESIA COSTS						
1.00	EMERGENCY	91.00	387,146	44,730	0		1.00
	0		387,146	44,730			
	L - RECLASS MALPRACTICE EXPENSE						
1.00		0.00	0	0	0		1.00
2.00	RURAL HEALTH CLINIC	88.00	0	39,864	0		2.00
	0		0	39,864			
500.00	Grand Total: Decreases		575,894	2,934,193			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1348 | Period: From 07/01/2016 To 06/30/2017 | Worksheet A-7 Part I | Date/Time Prepared: 11/29/2017 10:46 am

		Beginning Balances	Acquisitions: Purchases	Acquisitions: Donation	Acquisitions: Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	0	0	0	0	0	1.00
2.00	Land Improvements	311,428	0	0	0	0	2.00
3.00	Buildings and Fixtures	5,080,805	6,071	0	6,071	0	3.00
4.00	Building Improvements	7,251,164	1,043,034	0	1,043,034	107,952	4.00
5.00	Fixed Equipment	2,366,721	92,446	0	92,446	0	5.00
6.00	Movable Equipment	8,945,152	616,404	0	616,404	177,367	6.00
7.00	HIT designated Assets	3,105,962	0	0	0	2,865	7.00
8.00	Subtotal (sum of lines 1-7)	27,061,232	1,757,955	0	1,757,955	288,184	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	27,061,232	1,757,955	0	1,757,955	288,184	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	311,428	0	2.00
3.00	Buildings and Fixtures	5,086,876	0	3.00
4.00	Building Improvements	8,186,246	0	4.00
5.00	Fixed Equipment	2,459,167	0	5.00
6.00	Movable Equipment	9,384,189	0	6.00
7.00	HIT designated Assets	3,103,097	0	7.00
8.00	Subtotal (sum of lines 1-7)	28,531,003	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	28,531,003	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1348 | Period: From 07/01/2016 To 06/30/2017 | Worksheet A-7 Part II | Date/Time Prepared: 11/29/2017 10:46 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	360,674	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	1,201,297	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	1,561,971	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	360,674	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	1,201,297	2.00
3.00	Total (sum of lines 1-2)	0	1,561,971	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1348 | Period: From 07/01/2016 To 06/30/2017 | Worksheet A-7 Part III Date/Time Prepared: 11/29/2017 10:46 am

	Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	15,894,717	0	15,894,717	0.560028	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	12,487,286	0	12,487,286	0.439972	0	2.00
3.00	Total (sum of lines 1-2)	28,382,003	0	28,382,003	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	540,658	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	1,033,597	499,858	2.00
3.00	Total (sum of lines 1-2)	0	0	0	1,574,255	499,858	3.00

