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: 14-0001	Period: From 07/01/2017 To 06/30/2018	Worksheet S Parts I-III Date/Time Prepared: 11/12/2018 2:10 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 11/12/2018 Time: 2:10 pm
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by GRAHAM HOSPITAL ASSOCIATION (14-0001) for the cost reporting period beginning 07/01/2017 and ending 06/30/2018 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

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

_____
Title

_____
Date

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	-216,560	20,508	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
7.00	SKILLED NURSING FACILITY	0	318,396	67		0	7.00
8.00	NURSING FACILITY	0				0	8.00
10.00	RURAL HEALTH CLINIC I	0		352,168		0	10.00
11.00	FEDERALLY QUALIFIED HEALTH CENTER I	0		0		0	11.00
200.00	Total	0	101,836	372,743	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: 14-0001 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-2 Part I | Date/Time Prepared: 11/12/2018 1:38 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 210 WEST WALNUT	PO Box:			1.00
2.00	City: CANTON	State: IL	Zip Code: 61520-	County: FULTON	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	GRAHAM HOSPITAL ASSOCIATION	140001	99914	1	07/19/1966	N	P	N	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									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF	GRAHAM HOSPITAL ASSOCIATION ECF	145572	99914		07/02/1987	N	P	N	9.00
10.00	Hospital-Based NF	GRAHAM HOSPITAL ASSOCIATION ECF	145572	99914		07/02/1987	N		O	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	COLEMAN CLINIC	143493	99914		01/01/2008	N	O	N	15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From: 1.00	To: 2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	07/01/2017	06/30/2018	20.00
21.00	Type of Control (see instructions)	2		21.00
	Inpatient PPS Information			
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	Y	N	22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	Y	Y	22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N	22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.	N	N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	2	N	23.00

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	1,544	0	0	0	134	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: 14-0001 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-2 Part I Date/Time Prepared: 11/12/2018 1:38 pm

		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.	1		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.	07/01/2017	06/30/2018	36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.	0		37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)	N		37.01
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.			38.00
		Y/N	Y/N	
		1.00	2.00	
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i) or (ii)? Enter in column 1 “Y” for yes or “N” for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i) or (ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	Y	Y	39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	N	N	40.00

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

		NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code	
		1.00	2.00	3.00	
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under §413.85? (see instructions)	Y			60.00
60.01	If line 60 is yes, complete columns 2 and 3 for each program. (see instructions)		20.00	1	60.01

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

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		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).						61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.06

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-0001 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-2 Part I Date/Time Prepared: 11/12/2018 1:38 pm

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

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

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

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

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		1.00	2.00	3.00	
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0	76.00

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

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

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

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

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

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

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	0	0	1,469,942	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.	Y	Y	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	Y	44.00	122.00
	Transplant Center Information			
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 14-0001	Period: From 07/01/2017 To 06/30/2018	Worksheet S-2 Part I Date/Time Prepared: 11/12/2018 1:38 pm

		1.00	2.00	
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	N		140.00

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

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

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

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

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

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

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

		1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act		
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.	Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)	0	168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)		168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	9.99	169.00

		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	07/01/2017	09/30/2017	170.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 14-0001	Period: From 07/01/2017 To 06/30/2018	Worksheet S-2 Part I Date/Time Prepared: 11/12/2018 1:38 pm

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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 14-0001 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-2 Part II | Date/Time Prepared: 11/12/2018 1:38 pm

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

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

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

		Y/N	Legal Oper.	
		1.00	2.00	
	Approved Educational Activities			
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	Y	Y	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)	N		N		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	10/18/2018	Y	10/18/2018	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 14-0001 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-2 Part II | Date/Time Prepared: 11/12/2018 1:38 pm

		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00

		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00

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

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

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	DAN	LINHART	41.00
42.00	Enter the employer/company name of the cost report preparer.	RSM US LLP		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	563.888.4404	DAN.LINHART@RSMUS.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 14-0001	Period: From 07/01/2017 To 06/30/2018	Worksheet S-2 Part II Date/Time Prepared: 11/12/2018 1:38 pm

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 14-0001 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-3 Part I | Date/Time Prepared: 11/12/2018 1:38 pm

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	38	13,870	0.00	0	1.00
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		38	13,870	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	5	1,825	0.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		43	15,695	0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	44.00	20	7,300		0	19.00
20.00	NURSING FACILITY	45.00	18	6,570		0	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	RHC (CONSOLIDATED)	88.00				0	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		81				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00
33.01	LTCH site neutral days and discharges						33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 14-0001 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-3 Part I | Date/Time Prepared: 11/12/2018 1:38 pm

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	3,094	1,095	6,430			1.00
2.00	HMO and other (see instructions)	1,415	134				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	3,094	1,095	6,430			7.00
8.00	INTENSIVE CARE UNIT	594	105	993			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		263	463			13.00
14.00	Total (see instructions)	3,688	1,463	7,886	0.00	470.32	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	2,503	7	3,729	0.00	17.28	19.00
20.00	NURSING FACILITY		3,398	5,592	0.00	15.81	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	RHC (CONSOLIDATED)	19,262	26,370	96,002	0.00	77.06	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	580.47	27.00
28.00	Observation Bed Days		0	1,141			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			94			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	81	123			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 14-0001 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-3 Part I | Date/Time Prepared: 11/12/2018 1:38 pm

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	923	436	2,154	1.00
2.00	HMO and other (see instructions)			353	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	923	436	2,154	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	0.00					19.00
20.00	NURSING FACILITY	0.00					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	RHC (CONSOLIDATED)	0.00					26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 14-0001 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-3 Part II | Date/Time Prepared: 11/12/2018 1:38 pm

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA							
	SALARIES							
1.00	Total salaries (see instructions)	200.00	31,185,323	0	31,185,323	1,207,379.95	25.83	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician and Non Physician-Part B		3,893,326	0	3,893,326	33,605.87	115.85	5.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		2,866,754	0	2,866,754	142,526.83	20.11	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	951,774	0	951,774	35,951.21	26.47	9.00
10.00	Excluded area salaries (see instructions)		1,727,611	135,486	1,863,097	100,181.88	18.60	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		1,683,885	0	1,683,885	27,194.23	61.92	11.00
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00	12.00
13.00	Contract labor: Physician-Part A - Administrative		0	0	0	0.00	0.00	13.00
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00	14.00
14.01	Home office salaries		0	0	0	0.00	0.00	14.01
14.02	Related organization salaries		0	0	0	0.00	0.00	14.02
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
	WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		6,467,390	0	6,467,390			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		929,080	0	929,080			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		0	0	0			21.00
22.00	Physician Part A - Administrative		0	0	0			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		427,939	0	427,939			23.00
24.00	Wage-related costs (RHC/FQHC)		1,005,123	0	1,005,123			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
25.50	Home office wage-related (core)		0	0	0			25.50
25.51	Related organization wage-related (core)		0	0	0			25.51
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0			25.52
25.53	Home office & Contract Physicians Part A - Teaching - wage-related (core)		0	0	0			25.53

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 14-0001 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-3 Part II | Date/Time Prepared: 11/12/2018 1:38 pm

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	188,089	0	188,089	7,670.70	24.52	26.00
27.00	Administrative & General	5.00	6,416,216	0	6,416,216	247,484.55	25.93	27.00
28.00	Administrative & General under contract (see inst.)		1,224,687	0	1,224,687	14,729.66	83.14	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	837,491	-420	837,071	48,651.19	17.21	30.00
31.00	Laundry & Linen Service	8.00	28,469	0	28,469	2,430.01	11.72	31.00
32.00	Housekeeping	9.00	892,374	0	892,374	68,369.87	13.05	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	714,589	-440,302	274,287	18,469.12	14.85	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	440,302	440,302	29,647.82	14.85	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	456,551	0	456,551	11,923.98	38.29	38.00
39.00	Central Services and Supply	14.00	0	0	0	0.00	0.00	39.00
40.00	Pharmacy	15.00	757,069	0	757,069	25,088.45	30.18	40.00
41.00	Medical Records & Medical Records Library	16.00	441,630	0	441,630	44,077.29	10.02	41.00
42.00	Social Service	17.00	0	0	0	0.00	0.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 14-0001 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-3 Part III Date/Time Prepared: 11/12/2018 1:38 pm

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)		25,649,930	0	25,649,930	1,045,976.91	24.52	1.00
2.00	Excluded area salaries (see instructions)		2,679,385	135,486	2,814,871	136,133.09	20.68	2.00
3.00	Subtotal salaries (line 1 minus line 2)		22,970,545	-135,486	22,835,059	909,843.82	25.10	3.00
4.00	Subtotal other wages & related costs (see inst.)		1,683,885	0	1,683,885	27,194.23	61.92	4.00
5.00	Subtotal wage-related costs (see inst.)		6,467,390	0	6,467,390	0.00	28.32	5.00
6.00	Total (sum of lines 3 thru 5)		31,121,820	-135,486	30,986,334	937,038.05	33.07	6.00
7.00	Total overhead cost (see instructions)		11,957,165	-420	11,956,745	518,542.64	23.06	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 14-0001 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-3 Part IV Date/Time Prepared: 11/12/2018 1:38 pm

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	685,107	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	17,334	6.00
7.00	Employee Managed Care Program Administration Fees	271,887	7.00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	0	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)	5,279,516	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	0	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	7,958	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)	103,964	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	-43,571	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	2,173,012	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	61,420	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
	OTHER		
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	138,195	21.00
22.00	Day Care Cost and Allowances	23,105	22.00
23.00	Tuition Reimbursement	111,606	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	8,829,533	24.00
	Part B - Other than Core Related Cost		
25.00	OTHER WAGE RELATED COSTS	0	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST | Provider CCN: 14-0001 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-3 Part V | Date/Time Prepared: 11/12/2018 1:38 pm

	Cost Center Description	Contract Labor	Benefit Cost	
		1.00	2.00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	2,061,998	8,829,533	1.00
2.00	Hospital	1,683,885	8,829,533	2.00
3.00	Subprovider - IPF			3.00
4.00	Subprovider - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF	378,113	0	8.00
9.00	Hospital-Based NF	0	0	9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC	0	0	14.00
15.00	Hospital-Based Health Clinic FQHC	0	0	15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis			17.00
18.00	Other	0	0	18.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA | Provider CCN: 14-0001 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-7 | Date/Time Prepared: 11/12/2018 1:38 pm

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

		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
		1.00	2.00	3.00	4.00	
3.00		RUX	0	0	0	3.00
4.00		RUL	0	0	0	4.00
5.00		RVX	0	0	0	5.00
6.00		RVL	0	0	0	6.00
7.00		RHX	0	0	0	7.00
8.00		RHL	0	0	0	8.00
9.00		RMX	0	0	0	9.00
10.00		RML	0	0	0	10.00
11.00		RLX	0	0	0	11.00
12.00		RUC	151	0	151	12.00
13.00		RUB	130	0	130	13.00
14.00		RUA	370	0	370	14.00
15.00		RVC	431	0	431	15.00
16.00		RVB	176	0	176	16.00
17.00		RVA	635	0	635	17.00
18.00		RHC	133	0	133	18.00
19.00		RHB	45	0	45	19.00
20.00		RHA	180	0	180	20.00
21.00		RMC	33	0	33	21.00
22.00		RMB	7	0	7	22.00
23.00		RMA	52	0	52	23.00
24.00		RLB	0	0	0	24.00
25.00		RLA	0	0	0	25.00
26.00		ES3	0	0	0	26.00
27.00		ES2	0	0	0	27.00
28.00		ES1	0	0	0	28.00
29.00		HE2	0	0	0	29.00
30.00		HE1	0	0	0	30.00
31.00		HD2	0	0	0	31.00
32.00		HD1	45	0	45	32.00
33.00		HC2	0	0	0	33.00
34.00		HC1	27	0	27	34.00
35.00		HB2	0	0	0	35.00
36.00		HB1	7	0	7	36.00
37.00		LE2	0	0	0	37.00
38.00		LE1	3	0	3	38.00
39.00		LD2	0	0	0	39.00
40.00		LD1	2	0	2	40.00
41.00		LC2	0	0	0	41.00
42.00		LC1	0	0	0	42.00
43.00		LB2	0	0	0	43.00
44.00		LB1	0	0	0	44.00
45.00		CE2	0	0	0	45.00
46.00		CE1	0	0	0	46.00
47.00		CD2	0	0	0	47.00
48.00		CD1	10	0	10	48.00
49.00		CC2	0	0	0	49.00
50.00		CC1	0	0	0	50.00
51.00		CB2	0	0	0	51.00
52.00		CB1	24	0	24	52.00
53.00		CA2	0	0	0	53.00
54.00		CA1	36	0	36	54.00
55.00		SE3	0	0	0	55.00
56.00		SE2	0	0	0	56.00
57.00		SE1	0	0	0	57.00
58.00		SSC	0	0	0	58.00
59.00		SSB	0	0	0	59.00
60.00		SSA	0	0	0	60.00
61.00		IB2	0	0	0	61.00
62.00		IB1	0	0	0	62.00
63.00		IA2	0	0	0	63.00
64.00		IA1	0	0	0	64.00
65.00		BB2	0	0	0	65.00
66.00		BB1	0	0	0	66.00
67.00		BA2	0	0	0	67.00
68.00		BA1	0	0	0	68.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA | Provider CCN: 14-0001 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-7 | Date/Time Prepared: 11/12/2018 1:38 pm

		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
		1.00	2.00	3.00	4.00	
69.00		PE2	0	0	0	69.00
70.00		PE1	0	0	0	70.00
71.00		PD2	0	0	0	71.00
72.00		PD1	5	0	5	72.00
73.00		PC2	0	0	0	73.00
74.00		PC1	0	0	0	74.00
75.00		PB2	0	0	0	75.00
76.00		PB1	0	0	0	76.00
77.00		PA2	0	0	0	77.00
78.00		PA1	1	0	1	78.00
199.00		AAA	0	0	0	199.00
200.00	TOTAL		2,503	0	2,503	200.00

		CBSA at Beginning of Cost Reporting Period	CBSA on/after October 1 of the Cost Reporting Period (if applicable)	
		1.00	2.00	
	SNF SERVICES			
201.00	Enter in column 1 the SNF CBSA code or 5 character non-CBSA code if a rural facility, in effect at the beginning of the cost reporting period. Enter in column 2, the code in effect on or after October 1 of the cost reporting period (if applicable).	99914	99914	201.00

		Expenses	Percentage	Associated with Direct Patient Care and Related Expenses?	
		1.00	2.00	3.00	
	A notice published in the Federal Register Volume 68, No. 149 August 4, 2003 provided for an increase in the RUG payments beginning 10/01/2003. Congress expected this increase to be used for direct patient care and related expenses. For lines 202 through 207: Enter in column 1 the amount of the expense for each category. Enter in column 2 the percentage of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 7, column 3. In column 3, enter "Y" for yes or "N" for no if the spending reflects increases associated with direct patient care and related expenses for each category. (see instructions)				
202.00	Staffing	951,774	52.64	Y	202.00
203.00	Recruitment	0	0.00	N	203.00
204.00	Retention of employees	0	0.00	N	204.00
205.00	Training	2,446	0.14	Y	205.00
206.00	OTHER (SPECIFY)	0	0.00		206.00
207.00	Total SNF revenue (Worksheet G-2, Part I, line 7, column 3)	1,808,184			207.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 14-0001 | Component CCN: 14-3493 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-8 | Date/Time Prepared: 11/12/2018 1:38 pm

RHC I | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			180 S MAIN STREET		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	CANTON		IL	61520	2.00
					1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0	3.00
			Grant Award		Date	
			1.00		2.00	
	Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)					4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)					5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)					6.00
7.00	Appalachian Regional Commission					7.00
8.00	Look-Alikes					8.00
9.00	OTHER (SPECIFY)					9.00
				1.00	2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N	0	10.00

		Sunday		Monday		Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
	Facility hours of operations (1)						
11.00	CLINIC	08:30	15:00	07:30	17:30	07:30	11.00

				1.00	2.00	
12.00	Have you received an approval for an exception to the productivity standard?			N		12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.			Y	4	13.00
			Provider name		CCN number	
			1.00		2.00	
14.00	RHC/FQHC name, CCN number		FARMINGTON CLINIC		143494	14.00
14.01			CANTON CLINIC		143492	14.01
14.02			CUBA CLINIC		143497	14.02
14.03			COLEMAN CLINIC		143493	14.03

		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		FULTON				2.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 14-0001 | Component CCN: 14-3493 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-8 | Date/Time Prepared: 11/12/2018 1:38 pm

