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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 14-0294	Period: From 01/01/2018 To 12/31/2018	Worksheet S Parts I-III Date/Time Prepared: 5/30/2019 12:58 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 5/30/2019 Time: 12:58 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 CROSSROADS COMMUNITY HOSPITAL (14-0294) for the cost reporting period beginning 01/01/2018 and ending 12/31/2018 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.

[X] 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) RICK SCHUMACHER
Officer or Administrator of Provider(s)

CFO
Title

(Dated when report is electronically signed.)
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	-150,650	-7,740	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
10.00	RURAL HEALTH CLINIC I	0		39,818		0	10.00
10.01	RURAL HEALTH CLINIC II	0		-3,859		0	10.01
200.00	Total	0	-150,650	28,219	0	0	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-0294 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part I | Date/Time Prepared: 5/30/2019 12:58 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 8 DOCTORS PARK ROAD	PO Box:			1.00
2.00	City: MT VERNON	State: IL	Zip Code: 62864	County: JEFFERSON	2.00

		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
	Hospital and Hospital-Based Component Identification:									
3.00	Hospital	CROSSROADS COMMUNITY HOSPITAL	140294	99914	1	07/01/1966	N	P	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	CROSSROADS COMMUNITY HOSPITAL	14U294	99914		04/12/1989	N	P	N	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC	CROSSROADS FAMILY MED OF MT. VERNON	148524	99914		07/19/2013	N	O	N	15.00
15.01	Hospital-Based Health Clinic - RHC II	CROSSROADS FAMILY MED OF WAYNE CITY	148523	99914		07/19/2013	N	O	N	15.01
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	01/01/2018	12/31/2018	20.00
21.00	Type of Control (see instructions)	4		21.00

		1.00	2.00	3.00	
	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	N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	3	N		23.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-0294 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part I | Date/Time Prepared: 5/30/2019 12:58 pm

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
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.	250	0	0	0	258	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

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

		Beginning:	Ending:	
		1.00	2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.			36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.	1		37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)			37.01
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.	01/01/2018	12/31/2018	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), (ii), or (iii)? 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), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	N	N	39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	N	N	40.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-0294 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part I Date/Time Prepared: 5/30/2019 12:58 pm

		NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code	
		1.00	2.00	3.00	
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under §413.85? (see instructions)	N			60.00

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-0294 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part I | Date/Time Prepared: 5/30/2019 12:58 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
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0	76.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 14-0294	Period: From 01/01/2018 To 12/31/2018	Worksheet S-2 Part I Date/Time Prepared: 5/30/2019 12:58 pm

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-0294 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part I Date/Time Prepared: 5/30/2019 12:58 pm

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

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

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	19,311	93,185	0	118.01

		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	Y	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N		122.00
	Transplant Center Information			
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	HB0776	140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-0294 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part I | Date/Time Prepared: 5/30/2019 12:58 pm

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

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

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

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

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

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

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

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

		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	01/01/2018	12/31/2018	170.00

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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 14-0294 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part II | Date/Time Prepared: 5/30/2019 12:58 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.	N			4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00
			Y/N	Legal Oper.	
			1.00	2.00	
	Approved Educational Activities				
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?		N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.		N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.		N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.		N		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.		N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.		N		11.00
				Y/N	
				1.00	
	Bad Debts				
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.			Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.			N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.			N	14.00
	Bed Complement				
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			N	15.00
		Part A		Part B	
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
	PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	Y	03/20/2019	Y	03/20/2019
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N	
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N	
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N	

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 14-0294 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part II Date/Time Prepared: 5/30/2019 12:58 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				Y	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				N	27.00
	Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				N	31.00
	Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				N	33.00
	Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				N	35.00
				Y/N	Date	
				1.00	2.00	
	Home Office Costs					
36.00	Were home office costs claimed on the cost report?			Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			Y		37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.			N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			N		40.00
		1.00		2.00		
	Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	JOSEPH		MORAN		41.00
42.00	Enter the employer/company name of the cost report preparer.	QHC				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	(615) 221-3613		JOSEPH_MORAN@QUORUMHEALTH.COM		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 14-0294	Period: From 01/01/2018 To 12/31/2018	Worksheet S-2 Part II Date/Time Prepared: 5/30/2019 12:58 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, REIMBURSEMENT		41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 14-0294 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-3 Part I | Date/Time Prepared: 5/30/2019 12:58 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	40	14,600	0.00	0	1.00
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		40	14,600	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	7	2,555	0.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)		47	17,155	0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	88.00				0	26.00
26.01	RURAL HEALTH CLINIC II	88.01				0	26.01
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		47				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00
33.01	LTCH site neutral days and discharges						33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 14-0294 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-3 Part I | Date/Time Prepared: 5/30/2019 12:58 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)	1,722	230	2,997			1.00
2.00	HMO and other (see instructions)	193	258				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,722	230	2,997			7.00
8.00	INTENSIVE CARE UNIT	224	20	355			8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	1,946	250	3,352	0.00	181.42	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	1,848	0	5,487	0.00	7.85	26.00
26.01	RURAL HEALTH CLINIC II	1,019	0	4,586	0.00	3.25	26.01
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	192.52	27.00
28.00	Observation Bed Days		0	759			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 14-0294 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-3 Part I | Date/Time Prepared: 5/30/2019 12:58 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	558	210	1,115	1.00
2.00	HMO and other (see instructions)			0	0		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				0		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	558	210	1,115	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	0.00					26.00
26.01	RURAL HEALTH CLINIC II	0.00					26.01
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 14-0294 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-3 Part II Date/Time Prepared: 5/30/2019 12:58 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	11,568,703	0	11,568,703	377,363.00	30.66	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		514,309	0	514,309	4,567.00	112.61	5.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		416,896	0	416,896	17,771.00	23.46	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		58,343	63,232	121,575	4,108.00	29.59	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		524,018	0	524,018	8,472.00	61.85	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		375,215	0	375,215	5,121.00	73.27	14.01
14.02	Related organization salaries		0	0	0	0.00	0.00	14.02
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
	WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		2,892,110	0	2,892,110			17.00
18.00	Wage-related costs (other) (see instructions)		74,246	0	74,246			18.00
19.00	Excluded areas		34,932	0	34,932			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		57,979	0	57,979			23.00
24.00	Wage-related costs (RHC/FQHC)		140,687	0	140,687			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
25.50	Home office wage-related (core)		0	0	0			25.50
25.51	Related organization wage-related (core)		0	0	0			25.51
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0			25.52
25.53	Home office & Contract Physicians Part A - Teaching - wage-related (core)		0	0	0			25.53
	OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	125,927	0	125,927	4,404.00	28.59	26.00
27.00	Administrative & General	5.00	1,882,128	-63,232	1,818,896	65,253.00	27.87	27.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 14-0294 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-3 Part II Date/Time Prepared: 5/30/2019 12:58 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	
28.00	Administrative & General under contract (see inst.)		0	0	0	0.00	0.00	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	194,397	0	194,397	7,152.00	27.18	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	0	0	0	0.00	0.00	32.00
33.00	Housekeeping under contract (see instructions)		459,531	0	459,531	29,177.00	15.75	33.00
34.00	Dietary	10.00	0	0	0	0.00	0.00	34.00
35.00	Dietary under contract (see instructions)		417,731	0	417,731	25,256.00	16.54	35.00
36.00	Cafeteria	11.00	0	0	0	0.00	0.00	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	726,088	0	726,088	18,132.00	40.04	38.00
39.00	Central Services and Supply	14.00	211,367	0	211,367	11,407.00	18.53	39.00
40.00	Pharmacy	15.00	392,447	0	392,447	6,298.00	62.31	40.00
41.00	Medical Records & Medical Records Library	16.00	295,786	0	295,786	15,985.00	18.50	41.00
42.00	Social Service	17.00	0	0	0	0.00	0.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 14-0294 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-3 Part III Date/Time Prepared: 5/30/2019 12:58 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)		11,514,760	0	11,514,760	409,458.00	28.12	1.00
2.00	Excluded area salaries (see instructions)		58,343	63,232	121,575	4,108.00	29.59	2.00
3.00	Subtotal salaries (line 1 minus line 2)		11,456,417	-63,232	11,393,185	405,350.00	28.11	3.00
4.00	Subtotal other wages & related costs (see inst.)		899,233	0	899,233	13,593.00	66.15	4.00
5.00	Subtotal wage-related costs (see inst.)		2,966,356	0	2,966,356	0.00	26.04	5.00
6.00	Total (sum of lines 3 thru 5)		15,322,006	-63,232	15,258,774	418,943.00	36.42	6.00
7.00	Total overhead cost (see instructions)		4,705,402	-63,232	4,642,170	183,064.00	25.36	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 14-0294 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-3 Part IV Date/Time Prepared: 5/30/2019 12:58 pm

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	146,757	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	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)	1,909,347	8.02
8.03	Health Insurance (Purchased)	0	8.03
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	15,166	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	10,493	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)	10,809	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	123,625	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	618,761	17.00
18.00	Medicare Taxes - Employers Portion Only	144,710	18.00
19.00	Unemployment Insurance	0	19.00
20.00	State or Federal Unemployment Taxes	71,795	20.00
	OTHER		
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	0	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	3,051,463	24.00
	Part B - Other than Core Related Cost		
25.00	WAGE RELATED COSTS - OTHER	74,246	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST | Provider CCN: 14-0294 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-3 Part V | Date/Time Prepared: 5/30/2019 12:58 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	524,018	3,051,463	1.00
2.00	Hospital	524,018	3,051,463	2.00
3.00	Subprovider - IPF			3.00
4.00	Subprovider - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC	0	0	14.00
14.01	Hospital-Based Health Clinic RHC 1	0	0	14.01
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis	0	0	17.00
18.00	Other	0	0	18.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 14-0294 | Component CCN: 14-8524 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-8 | Date/Time Prepared: 5/30/2019 12:58 pm

RHC I | Cost

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

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

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

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

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

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

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

Period:
From 01/01/2018
To 12/31/2018

Worksheet S-8
Date/Time Prepared:
5/30/2019 12:58 pm

RHC I | Cost

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

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 14-0294 | Component CCN: 14-8523 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-8 | Date/Time Prepared: 5/30/2019 12:58 pm

RHC II | Cost

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

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

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

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

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

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

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

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

Period:
From 01/01/2018
To 12/31/2018

Worksheet S-8
Date/Time Prepared:
5/30/2019 12:58 pm

RHC II | Cost

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

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 14-0294 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-10 | Date/Time Prepared: 5/30/2019 12:58 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)	0.139391	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	1,191,582	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	933,382	5.00
6.00	Medicaid charges	25,278,079	6.00
7.00	Medicaid cost (line 1 times line 6)	3,523,537	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)	1,398,573	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)	71	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	2,163	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	302	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)	231	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)	1,398,804	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)	1,450,479	23,986	1,474,465	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	202,184	23,986	226,170	21.00
22.00	Payments received from patients for amounts previously written off as charity care	65,521	0	65,521	22.00
23.00	Cost of charity care (line 21 minus line 22)	136,663	23,986	160,649	23.00