	Cost Center Description	SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	9,967	0	0	550,625	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	7,830	0	1,541,285	2.00
3.00	Total (sum of lines 1-2)	0	9,967	7,830	0	2,091,910	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-1348 | Period: From 07/01/2016 To 06/30/2017 | Worksheet A-8 | Date/Time Prepared: 11/29/2017 10:46 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	-1,043	ADMINISTRATIVE & GENERAL	5.00	0	7.00
8.00	Television and radio service (chapter 21)	A	-5,043	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	-543,167			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)	B	-285	CAP REL COSTS-MVBLE EQUIP	2.00	9	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	147,036			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-1,481	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	B	-349	DRUGS CHARGED TO PATIENTS	73.00	0	17.00
18.00	Sale of medical records and abstracts		0		0.00	0	18.00
19.00	Nursing school (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	148,638	CAP REL COSTS-BLDG & FIXT	1.00	9	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP	A	-165,600	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	TELEPHONE SERVICES	A	-235	ADMINISTRATIVE & GENERAL	5.00	0	33.00
36.00	OTHER MISC REVENUE	B	-3,524	ADMINISTRATIVE & GENERAL	5.00	0	36.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-1348 | Period: From 07/01/2016 To 06/30/2017 | Worksheet A-8 | Date/Time Prepared: 11/29/2017 10:46 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	
38.00	NON RHC COSTS	A	-564,944	RURAL HEALTH CLINIC	88.00	0	38.00
38.03	TELEPHONE SERVICES	A	-14,013	ADMINISTRATIVE & GENERAL	5.00	0	38.03
38.04	TELEPHONE DEPRECIATION	A	-4,514	CAP REL COSTS-MVBLE EQUIP	2.00	9	38.04
39.00	ADVERTISING	A	-47,833	ADMINISTRATIVE & GENERAL	5.00	0	39.00
39.01	PROFESSIONAL FEE BENEFITS	A	-23,182	ADULTS & PEDIATRICS	30.00	0	39.01
41.00	PROFESSIONAL FEE BENEFITS	A	-13,202	EMERGENCY	91.00	0	41.00
42.00	LOBBYING EXPENSE IN ASSOCIATION DUES	A	-10,756	ADMINISTRATIVE & GENERAL	5.00	0	42.00
44.00	SPECIAL EVENTS	A	-5,437	ADMINISTRATIVE & GENERAL	5.00	0	44.00
45.01	CRNA COSTS	A	-431,876	ANESTHESIOLOGY	53.00	0	45.01
45.02	CRNA BENEFITS	A	-55,041	ANESTHESIOLOGY	53.00	0	45.02
45.03	ILLINOIS PROVIDER TAX	B	-695,494	ADMINISTRATIVE & GENERAL	5.00	0	45.03
45.04	ADD BACK NH CREDIT FOR DIETARY	A	406,065	DIETARY	10.00	0	45.04
45.06	HOSPICE REVENUE	B	-6,505	ADULTS & PEDIATRICS	30.00	0	45.06
45.07	CHARITABLE CONTRIBUTIONS	A	-384	ADMINISTRATIVE & GENERAL	5.00	0	45.07
45.08	REMOVAL OF LEASE REVENUE	A	64,500	WATERLOO SPECIALTY CLINIC	194.04	0	45.08
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-1,827,669				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: 14-1348 | Period: From 07/01/2016 To 06/30/2017 | Worksheet A-8-1 | Date/Time Prepared: 11/29/2017 10:46 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	ALLOCATED CAPITAL	31,346	0	1.00
2.00	2.00	CAP REL COSTS-MVBLE EQUIP	ALLOCATED CAPITAL	7,742	0	2.00
3.00	5.00	ADMINISTRATIVE & GENERAL	NON CAPITAL HOME OFFICE COST	663,797	555,849	3.00
4.00	0.00			0	0	4.00
4.01	0.00			0	0	4.01
4.02	0.00			0	0	4.02
4.03	0.00			0	0	4.03
4.04	0.00			0	0	4.04
4.05	0.00			0	0	4.05
4.06	0.00			0	0	4.06
4.07	0.00			0	0	4.07
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			702,885	555,849	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	QHR	100.00	QUORUM HEALTH	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: 14-1348	Period: From 07/01/2016 To 06/30/2017	Worksheet A-8-1 Date/Time Prepared: 11/29/2017 10:46 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	31,346	9		1.00
2.00	7,742	9		2.00
3.00	107,948	0		3.00
4.00	0	0		4.00
4.01	0	0		4.01
4.02	0	0		4.02
4.03	0	0		4.03
4.04	0	0		4.04
4.05	0	0		4.05
4.06	0	0		4.06
4.07	0	0		4.07
5.00	147,036			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 MANAGEMENT COMPA		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: 14-1348 | Period: From 07/01/2016 To 06/30/2017 | Worksheet A-8-2 | Date/Time Prepared: 11/29/2017 10:46 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	163,059	163,059	0	0	0	1.00
2.00	0.00		0	0	0	0	0	2.00
3.00	0.00		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	60.00	AGGREGATE-LABORATORY	117,112	72,112	45,000	0	0	7.00
8.00	91.00	AGGREGATE-EMERGENCY	634,835	307,996	326,839	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			915,006	543,167	371,839		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	0.00		0	0	0	0	0	2.00
3.00	0.00		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	60.00	AGGREGATE-LABORATORY	0	0	0	0	0	7.00
8.00	91.00	AGGREGATE-EMERGENCY	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	163,059		1.00
2.00	0.00		0	0	0	0		2.00
3.00	0.00		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	60.00	AGGREGATE-LABORATORY	0	0	0	72,112		7.00
8.00	91.00	AGGREGATE-EMERGENCY	0	0	0	307,996		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	543,167		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1348 | Period: From 07/01/2016 To 06/30/2017 | Worksheet B Part I Date/Time Prepared: 11/29/2017 10:46 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	550,625	550,625				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	1,541,285		1,541,285			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,491,472	8,107	24,290	1,523,869		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	3,389,175	88,651	265,622	158,060	3,901,508	5.00
7.00	00700	OPERATION OF PLANT	1,110,994	135,761	406,777	25,299	1,678,831	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	87,230	1,224	3,667	0	92,121	8.00
9.00	00900	HOUSEKEEPING	208,944	8,838	26,482	25,208	269,472	9.00
10.00	01000	DIETARY	965,028	23,620	70,771	0	1,059,419	10.00
11.00	01100	CAFETERIA	216,892	13,916	41,697	0	272,505	11.00
13.00	01300	NURSING ADMINISTRATION	654,738	5,344	16,012	88,740	764,834	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	90,971	5,065	15,175	5,676	116,887	14.00
15.00	01500	PHARMACY	372,903	6,417	19,227	51,584	450,131	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	346,225	14,080	42,189	39,832	442,326	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,596,677	57,989	173,751	238,083	2,066,500	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	481,164	31,638	94,795	54,631	662,228	50.00
53.00	05300	ANESTHESIOLOGY	-37,961	679	2,033	61,710	26,461	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	989,988	22,001	65,920	88,356	1,166,265	54.00
60.00	06000	LABORATORY	835,872	12,781	38,295	71,241	958,189	60.00
65.00	06500	RESPIRATORY THERAPY	136,046	1,597	4,784	18,527	160,954	65.00
66.00	06600	PHYSICAL THERAPY	503,950	17,908	53,656	71,728	647,242	66.00
67.00	06700	OCCUPATIONAL THERAPY	181,603	2,200	6,591	26,770	217,164	67.00
68.00	06800	SPEECH PATHOLOGY	55,139	0	0	8,102	63,241	68.00
69.00	06900	ELECTROCARDIOLOGY	34,550	4,377	13,115	4,216	56,258	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	98,816	0	0	0	98,816	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	97,235	0	0	0	97,235	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	421,616	0	0	0	421,616	73.00
76.00	03610	SLEEP LAB	60,567	8,838	26,482	8,450	104,337	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,463,178	27,300	81,799	265,426	1,837,703	88.00
91.00	09100	EMERGENCY	1,573,717	13,393	40,129	175,265	1,802,504	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	19,518,639	511,724	1,533,259	1,486,904	19,434,747	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	-13,991	34,844	0	0	20,853	192.00
194.00	07950	HOME HEALTH	0	0	0	0	0	194.00
194.01	07951	MARKETING	72,258	1,920	5,754	19	79,951	194.01
194.02	07952	SENIOR CIRCLE	52,270	758	2,272	6,879	62,179	194.02
194.03	07953	RED BUD SPECIALTY CLINIC	0	0	0	0	0	194.03
194.04	07954	WATERLOO SPECIALTY CLINIC	64,443	0	0	0	64,443	194.04
194.05	07955	FREE STANDING NURSING HOME	197,487	0	0	30,067	227,554	194.05
194.06	07956	CLINIC CORPORATION	0	0	0	0	0	194.06
194.07	07957	VACANT SPACE	0	1,379	0	0	1,379	194.07
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	19,891,106	550,625	1,541,285	1,523,869	19,891,106	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1348 | Period: From 07/01/2016 To 06/30/2017 | Worksheet B Part I | Date/Time Prepared: 11/29/2017 10:46 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	3,901,508					5.00
7.00	00700	OPERATION OF PLANT	417,814	2,096,645				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	22,926	8,067	123,114			8.00
9.00	00900	HOUSEKEEPING	67,064	58,255	9,213	404,004		9.00
10.00	01000	DIETARY	263,660	155,677	3,411	30,977	1,513,144	10.00
11.00	01100	CAFETERIA	67,819	91,723	0	18,251	0	11.00
13.00	01300	NURSING ADMINISTRATION	190,346	35,222	0	7,009	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	29,090	33,380	0	6,642	0	14.00
15.00	01500	PHARMACY	112,025	42,295	0	8,416	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	110,083	92,804	0	18,467	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	514,297	382,208	47,840	76,054	227,179	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	164,810	208,525	11,980	41,493	0	50.00
53.00	05300	ANESTHESIOLOGY	6,585	4,472	0	890	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	290,251	145,008	14,935	28,855	0	54.00
60.00	06000	LABORATORY	238,466	84,240	69	16,762	0	60.00
65.00	06500	RESPIRATORY THERAPY	40,057	10,523	0	2,094	0	65.00
66.00	06600	PHYSICAL THERAPY	161,080	118,029	7,085	23,486	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	54,046	14,498	0	2,885	0	67.00
68.00	06800	SPEECH PATHOLOGY	15,739	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	14,001	28,850	0	5,741	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	24,593	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	24,199	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	104,928	0	0	0	0	73.00
76.00	03610	SLEEP LAB	25,967	58,255	484	11,592	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	457,353	179,938	0	35,805	0	88.00
91.00	09100	EMERGENCY	448,593	88,274	27,618	17,565	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	3,865,792	1,840,243	122,635	352,984	227,179	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	229,658	412	45,698	0	192.00
194.00	07950	HOME HEALTH	0	0	0	0	0	194.00
194.01	07951	MARKETING	19,898	12,656	0	2,518	0	194.01
194.02	07952	SENIOR CIRCLE	15,475	4,998	67	995	0	194.02
194.03	07953	RED BUD SPECIALTY CLINIC	0	0	0	0	0	194.03
194.04	07954	WATERLOO SPECIALTY CLINIC	0	0	0	0	0	194.04
194.05	07955	FREE STANDING NURSING HOME	0	0	0	0	1,285,965	194.05
194.06	07956	CLINIC CORPORATION	0	0	0	0	0	194.06
194.07	07957	VACANT SPACE	343	9,090	0	1,809	0	194.07
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	3,901,508	2,096,645	123,114	404,004	1,513,144	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1348 | Period: From 07/01/2016 To 06/30/2017 | Worksheet B Part I | Date/Time Prepared: 11/29/2017 10:46 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	450,298					11.00
13.00	01300	NURSING ADMINISTRATION	30,827	1,028,238				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	5,203	0	191,202			14.00
15.00	01500	PHARMACY	9,658	88,430	2,085	713,040		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	24,007	0	756	0	688,443	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	103,162	408,146	28,758	0	76,181	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	21,445	93,655	14,453	0	44,460	50.00
53.00	05300	ANESTHESIOLOGY	0	0	2,486	0	1,200	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	35,872	0	12,051	0	187,967	54.00
60.00	06000	LABORATORY	35,833	0	52,030	0	166,297	60.00
65.00	06500	RESPIRATORY THERAPY	7,845	31,761	1,453	0	8,973	65.00
66.00	06600	PHYSICAL THERAPY	25,663	0	769	0	41,288	66.00
67.00	06700	OCCUPATIONAL THERAPY	9,264	0	17	0	11,266	67.00
68.00	06800	SPEECH PATHOLOGY	1,616	0	0	0	1,523	68.00
69.00	06900	ELECTROCARDIOLOGY	2,365	0	355	0	13,669	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	25,762	0	15,355	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	25,350	0	2,944	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	713,040	30,053	73.00
76.00	03610	SLEEP LAB	2,957	0	0	0	323	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	69,853	0	11,379	0	14,746	88.00
91.00	09100	EMERGENCY	61,141	406,246	13,222	0	72,198	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	446,711	1,028,238	190,926	713,040	688,443	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	HOME HEALTH	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	0	124	0	0	194.01
194.02	07952	SENIOR CIRCLE	3,587	0	152	0	0	194.02
194.03	07953	RED BUD SPECIALTY CLINIC	0	0	0	0	0	194.03
194.04	07954	WATERLOO SPECIALTY CLINIC	0	0	0	0	0	194.04
194.05	07955	FREE STANDING NURSING HOME	0	0	0	0	0	194.05
194.06	07956	CLINIC CORPORATION	0	0	0	0	0	194.06
194.07	07957	VACANT SPACE	0	0	0	0	0	194.07
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	450,298	1,028,238	191,202	713,040	688,443	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1348 | Period: From 07/01/2016 To 06/30/2017 | Worksheet B Part I | Date/Time Prepared: 11/29/2017 10:46 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	3,930,325	0	3,930,325		30.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	1,263,049	0	1,263,049		50.00
53.00	05300	ANESTHESIOLOGY	42,094	0	42,094		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,881,204	0	1,881,204		54.00
60.00	06000	LABORATORY	1,551,886	0	1,551,886		60.00
65.00	06500	RESPIRATORY THERAPY	263,660	0	263,660		65.00
66.00	06600	PHYSICAL THERAPY	1,024,642	0	1,024,642		66.00
67.00	06700	OCCUPATIONAL THERAPY	309,140	0	309,140		67.00
68.00	06800	SPEECH PATHOLOGY	82,119	0	82,119		68.00
69.00	06900	ELECTROCARDIOLOGY	121,239	0	121,239		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	164,526	0	164,526		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	149,728	0	149,728		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,269,637	0	1,269,637		73.00
76.00	03610	SLEEP LAB	203,915	0	203,915		76.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	2,606,777	0	2,606,777		88.00
91.00	09100	EMERGENCY	2,937,361	0	2,937,361		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0			92.00
		SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1-117)	17,801,302	0	17,801,302		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	296,621	0	296,621		192.00
194.00	07950	HOME HEALTH	0	0	0		194.00
194.01	07951	MARKETING	115,147	0	115,147		194.01
194.02	07952	SENIOR CIRCLE	87,453	0	87,453		194.02
194.03	07953	RED BUD SPECIALTY CLINIC	0	0	0		194.03
194.04	07954	WATERLOO SPECIALTY CLINIC	64,443	0	64,443		194.04
194.05	07955	FREE STANDING NURSING HOME	1,513,519	0	1,513,519		194.05
194.06	07956	CLINIC CORPORATION	0	0	0		194.06
194.07	07957	VACANT SPACE	12,621	0	12,621		194.07
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 118-201)	19,891,106	0	19,891,106		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1348 | Period: From 07/01/2016 To 06/30/2017 | Worksheet B Part II Date/Time Prepared: 11/29/2017 10:46 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	8,107	24,290	32,397	32,397	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	88,651	265,622	354,273	3,361	5.00
7.00	00700	OPERATION OF PLANT	0	135,761	406,777	542,538	538	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	1,224	3,667	4,891	0	8.00
9.00	00900	HOUSEKEEPING	0	8,838	26,482	35,320	536	9.00
10.00	01000	DIETARY	0	23,620	70,771	94,391	0	10.00
11.00	01100	CAFETERIA	0	13,916	41,697	55,613	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	5,344	16,012	21,356	1,887	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	5,065	15,175	20,240	121	14.00
15.00	01500	PHARMACY	0	6,417	19,227	25,644	1,097	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	14,080	42,189	56,269	847	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	57,989	173,751	231,740	5,062	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	31,638	94,795	126,433	1,162	50.00
53.00	05300	ANESTHESIOLOGY	0	679	2,033	2,712	1,312	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	22,001	65,920	87,921	1,879	54.00
60.00	06000	LABORATORY	0	12,781	38,295	51,076	1,515	60.00
65.00	06500	RESPIRATORY THERAPY	0	1,597	4,784	6,381	394	65.00
66.00	06600	PHYSICAL THERAPY	0	17,908	53,656	71,564	1,525	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	2,200	6,591	8,791	569	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	172	68.00
69.00	06900	ELECTROCARDIOLOGY	0	4,377	13,115	17,492	90	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	03610	SLEEP LAB	0	8,838	26,482	35,320	180	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	27,300	81,799	109,099	5,639	88.00
91.00	09100	EMERGENCY	0	13,393	40,129	53,522	3,726	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	511,724	1,533,259	2,044,983	31,612	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	34,844	0	34,844	0	192.00
194.00	07950	HOME HEALTH	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	1,920	5,754	7,674	0	194.01
194.02	07952	SENIOR CIRCLE	0	758	2,272	3,030	146	194.02
194.03	07953	RED BUD SPECIALTY CLINIC	0	0	0	0	0	194.03
194.04	07954	WATERLOO SPECIALTY CLINIC	0	0	0	0	0	194.04
194.05	07955	FREE STANDING NURSING HOME	0	0	0	0	639	194.05
194.06	07956	CLINIC CORPORATION	0	0	0	0	0	194.06
194.07	07957	VACANT SPACE	0	1,379	0	1,379	0	194.07
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	0	550,625	1,541,285	2,091,910	32,397	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1348 | Period: From 07/01/2016 To 06/30/2017 | Worksheet B Part II | Date/Time Prepared: 11/29/2017 10:46 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	357,634					5.00
7.00	00700	OPERATION OF PLANT	38,299	581,375				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,102	2,237	9,230			8.00
9.00	00900	HOUSEKEEPING	6,147	16,153	691	58,847		9.00
10.00	01000	DIETARY	24,169	43,167	256	4,512	166,495	10.00
11.00	01100	CAFETERIA	6,217	25,434	0	2,658	0	11.00
13.00	01300	NURSING ADMINISTRATION	17,448	9,767	0	1,021	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,667	9,256	0	967	0	14.00
15.00	01500	PHARMACY	10,269	11,728	0	1,226	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	10,091	25,734	0	2,690	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	47,143	105,982	3,586	11,079	24,997	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	15,107	57,821	898	6,044	0	50.00
53.00	05300	ANESTHESIOLOGY	604	1,240	0	130	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	26,606	40,209	1,120	4,203	0	54.00
60.00	06000	LABORATORY	21,859	23,359	5	2,442	0	60.00
65.00	06500	RESPIRATORY THERAPY	3,672	2,918	0	305	0	65.00
66.00	06600	PHYSICAL THERAPY	14,766	32,728	531	3,421	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	4,954	4,020	0	420	0	67.00
68.00	06800	SPEECH PATHOLOGY	1,443	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	1,283	8,000	0	836	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,254	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,218	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	9,618	0	0	0	0	73.00
76.00	03610	SLEEP LAB	2,380	16,153	36	1,688	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	41,924	49,895	0	5,215	0	88.00
91.00	09100	EMERGENCY	41,121	24,477	2,071	2,559	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	354,361	510,278	9,194	51,416	24,997	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	63,681	31	6,656	0	192.00
194.00	07950	HOME HEALTH	0	0	0	0	0	194.00
194.01	07951	MARKETING	1,824	3,509	0	367	0	194.01
194.02	07952	SENIOR CIRCLE	1,418	1,386	5	145	0	194.02
194.03	07953	RED BUD SPECIALTY CLINIC	0	0	0	0	0	194.03
194.04	07954	WATERLOO SPECIALTY CLINIC	0	0	0	0	0	194.04
194.05	07955	FREE STANDING NURSING HOME	0	0	0	0	141,498	194.05
194.06	07956	CLINIC CORPORATION	0	0	0	0	0	194.06
194.07	07957	VACANT SPACE	31	2,521	0	263	0	194.07
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	357,634	581,375	9,230	58,847	166,495	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1348 | Period: From 07/01/2016 To 06/30/2017 | Worksheet B Part II Date/Time Prepared: 11/29/2017 10:46 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	89,922					11.00
13.00	01300	NURSING ADMINISTRATION	6,156	57,635				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,039	0	34,290			14.00
15.00	01500	PHARMACY	1,929	4,957	374	57,224		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,794	0	136	0	100,561	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	20,601	22,876	5,157	0	11,121	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,282	5,250	2,592	0	6,490	50.00
53.00	05300	ANESTHESIOLOGY	0	0	446	0	175	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,164	0	2,161	0	27,503	54.00
60.00	06000	LABORATORY	7,156	0	9,331	0	24,276	60.00
65.00	06500	RESPIRATORY THERAPY	1,567	1,780	261	0	1,310	65.00
66.00	06600	PHYSICAL THERAPY	5,125	0	138	0	6,027	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,850	0	3	0	1,645	67.00
68.00	06800	SPEECH PATHOLOGY	323	0	0	0	222	68.00
69.00	06900	ELECTROCARDIOLOGY	472	0	64	0	1,995	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	4,620	0	2,241	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	4,546	0	430	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	57,224	4,387	73.00
76.00	03610	SLEEP LAB	590	0	0	0	47	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	13,949	0	2,041	0	2,153	88.00
91.00	09100	EMERGENCY	12,209	22,772	2,371	0	10,539	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	89,206	57,635	34,241	57,224	100,561	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	HOME HEALTH	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	0	22	0	0	194.01
194.02	07952	SENIOR CIRCLE	716	0	27	0	0	194.02
194.03	07953	RED BUD SPECIALTY CLINIC	0	0	0	0	0	194.03
194.04	07954	WATERLOO SPECIALTY CLINIC	0	0	0	0	0	194.04
194.05	07955	FREE STANDING NURSING HOME	0	0	0	0	0	194.05
194.06	07956	CLINIC CORPORATION	0	0	0	0	0	194.06
194.07	07957	VACANT SPACE	0	0	0	0	0	194.07
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	89,922	57,635	34,290	57,224	100,561	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1348 | Period: From 07/01/2016 To 06/30/2017 | Worksheet B Part II | Date/Time Prepared: 11/29/2017 10:46 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	489,344	0	489,344		30.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	226,079	0	226,079		50.00
53.00	05300	ANESTHESIOLOGY	6,619	0	6,619		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	198,766	0	198,766		54.00
60.00	06000	LABORATORY	141,019	0	141,019		60.00
65.00	06500	RESPIRATORY THERAPY	18,588	0	18,588		65.00
66.00	06600	PHYSICAL THERAPY	135,825	0	135,825		66.00
67.00	06700	OCCUPATIONAL THERAPY	22,252	0	22,252		67.00
68.00	06800	SPEECH PATHOLOGY	2,160	0	2,160		68.00
69.00	06900	ELECTROCARDIOLOGY	30,232	0	30,232		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	9,115	0	9,115		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	7,194	0	7,194		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	71,229	0	71,229		73.00
76.00	03610	SLEEP LAB	56,394	0	56,394		76.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	229,915	0	229,915		88.00
91.00	09100	EMERGENCY	175,367	0	175,367		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0			92.00
		SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,820,098	0	1,820,098		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	105,212	0	105,212		192.00
194.00	07950	HOME HEALTH	0	0	0		194.00
194.01	07951	MARKETING	13,396	0	13,396		194.01
194.02	07952	SENIOR CIRCLE	6,873	0	6,873		194.02
194.03	07953	RED BUD SPECIALTY CLINIC	0	0	0		194.03
194.04	07954	WATERLOO SPECIALTY CLINIC	0	0	0		194.04
194.05	07955	FREE STANDING NURSING HOME	142,137	0	142,137		194.05
194.06	07956	CLINIC CORPORATION	0	0	0		194.06
194.07	07957	VACANT SPACE	4,194	0	4,194		194.07
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 118-201)	2,091,910	0	2,091,910		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1348 | Period: From 07/01/2016 To 06/30/2017 | Worksheet B-1 | Date/Time Prepared: 11/29/2017 10:46 am