RHC I | Cost

		Tuesday	Wednesday		Thursday		
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)						
11.00	CLINIC	17:30	07:30	17:30	07:30	17:30	11.00

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	CLINIC	07:30	17:30	08:30	17:00		11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 14-0001 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-10 | Date/Time Prepared: 11/12/2018 1:38 pm

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.306075	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	8,960,080	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?	N	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	3,979,934	5.00
6.00	Medicaid charges	49,418,324	6.00
7.00	Medicaid cost (line 1 times line 6)	15,125,714	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)	2,185,700	8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone CHIP	0	9.00
10.00	Stand-alone CHIP charges	0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	2,185,700	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
	Uncompensated Care (see instructions for each line)				
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	2,580,540	1,183,575	3,764,115	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	789,839	1,183,575	1,973,414	21.00
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	789,839	1,183,575	1,973,414	23.00

		1.00	
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	4,263,228	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	246,333	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	378,974	27.01
28.00	Non-Medicare bad debt expense (see instructions)	3,884,254	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	1,321,514	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	3,294,928	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	5,480,628	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-0001 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A | Date/Time Prepared: 11/12/2018 1:38 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		6,996,478	6,996,478	-2,498,926	4,497,552	1.00
1.01	00101	NEW CAP REL COSTS-CARDIAC REHAB		0	0	3,832	3,832	1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP		0	0	2,532,089	2,532,089	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	188,089	9,153,414	9,341,503	19,200	9,360,703	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	6,416,216	8,655,322	15,071,538	-97,925	14,973,613	5.00
7.00	00700	OPERATION OF PLANT	837,491	2,044,536	2,882,027	-420	2,881,607	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	28,469	228,676	257,145	0	257,145	8.00
9.00	00900	HOUSEKEEPING	892,374	194,205	1,086,579	0	1,086,579	9.00
10.00	01000	DIETARY	714,589	613,145	1,327,734	-818,098	509,636	10.00
11.00	01100	CAFETERIA	0	0	0	818,098	818,098	11.00
13.00	01300	NURSING ADMINISTRATION	456,551	18,377	474,928	0	474,928	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	177,424	177,424	-170,786	6,638	14.00
15.00	01500	PHARMACY	757,069	82,519	839,588	0	839,588	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	441,630	303,419	745,049	0	745,049	16.00
20.00	02000	NURSING SCHOOL	1,046,861	177,922	1,224,783	0	1,224,783	20.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,681,275	372,097	3,053,372	0	3,053,372	30.00
31.00	03100	INTENSIVE CARE UNIT	748,248	66,277	814,525	0	814,525	31.00
43.00	04300	NURSERY	290,305	19,665	309,970	0	309,970	43.00
44.00	04400	SKILLED NURSING FACILITY	951,774	72,793	1,024,567	0	1,024,567	44.00
45.00	04500	NURSING FACILITY	636,111	31,513	667,624	0	667,624	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,775,197	2,960,872	4,736,069	-2,096,764	2,639,305	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	77,724	399	78,123	0	78,123	52.00
53.00	05300	ANESTHESIOLOGY	0	1,162,489	1,162,489	0	1,162,489	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	868,465	812,411	1,680,876	-1,809	1,679,067	54.00
57.00	05700	CT SCAN	67,572	199,588	267,160	0	267,160	57.00
58.00	05800	MRI	73,187	124,865	198,052	0	198,052	58.00
60.00	06000	LABORATORY	1,648,323	1,935,867	3,584,190	0	3,584,190	60.00
65.00	06500	RESPIRATORY THERAPY	589,499	56,304	645,803	0	645,803	65.00
66.00	06600	PHYSICAL THERAPY	31,982	1,890,718	1,922,700	0	1,922,700	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	853,388	853,388	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1,418,319	1,418,319	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,609,870	2,609,870	0	2,609,870	73.00
76.97	07697	CARDIAC REHABILITATION	188,729	70,622	259,351	0	259,351	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	4,440,415	9,949,512	14,389,927	-1,966,734	12,423,193	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CLINIC	568,840	811,872	1,380,712	-9,452	1,371,260	90.01
91.00	09100	EMERGENCY	3,323,954	269,468	3,593,422	0	3,593,422	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	399,745	622,967	1,022,712	34,333	1,057,045	96.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		0	0	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	31,140,684	52,685,606	83,826,290	-1,981,655	81,844,635	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	5,064	5,064	1,974,258	1,979,322	192.00
192.01	19201	CANTON RHC RENTED SPACE	0	0	0	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.02	19302	FOUNDATION	0	0	0	0	0	193.02
194.00	07950	PHYSICIANS CLINIC	0	0	0	0	0	194.00
194.01	07951	PROCTOR CHEMICAL DEPENDENCY	0	0	0	0	0	194.01
194.02	07952	FRESENIUS	0	0	0	0	0	194.02
194.03	07953	RUCHFORD POB	0	0	0	7,397	7,397	194.03
194.04	07954	EP COLEMAN RENTAL SPACE	0	0	0	0	0	194.04
194.05	07955	FARMINGTON POB	0	0	0	0	0	194.05
194.06	07956	LEWISTON POB	0	0	0	0	0	194.06
194.07	07957	OTHER RENTAL PROPERTY	0	423	423	0	423	194.07
194.08	07958	KELLEY HOME	0	0	0	0	0	194.08
194.09	07959	EMPLOYEE PURCHASE	0	0	0	0	0	194.09
194.10	07960	RETAIL PHARMACY	0	1,373,028	1,373,028	0	1,373,028	194.10
194.11	07961	WELLNESS CENTER	44,639	14,940	59,579	0	59,579	194.11
200.00		TOTAL (SUM OF LINES 118 through 199)	31,185,323	54,079,061	85,264,384	0	85,264,384	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-0001 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A | Date/Time Prepared: 11/12/2018 1:38 pm

		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	-967,032	3,530,520		1.00
1.01	00101	NEW CAP REL COSTS-CARDIAC REHAB	0	3,832		1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-4,814	2,527,275		2.00
3.00	00300	OTHER CAP REL COSTS	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-3,598,579	5,762,124		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-2,921,614	12,051,999		5.00
7.00	00700	OPERATION OF PLANT	0	2,881,607		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	257,145		8.00
9.00	00900	HOUSEKEEPING	0	1,086,579		9.00
10.00	01000	DIETARY	-247,820	261,816		10.00
11.00	01100	CAFETERIA	-389,602	428,496		11.00
13.00	01300	NURSING ADMINISTRATION	-1,533	473,395		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	6,638		14.00
15.00	01500	PHARMACY	-146,613	692,975		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-12,624	732,425		16.00
20.00	02000	NURSING SCHOOL	-330,808	893,975		20.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	3,053,372		30.00
31.00	03100	INTENSIVE CARE UNIT	0	814,525		31.00
43.00	04300	NURSERY	0	309,970		43.00
44.00	04400	SKILLED NURSING FACILITY	10,151	1,034,718		44.00
45.00	04500	NURSING FACILITY	9,855	677,479		45.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	2,639,305		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	78,123		52.00
53.00	05300	ANESTHESIOLOGY	-1,134,315	28,174		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,679,067		54.00
57.00	05700	CT SCAN	-200	266,960		57.00
58.00	05800	MRI	0	198,052		58.00
60.00	06000	LABORATORY	-117,590	3,466,600		60.00
65.00	06500	RESPIRATORY THERAPY	0	645,803		65.00
66.00	06600	PHYSICAL THERAPY	0	1,922,700		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	853,388		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,418,319		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,609,870		73.00
76.97	07697	CARDIAC REHABILITATION	-50,565	208,786		76.97
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	-18,274	12,404,919		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0		89.00
90.00	09000	CLINIC	0	0		90.00
90.01	09001	WOUND CLINIC	-310,010	1,061,250		90.01
91.00	09100	EMERGENCY	-2,114,975	1,478,447		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
		OTHER REIMBURSABLE COST CENTERS				
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	-102,167	954,878		96.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-12,449,129	69,395,506		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	1,979,322		192.00
192.01	19201	CANTON RHC RENTED SPACE	0	0		192.01
193.00	19300	NONPAID WORKERS	0	0		193.00
193.02	19302	FOUNDATION	0	0		193.02
194.00	07950	PHYSICIANS CLINIC	0	0		194.00
194.01	07951	PROCTOR CHEMICAL DEPENDENCY	0	0		194.01
194.02	07952	FRESENIUS	0	0		194.02
194.03	07953	RUCHFORD POB	0	7,397		194.03
194.04	07954	EP COLEMAN RENTAL SPACE	0	0		194.04
194.05	07955	FARMINGTON POB	0	0		194.05
194.06	07956	LEWISTON POB	0	0		194.06
194.07	07957	OTHER RENTAL PROPERTY	0	423		194.07
194.08	07958	KELLEY HOME	0	0		194.08
194.09	07959	EMPLOYEE PURCHASE	0	0		194.09
194.10	07960	RETAIL PHARMACY	0	1,373,028		194.10
194.11	07961	WELLNESS CENTER	0	59,579		194.11
200.00		TOTAL (SUM OF LINES 118 through 199)	-12,449,129	72,815,255		200.00

RECLASSIFICATIONS | Provider CCN: 14-0001 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-6 | Date/Time Prepared: 11/12/2018 1:38 pm

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - CAFETERIA RECLASS				
1.00	CAFETERIA	11.00	440,302	377,796	1.00
	TOTALS		440,302	377,796	
	B - MAINTENANCE LABOR RECLASS				
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	420	0	1.00
	TOTALS		420	0	
	C - OFFSITE CAPITAL RECLASS				
1.00	DURABLE MEDICAL EQUIP-RENTED	96.00	0	34,333	1.00
2.00	RUCHFORD POB	194.03	0	6,732	2.00
	TOTALS		0	41,065	
	D - PROPERTY INSURANCE RECLASS				
1.00	OTHER CAP REL COSTS	3.00	0	78,060	1.00
2.00	RUCHFORD POB	194.03	0	665	2.00
	TOTALS		0	78,725	
	E - DEPRECIATION RECLASS				
1.00	NEW CAP REL COSTS-CARDIAC REHAB	1.01	0	2,524	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	2,512,940	2.00
	TOTALS		0	2,515,464	
	F - RHC EXPENSE RECLASS				
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	135,066	1,838,772	1.00
2.00	RURAL HEALTH CLINIC	88.00	7,104	0	2.00
	TOTALS		142,170	1,838,772	
	G - EMPLOYEE BENEFIT AUDIT RECLASS				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	19,200	1.00
	TOTALS		0	19,200	
	H - IMPLANT RECLASS				
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	1,418,319	1.00
	TOTALS		0	1,418,319	
	I - MED SUP CHARGE TO PATIENTS RECLASS				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	853,388	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
	TOTALS		0	853,388	
500.00	Grand Total: Increases		582,892	7,142,729	500.00

RECLASSIFICATIONS | Provider CCN: 14-0001 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-6 | Date/Time Prepared: 11/12/2018 1:38 pm

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - CAFETERIA RECLASS						
1.00	DIETARY	10.00	440,302	377,796	0		1.00
	TOTALS		440,302	377,796			
	B - MAINTENANCE LABOR RECLASS						
1.00	OPERATION OF PLANT	7.00	420	0	0		1.00
	TOTALS		420	0			
	C - OFFSITE CAPITAL RECLASS						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	41,065	9		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		0	41,065			
	D - PROPERTY INSURANCE RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	78,725	12		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		0	78,725			
	E - DEPRECIATION RECLASS						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	2,515,464	9		1.00
2.00		0.00	0	0	9		2.00
	TOTALS		0	2,515,464			
	F - RHC EXPENSE RECLASS						
1.00	RURAL HEALTH CLINIC	88.00	135,066	1,838,772	0		1.00
2.00	WOUND CLINIC	90.01	7,104	0	0		2.00
	TOTALS		142,170	1,838,772			
	G - EMPLOYEE BENEFIT AUDIT RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	19,200	0		1.00
	TOTALS		0	19,200			
	H - IMPLANT RECLASS						
1.00	OPERATING ROOM	50.00	0	1,418,319	0		1.00
	TOTALS		0	1,418,319			
	I - MED SUP CHARGE TO PATIENTS RECLASS						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	170,786	0		1.00
2.00	OPERATING ROOM	50.00	0	678,445	0		2.00
3.00	RADIOLOGY-DIAGNOSTIC	54.00	0	1,809	0		3.00
4.00	WOUND CLINIC	90.01	0	2,348	0		4.00
	TOTALS		0	853,388			
500.00	Grand Total: Decreases		582,892	7,142,729			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-0001 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-7 Part I | Date/Time Prepared: 11/12/2018 1:38 pm

		Beginning Balances	Acquisitions: Purchases	Acquisitions: Donation	Acquisitions: Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	5,253,008	372,982	0	372,982	0	1.00
2.00	Land Improvements	0	0	0	0	0	2.00
3.00	Buildings and Fixtures	85,692,689	788,983	0	788,983	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	11,598,279	1,695,266	0	1,695,266	0	5.00
6.00	Movable Equipment	30,921,859	3,338,057	0	3,338,057	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	133,465,835	6,195,288	0	6,195,288	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	133,465,835	6,195,288	0	6,195,288	0	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	5,625,990	0	1.00
2.00	Land Improvements	0	0	2.00
3.00	Buildings and Fixtures	86,481,672	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	13,293,545	0	5.00
6.00	Movable Equipment	34,259,916	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	139,661,123	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	139,661,123	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-0001 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-7 Part II | Date/Time Prepared: 11/12/2018 1:38 pm

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	6,996,478	0	0	0	0	1.00
1.01	NEW CAP REL COSTS-CARDIAC REHAB	0	0	0	0	0	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	6,996,478	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	6,996,478		1.00
1.01	NEW CAP REL COSTS-CARDIAC REHAB	0	0		1.01
2.00	CAP REL COSTS-MVBLE EQUIP	0	0		2.00
3.00	Total (sum of lines 1-2)	0	6,996,478		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-0001 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-7 Part III | Date/Time Prepared: 11/12/2018 1:38 pm

	Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	103,060,512	0	103,060,512	0.737933	57,603	1.00
1.01	NEW CAP REL COSTS-CARDIAC REHAB	2,340,695	0	2,340,695	0.016760	1,308	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	34,259,916	0	34,259,916	0.245307	19,149	2.00
3.00	Total (sum of lines 1-2)	139,661,123	0	139,661,123	1.000000	78,060	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	57,603	4,439,949	0	1.00
1.01	NEW CAP REL COSTS-CARDIAC REHAB	0	0	1,308	2,524	0	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	19,149	2,508,126	0	2.00
3.00	Total (sum of lines 1-2)	0	0	78,060	6,950,599	0	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	-967,032	57,603	0	0	3,530,520	1.00
1.01	NEW CAP REL COSTS-CARDIAC REHAB	0	1,308	0	0	3,832	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	0	19,149	0	0	2,527,275	2.00
3.00	Total (sum of lines 1-2)	-967,032	78,060	0	0	6,061,627	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-0001 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-8 | Date/Time Prepared: 11/12/2018 1:38 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
1.01	Investment income - NEW CAP REL COSTS-CARDIAC REHAB (chapter 2)		0	NEW CAP REL COSTS-CARDIAC REHAB	1.01	0	1.01
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)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-2,583,906			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	0			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests		0		0.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts		0		0.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
26.01	Depreciation - NEW CAP REL COSTS-CARDIAC REHAB		0	NEW CAP REL COSTS-CARDIAC REHAB	1.01	0	26.01
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-0001 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-8 | Date/Time Prepared: 11/12/2018 1:38 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	INVST INCOME-NEW BLDGS AND FIXTURES	B	-435,697	CAP REL COSTS-BLDG & FIXT	1.00	11	33.00
33.01	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.01
33.02	TRADE, QUANTITY AND TIME DISCOUNTS	B	-88,129	ADMINISTRATIVE & GENERAL	5.00	0	33.02
33.03	MEDICAL STAFF DUES	B	-18,470	ADMINISTRATIVE & GENERAL	5.00	0	33.03
33.04	OTHER INCOME & PURCHASE GROUP	B	-67,950	ADMINISTRATIVE & GENERAL	5.00	0	33.04
33.05	HOUSKEEPING OTHER REVENUE	B	0	HOUSEKEEPING	9.00	0	33.05
33.06	DIETARY CONSULTANT AND EMP PURCHASE	B	-239,501	DIETARY	10.00	0	33.06
33.07	REFUND/EXP REBATE	B	-8,294	DIETARY	10.00	0	33.07
33.08	CAFETERIA--EMPLOYEES AND GUESTS	B	-389,602	CAFETERIA	11.00	0	33.08
33.09	NRSG SVS CPR CLASS FEES	B	-1,533	NURSING ADMINISTRATION	13.00	0	33.09
33.10	SALE OF DRUGS TO OTHER THAN PATIENTS	B	-146,472	PHARMACY	15.00	0	33.10
33.11	REFUND/EXP REBATE	B	-158	PHARMACY	15.00	0	33.11
33.12	SALE OF MEDICAL RECORDS & ABSTRACTS	B	-12,624	MEDICAL RECORDS & LIBRARY	16.00	0	33.12
33.13	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.13
33.14	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.14
33.15	CARDIAC OTHER REVENUE	B	-36,529	CARDIAC REHABILITATION	76.97	0	33.15
33.16	RHC OTHER INCOME	B	-18,274	RURAL HEALTH CLINIC	88.00	0	33.16
33.17	HME NON PATIENT SALES	B	-15,412	DURABLE MEDICAL EQUIP-RENTED	96.00	0	33.17
33.18	HME HME OTHER REVENUE	B	-19,456	DURABLE MEDICAL EQUIP-RENTED	96.00	0	33.18
33.19	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.19
33.20	GRI FOOD/NUTRI GUEST MEAL VOUCHERS	B	-25	DIETARY	10.00	0	33.20
33.21	GRI MARKETING OTHER REVENUE	B	-144	ADMINISTRATIVE & GENERAL	5.00	0	33.21
33.22	NURSG SCHOOL(TUITN,FEES,BOOKS, ETC.)	B	-330,808	NURSING SCHOOL	20.00	0	33.22
33.23	DONATIONS & DUES	A	-26,715	ADMINISTRATIVE & GENERAL	5.00	0	33.23
33.24	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.24
33.25	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.25
33.26	CRNA CONTRACTED EXPENSE	A	-1,134,315	ANESTHESIOLOGY	53.00	0	33.26
33.27	IL PROVIDER PARTICIPATION FEE	A	10,950	SKILLED NURSING FACILITY	44.00	0	33.27
33.28	IL PROVIDER PARTICIPATION FEE	A	9,855	NURSING FACILITY	45.00	0	33.28
33.29	IL HOSPITAL PROVIDER TAX	A	-2,109,624	ADMINISTRATIVE & GENERAL	5.00	0	33.29
33.30	TELEVISION AND RADIO SERVICE	A	-4,348	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.30
33.31	PHONE SALARIES EXPENSE	A	-2,694	ADMINISTRATIVE & GENERAL	5.00	0	33.31
33.32	PHONE BENEFIT EXPENSE	A	-427	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.32
33.33	PHONE OTHER EXPENSE	A	-3,847	ADMINISTRATIVE & GENERAL	5.00	0	33.33
33.34	PHONE DEPREPATION M/M EXPENSE	A	-133	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.34
33.35	IHA & AHA DUES LOBBYING PORTION	A	-25,933	ADMINISTRATIVE & GENERAL	5.00	0	33.35
33.36	IL HEALTHCARE ASSOCIATION LOBBYING	A	-799	SKILLED NURSING FACILITY	44.00	0	33.36
33.37	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.37
33.38	MARKETING DEPT SALARY EXPENSE	A	-133,195	ADMINISTRATIVE & GENERAL	5.00	0	33.38
33.39	MARKETING DEPT BENEIFT EXPENSE	A	-12,602	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.39

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-0001 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-8 | Date/Time Prepared: 11/12/2018 1:38 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.40	MARKETING DEPT OTHER EXPENSE	A	-225,417	ADMINISTRATIVE & GENERAL	5.00	0	33.40
33.41	MARKETING DEPRECIATION EXPENSE	A	-333	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.41
33.42	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.42
33.43	PHYSICIAN RECRUITMENT	A	-192,401	ADMINISTRATIVE & GENERAL	5.00	0	33.43
33.44	LOAN FORGIVENESS EXPENSE	A	-241,865	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.44
33.45	PHYSICIAN BENEFITS	A	-73,561	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.45
33.46	SELF INSURANCE COSTS	A	-3,270,124	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.46
33.47	SWAP INTEREST RATE EXPENSE	A	-531,335	CAP REL COSTS-BLDG & FIXT	1.00	11	33.47
33.48	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.48
33.49	GRI PHARMACY OTHER REVENUE	B	17	PHARMACY	15.00	0	33.49
33.50	GRI HME EMPLOYEE & GUEST REVENUE	B	-67,299	DURABLE MEDICAL EQUIP-RENTED	96.00	0	33.50
33.51	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.51
33.52	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.52
33.53	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.53
33.54	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.54
33.55	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.55
33.56	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.56
33.57	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.57
33.58	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.58
33.59	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.59
33.60	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.60
33.61	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.61
33.62	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.62
33.63	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.63
33.64	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.64
33.65	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.65
33.66	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.66
33.67	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.67
33.68	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.68
33.69	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.69
33.70	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.70
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-12,449,129				50.00

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 14-0001 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-8-2 | Date/Time Prepared: 11/12/2018 1:38 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	91.00	EMERGENCY	2,102,576	2,102,576	0	0	0	1.00
2.00	90.01	WOUND CLINIC	250,969	250,969	0	0	0	2.00
3.00	76.97	CARDIAC REHABILITATION	14,036	14,036	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	60.00	LABORATORY	55,200	55,200	0	0	0	5.00
6.00	60.00	LABORATORY	62,390	62,390	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	90.01	WOUND CLINIC	41,648	41,648	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
11.00	91.00	EMERGENCY	12,399	12,399	0	0	0	11.00
12.00	57.00	CT SCAN	200	200	0	0	0	12.00
13.00	5.00	ADMINISTRATIVE & GENERAL	27,095	27,095	0	0	0	13.00
14.00	90.01	WOUND CLINIC	17,393	17,393	0	0	0	14.00
200.00			2,583,906	2,583,906	0		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	91.00	EMERGENCY	0	0	0	0	0	1.00
2.00	90.01	WOUND CLINIC	0	0	0	0	0	2.00
3.00	76.97	CARDIAC REHABILITATION	0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	60.00	LABORATORY	0	0	0	0	0	5.00
6.00	60.00	LABORATORY	0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	90.01	WOUND CLINIC	0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
11.00	91.00	EMERGENCY	0	0	0	0	0	11.00
12.00	57.00	CT SCAN	0	0	0	0	0	12.00
13.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	0	0	13.00
14.00	90.01	WOUND CLINIC	0	0	0	0	0	14.00
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	91.00	EMERGENCY	0	0	0	2,102,576		1.00
2.00	90.01	WOUND CLINIC	0	0	0	250,969		2.00
3.00	76.97	CARDIAC REHABILITATION	0	0	0	14,036		3.00
4.00	0.00		0	0	0	0		4.00
5.00	60.00	LABORATORY	0	0	0	55,200		5.00
6.00	60.00	LABORATORY	0	0	0	62,390		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	90.01	WOUND CLINIC	0	0	0	41,648		9.00
10.00	0.00		0	0	0	0		10.00
11.00	91.00	EMERGENCY	0	0	0	12,399		11.00
12.00	57.00	CT SCAN	0	0	0	200		12.00
13.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	27,095		13.00
14.00	90.01	WOUND CLINIC	0	0	0	17,393		14.00
200.00			0	0	0	2,583,906		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0001 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B Part I | Date/Time Prepared: 11/12/2018 1:38 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS				
				BLDG & FIXT	NEW CARDIAC REHAB	MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	1.01	2.00	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	3,530,520	3,530,520				1.00
1.01	00101	NEW CAP REL COSTS-CARDIAC REHAB	3,832	0	3,832			1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2,527,275			2,527,275		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	5,762,124	20,912	0	406	5,783,442	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	12,051,999	382,470	0	1,073,417	1,274,737	5.00
7.00	00700	OPERATION OF PLANT	2,881,607	382,385	0	50,589	169,902	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	257,145	50,433	0	1,797	5,778	8.00
9.00	00900	HOUSEKEEPING	1,086,579	42,482	0	8,357	181,127	9.00
10.00	01000	DIETARY	261,816	98,376	0	16,331	55,673	10.00
11.00	01100	CAFETERIA	428,496	26,298	0	0	89,369	11.00
13.00	01300	NURSING ADMINISTRATION	473,395	30,029	0	4,262	92,667	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	6,638	0	0	1,816	0	14.00
15.00	01500	PHARMACY	692,975	22,491	0	93,315	153,664	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	732,425	83,620	0	1,233	89,639	16.00
20.00	02000	NURSING SCHOOL	893,975	293,728	0	22,197	212,483	20.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,053,372	202,654	0	95,433	544,224	30.00
31.00	03100	INTENSIVE CARE UNIT	814,525	35,358	0	30,135	151,873	31.00
43.00	04300	NURSERY	309,970	10,254	0	2,448	58,924	43.00
44.00	04400	SKILLED NURSING FACILITY	1,034,718	85,810	0	26,733	193,183	44.00
45.00	04500	NURSING FACILITY	677,479	61,862	0	2,650	129,113	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,639,305	199,299	0	407,843	360,315	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	78,123	30,386	0	0	15,776	52.00
53.00	05300	ANESTHESIOLOGY	28,174	11,965	0	8,461	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,679,067	110,284	0	321,664	176,274	54.00
57.00	05700	CT SCAN	266,960	0	0	35,834	13,715	57.00
58.00	05800	MRI	198,052	28,149	0	1,706	14,855	58.00
60.00	06000	LABORATORY	3,466,600	153,283	0	108,617	334,563	60.00
65.00	06500	RESPIRATORY THERAPY	645,803	1,842	0	12,813	119,652	65.00
66.00	06600	PHYSICAL THERAPY	1,922,700	118,517	0	8,561	6,491	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	853,388	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,418,319	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,609,870	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	208,786	26,053	3,832	30,147	35,458	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	12,404,919	525,717	0	74,813	875,307	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CLINIC	1,061,250	31,457	0	1,950	63,077	90.01
91.00	09100	EMERGENCY	1,478,447	124,025	0	27,654	247,906	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	954,878	0	0	44,711	81,137	96.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	69,395,506	3,190,139	3,832	2,515,893	5,746,882	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	16,560	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,979,322	59,578	0	1,283	27,500	192.00
192.01	19201	CANTON RHC RENTED SPACE	0	119,015	0	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.02	19302	FOUNDATION	0	0	0	0	0	193.02
194.00	07950	PHYSICIANS CLINIC	0	26,119	0	0	0	194.00
194.01	07951	PROCTOR CHEMICAL DEPENDENCY	0	0	0	0	0	194.01
194.02	07952	FRESENIUS	0	56,392	0	0	0	194.02
194.03	07953	RUCHFORD POB	7,397	0	0	0	0	194.03
194.04	07954	EP COLEMAN RENTAL SPACE	0	62,717	0	0	0	194.04
194.05	07955	FARMINGTON POB	0	0	0	0	0	194.05
194.06	07956	LEWISTON POB	0	0	0	0	0	194.06
194.07	07957	OTHER RENTAL PROPERTY	423	0	0	0	0	194.07
194.08	07958	KELLEY HOME	0	0	0	0	0	194.08
194.09	07959	EMPLOYEE PURCHASE	0	0	0	0	0	194.09
194.10	07960	RETAIL PHARMACY	1,373,028	0	0	0	0	194.10
194.11	07961	WELLNESS CENTER	59,579	0	0	10,099	9,060	194.11
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	72,815,255	3,530,520	3,832	2,527,275	5,783,442	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0001 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B Part I | Date/Time Prepared: 11/12/2018 1:38 pm

		Cost Center Description	Subtotal	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			4A	5.00	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-CARDIAC REHAB						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	14,782,623	14,782,623				5.00
7.00	00700	OPERATION OF PLANT	3,484,483	887,599	4,372,082			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	315,153	80,279	80,335	475,767		8.00
9.00	00900	HOUSEKEEPING	1,318,545	335,872	67,669	7,199	1,729,285	9.00
10.00	01000	DIETARY	432,196	110,093	156,702	0	99,543	10.00
11.00	01100	CAFETERIA	544,163	138,614	41,889	0	26,610	11.00
13.00	01300	NURSING ADMINISTRATION	600,353	152,927	47,832	0	30,385	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	8,454	2,153	0	0	0	14.00
15.00	01500	PHARMACY	962,445	245,163	35,826	0	22,758	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	906,917	231,018	133,197	0	45,221	16.00
20.00	02000	NURSING SCHOOL	1,422,383	362,322	467,875	843	297,212	20.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,895,683	992,343	322,806	157,571	205,059	30.00
31.00	03100	INTENSIVE CARE UNIT	1,031,891	262,853	56,321	18,540	35,777	31.00
43.00	04300	NURSERY	381,596	97,204	16,333	2,047	10,376	43.00
44.00	04400	SKILLED NURSING FACILITY	1,340,444	341,450	136,686	67,299	86,828	44.00
45.00	04500	NURSING FACILITY	871,104	221,895	98,539	45,725	62,596	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,606,762	918,747	317,461	54,971	201,664	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	124,285	31,659	48,401	0	30,746	52.00
53.00	05300	ANESTHESIOLOGY	48,600	12,380	19,058	0	12,106	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,287,289	582,639	175,670	28,894	97,327	54.00
57.00	05700	CT SCAN	316,509	80,624	0	0	0	57.00
58.00	05800	MRI	242,762	61,839	44,838	0	28,483	58.00
60.00	06000	LABORATORY	4,063,063	1,034,980	244,163	1,565	119,629	60.00
65.00	06500	RESPIRATORY THERAPY	780,110	198,717	2,934	0	1,864	65.00
66.00	06600	PHYSICAL THERAPY	2,056,269	523,791	188,785	33,156	59,486	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	853,388	217,383	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,418,319	361,287	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,609,870	664,810	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	304,276	77,508	41,500	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	13,880,756	3,535,858	837,405	16,084	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CLINIC	1,157,734	294,908	50,108	2,432	31,831	90.01
91.00	09100	EMERGENCY	1,878,032	478,389	197,558	39,441	125,496	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0					92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	1,080,726	275,292	0	0	0	96.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	69,007,183	13,812,596	3,829,891	475,767	1,630,997	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	16,560	4,218	26,379	0	11,574	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2,067,683	526,699	94,901	0	60,285	192.00
192.01	19201	CANTON RHC RENTED SPACE	119,015	30,317	189,578	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.02	19302	FOUNDATION	0	0	0	0	0	193.02
194.00	07950	PHYSICIANS CLINIC	26,119	6,653	41,605	0	26,429	194.00
194.01	07951	PROCTOR CHEMICAL DEPENDENCY	0	0	0	0	0	194.01
194.02	07952	FRESENIUS	56,392	14,365	89,826	0	0	194.02
194.03	07953	RUCHFORD POB	7,397	1,884	0	0	0	194.03
194.04	07954	EP COLEMAN RENTAL SPACE	62,717	15,976	99,902	0	0	194.04
194.05	07955	FARMINGTON POB	0	0	0	0	0	194.05
194.06	07956	LEWISTON POB	0	0	0	0	0	194.06
194.07	07957	OTHER RENTAL PROPERTY	423	108	0	0	0	194.07
194.08	07958	KELLEY HOME	0	0	0	0	0	194.08
194.09	07959	EMPLOYEE PURCHASE	0	0	0	0	0	194.09
194.10	07960	RETAIL PHARMACY	1,373,028	349,750	0	0	0	194.10
194.11	07961	WELLNESS CENTER	78,738	20,057	0	0	0	194.11
200.00		Cross Foot Adjustments	0					200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	72,815,255	14,782,623	4,372,082	475,767	1,729,285	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0001 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B Part I | Date/Time Prepared: 11/12/2018 1:38 pm