		1.00	
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	2,944,872	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	208,548	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	320,844	27.01
28.00	Non-Medicare bad debt expense (see instructions)	2,624,028	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	478,062	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	638,711	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	2,037,515	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-0294 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A | Date/Time Prepared: 5/30/2019 12:58 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		771,975	771,975	358,124	1,130,099	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		1,166,196	1,166,196	1,006,057	2,172,253	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	125,927	28,456	154,383	2,021,645	2,176,028	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,882,128	9,700,126	11,582,254	-2,758,577	8,823,677	5.00
7.00	00700	OPERATION OF PLANT	194,397	1,359,739	1,554,136	-33,401	1,520,735	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	99,205	99,205	0	99,205	8.00
9.00	00900	HOUSEKEEPING	0	500,908	500,908	0	500,908	9.00
10.00	01000	DIETARY	0	668,463	668,463	-312,795	355,668	10.00
11.00	01100	CAFETERIA	0	0	0	311,778	311,778	11.00
13.00	01300	NURSING ADMINISTRATION	726,088	157,435	883,523	-4,116	879,407	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	211,367	422,923	634,290	-164,110	470,180	14.00
15.00	01500	PHARMACY	392,447	938,087	1,330,534	-875,653	454,881	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	295,786	132,153	427,939	-4,490	423,449	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,221,398	929,833	2,151,231	-8,824	2,142,407	30.00
31.00	03100	INTENSIVE CARE UNIT	915,718	371,627	1,287,345	-14,038	1,273,307	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	903,861	5,028,807	5,932,668	-1,678,692	4,253,976	50.00
51.00	05100	RECOVERY ROOM	578,967	71,230	650,197	-650,197	0	51.00
53.00	05300	ANESTHESIOLOGY	0	1,028,797	1,028,797	0	1,028,797	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	557,006	984,905	1,541,911	-121,863	1,420,048	54.00
54.01	03630	ULTRA SOUND	167,071	160,514	327,585	0	327,585	54.01
56.00	05600	RADIOISOTOPE	29,653	187,517	217,170	0	217,170	56.00
57.00	05700	CT SCAN	137,272	178,325	315,597	0	315,597	57.00
58.00	05800	MRI	0	118,889	118,889	0	118,889	58.00
60.00	06000	LABORATORY	646,559	618,515	1,265,074	-31,604	1,233,470	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	68,881	68,881	-49,784	19,097	62.00
65.00	06500	RESPIRATORY THERAPY	291,345	78,990	370,335	-19,237	351,098	65.00
66.00	06600	PHYSICAL THERAPY	0	775,270	775,270	-107,469	667,801	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	168,039	168,039	2,835	170,874	67.00
68.00	06800	SPEECH PATHOLOGY	482	21,315	21,797	-10,385	11,412	68.00
69.00	06900	ELECTROCARDIOLOGY	210,784	28,438	239,222	0	239,222	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	102,889	102,889	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	2,001,000	2,001,000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	824,023	824,023	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	89,310	26,832	116,142	-193	115,949	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	792,783	228,796	1,021,579	-71,336	950,243	88.00
88.01	08801	RURAL HEALTH CLINIC II	196,938	178,450	375,388	-41,893	333,495	88.01
91.00	09100	EMERGENCY	943,073	1,590,599	2,533,672	-13,601	2,520,071	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	11,510,360	28,790,235	40,300,595	-343,907	39,956,688	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	0	0	345,237	345,237	194.01
194.02	07954	SENIOR CIRCLE	58,343	14,215	72,558	-1,330	71,228	194.02
194.03	07953	VACANT SPACE	0	0	0	0	0	194.03
194.04	07952	GUEST MEALS	0	0	0	0	0	194.04
200.00		TOTAL (SUM OF LINES 118 through 199)	11,568,703	28,804,450	40,373,153	0	40,373,153	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-0294 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A | Date/Time Prepared: 5/30/2019 12:58 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	60,230	1,190,329		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	352,392	2,524,645		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-2,205	2,173,823		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-2,884,876	5,938,801		5.00
7.00	00700	OPERATION OF PLANT	-28,376	1,492,359		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	99,205		8.00
9.00	00900	HOUSEKEEPING	0	500,908		9.00
10.00	01000	DIETARY	0	355,668		10.00
11.00	01100	CAFETERIA	-77,936	233,842		11.00
13.00	01300	NURSING ADMINISTRATION	0	879,407		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	470,180		14.00
15.00	01500	PHARMACY	0	454,881		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-108	423,341		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-540,402	1,602,005		30.00
31.00	03100	INTENSIVE CARE UNIT	-160,775	1,112,532		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-63,600	4,190,376		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
53.00	05300	ANESTHESIOLOGY	-980,555	48,242		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-423,531	996,517		54.00
54.01	03630	ULTRA SOUND	-56	327,529		54.01
56.00	05600	RADIOISOTOPE	0	217,170		56.00
57.00	05700	CT SCAN	-448	315,149		57.00
58.00	05800	MRI	0	118,889		58.00
60.00	06000	LABORATORY	-9,848	1,223,622		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	19,097		62.00
65.00	06500	RESPIRATORY THERAPY	0	351,098		65.00
66.00	06600	PHYSICAL THERAPY	0	667,801		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	170,874		67.00
68.00	06800	SPEECH PATHOLOGY	0	11,412		68.00
69.00	06900	ELECTROCARDIOLOGY	0	239,222		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	102,889		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	2,001,000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	824,023		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
76.00	03020	ACUPUNCTURE	0	0		76.00
76.01	03610	SLEEP LAB	0	115,949		76.01
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	950,243		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	333,495		88.01
91.00	09100	EMERGENCY	-1,269,734	1,250,337		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-6,029,828	33,926,860		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0		192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0		194.00
194.01	07951	MARKETING	0	345,237		194.01
194.02	07954	SENIOR CIRCLE	0	71,228		194.02
194.03	07953	VACANT SPACE	0	0		194.03
194.04	07952	GUEST MEALS	0	0		194.04
200.00		TOTAL (SUM OF LINES 118 through 199)	-6,029,828	34,343,325		200.00

RECLASSIFICATIONS | Provider CCN: 14-0294 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-6 | Date/Time Prepared: 5/30/2019 12:58 pm

		Increases				
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - EMPLOYEE BENEFITS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	2,023,195		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
	0		0	2,023,195		
	B - OXYGEN SUPPLY					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	32,237		1.00
	0		0	32,237		
	C - RENTAL AND LEASE RECLASS					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	1,002,737		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15.00
16.00		0.00	0	0		16.00
17.00		0.00	0	0		17.00
18.00		0.00	0	0		18.00
19.00		0.00	0	0		19.00
	0		0	1,002,737		
	D - OTHER CAPITAL COSTS					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	358,124		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	3,320		2.00
3.00		0.00	0	0		3.00
	0		0	361,444		
	E - MARKETING					
1.00	MARKETING	194.01	63,232	282,005		1.00
	0		63,232	282,005		
	F - MEDICAL SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	70,652		1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	2,001,000		2.00
	0		0	2,071,652		
	G - COST OF DRUGS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	824,023		1.00
	0		0	824,023		
	H - BLOOD AND LAB					
1.00	LABORATORY	60.00	0	59,057		1.00
2.00	WHOLE BLOOD & PACKED RED BLOOD CELL	62.00	9,273	0		2.00
	0		9,273	59,057		
	I - MISCELLANEOUS DEPARTMENTS					
1.00	OPERATING ROOM	50.00	578,967	70,910		1.00
	0		578,967	70,910		
	J - DIETARY					
1.00	CAFETERIA	11.00	0	311,778		1.00
	0		0	311,778		
	K - RECLASS SPEECH THERAPY					
1.00	PHYSICAL THERAPY	66.00	391	7,159		1.00
2.00	OCCUPATIONAL THERAPY	67.00	85	2,750		2.00
	TOTALS		476	9,909		
	L - ATHENA BILLING AND COLLECTION SVCS					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	38,757		1.00
2.00		0.00	0	0		2.00
	TOTALS		0	38,757		
500.00	Grand Total: Increases		651,948	7,087,704		500.00

RECLASSIFICATIONS | Provider CCN: 14-0294 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-6 | Date/Time Prepared: 5/30/2019 12:58 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - EMPLOYEE BENEFITS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	1,948,723	0		1.00
2.00	RURAL HEALTH CLINIC	88.00	0	46,948	0		2.00
3.00	RURAL HEALTH CLINIC II	88.01	0	27,524	0		3.00
	0		0	2,023,195			
	B - OXYGEN SUPPLY						
1.00	OPERATION OF PLANT	7.00	0	32,237	0		1.00
	0		0	32,237			
	C - RENTAL AND LEASE RECLASS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	1,550	10		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	141,930	0		2.00
3.00	OPERATION OF PLANT	7.00	0	1,164	0		3.00
4.00	DIETARY	10.00	0	1,017	0		4.00
5.00	NURSING ADMINISTRATION	13.00	0	4,116	0		5.00
6.00	CENTRAL SERVICES & SUPPLY	14.00	0	1,911	0		6.00
7.00	PHARMACY	15.00	0	51,630	0		7.00
8.00	MEDICAL RECORDS & LIBRARY	16.00	0	4,490	0		8.00
9.00	ADULTS & PEDIATRICS	30.00	0	8,824	0		9.00
10.00	INTENSIVE CARE UNIT	31.00	0	14,038	0		10.00
11.00	OPERATING ROOM	50.00	0	419,116	0		11.00
12.00	RECOVERY ROOM	51.00	0	320	0		12.00
13.00	RADIOLOGY-DIAGNOSTIC	54.00	0	121,863	0		13.00
14.00	LABORATORY	60.00	0	81,388	0		14.00
15.00	RESPIRATORY THERAPY	65.00	0	19,237	0		15.00
16.00	PHYSICAL THERAPY	66.00	0	115,019	0		16.00
17.00	SLEEP LAB	76.01	0	193	0		17.00
18.00	EMERGENCY	91.00	0	13,601	0		18.00
19.00	SENIOR CIRCLE	194.02	0	1,330	0		19.00
	0		0	1,002,737			
	D - OTHER CAPITAL COSTS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	361,444	12		1.00
2.00		0.00	0	0	13		2.00
3.00		0.00	0	0	12		3.00
	0		0	361,444			
	E - MARKETING						
1.00	ADMINISTRATIVE & GENERAL	5.00	63,232	282,005	0		1.00
	0		63,232	282,005			
	F - MEDICAL SUPPLIES						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	162,199	0		1.00
2.00	OPERATING ROOM	50.00	0	1,909,453	0		2.00
	0		0	2,071,652			
	G - COST OF DRUGS						
1.00	PHARMACY	15.00	0	824,023	0		1.00
	0		0	824,023			
	H - BLOOD AND LAB						
1.00	WHOLE BLOOD & PACKED RED BLOOD CELL	62.00	0	59,057	0		1.00
2.00	LABORATORY	60.00	9,273	0	0		2.00
	0		9,273	59,057			
	I - MISCELLANEOUS DEPARTMENTS						
1.00	RECOVERY ROOM	51.00	578,967	70,910	0		1.00
	0		578,967	70,910			
	J - DIETARY						
1.00	DIETARY	10.00	0	311,778	0		1.00
	0		0	311,778			
	K - RECLASS SPEECH THERAPY						
1.00	SPEECH PATHOLOGY	68.00	476	9,909	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		476	9,909			
	L - ATHENA BILLING AND COLLECTION SVCS						
1.00	RURAL HEALTH CLINIC	88.00	0	24,388	0		1.00
2.00	RURAL HEALTH CLINIC II	88.01	0	14,369	0		2.00
	TOTALS		0	38,757			
500.00	Grand Total: Decreases		651,948	7,087,704			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-0294 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-7 Part I | Date/Time Prepared: 5/30/2019 12:58 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	961,157	0	0	0	0	1.00
2.00	Land Improvements	411,367	9,260	0	9,260	0	2.00
3.00	Buildings and Fixtures	28,890,671	0	0	0	81,281	3.00
4.00	Building Improvements	5,837,915	0	0	0	28,700	4.00
5.00	Fixed Equipment	2,279,148	0	0	0	4,355	5.00
6.00	Movable Equipment	12,582,167	96,478	0	96,478	72,142	6.00
7.00	HIT designated Assets	4,787,567	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	55,749,992	105,738	0	105,738	186,478	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	55,749,992	105,738	0	105,738	186,478	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	961,157	0	1.00
2.00	Land Improvements	420,627	0	2.00
3.00	Buildings and Fixtures	28,809,390	0	3.00
4.00	Building Improvements	5,809,215	0	4.00
5.00	Fixed Equipment	2,274,793	0	5.00
6.00	Movable Equipment	12,606,503	0	6.00
7.00	HIT designated Assets	4,787,567	0	7.00
8.00	Subtotal (sum of lines 1-7)	55,669,252	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	55,669,252	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-0294 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-7 Part II | Date/Time Prepared: 5/30/2019 12:58 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	771,975	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	1,166,196	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	1,938,171	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	771,975	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	1,166,196	2.00
3.00	Total (sum of lines 1-2)	0	1,938,171	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-0294 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-7 Part III Date/Time Prepared: 5/30/2019 12:58 pm