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	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	124,161					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		115,993				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,828	1,828	9,560,197			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	19,990	19,990	991,614	-3,901,508	15,676,748	5.00
7.00	00700	OPERATION OF PLANT	30,613	30,613	158,719	0	1,678,831	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	276	276	0	0	92,121	8.00
9.00	00900	HOUSEKEEPING	1,993	1,993	158,149	0	269,472	9.00
10.00	01000	DIETARY	5,326	5,326	0	0	1,059,419	10.00
11.00	01100	CAFETERIA	3,138	3,138	0	0	272,505	11.00
13.00	01300	NURSING ADMINISTRATION	1,205	1,205	556,724	0	764,834	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,142	1,142	35,612	0	116,887	14.00
15.00	01500	PHARMACY	1,447	1,447	323,617	0	450,131	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,175	3,175	249,891	0	442,326	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	13,076	13,076	1,493,646	0	2,066,500	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	7,134	7,134	342,738	0	662,228	50.00
53.00	05300	ANESTHESIOLOGY	153	153	387,146	0	26,461	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,961	4,961	554,314	0	1,166,265	54.00
60.00	06000	LABORATORY	2,882	2,882	446,942	0	958,189	60.00
65.00	06500	RESPIRATORY THERAPY	360	360	116,234	0	160,954	65.00
66.00	06600	PHYSICAL THERAPY	4,038	4,038	449,995	0	647,242	66.00
67.00	06700	OCCUPATIONAL THERAPY	496	496	167,948	0	217,164	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	50,829	0	63,241	68.00
69.00	06900	ELECTROCARDIOLOGY	987	987	26,451	0	56,258	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	98,816	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	97,235	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	421,616	73.00
76.00	03610	SLEEP LAB	1,993	1,993	53,010	0	104,337	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	6,156	6,156	1,665,159	0	1,837,703	88.00
91.00	09100	EMERGENCY	3,020	3,020	1,099,552	0	1,802,504	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	115,389	115,389	9,328,290	-3,901,508	15,533,239	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	7,857	0	0	-20,853	0	192.00
194.00	07950	HOME HEALTH	0	0	0	0	0	194.00
194.01	07951	MARKETING	433	433	117	0	79,951	194.01
194.02	07952	SENIOR CIRCLE	171	171	43,159	0	62,179	194.02
194.03	07953	RED BUD SPECIALTY CLINIC	0	0	0	0	0	194.03
194.04	07954	WATERLOO SPECIALTY CLINIC	0	0	0	-64,443	0	194.04
194.05	07955	FREE STANDING NURSING HOME	0	0	188,631	-227,554	0	194.05
194.06	07956	CLINIC CORPORATION	0	0	0	0	0	194.06
194.07	07957	VACANT SPACE	311	0	0	0	1,379	194.07
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)	550,625	1,541,285	1,523,869		3,901,508	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	4.434766	13.287742	0.159397		0.248872	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			32,397		357,634	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.003389		0.022813	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1348 | Period: From 07/01/2016 To 06/30/2017 | Worksheet B-1 | Date/Time Prepared: 11/29/2017 10:46 am