		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-CARDIAC REHAB						1.01
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	798,534					10.00
11.00	01100	CAFETERIA	0	751,276				11.00
13.00	01300	NURSING ADMINISTRATION	0	15,194	846,691			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	10,607		14.00
15.00	01500	PHARMACY	0	31,979	0	67	1,298,238	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	56,189	0	0	0	16.00
20.00	02000	NURSING SCHOOL	0	41,101	0	4	136	20.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	342,145	125,213	304,709	326	5,857	30.00
31.00	03100	INTENSIVE CARE UNIT	44,711	26,093	63,497	66	1,051	31.00
43.00	04300	NURSERY	0	14,240	34,652	42	16	43.00
44.00	04400	SKILLED NURSING FACILITY	164,698	45,821	111,507	68	855	44.00
45.00	04500	NURSING FACILITY	246,980	41,923	102,021	39	25	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	76,740	186,748	1,673	4,664	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	4,375	10,647	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	54	3	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	38,396	0	384	4,073	54.00
57.00	05700	CT SCAN	0	2,678	0	111	106	57.00
58.00	05800	MRI	0	4,322	0	41	0	58.00
60.00	06000	LABORATORY	0	111,610	0	191	244	60.00
65.00	06500	RESPIRATORY THERAPY	0	18,244	0	61	860	65.00
66.00	06600	PHYSICAL THERAPY	0	875	0	23	24	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	2,205	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	3,664	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	341	1,065,783	73.00
76.97	07697	CARDIAC REHABILITATION	0	8,989	0	5	88	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	403	201,642	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CLINIC	0	13,524	32,910	489	7,346	90.01
91.00	09100	EMERGENCY	0	73,770	0	320	5,411	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	30	54	96.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	798,534	751,276	846,691	10,607	1,298,238	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
192.01	19201	CANTON RHC RENTED SPACE	0	0	0	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.02	19302	FOUNDATION	0	0	0	0	0	193.02
194.00	07950	PHYSICIANS CLINIC	0	0	0	0	0	194.00
194.01	07951	PROCTOR CHEMICAL DEPENDENCY	0	0	0	0	0	194.01
194.02	07952	FRESENIUS	0	0	0	0	0	194.02
194.03	07953	RUCHFORD POB	0	0	0	0	0	194.03
194.04	07954	EP COLEMAN RENTAL SPACE	0	0	0	0	0	194.04
194.05	07955	FARMINGTON POB	0	0	0	0	0	194.05
194.06	07956	LEWISTON POB	0	0	0	0	0	194.06
194.07	07957	OTHER RENTAL PROPERTY	0	0	0	0	0	194.07
194.08	07958	KELLEY HOME	0	0	0	0	0	194.08
194.09	07959	EMPLOYEE PURCHASE	0	0	0	0	0	194.09
194.10	07960	RETAIL PHARMACY	0	0	0	0	0	194.10
194.11	07961	WELLNESS CENTER	0	0	0	0	0	194.11
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	798,534	751,276	846,691	10,607	1,298,238	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0001 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B Part I | Date/Time Prepared: 11/12/2018 1:38 pm

		Cost Center Description	MEDICAL RECORDS & LIBRARY	NURSING SCHOOL	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			16.00	20.00	24.00	25.00	26.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-CARDIAC REHAB						1.01
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	1,372,542					16.00
20.00	02000	NURSING SCHOOL	0	2,591,876				20.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	547,919	1,072,298	7,971,929	0	7,971,929	30.00
31.00	03100	INTENSIVE CARE UNIT	74,103	141,697	1,756,600	0	1,756,600	31.00
43.00	04300	NURSERY	39,997	0	596,503	0	596,503	43.00
44.00	04400	SKILLED NURSING FACILITY	28,543	464,180	2,788,379	0	2,788,379	44.00
45.00	04500	NURSING FACILITY	49,923	0	1,740,770	0	1,740,770	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	63,086	302,939	5,735,455	0	5,735,455	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	250,113	0	250,113	52.00
53.00	05300	ANESTHESIOLOGY	0	0	92,201	0	92,201	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	262,015	0	3,476,687	0	3,476,687	54.00
57.00	05700	CT SCAN	0	0	400,028	0	400,028	57.00
58.00	05800	MRI	0	0	382,285	0	382,285	58.00
60.00	06000	LABORATORY	163,877	0	5,739,322	0	5,739,322	60.00
65.00	06500	RESPIRATORY THERAPY	0	75,735	1,078,525	0	1,078,525	65.00
66.00	06600	PHYSICAL THERAPY	0	33,388	2,895,797	0	2,895,797	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	1,072,976	0	1,072,976	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	1,783,270	0	1,783,270	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	48,861	4,389,665	0	4,389,665	73.00
76.97	07697	CARDIAC REHABILITATION	0	39,089	471,455	0	471,455	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	309,453	18,781,601	0	18,781,601	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CLINIC	0	52,118	1,643,400	0	1,643,400	90.01
91.00	09100	EMERGENCY	143,079	52,118	2,993,614	0	2,993,614	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	1,356,102	0	1,356,102	96.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,372,542	2,591,876	67,396,677	0	67,396,677	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	58,731	0	58,731	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	2,749,568	0	2,749,568	192.00
192.01	19201	CANTON RHC RENTED SPACE	0	0	338,910	0	338,910	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.02	19302	FOUNDATION	0	0	0	0	0	193.02
194.00	07950	PHYSICIANS CLINIC	0	0	100,806	0	100,806	194.00
194.01	07951	PROCTOR CHEMICAL DEPENDENCY	0	0	0	0	0	194.01
194.02	07952	FRESENIUS	0	0	160,583	0	160,583	194.02
194.03	07953	RUCHFORD POB	0	0	9,281	0	9,281	194.03
194.04	07954	EP COLEMAN RENTAL SPACE	0	0	178,595	0	178,595	194.04
194.05	07955	FARMINGTON POB	0	0	0	0	0	194.05
194.06	07956	LEWISTON POB	0	0	0	0	0	194.06
194.07	07957	OTHER RENTAL PROPERTY	0	0	531	0	531	194.07
194.08	07958	KELLEY HOME	0	0	0	0	0	194.08
194.09	07959	EMPLOYEE PURCHASE	0	0	0	0	0	194.09
194.10	07960	RETAIL PHARMACY	0	0	1,722,778	0	1,722,778	194.10
194.11	07961	WELLNESS CENTER	0	0	98,795	0	98,795	194.11
200.00		Cross Foot Adjustments		0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,372,542	2,591,876	72,815,255	0	72,815,255	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0001 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B Part II | Date/Time Prepared: 11/12/2018 1:38 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS NEW CARDIAC REHAB	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	
			0	1.00	1.01	2.00	2A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-CARDIAC REHAB						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	20,912	0	406	21,318	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	382,470	0	1,073,417	1,455,887	5.00
7.00	00700	OPERATION OF PLANT	0	382,385	0	50,589	432,974	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	50,433	0	1,797	52,230	8.00
9.00	00900	HOUSEKEEPING	0	42,482	0	8,357	50,839	9.00
10.00	01000	DIETARY	0	98,376	0	16,331	114,707	10.00
11.00	01100	CAFETERIA	0	26,298	0	0	26,298	11.00
13.00	01300	NURSING ADMINISTRATION	0	30,029	0	4,262	34,291	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	1,816	1,816	14.00
15.00	01500	PHARMACY	0	22,491	0	93,315	115,806	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	83,620	0	1,233	84,853	16.00
20.00	02000	NURSING SCHOOL	0	293,728	0	22,197	315,925	20.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	202,654	0	95,433	298,087	30.00
31.00	03100	INTENSIVE CARE UNIT	0	35,358	0	30,135	65,493	31.00
43.00	04300	NURSERY	0	10,254	0	2,448	12,702	43.00
44.00	04400	SKILLED NURSING FACILITY	0	85,810	0	26,733	112,543	44.00
45.00	04500	NURSING FACILITY	0	61,862	0	2,650	64,512	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	199,299	0	407,843	607,142	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	30,386	0	0	30,386	52.00
53.00	05300	ANESTHESIOLOGY	0	11,965	0	8,461	20,426	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	110,284	0	321,664	431,948	54.00
57.00	05700	CT SCAN	0	0	0	35,834	35,834	57.00
58.00	05800	MRI	0	28,149	0	1,706	29,855	58.00
60.00	06000	LABORATORY	0	153,283	0	108,617	261,900	60.00
65.00	06500	RESPIRATORY THERAPY	0	1,842	0	12,813	14,655	65.00
66.00	06600	PHYSICAL THERAPY	0	118,517	0	8,561	127,078	66.00
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
76.97	07697	CARDIAC REHABILITATION	0	26,053	3,832	30,147	60,032	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	525,717	0	74,813	600,530	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CLINIC	0	31,457	0	1,950	33,407	90.01
91.00	09100	EMERGENCY	0	124,025	0	27,654	151,679	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	44,711	44,711	96.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	3,190,139	3,832	2,515,893	5,709,864	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	16,560	0	0	16,560	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	59,578	0	1,283	60,861	192.00
192.01	19201	CANTON RHC RENTED SPACE	0	119,015	0	0	119,015	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.02	19302	FOUNDATION	0	0	0	0	0	193.02
194.00	07950	PHYSICIANS CLINIC	0	26,119	0	0	26,119	194.00
194.01	07951	PROCTOR CHEMICAL DEPENDENCY	0	0	0	0	0	194.01
194.02	07952	FRESENIUS	0	56,392	0	0	56,392	194.02
194.03	07953	RUCHFORD POB	0	0	0	0	0	194.03
194.04	07954	EP COLEMAN RENTAL SPACE	0	62,717	0	0	62,717	194.04
194.05	07955	FARMINGTON POB	0	0	0	0	0	194.05
194.06	07956	LEWISTON POB	0	0	0	0	0	194.06
194.07	07957	OTHER RENTAL PROPERTY	0	0	0	0	0	194.07
194.08	07958	KELLEY HOME	0	0	0	0	0	194.08
194.09	07959	EMPLOYEE PURCHASE	0	0	0	0	0	194.09
194.10	07960	RETAIL PHARMACY	0	0	0	0	0	194.10
194.11	07961	WELLNESS CENTER	0	0	0	10,099	10,099	194.11
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	3,530,520	3,832	2,527,275	6,061,627	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0001 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B Part II | Date/Time Prepared: 11/12/2018 1:38 pm

		Cost Center Description	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			4.00	5.00	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-CARDIAC REHAB						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	21,318					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	4,702	1,460,589				5.00
7.00	00700	OPERATION OF PLANT	626	87,697	521,297			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	21	7,932	9,579	69,762		8.00
9.00	00900	HOUSEKEEPING	667	33,185	8,068	1,056	93,815	9.00
10.00	01000	DIETARY	205	10,878	18,684	0	5,400	10.00
11.00	01100	CAFETERIA	329	13,695	4,995	0	1,444	11.00
13.00	01300	NURSING ADMINISTRATION	342	15,110	5,703	0	1,648	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	213	0	0	0	14.00
15.00	01500	PHARMACY	566	24,223	4,272	0	1,235	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	330	22,825	15,882	0	2,453	16.00
20.00	02000	NURSING SCHOOL	783	35,799	55,786	124	16,124	20.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,006	98,047	38,489	23,104	11,125	30.00
31.00	03100	INTENSIVE CARE UNIT	560	25,971	6,715	2,719	1,941	31.00
43.00	04300	NURSERY	217	9,604	1,947	300	563	43.00
44.00	04400	SKILLED NURSING FACILITY	712	33,736	16,297	9,868	4,710	44.00
45.00	04500	NURSING FACILITY	476	21,924	11,749	6,705	3,396	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,328	90,775	37,852	8,060	10,940	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	58	3,128	5,771	0	1,668	52.00
53.00	05300	ANESTHESIOLOGY	0	1,223	2,272	0	657	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	650	57,566	20,946	4,237	5,280	54.00
57.00	05700	CT SCAN	51	7,966	0	0	0	57.00
58.00	05800	MRI	55	6,110	5,346	0	1,545	58.00
60.00	06000	LABORATORY	1,233	102,259	29,112	229	6,490	60.00
65.00	06500	RESPIRATORY THERAPY	441	19,634	350	0	101	65.00
66.00	06600	PHYSICAL THERAPY	24	51,752	22,509	4,862	3,227	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	21,478	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	35,696	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	65,685	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	131	7,658	4,948	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	3,226	349,376	99,848	2,358	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CLINIC	232	29,138	5,975	357	1,727	90.01
91.00	09100	EMERGENCY	914	47,266	23,555	5,783	6,808	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	299	27,200	0	0	0	96.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	21,184	1,364,749	456,650	69,762	88,482	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	417	3,145	0	628	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	101	52,039	11,315	0	3,271	192.00
192.01	19201	CANTON RHC RENTED SPACE	0	2,995	22,604	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.02	19302	FOUNDATION	0	0	0	0	0	193.02
194.00	07950	PHYSICIANS CLINIC	0	657	4,961	0	1,434	194.00
194.01	07951	PROCTOR CHEMICAL DEPENDENCY	0	0	0	0	0	194.01
194.02	07952	FRESENIUS	0	1,419	10,710	0	0	194.02
194.03	07953	RUCHFORD POB	0	186	0	0	0	194.03
194.04	07954	EP COLEMAN RENTAL SPACE	0	1,578	11,912	0	0	194.04
194.05	07955	FARMINGTON POB	0	0	0	0	0	194.05
194.06	07956	LEWISTON POB	0	0	0	0	0	194.06
194.07	07957	OTHER RENTAL PROPERTY	0	11	0	0	0	194.07
194.08	07958	KELLEY HOME	0	0	0	0	0	194.08
194.09	07959	EMPLOYEE PURCHASE	0	0	0	0	0	194.09
194.10	07960	RETAIL PHARMACY	0	34,556	0	0	0	194.10
194.11	07961	WELLNESS CENTER	33	1,982	0	0	0	194.11
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	21,318	1,460,589	521,297	69,762	93,815	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0001 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B Part II | Date/Time Prepared: 11/12/2018 1:38 pm

		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-CARDIAC REHAB						1.01
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	149,874					10.00
11.00	01100	CAFETERIA	0	46,761				11.00
13.00	01300	NURSING ADMINISTRATION	0	946	58,040			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	2,029		14.00
15.00	01500	PHARMACY	0	1,990	0	13	148,105	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	3,497	0	0	0	16.00
20.00	02000	NURSING SCHOOL	0	2,558	0	1	16	20.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	64,215	7,794	20,888	62	668	30.00
31.00	03100	INTENSIVE CARE UNIT	8,392	1,624	4,353	13	120	31.00
43.00	04300	NURSERY	0	886	2,375	8	2	43.00
44.00	04400	SKILLED NURSING FACILITY	30,912	2,852	7,644	13	98	44.00
45.00	04500	NURSING FACILITY	46,355	2,609	6,993	7	3	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	4,776	12,801	320	532	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	272	730	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	10	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,390	0	73	465	54.00
57.00	05700	CT SCAN	0	167	0	21	12	57.00
58.00	05800	MRI	0	269	0	8	0	58.00
60.00	06000	LABORATORY	0	6,947	0	36	28	60.00
65.00	06500	RESPIRATORY THERAPY	0	1,136	0	12	98	65.00
66.00	06600	PHYSICAL THERAPY	0	54	0	4	3	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	422	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	703	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	65	121,585	73.00
76.97	07697	CARDIAC REHABILITATION	0	560	0	1	10	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	77	23,004	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CLINIC	0	842	2,256	93	838	90.01
91.00	09100	EMERGENCY	0	4,592	0	61	617	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	6	6	96.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	149,874	46,761	58,040	2,029	148,105	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
192.01	19201	CANTON RHC RENTED SPACE	0	0	0	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.02	19302	FOUNDATION	0	0	0	0	0	193.02
194.00	07950	PHYSICIANS CLINIC	0	0	0	0	0	194.00
194.01	07951	PROCTOR CHEMICAL DEPENDENCY	0	0	0	0	0	194.01
194.02	07952	FRESENIUS	0	0	0	0	0	194.02
194.03	07953	RUCHFORD POB	0	0	0	0	0	194.03
194.04	07954	EP COLEMAN RENTAL SPACE	0	0	0	0	0	194.04
194.05	07955	FARMINGTON POB	0	0	0	0	0	194.05
194.06	07956	LEWISTON POB	0	0	0	0	0	194.06
194.07	07957	OTHER RENTAL PROPERTY	0	0	0	0	0	194.07
194.08	07958	KELLEY HOME	0	0	0	0	0	194.08
194.09	07959	EMPLOYEE PURCHASE	0	0	0	0	0	194.09
194.10	07960	RETAIL PHARMACY	0	0	0	0	0	194.10
194.11	07961	WELLNESS CENTER	0	0	0	0	0	194.11
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	149,874	46,761	58,040	2,029	148,105	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0001 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B Part II | Date/Time Prepared: 11/12/2018 1:38 pm