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	COMPUTATION OF RATIOS: Capitalized Leases	COMPUTATION OF RATIOS: Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	ALLOCATION OF OTHER CAPITAL: Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	36,000,389	0	36,000,389	0.646684	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	19,668,863	0	19,668,863	0.353316	0	2.00
3.00	Total (sum of lines 1-2)	55,669,252	0	55,669,252	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	ALLOCATION OF OTHER CAPITAL: Other Capital-Related Costs	ALLOCATION OF OTHER CAPITAL: Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	SUMMARY OF CAPITAL: Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	984,809	-152,604	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	1,518,588	1,002,737	2.00
3.00	Total (sum of lines 1-2)	0	0	0	2,503,397	850,133	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	SUMMARY OF CAPITAL: Insurance (see instructions)	SUMMARY OF CAPITAL: Taxes (see instructions)	SUMMARY OF CAPITAL: Other Capital-Related Costs (see instructions)	SUMMARY OF CAPITAL: Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	358,124	0	0	1,190,329	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	3,320	0	2,524,645	2.00
3.00	Total (sum of lines 1-2)	0	358,124	3,320	0	3,714,974	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-0294 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-8 | Date/Time Prepared: 5/30/2019 12:58 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
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-49,574	ADMINISTRATIVE & GENERAL	5.00	0	7.00
8.00	Television and radio service (chapter 21)	A	-5	CAP REL COSTS-MVBLE EQUIP	2.00	9	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-3,446,255			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)	B	-2,694	RADIOLOGY-DIAGNOSTIC	54.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	-421,670			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-77,936	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-108	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT	A	174,159	CAP REL COSTS-BLDG & FIXT	1.00	9	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP	A	343,030	CAP REL COSTS-MVBLE EQUIP	2.00	9	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-0294 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-8 | Date/Time Prepared: 5/30/2019 12:58 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	
33.00	ADMIN & GENERAL ORGANIZATION COST	A	-93,371	ADMINISTRATIVE & GENERAL	5.00	0	33.00
33.01	MARKETING EXPENSE	A	-126,698	ADMINISTRATIVE & GENERAL	5.00	0	33.01
33.02	HEALTH WOMAN SPONSORSHIP	B	-4,664	ADMINISTRATIVE & GENERAL	5.00	0	33.02
33.03	COUNTRY CLUB DUES	A	-17,066	ADMINISTRATIVE & GENERAL	5.00	0	33.03
33.04	PHYSICIAN RECRUITING	A	-53,418	ADMINISTRATIVE & GENERAL	5.00	0	33.04
33.05	LOBBYING EXPENSE	A	-16,692	ADMINISTRATIVE & GENERAL	5.00	0	33.05
33.06	PENALTIES	A	0	ADMINISTRATIVE & GENERAL	5.00	0	33.06
33.07	SPECIAL EVENTS	A	-73,183	ADMINISTRATIVE & GENERAL	5.00	0	33.07
33.08	MEDICAL STAFF RELATIONS	A	0	ADMINISTRATIVE & GENERAL	5.00	0	33.08
33.09	ILLINOIS PROVIDER TAX	A	-1,858,954	ADMINISTRATIVE & GENERAL	5.00	0	33.09
33.10	GIFT SHOP EXPENSE	A	0	ADMINISTRATIVE & GENERAL	5.00	0	33.10
33.11	NON-ALLOWABLE LEGAL FEES	A	-49,694	ADMINISTRATIVE & GENERAL	5.00	0	33.11
33.13	TELEPHONE BENEFIT COSTS	A	-2,205	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.13
33.14	TELEPHONE DEPRECIATION COST	A	-636	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.14
33.15	TELEVISION EXPENSE	A	-28,376	OPERATION OF PLANT	7.00	0	33.15
33.21	RENTAL INCOME	B	-152,604	CAP REL COSTS-BLDG & FIXT	1.00	10	33.21
33.22	OTHER MISCELLANEOUS REVENUE	B	-71,214	ADMINISTRATIVE & GENERAL	5.00	0	33.22
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-6,029,828				50.00

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 14-0294 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-8-1 | Date/Time Prepared: 5/30/2019 12:58 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	1.00	CAP REL COSTS-BLDG & FIXT	HOME OFFICE BLDG & FIXED	38,675	0	1.00
2.00	2.00	CAP REL COSTS-MVBLE EQUIP	HOME OFFICE MME	10,003	0	2.00
3.00	5.00	ADMINISTRATIVE & GENERAL	MALPRACTICE COSTS	112,496	563,392	3.00
4.00	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE OPERATING COSTS	621,156	957,709	4.00
4.01	5.00	ADMINISTRATIVE & GENERAL	POOLED NON-CAPITAL COSTS	317,101	0	4.01
4.02	0.00			0	0	4.02
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			1,099,431	1,521,101	5.00

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

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

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

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

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

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 14-0294 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-8-1 | Date/Time Prepared: 5/30/2019 12:58 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	38,675	9		1.00
2.00	10,003	9		2.00
3.00	-450,896	0		3.00
4.00	-336,553	0		4.00
4.01	317,101	0		4.01
4.02	0	0		4.02
5.00	-421,670			5.00

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

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

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

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

6.00	HOSPITAL MGMT		6.00
7.00			7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 14-0294 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-8-2 | Date/Time Prepared: 5/30/2019 12:58 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	30.00	ADULTS & PEDIATRICS	540,402	540,402	0	0	0	1.00
2.00	50.00	OPERATING ROOM	63,600	63,600	0	0	0	2.00
3.00	53.00	ANESTHESIOLOGY	980,555	980,555	0	0	0	3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	420,837	420,837	0	0	0	4.00
5.00	54.01	ULTRA SOUND	56	56	0	0	0	5.00
6.00	57.00	CT SCAN	448	448	0	0	0	6.00
7.00	60.00	LABORATORY	9,848	9,848	0	0	0	7.00
8.00	91.00	EMERGENCY	1,269,734	1,269,734	0	0	0	8.00
9.00	31.00	INTENSIVE CARE UNIT	160,775	160,775	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			3,446,255	3,446,255	0		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	50.00	OPERATING ROOM	0	0	0	0	0	2.00
3.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	4.00
5.00	54.01	ULTRA SOUND	0	0	0	0	0	5.00
6.00	57.00	CT SCAN	0	0	0	0	0	6.00
7.00	60.00	LABORATORY	0	0	0	0	0	7.00
8.00	91.00	EMERGENCY	0	0	0	0	0	8.00
9.00	31.00	INTENSIVE CARE UNIT	0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	540,402		1.00
2.00	50.00	OPERATING ROOM	0	0	0	63,600		2.00
3.00	53.00	ANESTHESIOLOGY	0	0	0	980,555		3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	420,837		4.00
5.00	54.01	ULTRA SOUND	0	0	0	56		5.00
6.00	57.00	CT SCAN	0	0	0	448		6.00
7.00	60.00	LABORATORY	0	0	0	9,848		7.00
8.00	91.00	EMERGENCY	0	0	0	1,269,734		8.00
9.00	31.00	INTENSIVE CARE UNIT	0	0	0	160,775		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	3,446,255		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0294 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part I | Date/Time Prepared: 5/30/2019 12:58 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	1,190,329	1,190,329				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2,524,645		2,524,645			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,173,823	7,610	16,140	2,197,573		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5,938,801	127,142	269,663	349,316	6,684,922	5.00
7.00	00700	OPERATION OF PLANT	1,492,359	232,672	493,495	37,334	2,255,860	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	99,205	5,218	11,067	0	115,490	8.00
9.00	00900	HOUSEKEEPING	500,908	39,230	83,204	0	623,342	9.00
10.00	01000	DIETARY	355,668	36,658	77,751	0	470,077	10.00
11.00	01100	CAFETERIA	233,842	0	0	0	233,842	11.00
13.00	01300	NURSING ADMINISTRATION	879,407	12,138	25,743	139,444	1,056,732	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	470,180	25,920	54,975	40,593	591,668	14.00
15.00	01500	PHARMACY	454,881	9,623	20,410	75,369	560,283	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	423,341	23,576	50,003	56,805	553,725	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,602,005	214,883	455,760	234,568	2,507,216	30.00
31.00	03100	INTENSIVE CARE UNIT	1,112,532	45,402	96,297	175,863	1,430,094	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,190,376	145,991	309,641	284,776	4,930,784	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	48,242	1,616	3,428	0	53,286	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	996,517	41,073	87,114	106,972	1,231,676	54.00
54.01	03630	ULTRA SOUND	327,529	4,812	10,205	32,086	374,632	54.01
56.00	05600	RADIOISOTOPE	217,170	4,036	8,561	5,695	235,462	56.00
57.00	05700	CT SCAN	315,149	0	0	26,363	341,512	57.00
58.00	05800	MRI	118,889	0	0	0	118,889	58.00
60.00	06000	LABORATORY	1,223,622	28,236	59,887	122,390	1,434,135	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	19,097	1,437	3,047	1,781	25,362	62.00
65.00	06500	RESPIRATORY THERAPY	351,098	12,913	27,387	55,953	447,351	65.00
66.00	06600	PHYSICAL THERAPY	667,801	5,209	11,047	75	684,132	66.00
67.00	06700	OCCUPATIONAL THERAPY	170,874	0	0	16	170,890	67.00
68.00	06800	SPEECH PATHOLOGY	11,412	0	0	1	11,413	68.00
69.00	06900	ELECTROCARDIOLOGY	239,222	0	0	40,481	279,703	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	102,889	0	0	0	102,889	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,001,000	0	0	0	2,001,000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	824,023	0	0	0	824,023	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	115,949	0	0	17,152	133,101	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	950,243	0	0	152,253	1,102,496	88.00
88.01	08801	RURAL HEALTH CLINIC II	333,495	0	0	37,822	371,317	88.01
91.00	09100	EMERGENCY	1,250,337	59,383	125,950	181,116	1,616,786	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	33,926,860	1,084,778	2,300,775	2,174,224	33,574,090	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	3,639	7,719	0	11,358	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	3,535	7,498	0	11,033	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	MARKETING	345,237	1,938	4,110	12,144	363,429	194.01
194.02	07954	SENIOR CIRCLE	71,228	5,105	10,827	11,205	98,365	194.02
194.03	07953	VACANT SPACE	0	91,334	193,716	0	285,050	194.03
194.04	07952	GUEST MEALS	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	34,343,325	1,190,329	2,524,645	2,197,573	34,343,325	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0294 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part I | Date/Time Prepared: 5/30/2019 12:58 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	6,684,922					5.00
7.00	00700	OPERATION OF PLANT	545,232	2,801,092				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	27,913	17,762	161,165			8.00
9.00	00900	HOUSEKEEPING	150,659	133,534	0	907,535		9.00
10.00	01000	DIETARY	113,616	124,782	0	42,737	751,212	10.00
11.00	01100	CAFETERIA	56,519	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	255,408	41,315	0	14,150	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	143,004	88,229	0	30,218	0	14.00
15.00	01500	PHARMACY	135,418	32,756	0	11,219	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	133,833	80,249	0	27,485	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	605,984	731,445	53,185	250,513	656,764	30.00
31.00	03100	INTENSIVE CARE UNIT	345,648	154,545	9,669	52,931	77,798	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,191,749	496,939	32,235	170,198	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	12,879	5,502	0	1,884	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	297,691	139,808	9,669	47,883	0	54.00
54.01	03630	ULTRA SOUND	90,547	16,378	0	5,609	0	54.01
56.00	05600	RADIOISOTOPE	56,910	13,740	0	4,706	0	56.00
57.00	05700	CT SCAN	82,542	0	0	0	0	57.00
58.00	05800	MRI	28,735	0	0	0	0	58.00
60.00	06000	LABORATORY	346,625	96,112	0	32,918	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	6,130	4,891	0	1,675	0	62.00
65.00	06500	RESPIRATORY THERAPY	108,123	43,954	4,835	15,054	0	65.00
66.00	06600	PHYSICAL THERAPY	165,352	17,729	0	6,072	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	41,303	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	2,758	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	67,603	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	24,868	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	483,634	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	199,163	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	32,170	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	266,469	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	89,746	0	0	0	0	88.01
91.00	09100	EMERGENCY	390,771	202,135	51,572	69,230	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	6,499,002	2,441,805	161,165	784,482	734,562	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,745	12,388	0	4,243	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2,667	12,034	0	4,122	0	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	MARKETING	87,839	6,596	0	2,259	0	194.01
194.02	07954	SENIOR CIRCLE	23,774	17,376	0	5,951	0	194.02
194.03	07953	VACANT SPACE	68,895	310,893	0	106,478	0	194.03
194.04	07952	GUEST MEALS	0	0	0	0	16,650	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	6,684,922	2,801,092	161,165	907,535	751,212	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0294 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part I | Date/Time Prepared: 5/30/2019 12:58 pm