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FULL TIME EQUIVALENT)	
			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	71,730					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	276	165,988				8.00
9.00	00900	HOUSEKEEPING	1,993	12,422	69,461			9.00
10.00	01000	DIETARY	5,326	4,599	5,326	123,074		10.00
11.00	01100	CAFETERIA	3,138	0	3,138	0	11,423	11.00
13.00	01300	NURSING ADMINISTRATION	1,205	0	1,205	0	782	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,142	0	1,142	0	132	14.00
15.00	01500	PHARMACY	1,447	0	1,447	0	245	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,175	0	3,175	0	609	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	13,076	64,499	13,076	18,478	2,617	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	7,134	16,152	7,134	0	544	50.00
53.00	05300	ANESTHESIOLOGY	153	0	153	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,961	20,136	4,961	0	910	54.00
60.00	06000	LABORATORY	2,882	93	2,882	0	909	60.00
65.00	06500	RESPIRATORY THERAPY	360	0	360	0	199	65.00
66.00	06600	PHYSICAL THERAPY	4,038	9,552	4,038	0	651	66.00
67.00	06700	OCCUPATIONAL THERAPY	496	0	496	0	235	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	41	68.00
69.00	06900	ELECTROCARDIOLOGY	987	0	987	0	60	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	03610	SLEEP LAB	1,993	652	1,993	0	75	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	6,156	0	6,156	0	1,772	88.00
91.00	09100	EMERGENCY	3,020	37,236	3,020	0	1,551	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	62,958	165,341	60,689	18,478	11,332	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	7,857	556	7,857	0	0	192.00
194.00	07950	HOME HEALTH	0	0	0	0	0	194.00
194.01	07951	MARKETING	433	0	433	0	0	194.01
194.02	07952	SENIOR CIRCLE	171	91	171	0	91	194.02
194.03	07953	RED BUD SPECIALTY CLINIC	0	0	0	0	0	194.03
194.04	07954	WATERLOO SPECIALTY CLINIC	0	0	0	0	0	194.04
194.05	07955	FREE STANDING NURSING HOME	0	0	0	104,596	0	194.05
194.06	07956	CLINIC CORPORATION	0	0	0	0	0	194.06
194.07	07957	VACANT SPACE	311	0	311	0	0	194.07
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	2,096,645	123,114	404,004	1,513,144	450,298	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	29.229681	0.741704	5.816271	12.294587	39.420292	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	581,375	9,230	58,847	166,495	89,922	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	8.105047	0.055606	0.847195	1.352804	7.872013	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1348 | Period: From 07/01/2016 To 06/30/2017 | Worksheet B-1 | Date/Time Prepared: 11/29/2017 10:46 am