		Cost Center Description	MEDICAL RECORDS & LIBRARY	NURSING SCHOOL	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			16.00	20.00	24.00	25.00	26.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-CARDIAC REHAB						1.01
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	129,840					16.00
20.00	02000	NURSING SCHOOL	0	427,116				20.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	51,831		616,316	0	616,316	30.00
31.00	03100	INTENSIVE CARE UNIT	7,010		124,911	0	124,911	31.00
43.00	04300	NURSERY	3,784		32,388	0	32,388	43.00
44.00	04400	SKILLED NURSING FACILITY	2,700		222,085	0	222,085	44.00
45.00	04500	NURSING FACILITY	4,723		169,452	0	169,452	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,968		780,494	0	780,494	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0		42,013	0	42,013	52.00
53.00	05300	ANESTHESIOLOGY	0		24,588	0	24,588	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	24,786		548,341	0	548,341	54.00
57.00	05700	CT SCAN	0		44,051	0	44,051	57.00
58.00	05800	MRI	0		43,188	0	43,188	58.00
60.00	06000	LABORATORY	15,503		423,737	0	423,737	60.00
65.00	06500	RESPIRATORY THERAPY	0		36,427	0	36,427	65.00
66.00	06600	PHYSICAL THERAPY	0		209,513	0	209,513	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0		21,900	0	21,900	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0		36,399	0	36,399	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0		187,335	0	187,335	73.00
76.97	07697	CARDIAC REHABILITATION	0		73,340	0	73,340	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0		1,078,419	0	1,078,419	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0	89.00
90.00	09000	CLINIC	0		0	0	0	90.00
90.01	09001	WOUND CLINIC	0		74,865	0	74,865	90.01
91.00	09100	EMERGENCY	13,535		254,810	0	254,810	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0		72,222	0	72,222	96.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	129,840	0	5,116,794	0	5,116,794	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		20,750	0	20,750	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0		127,587	0	127,587	192.00
192.01	19201	CANTON RHC RENTED SPACE	0		144,614	0	144,614	192.01
193.00	19300	NONPAID WORKERS	0		0	0	0	193.00
193.02	19302	FOUNDATION	0		0	0	0	193.02
194.00	07950	PHYSICIANS CLINIC	0		33,171	0	33,171	194.00
194.01	07951	PROCTOR CHEMICAL DEPENDENCY	0		0	0	0	194.01
194.02	07952	FRESENIUS	0		68,521	0	68,521	194.02
194.03	07953	RUCHFORD POB	0		186	0	186	194.03
194.04	07954	EP COLEMAN RENTAL SPACE	0		76,207	0	76,207	194.04
194.05	07955	FARMINGTON POB	0		0	0	0	194.05
194.06	07956	LEWISTON POB	0		0	0	0	194.06
194.07	07957	OTHER RENTAL PROPERTY	0		11	0	11	194.07
194.08	07958	KELLEY HOME	0		0	0	0	194.08
194.09	07959	EMPLOYEE PURCHASE	0		0	0	0	194.09
194.10	07960	RETAIL PHARMACY	0		34,556	0	34,556	194.10
194.11	07961	WELLNESS CENTER	0		12,114	0	12,114	194.11
200.00		Cross Foot Adjustments		427,116	427,116	0	427,116	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	129,840	427,116	6,061,627	0	6,061,627	202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0001 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B-1 | Date/Time Prepared: 11/12/2018 1:38 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	NEW CARDIAC REHAB (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIE)	Reconciliation	
			1.00	1.01	2.00	4.00	5A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	375,640					1.00
1.01	00101	NEW CAP REL COSTS-CARDIAC REHAB	0	30,653				1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2,512,944			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,225	0	404	28,493,763		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	40,694	0	1,067,331	6,280,327	-14,782,623	5.00
7.00	00700	OPERATION OF PLANT	40,685	0	50,302	837,071	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	5,366	0	1,787	28,469	0	8.00
9.00	00900	HOUSEKEEPING	4,520	0	8,310	892,374	0	9.00
10.00	01000	DIETARY	10,467	0	16,238	274,287	0	10.00
11.00	01100	CAFETERIA	2,798	0	0	440,302	0	11.00
13.00	01300	NURSING ADMINISTRATION	3,195	0	4,238	456,551	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	1,806	0	0	14.00
15.00	01500	PHARMACY	2,393	0	92,786	757,069	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	8,897	0	1,226	441,630	0	16.00
20.00	02000	NURSING SCHOOL	31,252	0	22,071	1,046,861	0	20.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	21,562	0	94,892	2,681,275	0	30.00
31.00	03100	INTENSIVE CARE UNIT	3,762	0	29,964	748,248	0	31.00
43.00	04300	NURSERY	1,091	0	2,434	290,305	0	43.00
44.00	04400	SKILLED NURSING FACILITY	9,130	0	26,581	951,774	0	44.00
45.00	04500	NURSING FACILITY	6,582	0	2,635	636,111	0	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	21,205	0	405,530	1,775,197	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,233	0	0	77,724	0	52.00
53.00	05300	ANESTHESIOLOGY	1,273	0	8,413	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	11,734	0	319,840	868,465	0	54.00
57.00	05700	CT SCAN	0	0	35,631	67,572	0	57.00
58.00	05800	MRI	2,995	0	1,696	73,187	0	58.00
60.00	06000	LABORATORY	16,309	0	108,001	1,648,323	0	60.00
65.00	06500	RESPIRATORY THERAPY	196	0	12,740	589,499	0	65.00
66.00	06600	PHYSICAL THERAPY	12,610	0	8,512	31,982	0	66.00
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
76.97	07697	CARDIAC REHABILITATION	2,772	30,653	29,976	174,693	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	55,935	0	74,389	4,312,453	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CLINIC	3,347	0	1,939	310,767	0	90.01
91.00	09100	EMERGENCY	13,196	0	27,497	1,221,378	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	44,457	399,745	0	96.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	339,424	30,653	2,501,626	28,313,639	-14,782,623	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,762	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	6,339	0	1,276	135,485	0	192.00
192.01	19201	CANTON RHC RENTED SPACE	12,663	0	0	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.02	19302	FOUNDATION	0	0	0	0	0	193.02
194.00	07950	PHYSICIANS CLINIC	2,779	0	0	0	0	194.00
194.01	07951	PROCTOR CHEMICAL DEPENDENCY	0	0	0	0	0	194.01
194.02	07952	FRESENIUS	6,000	0	0	0	0	194.02
194.03	07953	RUCHFORD POB	0	0	0	0	0	194.03
194.04	07954	EP COLEMAN RENTAL SPACE	6,673	0	0	0	0	194.04
194.05	07955	FARMINGTON POB	0	0	0	0	0	194.05
194.06	07956	LEWISTON POB	0	0	0	0	0	194.06
194.07	07957	OTHER RENTAL PROPERTY	0	0	0	0	0	194.07
194.08	07958	KELLEY HOME	0	0	0	0	0	194.08
194.09	07959	EMPLOYEE PURCHASE	0	0	0	0	0	194.09
194.10	07960	RETAIL PHARMACY	0	0	0	0	0	194.10
194.11	07961	WELLNESS CENTER	0	0	10,042	44,639	0	194.11
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0001 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B-1 | Date/Time Prepared: 11/12/2018 1:38 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	NEW CARDIAC REHAB (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIE)	Reconciliation	
			1.00	1.01	2.00	4.00	5A	
202.00		Cost to be allocated (per Wkst. B, Part I)	3,530,520	3,832	2,527,275	5,783,442		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	9.398680	0.125012	1.005703	0.202972		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)				21,318		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)				0.000748		205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0001 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B-1 | Date/Time Prepared: 11/12/2018 1:38 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-CARDIAC REHAB						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	58,032,632					5.00
7.00	00700	OPERATION OF PLANT	3,484,483	292,036				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	315,153	5,366	1,027,468			8.00
9.00	00900	HOUSEKEEPING	1,318,545	4,520	15,548	181,835		9.00
10.00	01000	DIETARY	432,196	10,467	0	10,467	54,240	10.00
11.00	01100	CAFETERIA	544,163	2,798	0	2,798	0	11.00
13.00	01300	NURSING ADMINISTRATION	600,353	3,195	0	3,195	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	8,454	0	0	0	0	14.00
15.00	01500	PHARMACY	962,445	2,393	0	2,393	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	906,917	8,897	0	4,755	0	16.00
20.00	02000	NURSING SCHOOL	1,422,383	31,252	1,820	31,252	0	20.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,895,683	21,562	340,288	21,562	23,240	30.00
31.00	03100	INTENSIVE CARE UNIT	1,031,891	3,762	40,040	3,762	3,037	31.00
43.00	04300	NURSERY	381,596	1,091	4,420	1,091	0	43.00
44.00	04400	SKILLED NURSING FACILITY	1,340,444	9,130	145,340	9,130	11,187	44.00
45.00	04500	NURSING FACILITY	871,104	6,582	98,748	6,582	16,776	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,606,762	21,205	118,716	21,205	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	124,285	3,233	0	3,233	0	52.00
53.00	05300	ANESTHESIOLOGY	48,600	1,273	0	1,273	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,287,289	11,734	62,400	10,234	0	54.00
57.00	05700	CT SCAN	316,509	0	0	0	0	57.00
58.00	05800	MRI	242,762	2,995	0	2,995	0	58.00
60.00	06000	LABORATORY	4,063,063	16,309	3,380	12,579	0	60.00
65.00	06500	RESPIRATORY THERAPY	780,110	196	0	196	0	65.00
66.00	06600	PHYSICAL THERAPY	2,056,269	12,610	71,604	6,255	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	853,388	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,418,319	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,609,870	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	304,276	2,772	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	13,880,756	55,935	34,736	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CLINIC	1,157,734	3,347	5,252	3,347	0	90.01
91.00	09100	EMERGENCY	1,878,032	13,196	85,176	13,196	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	1,080,726	0	0	0	0	96.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	54,224,560	255,820	1,027,468	171,500	54,240	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	16,560	1,762	0	1,217	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2,067,683	6,339	0	6,339	0	192.00
192.01	19201	CANTON RHC RENTED SPACE	119,015	12,663	0	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.02	19302	FOUNDATION	0	0	0	0	0	193.02
194.00	07950	PHYSICIANS CLINIC	26,119	2,779	0	2,779	0	194.00
194.01	07951	PROCTOR CHEMICAL DEPENDENCY	0	0	0	0	0	194.01
194.02	07952	FRESENIUS	56,392	6,000	0	0	0	194.02
194.03	07953	RUCHFORD POB	7,397	0	0	0	0	194.03
194.04	07954	EP COLEMAN RENTAL SPACE	62,717	6,673	0	0	0	194.04
194.05	07955	FARMINGTON POB	0	0	0	0	0	194.05
194.06	07956	LEWISTON POB	0	0	0	0	0	194.06
194.07	07957	OTHER RENTAL PROPERTY	423	0	0	0	0	194.07
194.08	07958	KELLEY HOME	0	0	0	0	0	194.08
194.09	07959	EMPLOYEE PURCHASE	0	0	0	0	0	194.09
194.10	07960	RETAIL PHARMACY	1,373,028	0	0	0	0	194.10
194.11	07961	WELLNESS CENTER	78,738	0	0	0	0	194.11
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)	14,782,623	4,372,082	475,767	1,729,285	798,534	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.254729	14.971038	0.463048	9.510188	14.722235	203.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0001 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B-1 | Date/Time Prepared: 11/12/2018 1:38 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	
			5.00	7.00	8.00	9.00	10.00	
204.00		Cost to be allocated (per Wkst. B, Part II)	1,460,589	521,297	69,762	93,815	149,874	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.025168	1.785044	0.067897	0.515935	2.763164	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0001 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B-1 | Date/Time Prepared: 11/12/2018 1:38 pm

		Cost Center Description	CAFETERIA (FTES)	NURSING ADMINISTRATION (FTES)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-CARDIAC REHAB						1.01
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	28,332					11.00
13.00	01300	NURSING ADMINISTRATION	573	13,121				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	4,105,277			14.00
15.00	01500	PHARMACY	1,206	0	25,909	4,430,330		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,119	0	63	0	37,748	16.00
20.00	02000	NURSING SCHOOL	1,550	0	1,583	465	0	20.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,722	4,722	126,296	19,989	15,069	30.00
31.00	03100	INTENSIVE CARE UNIT	984	984	25,390	3,587	2,038	31.00
43.00	04300	NURSERY	537	537	16,299	56	1,100	43.00
44.00	04400	SKILLED NURSING FACILITY	1,728	1,728	26,144	2,919	785	44.00
45.00	04500	NURSING FACILITY	1,581	1,581	15,068	85	1,373	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,894	2,894	647,343	15,917	1,735	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	165	165	6	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	20,847	10	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,448	0	148,776	13,898	7,206	54.00
57.00	05700	CT SCAN	101	0	42,837	362	0	57.00
58.00	05800	MRI	163	0	16,017	0	0	58.00
60.00	06000	LABORATORY	4,209	0	73,838	833	4,507	60.00
65.00	06500	RESPIRATORY THERAPY	688	0	23,789	2,934	0	65.00
66.00	06600	PHYSICAL THERAPY	33	0	8,933	81	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	853,388	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	1,418,320	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	131,830	3,637,059	0	73.00
76.97	07697	CARDIAC REHABILITATION	339	0	1,943	301	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	155,803	688,118	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CLINIC	510	510	189,068	25,068	0	90.01
91.00	09100	EMERGENCY	2,782	0	123,995	18,465	3,935	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	11,649	183	0	96.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	28,332	13,121	4,105,134	4,430,330	37,748	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	143	0	0	192.00
192.01	19201	CANTON RHC RENTED SPACE	0	0	0	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.02	19302	FOUNDATION	0	0	0	0	0	193.02
194.00	07950	PHYSICIANS CLINIC	0	0	0	0	0	194.00
194.01	07951	PROCTOR CHEMICAL DEPENDENCY	0	0	0	0	0	194.01
194.02	07952	FRESENIUS	0	0	0	0	0	194.02
194.03	07953	RUCHFORD POB	0	0	0	0	0	194.03
194.04	07954	EP COLEMAN RENTAL SPACE	0	0	0	0	0	194.04
194.05	07955	FARMINGTON POB	0	0	0	0	0	194.05
194.06	07956	LEWISTON POB	0	0	0	0	0	194.06
194.07	07957	OTHER RENTAL PROPERTY	0	0	0	0	0	194.07
194.08	07958	KELLEY HOME	0	0	0	0	0	194.08
194.09	07959	EMPLOYEE PURCHASE	0	0	0	0	0	194.09
194.10	07960	RETAIL PHARMACY	0	0	0	0	0	194.10
194.11	07961	WELLNESS CENTER	0	0	0	0	0	194.11
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)	751,276	846,691	10,607	1,298,238	1,372,542	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	26.516871	64.529457	0.002584	0.293034	36.360655	203.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0001 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B-1 | Date/Time Prepared: 11/12/2018 1:38 pm

		Cost Center Description	CAFETERIA (FTES)	NURSING ADMINISTRATION (FTES)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	
			11.00	13.00	14.00	15.00	16.00	
204.00		Cost to be allocated (per Wkst. B, Part II)	46,761	58,040	2,029	148,105	129,840	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	1.650466	4.423443	0.000494	0.033430	3.439652	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0001 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B-1 | Date/Time Prepared: 11/12/2018 1:38 pm

		Cost Center Description	NURSING SCHOOL (ASSIGNED TIME)		
			20.00		
		GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
1.01	00101	NEW CAP REL COSTS-CARDIAC REHAB			1.01
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
20.00	02000	NURSING SCHOOL	318,275		20.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	131,675		30.00
31.00	03100	INTENSIVE CARE UNIT	17,400		31.00
43.00	04300	NURSERY	0		43.00
44.00	04400	SKILLED NURSING FACILITY	57,000		44.00
45.00	04500	NURSING FACILITY	0		45.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	37,200		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0		52.00
53.00	05300	ANESTHESIOLOGY	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0		54.00
57.00	05700	CT SCAN	0		57.00
58.00	05800	MRI	0		58.00
60.00	06000	LABORATORY	0		60.00
65.00	06500	RESPIRATORY THERAPY	9,300		65.00
66.00	06600	PHYSICAL THERAPY	4,100		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,000		73.00
76.97	07697	CARDIAC REHABILITATION	4,800		76.97
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	38,000		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0		89.00
90.00	09000	CLINIC	0		90.00
90.01	09001	WOUND CLINIC	6,400		90.01
91.00	09100	EMERGENCY	6,400		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
		OTHER REIMBURSABLE COST CENTERS			
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0		96.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	318,275		118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0		192.00
192.01	19201	CANTON RHC RENTED SPACE	0		192.01
193.00	19300	NONPAID WORKERS	0		193.00
193.02	19302	FOUNDATION	0		193.02
194.00	07950	PHYSICIANS CLINIC	0		194.00
194.01	07951	PROCTOR CHEMICAL DEPENDENCY	0		194.01
194.02	07952	FRESENIUS	0		194.02
194.03	07953	RUCHFORD POB	0		194.03
194.04	07954	EP COLEMAN RENTAL SPACE	0		194.04
194.05	07955	FARMINGTON POB	0		194.05
194.06	07956	LEWISTON POB	0		194.06
194.07	07957	OTHER RENTAL PROPERTY	0		194.07
194.08	07958	KELLEY HOME	0		194.08
194.09	07959	EMPLOYEE PURCHASE	0		194.09
194.10	07960	RETAIL PHARMACY	0		194.10
194.11	07961	WELLNESS CENTER	0		194.11
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)	2,591,876		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	8.143511		203.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0001 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B-1 | Date/Time Prepared: 11/12/2018 1:38 pm