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	290,361					11.00
13.00	01300	NURSING ADMINISTRATION	18,902	1,386,507				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	11,879	0	864,998			14.00
15.00	01500	PHARMACY	6,568	76,806	4,652	827,702		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16,669	0	817	0	812,778	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	45,326	239,041	17,586	0	27,756	30.00
31.00	03100	INTENSIVE CARE UNIT	12,789	179,216	8,306	0	4,665	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	52,696	290,205	358,214	0	168,530	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	9,280	0	80,827	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	22,587	109,012	7,137	0	32,213	54.00
54.01	03630	ULTRA SOUND	6,330	32,698	1,293	0	9,421	54.01
56.00	05600	RADIOISOTOPE	1,019	5,803	667	0	6,296	56.00
57.00	05700	CT SCAN	5,766	26,866	5,862	0	110,407	57.00
58.00	05800	MRI	0	0	7	0	10,750	58.00
60.00	06000	LABORATORY	30,391	124,724	39,935	0	127,812	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	434	1,815	0	0	1,860	62.00
65.00	06500	RESPIRATORY THERAPY	11,944	57,019	6,086	0	15,409	65.00
66.00	06600	PHYSICAL THERAPY	0	0	1,451	0	16,400	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	147	0	3,580	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	239	68.00
69.00	06900	ELECTROCARDIOLOGY	10,535	41,253	298	0	19,436	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	11,510	0	4,387	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	368,374	0	60,971	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	827,702	31,426	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	3,121	17,479	2,347	0	3,599	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	4,745	0	2,815	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	1,878	88.01
91.00	09100	EMERGENCY	29,134	184,570	13,396	0	72,101	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	286,090	1,386,507	862,110	827,702	812,778	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	MARKETING	2,103	0	2,017	0	0	194.01
194.02	07954	SENIOR CIRCLE	2,168	0	871	0	0	194.02
194.03	07953	VACANT SPACE	0	0	0	0	0	194.03
194.04	07952	GUEST MEALS	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	290,361	1,386,507	864,998	827,702	812,778	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0294 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part I | Date/Time Prepared: 5/30/2019 12:58 pm

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	5,134,816	0	5,134,816		30.00
31.00	03100	INTENSIVE CARE UNIT	2,275,661	0	2,275,661		31.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	7,691,550	0	7,691,550		50.00
51.00	05100	RECOVERY ROOM	0	0	0		51.00
53.00	05300	ANESTHESIOLOGY	163,658	0	163,658		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,897,676	0	1,897,676		54.00
54.01	03630	ULTRA SOUND	536,908	0	536,908		54.01
56.00	05600	RADIOISOTOPE	324,603	0	324,603		56.00
57.00	05700	CT SCAN	572,955	0	572,955		57.00
58.00	05800	MRI	158,381	0	158,381		58.00
60.00	06000	LABORATORY	2,232,652	0	2,232,652		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	42,167	0	42,167		62.00
65.00	06500	RESPIRATORY THERAPY	709,775	0	709,775		65.00
66.00	06600	PHYSICAL THERAPY	891,136	0	891,136		66.00
67.00	06700	OCCUPATIONAL THERAPY	215,920	0	215,920		67.00
68.00	06800	SPEECH PATHOLOGY	14,410	0	14,410		68.00
69.00	06900	ELECTROCARDIOLOGY	418,828	0	418,828		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	143,654	0	143,654		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,913,979	0	2,913,979		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,882,314	0	1,882,314		73.00
74.00	07400	RENAL DIALYSIS	0	0	0		74.00
76.00	03020	ACUPUNCTURE	0	0	0		76.00
76.01	03610	SLEEP LAB	191,817	0	191,817		76.01
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	1,376,525	0	1,376,525		88.00
88.01	08801	RURAL HEALTH CLINIC II	462,941	0	462,941		88.01
91.00	09100	EMERGENCY	2,629,695	0	2,629,695		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0			92.00
		SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	32,882,021	0	32,882,021		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	30,734	0	30,734		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	29,856	0	29,856		192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0		194.00
194.01	07951	MARKETING	464,243	0	464,243		194.01
194.02	07954	SENIOR CIRCLE	148,505	0	148,505		194.02
194.03	07953	VACANT SPACE	771,316	0	771,316		194.03
194.04	07952	GUEST MEALS	16,650	0	16,650		194.04
200.00		Cross Foot Adjustments	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	34,343,325	0	34,343,325		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0294 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part II Date/Time Prepared: 5/30/2019 12:58 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	7,610	16,140	23,750	23,750	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	127,142	269,663	396,805	3,770	5.00
7.00	00700	OPERATION OF PLANT	0	232,672	493,495	726,167	404	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	5,218	11,067	16,285	0	8.00
9.00	00900	HOUSEKEEPING	0	39,230	83,204	122,434	0	9.00
10.00	01000	DIETARY	0	36,658	77,751	114,409	0	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	12,138	25,743	37,881	1,507	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	25,920	54,975	80,895	439	14.00
15.00	01500	PHARMACY	0	9,623	20,410	30,033	815	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	23,576	50,003	73,579	614	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	214,883	455,760	670,643	2,536	30.00
31.00	03100	INTENSIVE CARE UNIT	0	45,402	96,297	141,699	1,901	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	145,991	309,641	455,632	3,078	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	1,616	3,428	5,044	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	41,073	87,114	128,187	1,156	54.00
54.01	03630	ULTRA SOUND	0	4,812	10,205	15,017	347	54.01
56.00	05600	RADIOISOTOPE	0	4,036	8,561	12,597	62	56.00
57.00	05700	CT SCAN	0	0	0	0	285	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	28,236	59,887	88,123	1,323	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	1,437	3,047	4,484	19	62.00
65.00	06500	RESPIRATORY THERAPY	0	12,913	27,387	40,300	605	65.00
66.00	06600	PHYSICAL THERAPY	0	5,209	11,047	16,256	1	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	438	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	185	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	1,646	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	409	88.01
91.00	09100	EMERGENCY	0	59,383	125,950	185,333	1,958	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	1,084,778	2,300,775	3,385,553	23,498	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	3,639	7,719	11,358	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	3,535	7,498	11,033	0	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	1,938	4,110	6,048	131	194.01
194.02	07954	SENIOR CIRCLE	0	5,105	10,827	15,932	121	194.02
194.03	07953	VACANT SPACE	0	91,334	193,716	285,050	0	194.03
194.04	07952	GUEST MEALS	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	1,190,329	2,524,645	3,714,974	23,750	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0294 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part II | Date/Time Prepared: 5/30/2019 12:58 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	400,575					5.00
7.00	00700	OPERATION OF PLANT	32,672	759,243				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,673	4,814	22,772			8.00
9.00	00900	HOUSEKEEPING	9,028	36,195	0	167,657		9.00
10.00	01000	DIETARY	6,808	33,822	0	7,895	162,934	10.00
11.00	01100	CAFETERIA	3,387	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	15,305	11,199	0	2,614	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	8,569	23,915	0	5,582	0	14.00
15.00	01500	PHARMACY	8,115	8,879	0	2,073	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	8,020	21,752	0	5,077	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	36,312	198,259	7,515	46,283	142,449	30.00
31.00	03100	INTENSIVE CARE UNIT	20,712	41,890	1,366	9,778	16,874	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	71,410	134,697	4,555	31,442	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	772	1,491	0	348	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	17,838	37,895	1,366	8,846	0	54.00
54.01	03630	ULTRA SOUND	5,426	4,439	0	1,036	0	54.01
56.00	05600	RADIOISOTOPE	3,410	3,724	0	869	0	56.00
57.00	05700	CT SCAN	4,946	0	0	0	0	57.00
58.00	05800	MRI	1,722	0	0	0	0	58.00
60.00	06000	LABORATORY	20,771	26,051	0	6,081	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	367	1,326	0	309	0	62.00
65.00	06500	RESPIRATORY THERAPY	6,479	11,914	683	2,781	0	65.00
66.00	06600	PHYSICAL THERAPY	9,908	4,806	0	1,122	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,475	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	165	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	4,051	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,490	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	28,980	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	11,934	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	1,928	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	15,967	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	5,378	0	0	0	0	88.01
91.00	09100	EMERGENCY	23,416	54,789	7,287	12,789	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	389,434	661,857	22,772	144,925	159,323	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	164	3,358	0	784	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	160	3,262	0	761	0	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	MARKETING	5,264	1,788	0	417	0	194.01
194.02	07954	SENIOR CIRCLE	1,425	4,710	0	1,099	0	194.02
194.03	07953	VACANT SPACE	4,128	84,268	0	19,671	0	194.03
194.04	07952	GUEST MEALS	0	0	0	0	3,611	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	400,575	759,243	22,772	167,657	162,934	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0294 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part II | Date/Time Prepared: 5/30/2019 12:58 pm

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	3,387					11.00
13.00	01300	NURSING ADMINISTRATION	220	68,726				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	139	0	119,539			14.00
15.00	01500	PHARMACY	77	3,807	643	54,442		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	194	0	113	0	109,349	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	529	11,849	2,430	0	3,738	30.00
31.00	03100	INTENSIVE CARE UNIT	149	8,883	1,148	0	628	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	615	14,384	49,503	0	22,577	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	1,282	0	10,886	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	263	5,404	986	0	4,339	54.00
54.01	03630	ULTRA SOUND	74	1,621	179	0	1,269	54.01
56.00	05600	RADIOISOTOPE	12	288	92	0	848	56.00
57.00	05700	CT SCAN	67	1,332	810	0	14,871	57.00
58.00	05800	MRI	0	0	1	0	1,448	58.00
60.00	06000	LABORATORY	355	6,182	5,519	0	17,215	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	5	90	0	0	250	62.00
65.00	06500	RESPIRATORY THERAPY	139	2,826	841	0	2,075	65.00
66.00	06600	PHYSICAL THERAPY	0	0	200	0	2,209	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	20	0	482	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	32	68.00
69.00	06900	ELECTROCARDIOLOGY	123	2,045	41	0	2,618	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	1,591	0	591	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	50,910	0	8,212	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	54,442	4,233	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	36	866	324	0	485	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	656	0	379	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	253	88.01
91.00	09100	EMERGENCY	340	9,149	1,851	0	9,711	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	3,337	68,726	119,140	54,442	109,349	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	MARKETING	25	0	279	0	0	194.01
194.02	07954	SENIOR CIRCLE	25	0	120	0	0	194.02
194.03	07953	VACANT SPACE	0	0	0	0	0	194.03
194.04	07952	GUEST MEALS	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	3,387	68,726	119,539	54,442	109,349	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0294 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part II | Date/Time Prepared: 5/30/2019 12:58 pm

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	1,122,543	0	1,122,543		30.00
31.00	03100	INTENSIVE CARE UNIT	245,028	0	245,028		31.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	787,893	0	787,893		50.00
51.00	05100	RECOVERY ROOM	0	0	0		51.00
53.00	05300	ANESTHESIOLOGY	19,823	0	19,823		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	206,280	0	206,280		54.00
54.01	03630	ULTRA SOUND	29,408	0	29,408		54.01
56.00	05600	RADIOISOTOPE	21,902	0	21,902		56.00
57.00	05700	CT SCAN	22,311	0	22,311		57.00
58.00	05800	MRI	3,171	0	3,171		58.00
60.00	06000	LABORATORY	171,620	0	171,620		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	6,850	0	6,850		62.00
65.00	06500	RESPIRATORY THERAPY	68,643	0	68,643		65.00
66.00	06600	PHYSICAL THERAPY	34,502	0	34,502		66.00
67.00	06700	OCCUPATIONAL THERAPY	2,977	0	2,977		67.00
68.00	06800	SPEECH PATHOLOGY	197	0	197		68.00
69.00	06900	ELECTROCARDIOLOGY	9,316	0	9,316		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,672	0	3,672		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	88,102	0	88,102		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	70,609	0	70,609		73.00
74.00	07400	RENAL DIALYSIS	0	0	0		74.00
76.00	03020	ACUPUNCTURE	0	0	0		76.00
76.01	03610	SLEEP LAB	3,824	0	3,824		76.01
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	18,648	0	18,648		88.00
88.01	08801	RURAL HEALTH CLINIC II	6,040	0	6,040		88.01
91.00	09100	EMERGENCY	306,623	0	306,623		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0			92.00
		SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	3,249,982	0	3,249,982		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	15,664	0	15,664		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	15,216	0	15,216		192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0		194.00
194.01	07951	MARKETING	13,952	0	13,952		194.01
194.02	07954	SENIOR CIRCLE	23,432	0	23,432		194.02
194.03	07953	VACANT SPACE	393,117	0	393,117		194.03
194.04	07952	GUEST MEALS	3,611	0	3,611		194.04
200.00		Cross Foot Adjustments	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	3,714,974	0	3,714,974		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0294 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B-1 | Date/Time Prepared: 5/30/2019 12:58 pm