		Cost Center Description	NURSING ADMINISTRATION (NURSING SALARIE)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS REVENUE)		
			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	3,762,933					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	733,399				14.00
15.00	01500	PHARMACY	323,617	7,998	421,965			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	2,901	0	109,843,188		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,493,646	110,308	0	12,153,897		30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	342,738	55,437	0	7,093,247		50.00
53.00	05300	ANESTHESIOLOGY	0	9,535	0	191,504		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	46,223	0	29,997,002		54.00
60.00	06000	LABORATORY	0	199,575	0	26,531,114		60.00
65.00	06500	RESPIRATORY THERAPY	116,234	5,574	0	1,431,606		65.00
66.00	06600	PHYSICAL THERAPY	0	2,951	0	6,587,052		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	66	0	1,797,409		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	242,907		68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,360	0	2,180,775		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	98,817	0	2,449,682		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	97,235	0	469,665		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	421,965	4,794,624		73.00
76.00	03610	SLEEP LAB	0	0	0	51,600		76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	43,645	0	2,352,607		88.00
91.00	09100	EMERGENCY	1,486,698	50,715	0	11,518,497		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	3,762,933	732,340	421,965	109,843,188		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192.00
194.00	07950	HOME HEALTH	0	0	0	0		194.00
194.01	07951	MARKETING	0	475	0	0		194.01
194.02	07952	SENIOR CIRCLE	0	584	0	0		194.02
194.03	07953	RED BUD SPECIALTY CLINIC	0	0	0	0		194.03
194.04	07954	WATERLOO SPECIALTY CLINIC	0	0	0	0		194.04
194.05	07955	FREE STANDING NURSING HOME	0	0	0	0		194.05
194.06	07956	CLINIC CORPORATION	0	0	0	0		194.06
194.07	07957	VACANT SPACE	0	0	0	0		194.07
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)	1,028,238	191,202	713,040	688,443		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.273254	0.260707	1.689808	0.006268		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	57,635	34,290	57,224	100,561		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.015317	0.046755	0.135613	0.000915		205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1348 | Period: From 07/01/2016 To 06/30/2017 | Worksheet C Part I Date/Time Prepared: 11/29/2017 10:46 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	3,930,325		3,930,325	0	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,263,049		1,263,049	0	0	50.00
53.00	05300	ANESTHESIOLOGY	42,094		42,094	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,881,204		1,881,204	0	0	54.00
60.00	06000	LABORATORY	1,551,886		1,551,886	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	263,660	0	263,660	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,024,642	0	1,024,642	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	309,140	0	309,140	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	82,119	0	82,119	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	121,239		121,239	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	164,526		164,526	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	149,728		149,728	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,269,637		1,269,637	0	0	73.00
76.00	03610	SLEEP LAB	203,915		203,915	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	2,606,777		2,606,777	0	0	88.00
91.00	09100	EMERGENCY	2,937,361		2,937,361	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	238,042		238,042		0	92.00
200.00		Subtotal (see instructions)	18,039,344	0	18,039,344	0	0	200.00
201.00		Less Observation Beds	238,042		238,042		0	201.00
202.00		Total (see instructions)	17,801,302	0	17,801,302	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1348 | Period: From 07/01/2016 To 06/30/2017 | Worksheet C Part I Date/Time Prepared: 11/29/2017 10:46 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	11,170,982		11,170,982			30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,095,400	5,997,847	7,093,247	0.178064	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	33,868	157,636	191,504	0.219807	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,809,990	27,187,012	29,997,002	0.062713	0.000000	54.00
60.00	06000	LABORATORY	6,114,894	20,416,220	26,531,114	0.058493	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	1,345,858	85,748	1,431,606	0.184171	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	3,131,870	3,455,182	6,587,052	0.155554	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,638,923	158,486	1,797,409	0.171992	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	189,498	53,409	242,907	0.338068	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	211,230	1,969,545	2,180,775	0.055594	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,989,343	460,339	2,449,682	0.067162	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	382,613	87,052	469,665	0.318797	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,407,194	2,387,430	4,794,624	0.264804	0.000000	73.00
76.00	03610	SLEEP LAB	0	51,600	51,600	3.951841	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	2,352,607	2,352,607			88.00
91.00	09100	EMERGENCY	441,023	11,077,474	11,518,497	0.255013	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	63,606	919,309	982,915	0.242180	0.000000	92.00
200.00		Subtotal (see instructions)	33,026,292	76,816,896	109,843,188			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	33,026,292	76,816,896	109,843,188			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1348 | Period: From 07/01/2016 To 06/30/2017 | Worksheet C Part I Date/Time Prepared: 11/29/2017 10:46 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
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	54.00
60.00	06000	LABORATORY	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	66.00
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	03610	SLEEP LAB	0.000000	76.00
		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: 14-1348 | Period: From 07/01/2016 To 06/30/2017 | Worksheet C Part I Date/Time Prepared: 11/29/2017 10:46 am

Title XIX | Hospital | PPS

		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	3,930,325		3,930,325	0	3,930,325	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,263,049		1,263,049	0	1,263,049	50.00
53.00	05300	ANESTHESIOLOGY	42,094		42,094	0	42,094	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,881,204		1,881,204	0	1,881,204	54.00
60.00	06000	LABORATORY	1,551,886		1,551,886	0	1,551,886	60.00
65.00	06500	RESPIRATORY THERAPY	263,660	0	263,660	0	263,660	65.00
66.00	06600	PHYSICAL THERAPY	1,024,642	0	1,024,642	0	1,024,642	66.00
67.00	06700	OCCUPATIONAL THERAPY	309,140	0	309,140	0	309,140	67.00
68.00	06800	SPEECH PATHOLOGY	82,119	0	82,119	0	82,119	68.00
69.00	06900	ELECTROCARDIOLOGY	121,239		121,239	0	121,239	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	164,526		164,526	0	164,526	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	149,728		149,728	0	149,728	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,269,637		1,269,637	0	1,269,637	73.00
76.00	03610	SLEEP LAB	203,915		203,915	0	203,915	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	2,606,777		2,606,777	0	2,606,777	88.00
91.00	09100	EMERGENCY	2,937,361		2,937,361	0	2,937,361	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	238,042		238,042		238,042	92.00
200.00		Subtotal (see instructions)	18,039,344	0	18,039,344	0	18,039,344	200.00
201.00		Less Observation Beds	238,042		238,042		238,042	201.00
202.00		Total (see instructions)	17,801,302	0	17,801,302	0	17,801,302	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1348 | Period: From 07/01/2016 To 06/30/2017 | Worksheet C Part I Date/Time Prepared: 11/29/2017 10:46 am

Title XIX | Hospital | PPS

		Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
			Inpatient	Outpatient	Total (col. 6 + col. 7)			
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	11,170,982		11,170,982			30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,095,400	5,997,847	7,093,247	0.178064	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	33,868	157,636	191,504	0.219807	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,809,990	27,187,012	29,997,002	0.062713	0.000000	54.00
60.00	06000	LABORATORY	6,114,894	20,416,220	26,531,114	0.058493	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	1,345,858	85,748	1,431,606	0.184171	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	3,131,870	3,455,182	6,587,052	0.155554	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,638,923	158,486	1,797,409	0.171992	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	189,498	53,409	242,907	0.338068	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	211,230	1,969,545	2,180,775	0.055594	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,989,343	460,339	2,449,682	0.067162	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	382,613	87,052	469,665	0.318797	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,407,194	2,387,430	4,794,624	0.264804	0.000000	73.00
76.00	03610	SLEEP LAB	0	51,600	51,600	3.951841	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	2,352,607	2,352,607	1.108038	0.000000	88.00
91.00	09100	EMERGENCY	441,023	11,077,474	11,518,497	0.255013	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	63,606	919,309	982,915	0.242180	0.000000	92.00
200.00		Subtotal (see instructions)	33,026,292	76,816,896	109,843,188			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	33,026,292	76,816,896	109,843,188			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1348 | Period: From 07/01/2016 To 06/30/2017 | Worksheet C Part I Date/Time Prepared: 11/29/2017 10:46 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
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.178064		50.00
53.00	05300	ANESTHESIOLOGY	0.219807		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.062713		54.00
60.00	06000	LABORATORY	0.058493		60.00
65.00	06500	RESPIRATORY THERAPY	0.184171		65.00
66.00	06600	PHYSICAL THERAPY	0.155554		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.171992		67.00
68.00	06800	SPEECH PATHOLOGY	0.338068		68.00
69.00	06900	ELECTROCARDIOLOGY	0.055594		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.067162		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.318797		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.264804		73.00
76.00	03610	SLEEP LAB	3.951841		76.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	1.108038		88.00
91.00	09100	EMERGENCY	0.255013		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.242180		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: 14-1348 | Period: From 07/01/2016 To 06/30/2017 | Worksheet C Part II | Date/Time Prepared: 11/29/2017 10:46 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	1,263,049	226,079	1,036,970	0	0	50.00
53.00	05300	ANESTHESIOLOGY	42,094	6,619	35,475	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,881,204	198,766	1,682,438	0	0	54.00
60.00	06000	LABORATORY	1,551,886	141,019	1,410,867	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	263,660	18,588	245,072	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,024,642	135,825	888,817	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	309,140	22,252	286,888	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	82,119	2,160	79,959	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	121,239	30,232	91,007	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	164,526	9,115	155,411	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	149,728	7,194	142,534	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,269,637	71,229	1,198,408	0	0	73.00
76.00	03610	SLEEP LAB	203,915	56,394	147,521	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	2,606,777	229,915	2,376,862	0	0	88.00
91.00	09100	EMERGENCY	2,937,361	175,367	2,761,994	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	238,042	29,637	208,405	0	0	92.00
200.00		Subtotal (sum of lines 50 thru 199)	14,109,019	1,360,391	12,748,628	0	0	200.00
201.00		Less Observation Beds	238,042	29,637	208,405	0	0	201.00
202.00		Total (line 200 minus line 201)	13,870,977	1,330,754	12,540,223	0	0	202.00