		Cost Center Description	NURSING SCHOOL (ASSIGNED TIME)		
			20.00		
204.00		Cost to be allocated (per Wkst. B, Part II)	427,116		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	1.341972		205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)	0		206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)	0.000000		207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0001 | Period: From 07/01/2017 To 06/30/2018 | Worksheet C Part I Date/Time Prepared: 11/12/2018 1:38 pm

Title XVIII | 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	7,971,929		7,971,929	0	7,971,929	30.00
31.00	03100	INTENSIVE CARE UNIT	1,756,600		1,756,600	0	1,756,600	31.00
43.00	04300	NURSERY	596,503		596,503	0	596,503	43.00
44.00	04400	SKILLED NURSING FACILITY	2,788,379		2,788,379	0	2,788,379	44.00
45.00	04500	NURSING FACILITY	1,740,770		1,740,770	0	1,740,770	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,735,455		5,735,455	0	5,735,455	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	250,113		250,113	0	250,113	52.00
53.00	05300	ANESTHESIOLOGY	92,201		92,201	0	92,201	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,476,687		3,476,687	0	3,476,687	54.00
57.00	05700	CT SCAN	400,028		400,028	0	400,028	57.00
58.00	05800	MRI	382,285		382,285	0	382,285	58.00
60.00	06000	LABORATORY	5,739,322		5,739,322	0	5,739,322	60.00
65.00	06500	RESPIRATORY THERAPY	1,078,525	0	1,078,525	0	1,078,525	65.00
66.00	06600	PHYSICAL THERAPY	2,895,797	0	2,895,797	0	2,895,797	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,072,976		1,072,976	0	1,072,976	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,783,270		1,783,270	0	1,783,270	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,389,665		4,389,665	0	4,389,665	73.00
76.97	07697	CARDIAC REHABILITATION	471,455		471,455	0	471,455	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	18,781,601		18,781,601	0	18,781,601	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0	89.00
90.00	09000	CLINIC	0		0	0	0	90.00
90.01	09001	WOUND CLINIC	1,643,400		1,643,400	0	1,643,400	90.01
91.00	09100	EMERGENCY	2,993,614		2,993,614	0	2,993,614	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,201,427		1,201,427		1,201,427	92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	1,356,102		1,356,102	0	1,356,102	96.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	68,598,104	0	68,598,104	0	68,598,104	200.00
201.00		Less Observation Beds	1,201,427		1,201,427		1,201,427	201.00
202.00		Total (see instructions)	67,396,677	0	67,396,677	0	67,396,677	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0001 | Period: From 07/01/2017 To 06/30/2018 | Worksheet C Part I Date/Time Prepared: 11/12/2018 1:38 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	10,948,621		10,948,621			30.00
31.00	03100	INTENSIVE CARE UNIT	2,771,893		2,771,893			31.00
43.00	04300	NURSERY	306,523		306,523			43.00
44.00	04400	SKILLED NURSING FACILITY	1,796,818		1,796,818			44.00
45.00	04500	NURSING FACILITY	1,055,730		1,055,730			45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	7,472,109	19,423,563	26,895,672	0.213248	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	643,126	143,638	786,764	0.317901	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	1,289,077	2,439,475	3,728,552	0.024728	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,499,021	18,523,918	21,022,939	0.165376	0.000000	54.00
57.00	05700	CT SCAN	2,313,415	14,273,764	16,587,179	0.024117	0.000000	57.00
58.00	05800	MRI	363,622	5,299,465	5,663,087	0.067505	0.000000	58.00
60.00	06000	LABORATORY	6,581,313	24,161,405	30,742,718	0.186689	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	4,767,251	2,347,891	7,115,142	0.151582	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	3,208,638	5,282,947	8,491,585	0.341020	0.000000	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,327,980	2,184,305	4,512,285	0.237790	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,411,273	1,030,298	4,441,571	0.401495	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	7,240,776	5,263,772	12,504,548	0.351045	0.000000	73.00
76.97	07697	CARDIAC REHABILITATION	412	1,023,479	1,023,891	0.460454	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	30,888,579	30,888,579			88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0			89.00
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
90.01	09001	WOUND CLINIC	34,079	5,405,706	5,439,785	0.302108	0.000000	90.01
91.00	09100	EMERGENCY	3,420,078	15,027,048	18,447,126	0.162281	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	385,265	1,191,737	1,577,002	0.761842	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	3,448,714	3,448,714	0.393220	0.000000	96.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	62,837,020	157,359,704	220,196,724			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	62,837,020	157,359,704	220,196,724			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0001 | Period: From 07/01/2017 To 06/30/2018 | Worksheet C Part I Date/Time Prepared: 11/12/2018 1:38 pm

Title XVIII | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
43.00	04300	NURSERY		43.00
44.00	04400	SKILLED NURSING FACILITY		44.00
45.00	04500	NURSING FACILITY		45.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.213248	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.317901	52.00
53.00	05300	ANESTHESIOLOGY	0.024728	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.165376	54.00
57.00	05700	CT SCAN	0.024117	57.00
58.00	05800	MRI	0.067505	58.00
60.00	06000	LABORATORY	0.186689	60.00
65.00	06500	RESPIRATORY THERAPY	0.151582	65.00
66.00	06600	PHYSICAL THERAPY	0.341020	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.237790	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.401495	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.351045	73.00
76.97	07697	CARDIAC REHABILITATION	0.460454	76.97
		OUTPATIENT SERVICE COST CENTERS		
88.00	08800	RURAL HEALTH CLINIC		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER		89.00
90.00	09000	CLINIC	0.000000	90.00
90.01	09001	WOUND CLINIC	0.302108	90.01
91.00	09100	EMERGENCY	0.162281	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.761842	92.00
		OTHER REIMBURSABLE COST CENTERS		
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.393220	96.00
		SPECIAL PURPOSE COST CENTERS		
113.00	11300	INTEREST EXPENSE		113.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 14-0001 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part I Date/Time Prepared: 11/12/2018 1:38 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	616,316	0	616,316	7,571	81.40	30.00
31.00	INTENSIVE CARE UNIT	124,911		124,911	993	125.79	31.00
43.00	NURSERY	32,388		32,388	463	69.95	43.00
44.00	SKILLED NURSING FACILITY	222,085		222,085	3,729	59.56	44.00
45.00	NURSING FACILITY	169,452		169,452	5,592	30.30	45.00
200.00	Total (lines 30 through 199)	1,165,152		1,165,152	18,348		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	3,094	251,852				30.00
31.00	INTENSIVE CARE UNIT	594	74,719				31.00
43.00	NURSERY	0	0				43.00
44.00	SKILLED NURSING FACILITY	2,503	149,079				44.00
45.00	NURSING FACILITY	0	0				45.00
200.00	Total (lines 30 through 199)	6,191	475,650				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 14-0001 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part II Date/Time Prepared: 11/12/2018 1:38 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	780,494	26,895,672	0.029019	3,080,958	89,406	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	42,013	786,764	0.053400	0	0	52.00
53.00	05300	ANESTHESIOLOGY	24,588	3,728,552	0.006595	438,606	2,893	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	548,341	21,022,939	0.026083	1,043,080	27,207	54.00
57.00	05700	CT SCAN	44,051	16,587,179	0.002656	1,218,364	3,236	57.00
58.00	05800	MRI	43,188	5,663,087	0.007626	157,787	1,203	58.00
60.00	06000	LABORATORY	423,737	30,742,718	0.013783	2,681,377	36,957	60.00
65.00	06500	RESPIRATORY THERAPY	36,427	7,115,142	0.005120	1,267,128	6,488	65.00
66.00	06600	PHYSICAL THERAPY	209,513	8,491,585	0.024673	546,957	13,495	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	21,900	4,512,285	0.004853	1,367,649	6,637	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	36,399	4,441,571	0.008195	1,477,646	12,109	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	187,335	12,504,548	0.014981	3,074,951	46,066	73.00
76.97	07697	CARDIAC REHABILITATION	73,340	1,023,891	0.071629	412	30	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,078,419	30,888,579	0.034913	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
90.01	09001	WOUND CLINIC	74,865	5,439,785	0.013762	14,081	194	90.01
91.00	09100	EMERGENCY	254,810	18,447,126	0.013813	1,787,940	24,697	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	92,884	1,577,002	0.058899	209,478	12,338	92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	72,222	3,448,714	0.020942	0	0	96.00
200.00		Total (lines 50 through 199)	4,044,526	203,317,139		18,366,414	282,956	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 14-0001 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part III Date/Time Prepared: 11/12/2018 1:38 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
			1A	1.00	2A	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	1,072,298	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	141,697	0	0	0	31.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	464,180	0	0		44.00
45.00	04500	NURSING FACILITY	0	0	0	0		45.00
200.00		Total (lines 30 through 199)	0	1,678,175	0	0	0	200.00

		Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
			4.00	5.00	6.00	7.00	8.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	1,072,298	7,571	141.63	3,094	30.00
31.00	03100	INTENSIVE CARE UNIT		141,697	993	142.70	594	31.00
43.00	04300	NURSERY		0	463	0.00	0	43.00
44.00	04400	SKILLED NURSING FACILITY		464,180	3,729	124.48	2,503	44.00
45.00	04500	NURSING FACILITY		0	5,592	0.00	0	45.00
200.00		Total (lines 30 through 199)		1,678,175	18,348		6,191	200.00

		Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
			9.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS	438,203	30.00
31.00	03100	INTENSIVE CARE UNIT	84,764	31.00
43.00	04300	NURSERY	0	43.00
44.00	04400	SKILLED NURSING FACILITY	311,573	44.00
45.00	04500	NURSING FACILITY	0	45.00
200.00		Total (lines 30 through 199)	834,540	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0001 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part IV | Date/Time Prepared: 11/12/2018 1:38 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	302,939	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	75,735	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	33,388	0	0	66.00
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	48,861	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	39,089	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	309,453	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CLINIC	0	0	52,118	0	0	90.01
91.00	09100	EMERGENCY	0	0	52,118	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		161,603		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
200.00		Total (lines 50 through 199)	0	0	1,075,304	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 14-0001 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part IV Date/Time Prepared: 11/12/2018 1:38 pm

Title XVIII | Hospital | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	302,939	302,939	26,895,672	0.011263	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	786,764	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	3,728,552	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	21,022,939	0.000000	54.00
57.00	05700	CT SCAN	0	0	0	16,587,179	0.000000	57.00
58.00	05800	MRI	0	0	0	5,663,087	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	30,742,718	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	75,735	75,735	7,115,142	0.010644	65.00
66.00	06600	PHYSICAL THERAPY	0	33,388	33,388	8,491,585	0.003932	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	4,512,285	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	4,441,571	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	48,861	48,861	12,504,548	0.003907	73.00
76.97	07697	CARDIAC REHABILITATION	0	39,089	39,089	1,023,891	0.038177	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	309,453	309,453	30,888,579	0.010018	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0.000000	89.00
90.00	09000	CLINIC	0	0	0	0	0.000000	90.00
90.01	09001	WOUND CLINIC	0	52,118	52,118	5,439,785	0.009581	90.01
91.00	09100	EMERGENCY	0	52,118	52,118	18,447,126	0.002825	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	161,603	161,603	1,577,002	0.102475	92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	3,448,714	0.000000	96.00
200.00		Total (lines 50 through 199)	0	1,075,304	1,075,304	203,317,139		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0001 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part IV Date/Time Prepared: 11/12/2018 1:38 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.011263	3,080,958	34,701	4,835,503	54,462	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	438,606	0	532,678	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	1,043,080	0	5,433,506	0	54.00
57.00	05700	CT SCAN	0.000000	1,218,364	0	4,908,250	0	57.00
58.00	05800	MRI	0.000000	157,787	0	1,393,934	0	58.00
60.00	06000	LABORATORY	0.000000	2,681,377	0	3,382,891	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.010644	1,267,128	13,487	722,306	7,688	65.00
66.00	06600	PHYSICAL THERAPY	0.003932	546,957	2,151	35,049	138	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	1,367,649	0	363,932	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	1,477,646	0	425,548	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.003907	3,074,951	12,014	1,706,461	6,667	73.00
76.97	07697	CARDIAC REHABILITATION	0.038177	412	16	539,165	20,584	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.010018	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	0	0	0	89.00
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	WOUND CLINIC	0.009581	14,081	135	2,135,462	20,460	90.01
91.00	09100	EMERGENCY	0.002825	1,787,940	5,051	3,859,675	10,904	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.102475	209,478	21,466	424,881	43,540	92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0	0	0	96.00
200.00		Total (lines 50 through 199)		18,366,414	89,021	30,699,241	164,443	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-0001 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part V Date/Time Prepared: 11/12/2018 1:38 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.213248	4,835,503	0	2	1,031,161	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.317901	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.024728	532,678	0	0	13,172	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.165376	5,433,506	0	114	898,571	54.00
57.00	05700	CT SCAN	0.024117	4,908,250	0	9	118,372	57.00
58.00	05800	MRI	0.067505	1,393,934	0	13	94,098	58.00
60.00	06000	LABORATORY	0.186689	3,382,891	353	0	631,549	60.00
65.00	06500	RESPIRATORY THERAPY	0.151582	722,306	0	0	109,489	65.00
66.00	06600	PHYSICAL THERAPY	0.341020	35,049	0	0	11,952	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.237790	363,932	0	2	86,539	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.401495	425,548	0	0	170,855	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.351045	1,706,461	0	3,907	599,045	73.00
76.97	07697	CARDIAC REHABILITATION	0.460454	539,165	0	0	248,261	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000				0	89.00
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	WOUND CLINIC	0.302108	2,135,462	0	96	645,140	90.01
91.00	09100	EMERGENCY	0.162281	3,859,675	0	0	626,352	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.761842	424,881	0	0	323,692	92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.393220	0	0	0	0	96.00
200.00		Subtotal (see instructions)		30,699,241	353	4,143	5,608,248	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		30,699,241	353	4,143	5,608,248	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-0001 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part V Date/Time Prepared: 11/12/2018 1:38 pm

Title XVIII | Hospital | PPS

		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
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	19		54.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MRI	0	1		58.00
60.00	06000	LABORATORY	66	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
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	1,372		73.00
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0		89.00
90.00	09000	CLINIC	0	0		90.00
90.01	09001	WOUND CLINIC	0	29		90.01
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
		OTHER REIMBURSABLE COST CENTERS				
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0		96.00
200.00		Subtotal (see instructions)	66	1,421		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	66	1,421		202.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0001 | Component CCN: 14-5572 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part IV | Date/Time Prepared: 11/12/2018 1:38 pm

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	302,939	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	75,735	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	33,388	0	0	66.00
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	48,861	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	39,089	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	309,453	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CLINIC	0	0	52,118	0	0	90.01
91.00	09100	EMERGENCY	0	0	52,118	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
200.00		Total (lines 50 through 199)	0	0	913,701	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0001 | Component CCN: 14-5572 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part IV | Date/Time Prepared: 11/12/2018 1:38 pm

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	302,939	302,939	26,895,672	0.011263	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	786,764	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	3,728,552	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	21,022,939	0.000000	54.00
57.00	05700	CT SCAN	0	0	0	16,587,179	0.000000	57.00
58.00	05800	MRI	0	0	0	5,663,087	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	30,742,718	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	75,735	75,735	7,115,142	0.010644	65.00
66.00	06600	PHYSICAL THERAPY	0	33,388	33,388	8,491,585	0.003932	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	4,512,285	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	4,441,571	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	48,861	48,861	12,504,548	0.003907	73.00
76.97	07697	CARDIAC REHABILITATION	0	39,089	39,089	1,023,891	0.038177	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	309,453	309,453	30,888,579	0.010018	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0.000000	89.00
90.00	09000	CLINIC	0	0	0	0	0.000000	90.00
90.01	09001	WOUND CLINIC	0	52,118	52,118	5,439,785	0.009581	90.01
91.00	09100	EMERGENCY	0	52,118	52,118	18,447,126	0.002825	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	1,577,002	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	3,448,714	0.000000	96.00
200.00		Total (lines 50 through 199)	0	913,701	913,701	203,317,139		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0001 | Component CCN: 14-5572 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part IV | Date/Time Prepared: 11/12/2018 1:38 pm