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	125,922					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		125,922				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	805	805	11,442,776			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	13,450	13,450	1,818,896	-6,684,922	27,658,403	5.00
7.00	00700	OPERATION OF PLANT	24,614	24,614	194,397	0	2,255,860	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	552	552	0	0	115,490	8.00
9.00	00900	HOUSEKEEPING	4,150	4,150	0	0	623,342	9.00
10.00	01000	DIETARY	3,878	3,878	0	0	470,077	10.00
11.00	01100	CAFETERIA	0	0	0	0	233,842	11.00
13.00	01300	NURSING ADMINISTRATION	1,284	1,284	726,088	0	1,056,732	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,742	2,742	211,367	0	591,668	14.00
15.00	01500	PHARMACY	1,018	1,018	392,447	0	560,283	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,494	2,494	295,786	0	553,725	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	22,732	22,732	1,221,398	0	2,507,216	30.00
31.00	03100	INTENSIVE CARE UNIT	4,803	4,803	915,718	0	1,430,094	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	15,444	15,444	1,482,828	0	4,930,784	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	171	171	0	0	53,286	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,345	4,345	557,006	0	1,231,676	54.00
54.01	03630	ULTRA SOUND	509	509	167,071	0	374,632	54.01
56.00	05600	RADIOISOTOPE	427	427	29,653	0	235,462	56.00
57.00	05700	CT SCAN	0	0	137,272	0	341,512	57.00
58.00	05800	MRI	0	0	0	0	118,889	58.00
60.00	06000	LABORATORY	2,987	2,987	637,286	0	1,434,135	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	152	152	9,273	0	25,362	62.00
65.00	06500	RESPIRATORY THERAPY	1,366	1,366	291,345	0	447,351	65.00
66.00	06600	PHYSICAL THERAPY	551	551	391	0	684,132	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	85	0	170,890	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	6	0	11,413	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	210,784	0	279,703	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	102,889	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	2,001,000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	824,023	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	89,310	0	133,101	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	792,783	0	1,102,496	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	196,938	0	371,317	88.01
91.00	09100	EMERGENCY	6,282	6,282	943,073	0	1,616,786	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	114,756	114,756	11,321,201	-6,684,922	26,889,168	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	385	385	0	0	11,358	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	374	374	0	0	11,033	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	MARKETING	205	205	63,232	0	363,429	194.01
194.02	07954	SENIOR CIRCLE	540	540	58,343	0	98,365	194.02
194.03	07953	VACANT SPACE	9,662	9,662	0	0	285,050	194.03
194.04	07952	GUEST MEALS	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,190,329	2,524,645	2,197,573		6,684,922	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	9.452907	20.049277	0.192049		0.241696	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			23,750		400,575	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.002076		0.014483	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0294 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B-1 | Date/Time Prepared: 5/30/2019 12:58 pm

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTES)	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	87,053					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	552	141,262				8.00
9.00	00900	HOUSEKEEPING	4,150	0	82,351			9.00
10.00	01000	DIETARY	3,878	0	3,878	45,750		10.00
11.00	01100	CAFETERIA	0	0	0	0	13,395	11.00
13.00	01300	NURSING ADMINISTRATION	1,284	0	1,284	0	872	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,742	0	2,742	0	548	14.00
15.00	01500	PHARMACY	1,018	0	1,018	0	303	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,494	0	2,494	0	769	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	22,732	46,617	22,732	39,998	2,091	30.00
31.00	03100	INTENSIVE CARE UNIT	4,803	8,475	4,803	4,738	590	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	15,444	28,254	15,444	0	2,431	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	171	0	171	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,345	8,475	4,345	0	1,042	54.00
54.01	03630	ULTRA SOUND	509	0	509	0	292	54.01
56.00	05600	RADIOISOTOPE	427	0	427	0	47	56.00
57.00	05700	CT SCAN	0	0	0	0	266	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	2,987	0	2,987	0	1,402	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	152	0	152	0	20	62.00
65.00	06500	RESPIRATORY THERAPY	1,366	4,238	1,366	0	551	65.00
66.00	06600	PHYSICAL THERAPY	551	0	551	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	486	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	144	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
91.00	09100	EMERGENCY	6,282	45,203	6,282	0	1,344	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	75,887	141,262	71,185	44,736	13,198	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	385	0	385	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	374	0	374	0	0	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	MARKETING	205	0	205	0	97	194.01
194.02	07954	SENIOR CIRCLE	540	0	540	0	100	194.02
194.03	07953	VACANT SPACE	9,662	0	9,662	0	0	194.03
194.04	07952	GUEST MEALS	0	0	0	1,014	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	2,801,092	161,165	907,535	751,212	290,361	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	32.176858	1.140894	11.020328	16.419934	21.676820	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	759,243	22,772	167,657	162,934	3,387	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	8.721618	0.161204	2.035883	3.561399	0.252856	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0294 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B-1 | Date/Time Prepared: 5/30/2019 12:58 pm

		Cost Center Description	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)		
			13.00	14.00	15.00	16.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	7,084,465					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	4,483,101				14.00
15.00	01500	PHARMACY	392,447	24,108	824,023			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	4,236	0	235,897,363		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,221,398	91,147	0	8,056,754		30.00
31.00	03100	INTENSIVE CARE UNIT	915,718	43,049	0	1,354,085		31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,482,829	1,856,553	0	48,887,992		50.00
51.00	05100	RECOVERY ROOM	0	0	0	0		51.00
53.00	05300	ANESTHESIOLOGY	0	48,095	0	23,462,251		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	557,006	36,988	0	9,350,796		54.00
54.01	03630	ULTRA SOUND	167,071	6,701	0	2,734,709		54.01
56.00	05600	RADIOISOTOPE	29,653	3,457	0	1,827,505		56.00
57.00	05700	CT SCAN	137,272	30,379	0	32,048,580		57.00
58.00	05800	MRI	0	34	0	3,120,410		58.00
60.00	06000	LABORATORY	637,286	206,977	0	37,100,745		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	9,273	0	0	539,845		62.00
65.00	06500	RESPIRATORY THERAPY	291,345	31,542	0	4,472,874		65.00
66.00	06600	PHYSICAL THERAPY	0	7,518	0	4,760,515		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	764	0	1,039,131		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	69,396		68.00
69.00	06900	ELECTROCARDIOLOGY	210,784	1,542	0	5,641,827		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	59,653	0	1,273,344		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,909,204	0	17,698,275		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	824,023	9,122,147		73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0		74.00
76.00	03020	ACUPUNCTURE	0	0	0	0		76.00
76.01	03610	SLEEP LAB	89,310	12,162	0	1,044,774		76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	24,590	0	817,194		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	545,003		88.01
91.00	09100	EMERGENCY	943,073	69,430	0	20,929,211		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	7,084,465	4,468,129	824,023	235,897,363		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0		194.00
194.01	07951	MARKETING	0	10,456	0	0		194.01
194.02	07954	SENIOR CIRCLE	0	4,516	0	0		194.02
194.03	07953	VACANT SPACE	0	0	0	0		194.03
194.04	07952	GUEST MEALS	0	0	0	0		194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,386,507	864,998	827,702	812,778		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.195711	0.192946	1.004465	0.003445		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	68,726	119,539	54,442	109,349		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.009701	0.026664	0.066069	0.000464		205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0294 | Period: From 01/01/2018 To 12/31/2018 | Worksheet C Part I Date/Time Prepared: 5/30/2019 12:58 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	Costs RCE Disallowance	Costs Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,134,816		5,134,816	0	5,134,816	30.00
31.00	03100	INTENSIVE CARE UNIT	2,275,661		2,275,661	0	2,275,661	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	7,691,550		7,691,550	0	7,691,550	50.00
51.00	05100	RECOVERY ROOM	0		0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	163,658		163,658	0	163,658	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,897,676		1,897,676	0	1,897,676	54.00
54.01	03630	ULTRA SOUND	536,908		536,908	0	536,908	54.01
56.00	05600	RADIOISOTOPE	324,603		324,603	0	324,603	56.00
57.00	05700	CT SCAN	572,955		572,955	0	572,955	57.00
58.00	05800	MRI	158,381		158,381	0	158,381	58.00
60.00	06000	LABORATORY	2,232,652		2,232,652	0	2,232,652	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	42,167		42,167	0	42,167	62.00
65.00	06500	RESPIRATORY THERAPY	709,775	0	709,775	0	709,775	65.00
66.00	06600	PHYSICAL THERAPY	891,136	0	891,136	0	891,136	66.00
67.00	06700	OCCUPATIONAL THERAPY	215,920	0	215,920	0	215,920	67.00
68.00	06800	SPEECH PATHOLOGY	14,410	0	14,410	0	14,410	68.00
69.00	06900	ELECTROCARDIOLOGY	418,828		418,828	0	418,828	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	143,654		143,654	0	143,654	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,913,979		2,913,979	0	2,913,979	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,882,314		1,882,314	0	1,882,314	73.00
74.00	07400	RENAL DIALYSIS	0		0	0	0	74.00
76.00	03020	ACUPUNCTURE	0		0	0	0	76.00
76.01	03610	SLEEP LAB	191,817		191,817	0	191,817	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,376,525		1,376,525	0	1,376,525	88.00
88.01	08801	RURAL HEALTH CLINIC II	462,941		462,941	0	462,941	88.01
91.00	09100	EMERGENCY	2,629,695		2,629,695	0	2,629,695	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,037,629		1,037,629		1,037,629	92.00
200.00		Subtotal (see instructions)	33,919,650	0	33,919,650	0	33,919,650	200.00
201.00		Less Observation Beds	1,037,629		1,037,629		1,037,629	201.00
202.00		Total (see instructions)	32,882,021	0	32,882,021	0	32,882,021	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0294 | Period: From 01/01/2018 To 12/31/2018 | Worksheet C Part I Date/Time Prepared: 5/30/2019 12:58 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	6,763,516		6,763,516			30.00
31.00	03100	INTENSIVE CARE UNIT	1,354,085		1,354,085			31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	14,380,150	34,507,842	48,887,992	0.157330	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0.000000	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	6,929,020	16,533,231	23,462,251	0.006975	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,579,759	7,771,037	9,350,796	0.202943	0.000000	54.00
54.01	03630	ULTRA SOUND	265,456	2,469,253	2,734,709	0.196331	0.000000	54.01
56.00	05600	RADIOISOTOPE	150,993	1,676,512	1,827,505	0.177621	0.000000	56.00
57.00	05700	CT SCAN	5,685,189	26,363,391	32,048,580	0.017878	0.000000	57.00
58.00	05800	MRI	103,286	3,017,124	3,120,410	0.050756	0.000000	58.00
60.00	06000	LABORATORY	6,525,295	30,575,450	37,100,745	0.060178	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	324,881	214,964	539,845	0.078109	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	3,022,895	1,449,979	4,472,874	0.158684	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	953,182	3,807,333	4,760,515	0.187193	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	383,019	656,112	1,039,131	0.207789	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	28,083	41,313	69,396	0.207649	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	1,231,116	4,410,711	5,641,827	0.074236	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,191,484	81,860	1,273,344	0.112816	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	11,872,779	5,825,496	17,698,275	0.164648	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,871,804	4,250,343	9,122,147	0.206346	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0.000000	0.000000	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0.000000	0.000000	76.00
76.01	03610	SLEEP LAB	0	1,044,774	1,044,774	0.183597	0.000000	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	817,194	817,194			88.00
88.01	08801	RURAL HEALTH CLINIC II	0	545,003	545,003			88.01
91.00	09100	EMERGENCY	2,731,129	18,198,082	20,929,211	0.125647	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	346,645	946,593	1,293,238	0.802350	0.000000	92.00
200.00		Subtotal (see instructions)	70,693,766	165,203,597	235,897,363			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	70,693,766	165,203,597	235,897,363			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0294 | Period: From 01/01/2018 To 12/31/2018 | Worksheet C Part I Date/Time Prepared: 5/30/2019 12:58 pm