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

Provider CCN: 14-1348 | Period: From 07/01/2016 To 06/30/2017 | Worksheet C Part II | Date/Time Prepared: 11/29/2017 10:46 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	1,263,049	7,093,247	0.178064		50.00
53.00	05300	ANESTHESIOLOGY	42,094	191,504	0.219807		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,881,204	29,997,002	0.062713		54.00
60.00	06000	LABORATORY	1,551,886	26,531,114	0.058493		60.00
65.00	06500	RESPIRATORY THERAPY	263,660	1,431,606	0.184171		65.00
66.00	06600	PHYSICAL THERAPY	1,024,642	6,587,052	0.155554		66.00
67.00	06700	OCCUPATIONAL THERAPY	309,140	1,797,409	0.171992		67.00
68.00	06800	SPEECH PATHOLOGY	82,119	242,907	0.338068		68.00
69.00	06900	ELECTROCARDIOLOGY	121,239	2,180,775	0.055594		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	164,526	2,449,682	0.067162		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	149,728	469,665	0.318797		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,269,637	4,794,624	0.264804		73.00
76.00	03610	SLEEP LAB	203,915	51,600	3.951841		76.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	2,606,777	2,352,607	1.108038		88.00
91.00	09100	EMERGENCY	2,937,361	11,518,497	0.255013		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	238,042	982,915	0.242180		92.00
200.00		Subtotal (sum of lines 50 thru 199)	14,109,019	98,672,206			200.00
201.00		Less Observation Beds	238,042	0			201.00
202.00		Total (line 200 minus line 201)	13,870,977	98,672,206			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-1348 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D Part II Date/Time Prepared: 11/29/2017 10:46 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	226,079	7,093,247	0.031872	485,899	15,487	50.00
53.00	05300	ANESTHESIOLOGY	6,619	191,504	0.034563	13,938	482	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	198,766	29,997,002	0.006626	1,177,133	7,800	54.00
60.00	06000	LABORATORY	141,019	26,531,114	0.005315	2,693,056	14,314	60.00
65.00	06500	RESPIRATORY THERAPY	18,588	1,431,606	0.012984	560,187	7,273	65.00
66.00	06600	PHYSICAL THERAPY	135,825	6,587,052	0.020620	559,893	11,545	66.00
67.00	06700	OCCUPATIONAL THERAPY	22,252	1,797,409	0.012380	142,713	1,767	67.00
68.00	06800	SPEECH PATHOLOGY	2,160	242,907	0.008892	78,889	701	68.00
69.00	06900	ELECTROCARDIOLOGY	30,232	2,180,775	0.013863	91,754	1,272	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	9,115	2,449,682	0.003721	840,937	3,129	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	7,194	469,665	0.015317	115,766	1,773	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	71,229	4,794,624	0.014856	854,641	12,697	73.00
76.00	03610	SLEEP LAB	56,394	51,600	1.092907	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	229,915	2,352,607	0.097728	0	0	88.00
91.00	09100	EMERGENCY	175,367	11,518,497	0.015225	10,516	160	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	29,637	982,915	0.030152	531	16	92.00
200.00		Total (lines 50-199)	1,360,391	98,672,206		7,625,853	78,416	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1348 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D Part IV | Date/Time Prepared: 11/29/2017 10:46 am

Title XVIII | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
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	03610	SLEEP LAB	0	0	0	0	0	76.00
		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	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1348 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D Part IV | Date/Time Prepared: 11/29/2017 10:46 am

Title XVIII | Hospital | Cost

		Cost Center Description	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)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	7,093,247	0.000000	0.000000	485,899	50.00
53.00	05300	ANESTHESIOLOGY	0	191,504	0.000000	0.000000	13,938	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	29,997,002	0.000000	0.000000	1,177,133	54.00
60.00	06000	LABORATORY	0	26,531,114	0.000000	0.000000	2,693,056	60.00
65.00	06500	RESPIRATORY THERAPY	0	1,431,606	0.000000	0.000000	560,187	65.00
66.00	06600	PHYSICAL THERAPY	0	6,587,052	0.000000	0.000000	559,893	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,797,409	0.000000	0.000000	142,713	67.00
68.00	06800	SPEECH PATHOLOGY	0	242,907	0.000000	0.000000	78,889	68.00
69.00	06900	ELECTROCARDIOLOGY	0	2,180,775	0.000000	0.000000	91,754	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	2,449,682	0.000000	0.000000	840,937	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	469,665	0.000000	0.000000	115,766	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	4,794,624	0.000000	0.000000	854,641	73.00
76.00	03610	SLEEP LAB	0	51,600	0.000000	0.000000	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	2,352,607	0.000000	0.000000	0	88.00
91.00	09100	EMERGENCY	0	11,518,497	0.000000	0.000000	10,516	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	982,915	0.000000	0.000000	531	92.00
200.00		Total (lines 50-199)	0	98,672,206			7,625,853	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1348 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D Part IV | Date/Time Prepared: 11/29/2017 10:46 am

Title XVIII | Hospital | Cost

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
60.00	06000	LABORATORY	0	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
76.00	03610	SLEEP LAB	0	0	0		76.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	0		88.00
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0		92.00
200.00		Total (lines 50-199)	0	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-1348 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D Part V Date/Time Prepared: 11/29/2017 10:46 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	0.178064	0	1,566,316	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.219807	0	38,732	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.062713	0	8,856,207	0	0	54.00
60.00	06000	LABORATORY	0.058493	0	8,069,044	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.184171	0	36,111	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.155554	0	1,100,758	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.171992	0	17,371	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.338068	0	30,707	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.055594	0	1,741,646	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.067162	0	149,423	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.318797	0	25,017	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.264804	0	814,773	0	0	73.00
76.00	03610	SLEEP LAB	3.951841	0	39,700	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
91.00	09100	EMERGENCY	0.255013	0	3,382,469	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.242180	0	397,222	0	0	92.00
200.00		Subtotal (see instructions)		0	26,265,496	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	26,265,496	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-1348 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D Part V Date/Time Prepared: 11/29/2017 10:46 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	278,904	0		50.00
53.00	05300	ANESTHESIOLOGY	8,514	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	555,399	0		54.00
60.00	06000	LABORATORY	471,983	0		60.00
65.00	06500	RESPIRATORY THERAPY	6,651	0		65.00
66.00	06600	PHYSICAL THERAPY	171,227	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	2,988	0		67.00
68.00	06800	SPEECH PATHOLOGY	10,381	0		68.00
69.00	06900	ELECTROCARDIOLOGY	96,825	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	10,036	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	7,975	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	215,755	0		73.00
76.00	03610	SLEEP LAB	156,888	0		76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
91.00	09100	EMERGENCY	862,574	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	96,199	0		92.00
200.00		Subtotal (see instructions)	2,952,299	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	2,952,299	0		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1348 | Component CCN: 14-Z348 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D Part V Date/Time Prepared: 11/29/2017 10:46 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	0.178064	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.219807	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.062713	0	0	0	0	54.00
60.00	06000	LABORATORY	0.058493	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.184171	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.155554	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.171992	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.338068	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.055594	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.067162	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.318797	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.264804	0	0	0	0	73.00
76.00	03610	SLEEP LAB	3.951841	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
91.00	09100	EMERGENCY	0.255013	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.242180	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: 14-1348 | Component CCN: 14-Z348 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D Part V | Date/Time Prepared: 11/29/2017 10:46 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
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
60.00	06000	LABORATORY	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
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	03610	SLEEP LAB	0	0		76.00
		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: 14-1348 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D Part I Date/Time Prepared: 11/29/2017 10:46 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	489,344	267,102	222,242	2,576	86.27	30.00
200.00	Total (lines 30-199)	489,344		222,242	2,576		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	105	9,058	30.00
200.00	Total (lines 30-199)	105	9,058	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 14-1348 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D Part II Date/Time Prepared: 11/29/2017 10:46 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	226,079	7,093,247	0.031872	0	0	50.00
53.00	05300	ANESTHESIOLOGY	6,619	191,504	0.034563	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	198,766	29,997,002	0.006626	0	0	54.00
60.00	06000	LABORATORY	141,019	26,531,114	0.005315	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	18,588	1,431,606	0.012984	0	0	65.00
66.00	06600	PHYSICAL THERAPY	135,825	6,587,052	0.020620	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	22,252	1,797,409	0.012380	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	2,160	242,907	0.008892	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	30,232	2,180,775	0.013863	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	9,115	2,449,682	0.003721	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	7,194	469,665	0.015317	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	71,229	4,794,624	0.014856	0	0	73.00
76.00	03610	SLEEP LAB	56,394	51,600	1.092907	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	229,915	2,352,607	0.097728	0	0	88.00
91.00	09100	EMERGENCY	175,367	11,518,497	0.015225	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	29,937	982,915	0.030457	0	0	92.00
200.00		Total (lines 50-199)	1,360,691	98,672,206		0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 14-1348 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D Part III Date/Time Prepared: 11/29/2017 10:46 am

Title XIX | Hospital | PPS

		Cost Center Description	Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
200.00		Total (lines 30-199)	0	0	0		0	200.00

		Cost Center Description	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)		
			6.00	7.00	8.00	9.00		
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,576	0.00	105	0		30.00
200.00		Total (lines 30-199)	2,576		105	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1348 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D Part IV | Date/Time Prepared: 11/29/2017 10:46 am

Title XIX | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
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	03610	SLEEP LAB	0	0	0	0	0	76.00
		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	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1348 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D Part IV | Date/Time Prepared: 11/29/2017 10:46 am