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.011263	606	7	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	10,161	0	0	0	54.00
57.00	05700	CT SCAN	0.000000	114	0	0	0	57.00
58.00	05800	MRI	0.000000	0	0	0	0	58.00
60.00	06000	LABORATORY	0.000000	18,052	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.010644	330,497	3,518	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.003932	1,419,311	5,581	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	234,172	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.003907	316,359	1,236	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0.038177	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.010018	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	0	0	0	89.00
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	WOUND CLINIC	0.009581	487	5	0	0	90.01
91.00	09100	EMERGENCY	0.002825	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	707	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0	0	0	96.00
200.00		Total (lines 50 through 199)		2,330,466	10,347	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-0001 | Component CCN: 14-5572 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part V Date/Time Prepared: 11/12/2018 1:38 pm

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.213248	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.317901	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.024728	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.165376	0	1	27	0	54.00
57.00	05700	CT SCAN	0.024117	0	0	0	0	57.00
58.00	05800	MRI	0.067505	0	0	1	0	58.00
60.00	06000	LABORATORY	0.186689	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.151582	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.341020	0	0	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.237790	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.401495	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.351045	0	449	1,282	0	73.00
76.97	07697	CARDIAC REHABILITATION	0.460454	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000				0	89.00
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	WOUND CLINIC	0.302108	0	0	0	0	90.01
91.00	09100	EMERGENCY	0.162281	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.761842	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.393220	0	0	0	0	96.00
200.00		Subtotal (see instructions)		0	450	1,310	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	450	1,310	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0001 | Component CCN: 14-5572 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part V | Date/Time Prepared: 11/12/2018 1:38 pm

Title XVIII | Skilled Nursing Facility | PPS

		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
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	4		54.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MRI	0	0		58.00
60.00	06000	LABORATORY	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
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	158	450		73.00
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0		89.00
90.00	09000	CLINIC	0	0		90.00
90.01	09001	WOUND CLINIC	0	0		90.01
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
		OTHER REIMBURSABLE COST CENTERS				
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0		96.00
200.00		Subtotal (see instructions)	158	454		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	158	454		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-0001 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D-1 | Date/Time Prepared: 11/12/2018 1:38 pm

Title XVIII | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	7,571	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	7,571	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)	6,430	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	3,094	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	7,971,929	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	7,971,929	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)	7,971,929	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,052.96	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	3,257,858	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)	3,257,858	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-0001 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D-1 | Date/Time Prepared: 11/12/2018 1:38 pm

Title XVIII | 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)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	1,756,600	993	1,768.98	594	1,050,774	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)	4,211,677	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	8,520,309	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)	849,538	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	371,977	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	1,221,515	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	7,298,794	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)	1,141	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,052.96	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,201,427	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-0001 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D-1 | Date/Time Prepared: 11/12/2018 1:38 pm

Title XVIII | 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	616,316	7,971,929	0.077311	1,201,427	92,884	90.00
91.00	Nursing School cost	1,072,298	7,971,929	0.134509	1,201,427	161,603	91.00
92.00	Allied health cost	0	7,971,929	0.000000	1,201,427	0	92.00
93.00	All other Medical Education	0	7,971,929	0.000000	1,201,427	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 14-0001 Component CCN: 14-5572	Period: From 07/01/2017 To 06/30/2018	Worksheet D-1 Date/Time Prepared: 11/12/2018 1:38 pm
	Title XVIII	Skilled Nursing Facility	PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	3,729	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	3,729	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	3,729	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	2,503	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	2,788,379	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	2,788,379	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	2,788,379	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0001 | Component CCN: 14-5572 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D-1 | Date/Time Prepared: 11/12/2018 1:38 pm

Title XVIII | Skilled Nursing Facility | PPS

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)		48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)		49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)		50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)		51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)		52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)		53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges		54.00
55.00	Target amount per discharge		55.00
56.00	Target amount (line 54 x line 55)		56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)		57.00
58.00	Bonus payment (see instructions)		58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket		59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket		60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)		61.00
62.00	Relief payment (see instructions)		62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)		63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)		64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)		65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)		66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)		67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)		68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)		69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)	2,788,379	70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)	747.76	71.00
72.00	Program routine service cost (line 9 x line 71)	1,871,643	72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)	0	73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)	1,871,643	74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)	0	75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)	0.00	76.00
77.00	Program capital-related costs (line 9 x line 76)	0	77.00
78.00	Inpatient routine service cost (line 74 minus line 77)	0	78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)	0	79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)	0	80.00
81.00	Inpatient routine service cost per diem limitation	0.00	81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)	0	82.00
83.00	Reasonable inpatient routine service costs (see instructions)	1,871,643	83.00
84.00	Program inpatient ancillary services (see instructions)	706,718	84.00
85.00	Utilization review - physician compensation (see instructions)	0	85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)	2,578,361	86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 14-0001 Component CCN: 14-5572	Period: From 07/01/2017 To 06/30/2018	Worksheet D-1 Date/Time Prepared: 11/12/2018 1:38 pm
	Title XVIII	Skilled Nursing Facility	PPS

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

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 14-0001 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D-3 | Date/Time Prepared: 11/12/2018 1:38 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		4,583,614		30.00
31.00	03100	INTENSIVE CARE UNIT		1,470,464		31.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.213248	3,080,958	657,008	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.317901	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.024728	438,606	10,846	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.165376	1,043,080	172,500	54.00
57.00	05700	CT SCAN	0.024117	1,218,364	29,383	57.00
58.00	05800	MRI	0.067505	157,787	10,651	58.00
60.00	06000	LABORATORY	0.186689	2,681,377	500,584	60.00
65.00	06500	RESPIRATORY THERAPY	0.151582	1,267,128	192,074	65.00
66.00	06600	PHYSICAL THERAPY	0.341020	546,957	186,523	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.237790	1,367,649	325,213	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.401495	1,477,646	593,267	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.351045	3,074,951	1,079,446	73.00
76.97	07697	CARDIAC REHABILITATION	0.460454	412	190	76.97
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0	89.00
90.00	09000	CLINIC	0.000000	0	0	90.00
90.01	09001	WOUND CLINIC	0.302108	14,081	4,254	90.01
91.00	09100	EMERGENCY	0.162281	1,787,940	290,149	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.761842	209,478	159,589	92.00
		OTHER REIMBURSABLE COST CENTERS				
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.393220	0	0	96.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		18,366,414	4,211,677	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)		18,366,414		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 14-0001 | Component CCN: 14-5572 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D-3 | Date/Time Prepared: 11/12/2018 1:38 pm

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.213248	606	129	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.317901	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.024728	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.165376	10,161	1,680	54.00
57.00	05700	CT SCAN	0.024117	114	3	57.00
58.00	05800	MRI	0.067505	0	0	58.00
60.00	06000	LABORATORY	0.186689	18,052	3,370	60.00
65.00	06500	RESPIRATORY THERAPY	0.151582	330,497	50,097	65.00
66.00	06600	PHYSICAL THERAPY	0.341020	1,419,311	484,013	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.237790	234,172	55,684	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.401495	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.351045	316,359	111,056	73.00
76.97	07697	CARDIAC REHABILITATION	0.460454	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0	89.00
90.00	09000	CLINIC	0.000000	0	0	90.00
90.01	09001	WOUND CLINIC	0.302108	487	147	90.01
91.00	09100	EMERGENCY	0.162281	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.761842	707	539	92.00
		OTHER REIMBURSABLE COST CENTERS				
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.393220	0	0	96.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		2,330,466	706,718	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)		2,330,466		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0001	Period: From 07/01/2017 To 06/30/2018	Worksheet E Part A Date/Time Prepared: 11/12/2018 1:38 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS		
1.00	DRG Amounts Other than Outlier Payments	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)	1,405,526	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	4,671,006	1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)	0	1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)	0	1.04
2.00	Outlier payments for discharges. (see instructions)	38,892	2.00
2.01	Outlier reconciliation amount	0	2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)	0	2.02
3.00	Managed Care Simulated Payments	0	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)	39.87	4.00
	Indirect Medical Education Adjustment		
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)	0.00	5.00
6.00	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)	0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)	0.00	7.00
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.	0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).	0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.	0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)	0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see instructions)	0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records	0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.	0.00	11.00
12.00	Current year allowable FTE (see instructions)	0.00	12.00
13.00	Total allowable FTE count for the prior year.	0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.	0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.	0.00	15.00
16.00	Adjustment for residents in initial years of the program	0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure	0.00	17.00
18.00	Adjusted rolling average FTE count	0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).	0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)	0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)	0.000000	21.00
22.00	IME payment adjustment (see instructions)	0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)	0	22.01
	Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA		
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C).	0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)	0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)	0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)	0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)	0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)	0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)	0	28.01
29.00	Total IME payment (sum of lines 22 and 28)	0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)	0	29.01
	Disproportionate Share Adjustment		
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	3.07	30.00
31.00	Percentage of Medicaid patient days (see instructions)	20.71	31.00
32.00	Sum of lines 30 and 31	23.78	32.00
33.00	Allowable disproportionate share percentage (see instructions)	8.83	33.00
34.00	Disproportionate share adjustment (see instructions)	134,140	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0001	Period: From 07/01/2017 To 06/30/2018	Worksheet E Part A Date/Time Prepared: 11/12/2018 1:38 pm
	Title XVIII	Hospital	PPS

		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	Uncompensated Care Adjustment			
35.00	Total uncompensated care amount (see instructions)	5,977,483,147	6,766,695,164	35.00
35.01	Factor 3 (see instructions)	0.000049766	0.000056641	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	297,475	383,272	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	74,980	286,666	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	361,646		36.00
	Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)			
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)	0		40.00

		Before 1/1	On/After 1/1	
		1.00	1.01	
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0	0	41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0	0	41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)	0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)	0.00	0.00	45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)	0		46.00
47.00	Subtotal (see instructions)	6,611,210		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)	7,595,189		48.00

		Amount	
		1.00	
49.00	Total payment for inpatient operating costs (see instructions)	7,595,189	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)	492,019	50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)	0	51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).	0	52.00
53.00	Nursing and Allied Health Managed Care payment	669,310	53.00
54.00	Special add-on payments for new technologies	0	54.00
54.01	Islet isolation add-on payment	0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)	0	55.00
56.00	Cost of physicians' services in a teaching hospital (see intructions)	0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).	522,967	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)	89,021	58.00
59.00	Total (sum of amounts on lines 49 through 58)	9,368,506	59.00
60.00	Primary payer payments	0	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)	9,368,506	61.00
62.00	Deductibles billed to program beneficiaries	874,256	62.00
63.00	Coinsurance billed to program beneficiaries	8,040	63.00
64.00	Allowable bad debts (see instructions)	171,049	64.00
65.00	Adjusted reimbursable bad debts (see instructions)	111,182	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	112,542	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	8,597,392	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)	0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96).(For SCH see instructions)	0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	70.00
70.50	Rural Community Hospital Demonstration Project (§410A Demonstration) adjustment (see instructions)	0	70.50
70.87	Demonstration payment adjustment amount before sequestration	0	70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)	0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)		70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)	0	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)	0	70.91
70.92	Bundled Model 1 discount amount (see instructions)	0	70.92
70.93	HVBP payment adjustment amount (see instructions)	-8,533	70.93
70.94	HRR adjustment amount (see instructions)	-79,358	70.94
70.95	Recovery of accelerated depreciation	0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 14-0001 | Period: From 07/01/2017 To 06/30/2018 | Worksheet E Part A | Date/Time Prepared: 11/12/2018 1:38 pm

Title XVIII | Hospital | PPS

		FFY (yyyy)	Amount	
		0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	2017	129,144	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	2018	399,609	70.97
70.98	Low Volume Payment-3		0	70.98
70.99	HAC adjustment amount (see instructions)		0	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		9,038,254	71.00
71.01	Sequestration adjustment (see instructions)		180,765	71.01
71.02	Demonstration payment adjustment amount after sequestration		0	71.02
72.00	Interim payments		9,074,049	72.00
73.00	Tentative settlement (for contractor use only)		0	73.00
74.00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 73)		-216,560	74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	75.00
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)			
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2 (see instructions)		0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00
95.00	Time value of money for operating expenses (see instructions)		0	95.00
96.00	Time value of money for capital related expenses (see instructions)		0	96.00

		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	HSP Bonus Payment Amount			
100.00	HSP bonus amount (see instructions)	0	0	100.00
	HVBP Adjustment for HSP Bonus Payment			
101.00	HVBP adjustment factor (see instructions)	0.0000000000	0.0000000000	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)	0	0	102.00
	HRR Adjustment for HSP Bonus Payment			
103.00	HRR adjustment factor (see instructions)	0.0000	0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)	0	0	104.00
	Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment			
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
	Cost Reimbursement			
201.00	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)			201.00
202.00	Medicare discharges (see instructions)			202.00
203.00	Case-mix adjustment factor (see instructions)			203.00
	Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)			
204.00	Medicare target amount			204.00
205.00	Case-mix adjusted target amount (line 203 times line 204)			205.00
206.00	Medicare inpatient routine cost cap (line 202 times line 205)			206.00
	Adjustment to Medicare Part A Inpatient Reimbursement			
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)			208.00
209.00	Adjustment to Medicare IPPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
211.00	Total adjustment to Medicare IPPS payments (see instructions)			211.00
	Comparision of PPS versus Cost Reimbursement			
212.00	Total adjustment to Medicare Part A IPPS payments (from line 211)			212.00
213.00	Low-volume adjustment (see instructions)			213.00
218.00	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)			218.00

LOW VOLUME CALCULATION EXHIBIT 4 | Provider CCN: 14-0001 | Period: From 07/01/2017 To 06/30/2018 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 11/12/2018 1:38 pm

Title XVIII | Hospital | PPS

		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	1,405,526	0	1,405,526		1,405,526	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	4,671,006	0		4,671,006	4,671,006	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00	38,892	0	997	37,895	38,892	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0	2.01
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	0	4.00
	Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	0	6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	0	9.01
	Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0883	0.0883	0.0883	0.0883		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	134,140	0	31,027	103,113	134,140	11.00
11.01	Uncompensated care payments	36.00	361,646	0	74,980	286,666	361,646	11.01
	Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	6,611,210	0	1,512,530	5,098,680	6,611,210	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	7,595,189	0	1,775,451	5,819,738	7,595,189	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	7,595,189	0	1,775,451	5,819,738	7,595,189	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	492,019	0	112,816	379,203	492,019	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	0	17.00
17.01	Net organ aquisition cost							17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0	17.02

LOW VOLUME CALCULATION EXHIBIT 4 | Provider CCN: 14-0001 | Period: From 07/01/2017 To 06/30/2018 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 11/12/2018 1:38 pm

Title XVIII | Hospital | PPS

		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0	18.00
19.00	SUBTOTAL			0	1,888,267	6,198,941	8,087,208	19.00
		W/S L, line	(Amounts from L)					
		0	1.00	2.00	3.00	4.00	5.00	
20.00	Capital DRG other than outlier	1.00	488,185	0	112,425	375,760	488,185	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	3,834	0	391	3,443	3,834	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	492,019	0	112,816	379,203	492,019	26.00
		W/S E, Part A line	(Amounts to E, Part A)					
		0	1.00	2.00	3.00	4.00	5.00	
27.00	Low volume adjustment factor				0.068393	0.064464		27.00
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			129,144		129,144	28.00
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				399,609	399,609	29.00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 | Provider CCN: 14-0001 | Period: From 07/01/2017 To 06/30/2018 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 11/12/2018 1:38 pm

Title XVIII | Hospital | PPS

		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	1.00	2.00	3.00	4.00	
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	1,405,526	1,405,526		1,405,526	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	4,671,006		4,671,006	4,671,006	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00	38,892	997	37,895	38,892	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	2.01
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	4.00
	Indirect Medical Education Adjustment						
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA						
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	9.01
	Disproportionate Share Adjustment						
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0883	0.0883	0.0883		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	134,140	31,027	103,113	134,140	11.00
11.01	Uncompensated care payments	36.00	361,646	74,980	286,666	361,646	11.01
	Additional payment for high percentage of ESRD beneficiary discharges						
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	6,611,210	1,512,530	5,098,680	6,611,210	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	7,595,189	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	7,595,189	0	7,595,189	7,595,189	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	492,019	112,816	379,203	492,019	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	17.00
17.01	Net organ acquisition cost						17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	18.00
19.00	SUBTOTAL			112,816	7,974,392	8,087,208	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 | Provider CCN: 14-0001 | Period: From 07/01/2017 To 06/30/2018 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 11/12/2018 1:38 pm