Title XVIII | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio
			11.00
		INPATIENT ROUTINE SERVICE COST CENTERS	
30.00	03000	ADULTS & PEDIATRICS	
31.00	03100	INTENSIVE CARE UNIT	
		ANCILLARY SERVICE COST CENTERS	
50.00	05000	OPERATING ROOM	0.157330
51.00	05100	RECOVERY ROOM	0.000000
53.00	05300	ANESTHESIOLOGY	0.006975
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.202943
54.01	03630	ULTRA SOUND	0.196331
56.00	05600	RADIOISOTOPE	0.177621
57.00	05700	CT SCAN	0.017878
58.00	05800	MRI	0.050756
60.00	06000	LABORATORY	0.060178
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.078109
65.00	06500	RESPIRATORY THERAPY	0.158684
66.00	06600	PHYSICAL THERAPY	0.187193
67.00	06700	OCCUPATIONAL THERAPY	0.207789
68.00	06800	SPEECH PATHOLOGY	0.207649
69.00	06900	ELECTROCARDIOLOGY	0.074236
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.112816
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.164648
73.00	07300	DRUGS CHARGED TO PATIENTS	0.206346
74.00	07400	RENAL DIALYSIS	0.000000
76.00	03020	ACUPUNCTURE	0.000000
76.01	03610	SLEEP LAB	0.183597
		OUTPATIENT SERVICE COST CENTERS	
88.00	08800	RURAL HEALTH CLINIC	
88.01	08801	RURAL HEALTH CLINIC II	
91.00	09100	EMERGENCY	0.125647
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.802350
200.00		Subtotal (see instructions)	
201.00		Less Observation Beds	
202.00		Total (see instructions)	

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0294 | Period: From 01/01/2018 To 12/31/2018 | Worksheet C Part I Date/Time Prepared: 5/30/2019 12:58 pm

Title XIX | Hospital

		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	5,134,816		5,134,816	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	2,275,661		2,275,661	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	7,691,550		7,691,550	0	0	50.00
51.00	05100	RECOVERY ROOM	0		0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	163,658		163,658	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,897,676		1,897,676	0	0	54.00
54.01	03630	ULTRA SOUND	536,908		536,908	0	0	54.01
56.00	05600	RADIOISOTOPE	324,603		324,603	0	0	56.00
57.00	05700	CT SCAN	572,955		572,955	0	0	57.00
58.00	05800	MRI	158,381		158,381	0	0	58.00
60.00	06000	LABORATORY	2,232,652		2,232,652	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	42,167		42,167	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	709,775	0	709,775	0	0	65.00
66.00	06600	PHYSICAL THERAPY	891,136	0	891,136	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	215,920	0	215,920	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	14,410	0	14,410	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	418,828		418,828	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	143,654		143,654	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,913,979		2,913,979	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,882,314		1,882,314	0	0	73.00
74.00	07400	RENAL DIALYSIS	0		0	0	0	74.00
76.00	03020	ACUPUNCTURE	0		0	0	0	76.00
76.01	03610	SLEEP LAB	191,817		191,817	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,376,525		1,376,525	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	462,941		462,941	0	0	88.01
91.00	09100	EMERGENCY	2,629,695		2,629,695	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
200.00		Subtotal (see instructions)	32,882,021	0	32,882,021	0	0	200.00
201.00		Less Observation Beds	0		0		0	201.00
202.00		Total (see instructions)	32,882,021	0	32,882,021	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0294 | Period: From 01/01/2018 To 12/31/2018 | Worksheet C Part I Date/Time Prepared: 5/30/2019 12:58 pm

Title XIX | Hospital

		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	6,763,516		6,763,516			30.00
31.00	03100	INTENSIVE CARE UNIT	1,354,085		1,354,085			31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	14,380,150	34,507,842	48,887,992	0.157330	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0.000000	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	6,929,020	16,533,231	23,462,251	0.006975	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,579,759	7,771,037	9,350,796	0.202943	0.000000	54.00
54.01	03630	ULTRA SOUND	265,456	2,469,253	2,734,709	0.196331	0.000000	54.01
56.00	05600	RADIOISOTOPE	150,993	1,676,512	1,827,505	0.177621	0.000000	56.00
57.00	05700	CT SCAN	5,685,189	26,363,391	32,048,580	0.017878	0.000000	57.00
58.00	05800	MRI	103,286	3,017,124	3,120,410	0.050756	0.000000	58.00
60.00	06000	LABORATORY	6,525,295	30,575,450	37,100,745	0.060178	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	324,881	214,964	539,845	0.078109	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	3,022,895	1,449,979	4,472,874	0.158684	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	953,182	3,807,333	4,760,515	0.187193	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	383,019	656,112	1,039,131	0.207789	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	28,083	41,313	69,396	0.207649	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	1,231,116	4,410,711	5,641,827	0.074236	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,191,484	81,860	1,273,344	0.112816	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	11,872,779	5,825,496	17,698,275	0.164648	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,856,566	4,183,676	9,040,242	0.208215	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0.000000	0.000000	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0.000000	0.000000	76.00
76.01	03610	SLEEP LAB	0	1,044,774	1,044,774	0.183597	0.000000	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	817,194	817,194	1.684453	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	545,003	545,003	0.849428	0.000000	88.01
91.00	09100	EMERGENCY	2,731,129	18,198,082	20,929,211	0.125647	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	346,645	946,593	1,293,238	0.000000	0.000000	92.00
200.00		Subtotal (see instructions)	70,678,528	165,136,930	235,815,458			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	70,678,528	165,136,930	235,815,458			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0294 | Period: From 01/01/2018 To 12/31/2018 | Worksheet C Part I Date/Time Prepared: 5/30/2019 12:58 pm

Title XIX | Hospital

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

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 14-0294 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part I Date/Time Prepared: 5/30/2019 12:58 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	1,122,543	0	1,122,543	3,756	298.87	30.00
31.00	INTENSIVE CARE UNIT	245,028		245,028	355	690.22	31.00
200.00	Total (lines 30 through 199)	1,367,571		1,367,571	4,111		200.00

	Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)	
		6.00	7.00	
	INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	ADULTS & PEDIATRICS	1,722	514,654	30.00
31.00	INTENSIVE CARE UNIT	224	154,609	31.00
200.00	Total (lines 30 through 199)	1,946	669,263	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 14-0294 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part II Date/Time Prepared: 5/30/2019 12:58 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	787,893	48,887,992	0.016116	5,940,936	95,744	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0	0	51.00
53.00	05300	ANESTHESIOLOGY	19,823	23,462,251	0.000845	2,840,679	2,400	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	206,280	9,350,796	0.022060	928,177	20,476	54.00
54.01	03630	ULTRA SOUND	29,408	2,734,709	0.010754	118,148	1,271	54.01
56.00	05600	RADIOISOTOPE	21,902	1,827,505	0.011985	77,158	925	56.00
57.00	05700	CT SCAN	22,311	32,048,580	0.000696	3,354,498	2,335	57.00
58.00	05800	MRI	3,171	3,120,410	0.001016	57,257	58	58.00
60.00	06000	LABORATORY	171,620	37,100,745	0.004626	3,952,928	18,286	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	6,850	539,845	0.012689	238,053	3,021	62.00
65.00	06500	RESPIRATORY THERAPY	68,643	4,472,874	0.015347	1,897,667	29,123	65.00
66.00	06600	PHYSICAL THERAPY	34,502	4,760,515	0.007248	569,987	4,131	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,977	1,039,131	0.002865	192,095	550	67.00
68.00	06800	SPEECH PATHOLOGY	197	69,396	0.002839	18,335	52	68.00
69.00	06900	ELECTROCARDIOLOGY	9,316	5,641,827	0.001651	764,591	1,262	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,672	1,273,344	0.002884	779,664	2,249	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	88,102	17,698,275	0.004978	4,921,571	24,500	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	70,609	9,122,147	0.007740	2,496,325	19,322	73.00
74.00	07400	RENAL DIALYSIS	0	0	0.000000	0	0	74.00
76.00	03020	ACUPUNCTURE	0	0	0.000000	0	0	76.00
76.01	03610	SLEEP LAB	3,824	1,044,774	0.003660	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	18,648	817,194	0.022820	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	6,040	545,003	0.011083	0	0	88.01
91.00	09100	EMERGENCY	306,623	20,929,211	0.014650	1,526,789	22,367	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	226,840	1,293,238	0.175405	177,836	31,193	92.00
200.00		Total (lines 50 through 199)	2,109,251	227,779,762		30,852,694	279,265	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 14-0294 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part III Date/Time Prepared: 5/30/2019 12:58 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	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
200.00		Total (lines 30 through 199)	0	0	0	0	0	200.00

		Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
			4.00	5.00	6.00	7.00	8.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	3,756	0.00	1,722	30.00
31.00	03100	INTENSIVE CARE UNIT		0	355	0.00	224	31.00
200.00		Total (lines 30 through 199)		0	4,111		1,946	200.00

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

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0294 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part IV Date/Time Prepared: 5/30/2019 12:58 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	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0294 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part IV Date/Time Prepared: 5/30/2019 12:58 pm

Title XVIII | Hospital | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	48,887,992	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	23,462,251	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	9,350,796	0.000000	54.00
54.01	03630	ULTRA SOUND	0	0	0	2,734,709	0.000000	54.01
56.00	05600	RADIOISOTOPE	0	0	0	1,827,505	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	32,048,580	0.000000	57.00
58.00	05800	MRI	0	0	0	3,120,410	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	37,100,745	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	539,845	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	4,472,874	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	4,760,515	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,039,131	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	69,396	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	5,641,827	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	1,273,344	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	17,698,275	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	9,122,147	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0.000000	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0.000000	76.00
76.01	03610	SLEEP LAB	0	0	0	1,044,774	0.000000	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	817,194	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	545,003	0.000000	88.01
91.00	09100	EMERGENCY	0	0	0	20,929,211	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	1,293,238	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	227,779,762		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0294 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part IV | Date/Time Prepared: 5/30/2019 12:58 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	0.000000	5,940,936	0	9,865,494	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.000000	2,840,679	0	4,455,195	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	928,177	0	2,363,241	0	54.00
54.01	03630	ULTRA SOUND	0.000000	118,148	0	703,656	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	77,158	0	810,325	0	56.00
57.00	05700	CT SCAN	0.000000	3,354,498	0	9,280,432	0	57.00
58.00	05800	MRI	0.000000	57,257	0	1,025,098	0	58.00
60.00	06000	LABORATORY	0.000000	3,952,928	0	3,533,785	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000	238,053	0	74,237	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.000000	1,897,667	0	610,924	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	569,987	0	53,155	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	192,095	0	21,948	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	18,335	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	764,591	0	1,885,916	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	779,664	0	59,739	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	4,921,571	0	1,829,933	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	2,496,325	0	1,456,578	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	74.00
76.00	03020	ACUPUNCTURE	0.000000	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0.000000	0	0	384,120	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000	0	0	0	0	88.01
91.00	09100	EMERGENCY	0.000000	1,526,789	0	4,165,096	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	177,836	0	333,425	0	92.00
200.00		Total (lines 50 through 199)		30,852,694	0	42,912,297	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-0294 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part V Date/Time Prepared: 5/30/2019 12:58 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	0.157330	9,865,494	0	0	1,552,138	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.006975	4,455,195	0	0	31,075	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.202943	2,363,241	0	0	479,603	54.00
54.01	03630	ULTRA SOUND	0.196331	703,656	0	0	138,149	54.01
56.00	05600	RADIOISOTOPE	0.177621	810,325	0	0	143,931	56.00
57.00	05700	CT SCAN	0.017878	9,280,432	0	0	165,916	57.00
58.00	05800	MRI	0.050756	1,025,098	0	0	52,030	58.00
60.00	06000	LABORATORY	0.060178	3,533,785	0	0	212,656	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.078109	74,237	0	0	5,799	62.00
65.00	06500	RESPIRATORY THERAPY	0.158684	610,924	0	0	96,944	65.00
66.00	06600	PHYSICAL THERAPY	0.187193	53,155	0	0	9,950	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.207789	21,948	0	0	4,561	67.00
68.00	06800	SPEECH PATHOLOGY	0.207649	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.074236	1,885,916	0	0	140,003	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.112816	59,739	0	0	6,740	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.164648	1,829,933	0	0	301,295	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.206346	1,456,578	8,273	0	300,559	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	74.00
76.00	03020	ACUPUNCTURE	0.000000	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0.183597	384,120	0	0	70,523	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000				0	88.01
91.00	09100	EMERGENCY	0.125647	4,165,096	0	0	523,332	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.802350	333,425	0	0	267,524	92.00
200.00		Subtotal (see instructions)		42,912,297	8,273	0	4,502,728	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		42,912,297	8,273	0	4,502,728	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-0294 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part V Date/Time Prepared: 5/30/2019 12:58 pm