Title XIX | Hospital | PPS

		Cost Center Description	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)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	7,093,247	0.000000	0.000000	0	50.00
53.00	05300	ANESTHESIOLOGY	0	191,504	0.000000	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	29,997,002	0.000000	0.000000	0	54.00
60.00	06000	LABORATORY	0	26,531,114	0.000000	0.000000	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	1,431,606	0.000000	0.000000	0	65.00
66.00	06600	PHYSICAL THERAPY	0	6,587,052	0.000000	0.000000	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,797,409	0.000000	0.000000	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	242,907	0.000000	0.000000	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	2,180,775	0.000000	0.000000	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	2,449,682	0.000000	0.000000	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	469,665	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	4,794,624	0.000000	0.000000	0	73.00
76.00	03610	SLEEP LAB	0	51,600	0.000000	0.000000	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	2,352,607	0.000000	0.000000	0	88.00
91.00	09100	EMERGENCY	0	11,518,497	0.000000	0.000000	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	982,915	0.000000	0.000000	0	92.00
200.00		Total (lines 50-199)	0	98,672,206			0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1348 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D Part IV Date/Time Prepared: 11/29/2017 10:46 am

Title XIX | Hospital | PPS

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
60.00	06000	LABORATORY	0	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
76.00	03610	SLEEP LAB	0	0	0		76.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	0		88.00
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0		92.00
200.00		Total (lines 50-199)	0	0	0		200.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1348 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D-1 | Date/Time Prepared: 11/29/2017 10:46 am

Title XVIII | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	5,941	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,576	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	2,229	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	3,096	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	134	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)	135	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	1,597	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)	2,462	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	144.67	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	147.52	20.00
21.00	Total general inpatient routine service cost (see instructions)	3,930,325	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)	19,386	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)	19,915	25.00
26.00	Total swing-bed cost (see instructions)	2,163,188	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	1,767,137	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	1,767,137	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)	686.01	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,095,558	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)	1,095,558	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1348 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D-1 | Date/Time Prepared: 11/29/2017 10:46 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)	890,020	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	1,985,578	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	1,688,957	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	1,688,957	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)	347	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	686.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	238,042	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1348 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D-1 | Date/Time Prepared: 11/29/2017 10:46 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	489,344	3,930,325	0.124505	238,042	29,637	90.00
91.00	Nursing School cost	0	3,930,325	0.000000	238,042	0	91.00
92.00	Allied health cost	0	3,930,325	0.000000	238,042	0	92.00
93.00	All other Medical Education	0	3,930,325	0.000000	238,042	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1348 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D-1 | Date/Time Prepared: 11/29/2017 10:46 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)	5,941	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,576	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	2,229	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	3,096	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	269	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	105	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	3,930,325	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)	2,145,311	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	1,785,014	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	1,785,014	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)	692.94	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	72,759	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	72,759	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1348 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D-1 | Date/Time Prepared: 11/29/2017 10:46 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)	72,759	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)	9,058	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)	9,058	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	63,701	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)	347	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	692.94	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	240,450	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1348 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D-1 | Date/Time Prepared: 11/29/2017 10:46 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	489,344	3,930,325	0.124505	240,450	29,937	90.00
91.00	Nursing School cost	0	3,930,325	0.000000	240,450	0	91.00
92.00	Allied health cost	0	3,930,325	0.000000	240,450	0	92.00
93.00	All other Medical Education	0	3,930,325	0.000000	240,450	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 14-1348 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D-3 | Date/Time Prepared: 11/29/2017 10:46 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		4,572,964		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.178064	485,899	86,521	50.00
53.00	05300	ANESTHESIOLOGY	0.219807	13,938	3,064	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.062713	1,177,133	73,822	54.00
60.00	06000	LABORATORY	0.058493	2,693,056	157,525	60.00
65.00	06500	RESPIRATORY THERAPY	0.184171	560,187	103,170	65.00
66.00	06600	PHYSICAL THERAPY	0.155554	559,893	87,094	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.171992	142,713	24,545	67.00
68.00	06800	SPEECH PATHOLOGY	0.338068	78,889	26,670	68.00
69.00	06900	ELECTROCARDIOLOGY	0.055594	91,754	5,101	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.067162	840,937	56,479	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.318797	115,766	36,906	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.264804	854,641	226,312	73.00
76.00	03610	SLEEP LAB	3.951841	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
91.00	09100	EMERGENCY	0.255013	10,516	2,682	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.242180	531	129	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		7,625,853	890,020	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		7,625,853		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 14-1348 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D-3

Component CCN: 14-Z348 | Date/Time Prepared: 11/29/2017 10:46 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	0.178064	33,034	5,882	50.00
53.00	05300	ANESTHESIOLOGY	0.219807	558	123	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.062713	305,577	19,164	54.00
60.00	06000	LABORATORY	0.058493	1,356,933	79,371	60.00
65.00	06500	RESPIRATORY THERAPY	0.184171	493,813	90,946	65.00
66.00	06600	PHYSICAL THERAPY	0.155554	1,768,462	275,091	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.171992	1,034,980	178,008	67.00
68.00	06800	SPEECH PATHOLOGY	0.338068	85,981	29,067	68.00
69.00	06900	ELECTROCARDIOLOGY	0.055594	102,279	5,686	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.067162	706,221	47,431	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.318797	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.264804	845,330	223,847	73.00
76.00	03610	SLEEP LAB	3.951841	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
91.00	09100	EMERGENCY	0.255013	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.242180	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		6,733,168	954,616	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)		6,733,168		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-1348	Period: From 07/01/2016 To 06/30/2017	Worksheet E Part B Date/Time Prepared: 11/29/2017 10:46 am
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	2,952,299	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	PPS payments	0	3.00
4.00	Outlier payment (see instructions)	0	4.00
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 line 3 plus line 4 divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	2,952,299	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 (line 11 minus line 20) (for CAH see instructions)	2,981,822	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, 8 and 9)	0	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	29,559	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	3,620,733	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)	-668,470	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)	-668,470	30.00
31.00	Primary payer payments	1,425	31.00
32.00	Subtotal (line 30 minus line 31)	-669,895	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)	317,126	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	206,132	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	217,242	36.00
37.00	Subtotal (see instructions)	-463,763	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)	0	39.50
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)	-463,763	40.00
40.01	Sequestration adjustment (see instructions)	0	40.01
41.00	Interim payments	1,568,886	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	-2,032,649	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: 14-1348 | Period: From 07/01/2016 To 06/30/2017 | Worksheet E-1 Part I Date/Time Prepared: 11/29/2017 10:46 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		1,724,654		1,568,886	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	12/22/2016	51,700		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)		51,700		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)		1,776,354		1,568,886	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		194,799		2,032,649	6.02
7.00	Total Medicare program liability (see instructions)		1,581,555		-463,763	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: 14-1348 | Component CCN: 14-Z348 | Period: From 07/01/2016 To 06/30/2017 | Worksheet E-1 Part I | Date/Time Prepared: 11/29/2017 10:46 am

Title XVIII | Swing Beds - SNF | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		2,704,872		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		2,704,872		0	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		155,848		0	6.02
7.00	Total Medicare program liability (see instructions)		2,549,024		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: 14-1348	Period: From 07/01/2016 To 06/30/2017	Worksheet E-1 Part II Date/Time Prepared: 11/29/2017 10:46 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	705	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12	1,597	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2	232	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12	2,229	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200	109,843,188	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20	101,766	6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168	0	7.00
8.00	Calculation of the HIT incentive payment (see instructions)	0	8.00
9.00	Sequestration adjustment amount (see instructions)	0	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)	0	10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH		
30.00	Initial/interim HIT payment adjustment (see instructions)	0	30.00
31.00	Other Adjustment (specify)	0	31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)	0	32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

Provider CCN: 14-1348 | Component CCN: 14-Z348 | Period: From 07/01/2016 To 06/30/2017 | Worksheet E-2 | Date/Time Prepared: 11/29/2017 10:46 am

Title XVIII | Swing Beds - SNF | Cost

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	1,705,847	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)	964,162	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	2,462	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)		0	6.00
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	2,670,009	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	2,670,009	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0	0	11.00
12.00	Subtotal (line 10 minus line 11)	2,670,009	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	68,964	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)	2,601,045	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	0	16.50
16.55	410A RURAL DEMONSTRATION PROJECT	0		16.55
17.00	Allowable bad debts (see instructions)	0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (see instructions)	2,601,045	0	19.00
19.01	Sequestration adjustment (see instructions)	52,021	0	19.01
20.00	Interim payments	2,704,872	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)	-155,848	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