Title XVIII | Hospital | PPS

		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	488,185	112,425	375,760	488,185	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	3,834	391	3,443	3,834	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	492,019	112,816	379,203	492,019	26.00
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
		0	1.00	2.00	3.00	4.00	
27.00							27.00
28.00	Low volume adjustment prior to October 1	70.96	129,144	129,144		129,144	28.00
29.00	Low volume adjustment on or after October 1	70.97	399,609		399,609	399,609	29.00
30.00	HVBP payment adjustment (see instructions)	70.93	-8,533	-859	-7,674	-8,533	30.00
30.01	HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	0	0	0	0	30.01
31.00	HRR adjustment (see instructions)	70.94	-79,358	-14,898	-64,460	-79,358	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	0	0	0	0	31.01
						(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3.00	4.00	
32.00	HAC Reduction Program adjustment (see instructions)	70.99		0	0	0	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		N				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0001	Period: From 07/01/2017 To 06/30/2018	Worksheet E Part B Date/Time Prepared: 11/12/2018 1:38 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	1,487	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	5,443,805	2.00
3.00	OPPS payments	5,448,126	3.00
4.00	Outlier payment (see instructions)	327	4.00
4.01	Outlier reconciliation amount (see instructions)	0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.862	5.00
6.00	Line 2 times line 5	4,692,560	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	164,443	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	1,487	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	4,496	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)	4,496	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)	4,496	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	3,009	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (see instructions)	1,487	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	5,612,896	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	1,124,421	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	4,489,962	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	4,489,962	30.00
31.00	Primary payer payments	62	31.00
32.00	Subtotal (line 30 minus line 31)	4,489,900	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)	203,349	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	132,177	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	117,269	36.00
37.00	Subtotal (see instructions)	4,622,077	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		39.50
39.97	Demonstration payment adjustment amount before sequestration	0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	4,622,077	40.00
40.01	Sequestration adjustment (see instructions)	92,442	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
41.00	Interim payments	4,509,127	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	20,508	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0001 Component CCN: 14-5572	Period: From 07/01/2017 To 06/30/2018	Worksheet E Part B Date/Time Prepared: 11/12/2018 1:38 pm
	Title XVIII	Skilled Nursing Facility	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	612	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	OPPS payments		3.00
4.00	Outlier payment (see instructions)		4.00
4.01	Outlier reconciliation amount (see instructions)		4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)		5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	612	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	1,760	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)	1,760	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)	1,760	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	1,148	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (see instructions)	612	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	0	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	152	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		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)	460	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)	460	30.00
31.00	Primary payer payments	0	31.00
32.00	Subtotal (line 30 minus line 31)	460	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)	0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	36.00
37.00	Subtotal (see instructions)	460	37.00
38.00	MSP-LCC reconciliation amount from PS&R		38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		39.50
39.97	Demonstration payment adjustment amount before sequestration	0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	460	40.00
40.01	Sequestration adjustment (see instructions)	9	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
41.00	Interim payments	384	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	67	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)		90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		91.00
92.00	The rate used to calculate the Time Value of Money		92.00
93.00	Time Value of Money (see instructions)		93.00
94.00	Total (sum of lines 91 and 93)		94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-0001 | Period: From 07/01/2017 To 06/30/2018 | Worksheet E-1 Part I | Date/Time Prepared: 11/12/2018 1:38 pm

Title XVIII | Hospital | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		8,924,841		4,535,965	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER	06/25/2018	374,662		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	02/18/2018	225,454	02/18/2018	26,838	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)		149,208		-26,838	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)		9,074,049		4,509,127	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		20,508	6.01
6.02	SETTLEMENT TO PROGRAM		216,560		0	6.02
7.00	Total Medicare program liability (see instructions)		8,857,489		4,529,635	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: 14-0001 | Component CCN: 14-5572 | Period: From 07/01/2017 To 06/30/2018 | Worksheet E-1 Part I | Date/Time Prepared: 11/12/2018 1:38 pm

Title XVIII | Skilled Nursing Facility | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		910,489		384	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)		910,489		384	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		318,396		67	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,228,885		451	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: 14-0001	Period: From 07/01/2017 To 06/30/2018	Worksheet E-1 Part II Date/Time Prepared: 11/12/2018 1:38 pm
	Title XVIII	Hospital	PPS

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

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0001 Component CCN: 14-5572	Period: From 07/01/2017 To 06/30/2018	Worksheet E-3 Part VI Date/Time Prepared: 11/12/2018 1:38 pm
	Title XVIII	Skilled Nursing Facility	PPS

		1.00	
	PART VI - CALCULATION OF REIMBURSEMENT SETTLEMEMENT - ALL OTHER HEALTH SERVICES FOR TITLE XVIII PART A PPS SNF SERVICES		
	PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCTIONS)		
1.00	Resource Utilization Group Payment (RUGS)	1,105,466	1.00
2.00	Routine service other pass through costs	311,573	2.00
3.00	Ancillary service other pass through costs	10,347	3.00
4.00	Subtotal (sum of lines 1 through 3)	1,427,386	4.00
	COMPUTATION OF NET COST OF COVERED SERVICES		
5.00	Medical and other services (Do not use this line as vaccine costs are included in line 1 of W/S E, Part B. This line is now shaded.)		5.00
6.00	Deductible	0	6.00
7.00	Coinsurance	176,396	7.00
8.00	Allowable bad debts (see instructions)	4,576	8.00
9.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)	0	9.00
10.00	Adjusted reimbursable bad debts (see instructions)	2,974	10.00
11.00	Utilization review	0	11.00
12.00	Subtotal (sum of lines 4, 5 minus lines 6 and 7, plus lines 10 and 11)(see instructions)	1,253,964	12.00
13.00	Inpatient primary payer payments	0	13.00
14.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	14.00
14.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	14.50
14.99	Demonstration payment adjustment amount before sequestration	0	14.99
15.00	Subtotal (see instructions	1,253,964	15.00
15.01	Sequestration adjustment (see instructions)	25,079	15.01
15.02	Demonstration payment adjustment amount after sequestration	0	15.02
16.00	Interim payments	910,489	16.00
17.00	Tentative settlement (for contractor use only)	0	17.00
18.00	Balance due provider/program (line 15 minus lines 15.01, 15.02, 16, and 17)	318,396	18.00
19.00	Protested amounts (nonallowable cost report items) in accordance with CMS 19 Pub. 15-2, chapter 1, §115.2	0	19.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 14-0001 | Period: From 07/01/2017 To 06/30/2018 | Worksheet G | Date/Time Prepared: 11/12/2018 1:38 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	8,462,817	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	11,509,083	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	1,873,940	0	0	0	7.00
8.00	Prepaid expenses	3,553,555	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	25,399,395	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	5,625,990	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	86,481,672	0	0	0	15.00
16.00	Accumulated depreciation	-65,976,412	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	34,259,916	0	0	0	23.00
24.00	Accumulated depreciation	0	0	0	0	24.00
25.00	Minor equipment depreciable	13,293,545	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	73,684,711	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	82,971,214	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	15,287,917	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	98,259,131	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	197,343,237	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	3,656,852	0	0	0	37.00
38.00	Salaries, wages, and fees payable	4,068,338	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	1,325,000	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	1,106,538	0	0	0	43.00
44.00	Other current liabilities	350,000	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	10,506,728	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	44,053,239	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	10,740,803	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	54,794,042	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	65,300,770	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	132,042,467				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)	132,042,467	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	197,343,237	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 14-0001 | Period: From 07/01/2017 To 06/30/2018 | Worksheet G-1 | Date/Time Prepared: 11/12/2018 1:38 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		118,681,207		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		13,136,258				2.00
3.00	Total (sum of line 1 and line 2)		131,817,465		0		3.00
4.00	CHANGE IN BENEFICIAL INTEREST IN PER	227,351		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)		227,351		0		10.00
11.00	Subtotal (line 3 plus line 10)		132,044,816		0		11.00
12.00	CHANGE IN TEMPORARILY RESTRICTED NET	2,349		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)		2,349		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		132,042,467		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	CHANGE IN BENEFICIAL INTEREST IN PER		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	CHANGE IN TEMPORARILY RESTRICTED NET		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: 14-0001 | Period: From 07/01/2017 To 06/30/2018 | Worksheet G-2 Parts I & II | Date/Time Prepared: 11/12/2018 1:38 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	12,713,427		12,713,427	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	1,808,184		1,808,184	7.00
8.00	NURSING FACILITY	1,055,730		1,055,730	8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	15,577,341		15,577,341	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	2,780,693		2,780,693	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)	2,780,693		2,780,693	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	18,358,034		18,358,034	17.00
18.00	Ancillary services	41,464,595	102,674,396	144,138,991	18.00
19.00	Outpatient services	4,932,795	28,503,594	33,436,389	19.00
20.00	RURAL HEALTH CLINIC	0	30,888,579	30,888,579	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 NRCC	0	-209,837	-209,837	27.00
27.01	NURSERY	322,836	0	322,836	27.01
27.02	DIETARY	0	22,550	22,550	27.02
27.03	NURSING ADMINISTRATION	83,107	20,723	103,830	27.03
27.04	DURABLE MEDICAL EQUIP - RENTED	0	3,448,714	3,448,714	27.04
27.05	OTHER (SPECIFY)	0	0	0	27.05
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	65,161,367	165,348,719	230,510,086	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		85,264,384		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	AUDIT RECONCILIATION AMOUNT	984			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)		984		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		85,263,400		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 14-0001	Period: From 07/01/2017 To 06/30/2018	Worksheet G-3 Date/Time Prepared: 11/12/2018 1:38 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	230,510,086	1.00
2.00	Less contractual allowances and discounts on patients' accounts	143,291,501	2.00
3.00	Net patient revenues (line 1 minus line 2)	87,218,585	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	85,263,400	4.00
5.00	Net income from service to patients (line 3 minus line 4)	1,955,185	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	252,404	6.00
7.00	Income from investments	13,118,466	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	NET ASSETS RELEASED FROM RESTRICTION	92,454	24.00
24.01	OTHER OPERATION REVENUE	7,837,834	24.01
24.02	OTHER OPERATION REVENUE	334,238	24.02
24.03	CHANGE IN FV OF INTEREST RATE SWAP	1,254,705	24.03
25.00	Total other income (sum of lines 6-24)	22,890,101	25.00
26.00	Total (line 5 plus line 25)	24,845,286	26.00
27.00	PROVISION FOR UNCOLLECTIBLE ACCOUNTS	4,263,228	27.00
27.01	CHANGE IN UNREALIZED GAIN AND LOSS	7,445,800	27.01
27.02	OTHER EXPENSES (SPECIFY)	0	27.02
28.00	Total other expenses (sum of line 27 and subscripts)	11,709,028	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	13,136,258	29.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 14-0001	Period: From 07/01/2017 To 06/30/2018	Worksheet L Parts I-III Date/Time Prepared: 11/12/2018 1:38 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	488,185	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	3,834	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)	20.93	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)	492,019	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: 14-0001 | Component CCN: 14-3493 | Period: From 07/01/2017 To 06/30/2018 | Worksheet M-1 | Date/Time Prepared: 11/12/2018 1:38 pm

RHC I | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	392,004	0	392,004	7,104	399,108	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	87,212	0	87,212	0	87,212	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	2,547,377	0	2,547,377	-89,471	2,457,906	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	1,400,943	0	1,400,943	-45,594	1,355,349	9.00
10.00	Subtotal (sum of lines 1 through 9)	4,427,536	0	4,427,536	-127,961	4,299,575	10.00
11.00	Physician Services Under Agreement	0	9,684,682	9,684,682	-1,838,773	7,845,909	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	9,684,682	9,684,682	-1,838,773	7,845,909	14.00
15.00	Medical Supplies	0	186,633	186,633	0	186,633	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	13,732	13,732	0	13,732	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	200,365	200,365	0	200,365	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	4,427,536	9,885,047	14,312,583	-1,966,734	12,345,849	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	4,300	4,300	0	4,300	29.00
30.00	Administrative Costs	12,879	60,165	73,044	0	73,044	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	12,879	64,465	77,344	0	77,344	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	4,440,415	9,949,512	14,389,927	-1,966,734	12,423,193	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-0001 | Component CCN: 14-3493 | Period: From 07/01/2017 To 06/30/2018 | Worksheet M-1 | Date/Time Prepared: 11/12/2018 1:38 pm

RHC I | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	399,108		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	87,212		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	2,457,906		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	1,355,349		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	4,299,575		10.00
11.00	Physician Services Under Agreement	0	7,845,909		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	7,845,909		14.00
15.00	Medical Supplies	0	186,633		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	13,732		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	200,365		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	12,345,849		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	-18,274	-13,974		29.00
30.00	Administrative Costs	0	73,044		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-18,274	59,070		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-18,274	12,404,919		32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-0001 | Component CCN: 14-3493 | Period: From 07/01/2017 To 06/30/2018 | Worksheet M-2 | Date/Time Prepared: 11/12/2018 1:38 pm

RHC I | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	16.11	71,271	4,200	67,662		1.00
2.00	Physician Assistant	3.56	6,663	2,100	7,476		2.00
3.00	Nurse Practitioner	4.62	18,068	2,100	9,702		3.00
4.00	Subtotal (sum of lines 1 through 3)	24.29	96,002		84,840	96,002	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)	24.29	96,002			96,002	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)					12,345,849	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)					12,345,849	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)					59,070	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					6,376,682	15.00
16.00	Total overhead (sum of lines 14 and 15)					6,435,752	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					6,435,752	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					6,435,752	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					18,781,601	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 14-0001 Component CCN: 14-3493	Period: From 07/01/2017 To 06/30/2018	Worksheet M-3 Date/Time Prepared: 11/12/2018 1:38 pm
	Title XVIII	RHC I	Cost

				1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES				
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			18,781,601	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			189,358	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			18,592,243	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			96,002	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)			96,002	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			193.67	7.00
		Calculation of Limit (1)			
		Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)		
		1.00	2.00		
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	82.30	83.45		8.00
9.00	Rate for Program covered visits (see instructions)	193.67	193.67		9.00
	CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	0	19,262		10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	3,730,472		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	3,730,472		16.00
16.01	Total program charges (see instructions)(from contractor's records)		3,406,868		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		234,174		16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		256,418		16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)		2,587,950		16.04
16.05	Total program cost (see instructions)	0	2,844,368		16.05
17.00	Primary payer amounts		0		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		239,116		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		586,703		19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		2,844,368		20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		43,122		21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		2,887,490		22.00
23.00	Allowable bad debts (see instructions)		0		23.00
23.01	Adjusted reimbursable bad debts (see instructions)		0		23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0		24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0		25.50
25.99	Demonstration payment adjustment amount before sequestration		0		25.99
26.00	Net reimbursable amount (see instructions)		2,887,490		26.00
26.01	Sequestration adjustment (see instructions)		57,750		26.01
26.02	Demonstration payment adjustment amount after sequestration		0		26.02
27.00	Interim payments		2,477,572		27.00
28.00	Tentative settlement (for contractor use only)		0		28.00
29.00	Balance due component/program (line 26 minus lines 26.01, 26.02, 27, and 28)		352,168		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: 14-0001 Component CCN: 14-3493	Period: From 07/01/2017 To 06/30/2018	Worksheet M-4 Date/Time Prepared: 11/12/2018 1:38 pm
	Title XVIII	RHC I	Cost

		Pneumococcal	Influenza	
		1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	4,299,575	4,299,575	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.005831	0.009646	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	25,071	41,474	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	43,563	14,365	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	68,634	55,839	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	12,345,849	12,345,849	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	6,435,752	6,435,752	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.005559	0.004523	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	35,776	29,109	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	104,410	84,948	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	1,721	2,847	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	60.67	29.84	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	304	827	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	18,444	24,678	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)		189,358	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)		43,122	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 14-0001 Component CCN: 14-3493	Period: From 07/01/2017 To 06/30/2018	Worksheet M-5 Date/Time Prepared: 11/12/2018 1:38 pm
		RHC I	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		2,477,572	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00
	Program to Provider			
3.01			0	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
	Provider to Program			
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		2,477,572	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		352,168	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		2,829,740	7.00

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