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		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
54.01	03630	ULTRA SOUND	0	0		54.01
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MRI	0	0		58.00
60.00	06000	LABORATORY	0	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		62.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,707	0		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
76.00	03020	ACUPUNCTURE	0	0		76.00
76.01	03610	SLEEP LAB	0	0		76.01
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0		88.01
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
200.00		Subtotal (see instructions)	1,707	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	1,707	0		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-0294 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-1 | Date/Time Prepared: 5/30/2019 12:58 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)	3,756	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	3,756	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	2,997	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	1,722	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)	5,134,816	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)	5,134,816	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)	5,134,816	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)	1,367.10	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	2,354,146	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	2,354,146	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-0294 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-1 | Date/Time Prepared: 5/30/2019 12:58 pm

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	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	2,275,661	355	6,410.31	224	1,435,909	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	3,755,345	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	7,545,400	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)	669,263	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	279,265	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	948,528	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	6,596,872	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)	759	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,367.10	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,037,629	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-0294 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-1 | Date/Time Prepared: 5/30/2019 12:58 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	1,122,543	5,134,816	0.218614	1,037,629	226,840	90.00
91.00	Nursing School cost	0	5,134,816	0.000000	1,037,629	0	91.00
92.00	Allied health cost	0	5,134,816	0.000000	1,037,629	0	92.00
93.00	All other Medical Education	0	5,134,816	0.000000	1,037,629	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 14-0294 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-3 | Date/Time Prepared: 5/30/2019 12:58 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		3,897,799		30.00
31.00	03100	INTENSIVE CARE UNIT		852,009		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.157330	5,940,936	934,687	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.006975	2,840,679	19,814	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.202943	928,177	188,367	54.00
54.01	03630	ULTRA SOUND	0.196331	118,148	23,196	54.01
56.00	05600	RADIOISOTOPE	0.177621	77,158	13,705	56.00
57.00	05700	CT SCAN	0.017878	3,354,498	59,972	57.00
58.00	05800	MRI	0.050756	57,257	2,906	58.00
60.00	06000	LABORATORY	0.060178	3,952,928	237,879	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.078109	238,053	18,594	62.00
65.00	06500	RESPIRATORY THERAPY	0.158684	1,897,667	301,129	65.00
66.00	06600	PHYSICAL THERAPY	0.187193	569,987	106,698	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.207789	192,095	39,915	67.00
68.00	06800	SPEECH PATHOLOGY	0.207649	18,335	3,807	68.00
69.00	06900	ELECTROCARDIOLOGY	0.074236	764,591	56,760	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.112816	779,664	87,959	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.164648	4,921,571	810,327	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.206346	2,496,325	515,107	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	74.00
76.00	03020	ACUPUNCTURE	0.000000	0	0	76.00
76.01	03610	SLEEP LAB	0.183597	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000		0	88.01
91.00	09100	EMERGENCY	0.125647	1,526,789	191,836	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.802350	177,836	142,687	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		30,852,694	3,755,345	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)		30,852,694		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 14-0294 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-3 | Date/Time Prepared: 5/30/2019 12:58 pm

Title XIX | Hospital

		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
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.000000	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	0	0	54.00
54.01	03630	ULTRA SOUND	0.000000	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	57.00
58.00	05800	MRI	0.000000	0	0	58.00
60.00	06000	LABORATORY	0.000000	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.000000	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	74.00
76.00	03020	ACUPUNCTURE	0.000000	0	0	76.00
76.01	03610	SLEEP LAB	0.000000	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000	0	0	88.01
91.00	09100	EMERGENCY	0.000000	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		0	0	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)		0		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0294	Period: From 01/01/2018 To 12/31/2018	Worksheet E Part A Date/Time Prepared: 5/30/2019 12:58 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)	3,203,155	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	1,046,699	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)	332,540	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	632,022	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)	44.92	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 that 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)	4.14	30.00
31.00	Percentage of Medicaid patient days (see instructions)	15.16	31.00
32.00	Sum of lines 30 and 31	19.30	32.00
33.00	Allowable disproportionate share percentage (see instructions)	5.30	33.00
34.00	Disproportionate share adjustment (see instructions)	56,311	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0294	Period: From 01/01/2018 To 12/31/2018	Worksheet E Part A Date/Time Prepared: 5/30/2019 12:58 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)	6,766,695,164	8,272,872,447	35.00
35.01	Factor 3 (see instructions)	0.000017815	0.000024278	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	120,549	200,845	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	90,164	50,624	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	140,788		36.00
	Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)			
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)	0		40.00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0		41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0		41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)	0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)	0.00		45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)	0		46.00
47.00	Subtotal (see instructions)	4,779,493		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)	6,335,463		48.00

		Amount	
		1.00	
49.00	Total payment for inpatient operating costs (see instructions)	5,946,471	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)	419,022	50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)	0	51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).	0	52.00
53.00	Nursing and Allied Health Managed Care payment	0	53.00
54.00	Special add-on payments for new technologies	0	54.00
54.01	Islet isolation add-on payment	0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)	0	55.00
56.00	Cost of physicians' services in a teaching hospital (see intructions)	0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).	0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)	0	58.00
59.00	Total (sum of amounts on lines 49 through 58)	6,365,493	59.00
60.00	Primary payer payments	0	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)	6,365,493	61.00
62.00	Deductibles billed to program beneficiaries	584,120	62.00
63.00	Coinsurance billed to program beneficiaries	5,360	63.00
64.00	Allowable bad debts (see instructions)	156,568	64.00
65.00	Adjusted reimbursable bad debts (see instructions)	101,769	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	145,099	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	5,877,782	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)	0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96).(For SCH see instructions)	0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	70.00
70.50	Rural Community Hospital Demonstration Project (§410A Demonstration) adjustment (see instructions)	0	70.50
70.87	Demonstration payment adjustment amount before sequestration	0	70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)	0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)		70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)	-2,203	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)	-11,642	70.91
70.92	Bundled Model 1 discount amount (see instructions)	0	70.92
70.93	HVBP payment adjustment amount (see instructions)	-1,563	70.93
70.94	HRR adjustment amount (see instructions)	-42,381	70.94
70.95	Recovery of accelerated depreciation	0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0294	Period: From 01/01/2018 To 12/31/2018	Worksheet E Part A Date/Time Prepared: 5/30/2019 12:58 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)	0	0	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0	70.97
70.98	Low Volume Payment-3		0	70.98
70.99	HAC adjustment amount (see instructions)		0	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		5,819,993	71.00
71.01	Sequestration adjustment (see instructions)		116,400	71.01
71.02	Demonstration payment adjustment amount after sequestration		0	71.02
72.00	Interim payments		5,854,243	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)		-150,650	74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		285,191	75.00
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)			
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (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)	872,836	294,142	100.00
	HVBP Adjustment for HSP Bonus Payment			
101.00	HVBP adjustment factor (see instructions)	0.9981162138	0.9981000000	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)	-1,644	-559	102.00
	HRR Adjustment for HSP Bonus Payment			
103.00	HRR adjustment factor (see instructions)	0.9902	0.9895	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)	-8,554	-3,088	104.00
	Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment			
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
	Cost Reimbursement			
201.00	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)			201.00
202.00	Medicare discharges (see instructions)			202.00
203.00	Case-mix adjustment factor (see instructions)			203.00
	Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)			
204.00	Medicare target amount			204.00
205.00	Case-mix adjusted target amount (line 203 times line 204)			205.00
206.00	Medicare inpatient routine cost cap (line 202 times line 205)			206.00
	Adjustment to Medicare Part A Inpatient Reimbursement			
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)			208.00
209.00	Adjustment to Medicare IPPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
211.00	Total adjustment to Medicare IPPS payments (see instructions)			211.00
	Comparision of PPS versus Cost Reimbursement			
212.00	Total adjustment to Medicare Part A IPPS payments (from line 211)			212.00
213.00	Low-volume adjustment (see instructions)			213.00
218.00	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)			218.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0294	Period: From 01/01/2018 To 12/31/2018	Worksheet E Part B Date/Time Prepared: 5/30/2019 12:58 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	1,707	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	4,502,728	2.00
3.00	OPPS payments	3,479,880	3.00
4.00	Outlier payment (see instructions)	14,808	4.00
4.01	Outlier reconciliation amount (see instructions)	0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	1,707	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	8,273	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)	8,273	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)	8,273	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	6,566	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)	1,707	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	3,494,688	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)	17,420	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	670,013	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	2,808,962	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)	2,808,962	30.00
31.00	Primary payer payments	60	31.00
32.00	Subtotal (line 30 minus line 31)	2,808,902	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)	164,276	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	106,779	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	157,574	36.00
37.00	Subtotal (see instructions)	2,915,681	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		39.50
39.97	Demonstration payment adjustment amount before sequestration	0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	2,915,681	40.00
40.01	Sequestration adjustment (see instructions)	58,314	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
41.00	Interim payments	2,865,107	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	-7,740	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-0294 | Period: From 01/01/2018 To 12/31/2018 | Worksheet E-1 Part I | Date/Time Prepared: 5/30/2019 12:58 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		5,761,984		2,751,787	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		92,259		113,320	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)		5,854,243		2,865,107	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		150,650		7,740	6.02
7.00	Total Medicare program liability (see instructions)		5,703,593		2,857,367	7.00

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-0294 | Component CCN: 14-U294 | Period: From 01/01/2018 To 12/31/2018 | Worksheet E-1 Part I | Date/Time Prepared: 5/30/2019 12:58 pm

Title XVIII | Swing Beds - SNF | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		0		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		0		0	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		0		0	7.00

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

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 14-0294	Period: From 01/01/2018 To 12/31/2018	Worksheet E-1 Part II Date/Time Prepared: 5/30/2019 12:58 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 - SWING BEDS | Provider CCN: 14-0294 | Component CCN: 14-U294 | Period: From 01/01/2018 To 12/31/2018 | Worksheet E-2 | Date/Time Prepared: 5/30/2019 12:58 pm

Title XVIII | Swing Beds - SNF | PPS

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	0	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)			2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202, for Part B) (For CAH, see instructions)			3.00
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)		0.00	4.00
5.00	Program days	0	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)		0	6.00
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	0	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	0	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0	0	11.00
12.00	Subtotal (line 10 minus line 11)	0	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	0	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)	0	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)			16.50
16.55	Rural community hospital demonstration project (§410A Demonstration) payment adjustment (see instructions)	0		16.55
16.99	Demonstration payment adjustment amount before sequestration	0	0	16.99
17.00	Allowable bad debts (see instructions)	0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (see instructions)	0	0	19.00
19.01	Sequestration adjustment (see instructions)	0	0	19.01
19.02	Demonstration payment adjustment amount after sequestration)	0	0	19.02
20.00	Interim payments	0	0	20.00
21.00	Tentative settlement (for contractor use only)	0	0	21.00
22.00	Balance due provider/program (line 19 minus lines 19.01, 20, and 21)	0	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	23.00
	Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment			
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
	Cost Reimbursement			
201.00	Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital))			201.00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))			202.00
203.00	Total (sum of lines 201 and 202)			203.00
204.00	Medicare swing-bed SNF discharges (see instructions)			204.00
	Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)			
205.00	Medicare swing-bed SNF target amount			205.00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)			206.00
	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement			
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)			208.00
209.00	Adjustment to Medicare swing-bed SNF PPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
	Comparision of PPS versus Cost Reimbursement			
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see instructions)			215.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0294	Period: From 01/01/2018 To 12/31/2018	Worksheet E-3 Part VII Date/Time Prepared: 5/30/2019 12:58 pm
	Title XIX	Hospital	