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-1348	Period: From 07/01/2016 To 06/30/2017	Worksheet E-3 Part V Date/Time Prepared: 11/29/2017 10:46 am
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	1,985,578	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)	1,985,578	4.00
5.00	Primary payer payments	1,368	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	2,004,066	6.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
7.00	Routine service charges	0	7.00
8.00	Ancillary service charges	0	8.00
9.00	Organ acquisition charges, net of revenue	0	9.00
10.00	Total reasonable charges	0	10.00
	Customary charges		
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)	0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)	0.000000	13.00
14.00	Total customary charges (see instructions)	0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)	0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)	0	16.00
17.00	Cost of physicians' services in a teaching hospital (see instructions)	0	17.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)	0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)	2,004,066	19.00
20.00	Deductibles (exclude professional component)	422,156	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	1,581,910	22.00
23.00	Coinsurance	1,610	23.00
24.00	Subtotal (line 22 minus line 23)	1,580,300	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	51,587	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	33,532	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	32,693	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	1,613,832	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	Recovery of Accelerated Depreciation	0	29.99
30.00	Subtotal (see instructions)	1,613,832	30.00
30.01	Sequestration adjustment (see instructions)	32,277	30.01
31.00	Interim payments	1,776,354	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, 31, and 32)	-194,799	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: 14-1348 | Period: From 07/01/2016 To 06/30/2017 | Worksheet G | Date/Time Prepared: 11/29/2017 10:46 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	440,072	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	5,977,712	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-539,276	0	0	0	6.00
7.00	Inventory	491,744	0	0	0	7.00
8.00	Prepaid expenses	378,655	0	0	0	8.00
9.00	Other current assets	175,131	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)	6,924,038	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	39,727	0	0	0	12.00
13.00	Land improvements	356,121	0	0	0	13.00
14.00	Accumulated depreciation	-137,923	0	0	0	14.00
15.00	Buildings	1,854,784	0	0	0	15.00
16.00	Accumulated depreciation	-1,225,030	0	0	0	16.00
17.00	Leasehold improvements	4,483,244	0	0	0	17.00
18.00	Accumulated depreciation	-1,429,136	0	0	0	18.00
19.00	Fixed equipment	2,459,167	0	0	0	19.00
20.00	Accumulated depreciation	-1,326,548	0	0	0	20.00
21.00	Automobiles and trucks	36,543	0	0	0	21.00
22.00	Accumulated depreciation	-23,777	0	0	0	22.00
23.00	Major movable equipment	4,193,275	0	0	0	23.00
24.00	Accumulated depreciation	-3,326,884	0	0	0	24.00
25.00	Minor equipment depreciable	3,172,612	0	0	0	25.00
26.00	Accumulated depreciation	-2,635,864	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)	6,490,311	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	1,654,089	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	1,654,089	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	15,068,438	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	2,021,803	0	0	0	37.00
38.00	Salaries, wages, and fees payable	885,902	0	0	0	38.00
39.00	Payroll taxes payable	114,757	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	-201,717	0	0	0	43.00
44.00	Other current liabilities	78,516	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	2,899,261	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	-10,416	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	-10,416	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	2,888,845	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	12,179,593				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)	12,179,593	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	15,068,438	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 14-1348 | Period: From 07/01/2016 To 06/30/2017 | Worksheet G-1 | Date/Time Prepared: 11/29/2017 10:46 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		11,478,234		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		701,359				2.00
3.00	Total (sum of line 1 and line 2)		12,179,593		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		12,179,593		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)		12,179,593		0		19.00

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

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 14-1348 | Period: From 07/01/2016 To 06/30/2017 | Worksheet G-2 Parts I & II | Date/Time Prepared: 11/29/2017 10:46 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	11,170,918		11,170,918	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	11,170,918		11,170,918	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)	11,170,918		11,170,918	17.00
18.00	Ancillary services	22,085,309	0	22,085,309	18.00
19.00	Outpatient services	0	75,344,771	75,344,771	19.00
20.00	RURAL HEALTH CLINIC	0	2,352,607	2,352,607	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)	33,256,227	77,697,378	110,953,605	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		21,718,775		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)		21,718,775		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 14-1348	Period: From 07/01/2016 To 06/30/2017	Worksheet G-3 Date/Time Prepared: 11/29/2017 10:46 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	110,953,605	1.00
2.00	Less contractual allowances and discounts on patients' accounts	88,661,467	2.00
3.00	Net patient revenues (line 1 minus line 2)	22,292,138	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	21,718,775	4.00
5.00	Net income from service to patients (line 3 minus line 4)	573,363	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER MISCELLANEOUS REVENUES	127,996	24.00
25.00	Total other income (sum of lines 6-24)	127,996	25.00
26.00	Total (line 5 plus line 25)	701,359	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	701,359	29.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 14-1348	Period: From 07/01/2016 To 06/30/2017	Worksheet L Parts I-III Date/Time Prepared: 11/29/2017 10:46 am
	Title XVIII	Hospital	Cost

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

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1348 | Component CCN: 14-8514 | Period: From 07/01/2016 To 06/30/2017 | Worksheet M-1 | Date/Time Prepared: 11/29/2017 10:46 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	928,474	0	928,474	0	928,474	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	310,104	0	310,104	0	310,104	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	0	0	0	0	0	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	188,929	67,962	256,891	0	256,891	9.00
10.00	Subtotal (sum of lines 1 through 9)	1,427,507	67,962	1,495,469	0	1,495,469	10.00
11.00	Physician Services Under Agreement	0	13,253	13,253	0	13,253	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	13,253	13,253	0	13,253	14.00
15.00	Medical Supplies	0	47,238	47,238	0	47,238	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	39,864	39,864	-39,864	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	87,102	87,102	-39,864	47,238	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	1,427,507	168,317	1,595,824	-39,864	1,555,960	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	0	0	0	0	29.00
30.00	Administrative Costs	237,652	190,242	427,894	44,268	472,162	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	237,652	190,242	427,894	44,268	472,162	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	1,665,159	358,559	2,023,718	4,404	2,028,122	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1348 | Component CCN: 14-8514 | Period: From 07/01/2016 To 06/30/2017 | Worksheet M-1 | Date/Time Prepared: 11/29/2017 10:46 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	-383,208	545,266		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	-111,416	198,688		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	0		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	-70,320	186,571		9.00
10.00	Subtotal (sum of lines 1 through 9)	-564,944	930,525		10.00
11.00	Physician Services Under Agreement	0	13,253		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	13,253		14.00
15.00	Medical Supplies	0	47,238		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	47,238		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-564,944	991,016		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	472,162		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	472,162		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-564,944	1,463,178		32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1348 | Component CCN: 14-8514 | Period: From 07/01/2016 To 06/30/2017 | Worksheet M-2 | Date/Time Prepared: 11/29/2017 10:46 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	1.48	5,130	4,200	6,216		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	1.68	3,521	2,100	3,528		3.00
4.00	Subtotal (sum of lines 1 through 3)	3.16	8,651		9,744	9,744	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	3.16	8,651			9,744	8.00
9.00	Physician Services Under Agreements		0			0	9.00
						1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)					991,016	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)					991,016	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)					472,162	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					1,143,599	15.00
16.00	Total overhead (sum of lines 14 and 15)					1,615,761	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					1,615,761	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					1,615,761	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					2,606,777	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 14-1348 Component CCN: 14-8514	Period: From 07/01/2016 To 06/30/2017	Worksheet M-3 Date/Time Prepared: 11/29/2017 10:46 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)			2,606,777	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			19,170	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			2,587,607	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			9,744	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)			0	5.00
6.00	Total adjusted visits (line 4 plus line 5)			9,744	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			265.56	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)	80.44	81.32		8.00
9.00	Rate for Program covered visits (see instructions)	265.56	265.56		9.00
	CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	2,656	2,655		10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	705,327	705,062		11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0		12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0		13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0		14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)				15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *	0	1,410,389		16.00
16.01	Total program charges (see instructions)(from contractor's records)		976,492		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		7,489		16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		10,816		16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)		1,060,498		16.04
16.05	Total program cost (see instructions)	0	1,071,314		16.05
17.00	Primary payer amounts		0		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		73,950		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		179,010		19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		1,071,314		20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		18,045		21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		1,089,359		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
26.00	Net reimbursable amount (see instructions)		1,089,359		26.00
26.01	Sequestration adjustment (see instructions)		21,787		26.01
27.00	Interim payments		941,093		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, 27, and 28)		126,479		29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0		30.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA VACCINE COST	Provider CCN: 14-1348 Component CCN: 14-8514	Period: From 07/01/2016 To 06/30/2017	Worksheet M-4 Date/Time Prepared: 11/29/2017 10:46 am
	Title XVIII	RHC I	Cost

		Pneumococcal	Influenza	
		1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	930,525	930,525	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.001664	0.001051	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	1,548	978	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	2,351	2,411	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	3,899	3,389	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	991,016	991,016	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	1,615,761	1,615,761	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.003934	0.003420	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	6,356	5,526	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	10,255	8,915	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	103	54	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	99.56	165.09	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	100	49	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	9,956	8,089	14.00
15.00	Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2)		19,170	15.00
16.00	Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3, line 21)		18,045	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 14-1348 Component CCN: 14-8514	Period: From 07/01/2016 To 06/30/2017	Worksheet M-5 Date/Time Prepared: 11/29/2017 10:46 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		791,193	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00
	Program to Provider			
3.01		12/22/2016	149,900	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)		149,900	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		941,093	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		126,479	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		1,067,572	7.00

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