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	0		1.00
2.00	Medical and other services		0	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	0	0	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	0	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	0		8.00
9.00	Ancillary service charges	0	0	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	0	0	12.00
	CUSTOMARY CHARGES			
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	0	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	0	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	0	0	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.			
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0		24.00
25.00	Capital exception payments (see instructions)	0		25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	0	0	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30.00	Excess of reasonable cost (from line 18)	0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	0	0	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	0	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	0	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	0	0	40.00
41.00	Interim payments	0	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 14-0294 | Period: From 01/01/2018 To 12/31/2018 | Worksheet G | Date/Time Prepared: 5/30/2019 12:58 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	-486,581	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	-3,959,322	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-2,106,186	0	0	0	6.00
7.00	Inventory	1,542,295	0	0	0	7.00
8.00	Prepaid expenses	479,363	0	0	0	8.00
9.00	Other current assets	72,262	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)	-4,458,169	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	961,157	0	0	0	12.00
13.00	Land improvements	420,627	0	0	0	13.00
14.00	Accumulated depreciation	-233,182	0	0	0	14.00
15.00	Buildings	28,810,164	0	0	0	15.00
16.00	Accumulated depreciation	-10,478,314	0	0	0	16.00
17.00	Leasehold improvements	5,943,708	0	0	0	17.00
18.00	Accumulated depreciation	-2,978,235	0	0	0	18.00
19.00	Fixed equipment	2,274,793	0	0	0	19.00
20.00	Accumulated depreciation	-1,470,094	0	0	0	20.00
21.00	Automobiles and trucks	28,013	0	0	0	21.00
22.00	Accumulated depreciation	-26,759	0	0	0	22.00
23.00	Major movable equipment	9,838,563	0	0	0	23.00
24.00	Accumulated depreciation	-8,663,039	0	0	0	24.00
25.00	Minor equipment depreciable	3,392,321	0	0	0	25.00
26.00	Accumulated depreciation	-2,965,759	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)	24,853,964	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	-13,272,410	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	-13,272,410	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	7,123,385	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	638,149	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,056,491	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	-28,334,240	0	0	0	43.00
44.00	Other current liabilities	318,244	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	-26,321,356	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	0	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	-26,321,356	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	33,444,741				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)	33,444,741	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	7,123,385	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 14-0294 | Period: From 01/01/2018 To 12/31/2018 | Worksheet G-1 | Date/Time Prepared: 5/30/2019 12:58 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		28,902,995		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		4,556,837				2.00
3.00	Total (sum of line 1 and line 2)		33,459,832		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		33,459,832		0		11.00
12.00	RECONCILIATION ITEM	84,063		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)		84,063		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		33,375,769		0		19.00

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

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 14-0294 | Period: From 01/01/2018 To 12/31/2018 | Worksheet G-2 Parts I & II Date/Time Prepared: 5/30/2019 12:58 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	6,763,516		6,763,516	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	6,763,516		6,763,516	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	1,354,085		1,354,085	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)	1,354,085		1,354,085	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	8,117,601		8,117,601	17.00
18.00	Ancillary services	62,576,165	145,747,969	208,324,134	18.00
19.00	Outpatient services	0	18,077,494	18,077,494	19.00
20.00	RURAL HEALTH CLINIC	0	917,194	917,194	20.00
20.01	RURAL HEALTH CLINIC II	0	545,003	545,003	20.01
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	70,693,766	165,287,660	235,981,426	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		40,373,153		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		40,373,153		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 14-0294	Period: From 01/01/2018 To 12/31/2018	Worksheet G-3 Date/Time Prepared: 5/30/2019 12:58 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	235,981,426	1.00
2.00	Less contractual allowances and discounts on patients' accounts	191,297,267	2.00
3.00	Net patient revenues (line 1 minus line 2)	44,684,159	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	40,373,153	4.00
5.00	Net income from service to patients (line 3 minus line 4)	4,311,006	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	INCOME - OTHER	314,798	24.00
25.00	Total other income (sum of lines 6-24)	314,798	25.00
26.00	Total (line 5 plus line 25)	4,625,804	26.00
27.00	EXPENSES ADJ.	68,967	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	68,967	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	4,556,837	29.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 14-0294	Period: From 01/01/2018 To 12/31/2018	Worksheet L Parts I-III Date/Time Prepared: 5/30/2019 12:58 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	341,205	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	77,817	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)	9.18	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)	419,022	12.00
		1.00	
	PART II - PAYMENT UNDER REASONABLE COST		
1.00	Program inpatient routine capital cost (see instructions)	0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)	0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)	0	3.00
4.00	Capital cost payment factor (see instructions)	0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)	0	5.00
		1.00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS		
1.00	Program inpatient capital costs (see instructions)	0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)	0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)	0	3.00
4.00	Applicable exception percentage (see instructions)	0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)	0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)	0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)	0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)	0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)	0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)	0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)	0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)	0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)	0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)	0	14.00
15.00	Current year allowable operating and capital payment (see instructions)	0	15.00
16.00	Current year operating and capital costs (see instructions)	0	16.00
17.00	Current year exception offset amount (see instructions)	0	17.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-0294 | Component CCN: 14-8524 | Period: From 01/01/2018 To 12/31/2018 | Worksheet M-1 | Date/Time Prepared: 5/30/2019 12:58 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	546,880	0	546,880	0	546,880	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	95,266	0	95,266	0	95,266	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	75,647	0	75,647	0	75,647	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	3,375	3,375	0	3,375	8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	717,793	3,375	721,168	0	721,168	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	6,841	6,841	0	6,841	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	6,841	6,841	0	6,841	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	717,793	10,216	728,009	0	728,009	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	55,403	55,403	0	55,403	29.00
30.00	Administrative Costs	74,990	163,177	238,167	-71,336	166,831	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	74,990	218,580	293,570	-71,336	222,234	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	792,783	228,796	1,021,579	-71,336	950,243	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-0294 | Component CCN: 14-8524 | Period: From 01/01/2018 To 12/31/2018 | Worksheet M-1 | Date/Time Prepared: 5/30/2019 12:58 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	546,880		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	95,266		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	75,647		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	3,375		8.00
9.00	Other Facility Health Care Staff Costs	0	0		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	721,168		10.00
11.00	Physician Services Under Agreement	0	0		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	0		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0		14.00
15.00	Medical Supplies	0	6,841		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	6,841		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	728,009		22.00
	COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
25.01	Telehealth	0	0		25.01
25.02	Chronic Care Management	0	0		25.02
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs				27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	55,403		29.00
30.00	Administrative Costs	0	166,831		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	222,234		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	950,243		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-0294 | Component CCN: 14-8523 | Period: From 01/01/2018 To 12/31/2018 | Worksheet M-1 | Date/Time Prepared: 5/30/2019 12:58 pm

RHC II | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	0	0	0	0	0	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	112,072	0	112,072	0	112,072	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	55,579	0	55,579	0	55,579	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	28,351	28,351	0	28,351	8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	167,651	28,351	196,002	0	196,002	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	11,220	11,220	0	11,220	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	11,220	11,220	0	11,220	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	167,651	39,571	207,222	0	207,222	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	43,443	43,443	0	43,443	29.00
30.00	Administrative Costs	29,287	95,436	124,723	-41,893	82,830	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	29,287	138,879	168,166	-41,893	126,273	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	196,938	178,450	375,388	-41,893	333,495	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-0294 | Component CCN: 14-8523 | Period: From 01/01/2018 To 12/31/2018 | Worksheet M-1 | Date/Time Prepared: 5/30/2019 12:58 pm

RHC II | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	0		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	112,072		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	55,579		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	28,351		8.00
9.00	Other Facility Health Care Staff Costs	0	0		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	196,002		10.00
11.00	Physician Services Under Agreement	0	0		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	0		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0		14.00
15.00	Medical Supplies	0	11,220		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	11,220		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	207,222		22.00
	COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
25.01	Telehealth	0	0		25.01
25.02	Chronic Care Management	0	0		25.02
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs				27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	43,443		29.00
30.00	Administrative Costs	0	82,830		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	126,273		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	333,495		32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-0294 | Component CCN: 14-8524 | Period: From 01/01/2018 To 12/31/2018 | Worksheet M-2 | Date/Time Prepared: 5/30/2019 12:58 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	2.20	2,481	4,200	9,240		1.00
2.00	Physician Assistant	0.00	0	0	0		2.00
3.00	Nurse Practitioner	1.00	3,006	2,100	2,100		3.00
4.00	Subtotal (sum of lines 1 through 3)	3.20	5,487		11,340	11,340	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	3.20	5,487			11,340	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)					728,009	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)					728,009	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)					222,234	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					426,282	15.00
16.00	Total overhead (sum of lines 14 and 15)					648,516	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					648,516	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					648,516	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					1,376,525	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-0294 | Component CCN: 14-8523 | Period: From 01/01/2018 To 12/31/2018 | Worksheet M-2 | Date/Time Prepared: 5/30/2019 12:58 pm

RHC II | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	0.00	0	0	0		1.00
2.00	Physician Assistant	0.00	0	0	0		2.00
3.00	Nurse Practitioner	1.00	4,586	2,100	2,100		3.00
4.00	Subtotal (sum of lines 1 through 3)	1.00	4,586		2,100	4,586	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)	1.00	4,586			4,586	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)					207,222	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)					207,222	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)					126,273	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					129,446	15.00
16.00	Total overhead (sum of lines 14 and 15)					255,719	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					255,719	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					255,719	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					462,941	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 14-0294 Component CCN: 14-8524	Period: From 01/01/2018 To 12/31/2018	Worksheet M-3 Date/Time Prepared: 5/30/2019 12:58 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)		1,376,525	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)		38,662	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		1,337,863	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		11,340	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)		0	5.00
6.00	Total adjusted visits (line 4 plus line 5)		11,340	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		117.98	7.00
		Calculation of Limit (1)		
		Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	83.45	83.45	8.00
9.00	Rate for Program covered visits (see instructions)	117.98	117.98	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	1,848	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	218,027	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	218,027	16.00
16.01	Total program charges (see instructions)(from contractor's records)		278,235	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		40,307	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		31,585	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.)		123,126	16.04
16.05	Total program cost (see instructions)	0	154,711	16.05
17.00	Primary payer amounts		113	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		32,535	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		41,079	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		154,598	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		38,662	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		193,260	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)		193,260	26.00
26.01	Sequestration adjustment (see instructions)		3,865	26.01
26.02	Demonstration payment adjustment amount after sequestration		0	26.02
27.00	Interim payments		149,577	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)		39,818	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0	30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 14-0294 Component CCN: 14-8523	Period: From 01/01/2018 To 12/31/2018	Worksheet M-3 Date/Time Prepared: 5/30/2019 12:58 pm
	Title XVIII	RHC II	Cost

			1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES			
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)		462,941	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)		30,760	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		432,181	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		4,586	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)		4,586	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		94.24	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)	83.45	83.45	8.00
9.00	Rate for Program covered visits (see instructions)	94.24	94.24	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	1,019	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	96,031	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	96,031	16.00
16.01	Total program charges (see instructions)(from contractor's records)		152,475	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		9,844	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		6,200	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.)		54,542	16.04
16.05	Total program cost (see instructions)	0	60,742	16.05
17.00	Primary payer amounts		79	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		21,653	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		24,196	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		60,663	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		30,760	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		91,423	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)		91,423	26.00
26.01	Sequestration adjustment (see instructions)		1,828	26.01
26.02	Demonstration payment adjustment amount after sequestration		0	26.02
27.00	Interim payments		93,454	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)		-3,859	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0	30.00

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

Provider CCN: 14-0294 | Component CCN: 14-8524 | Period: From 01/01/2018 To 12/31/2018 | Worksheet M-4 | Date/Time Prepared: 5/30/2019 12:58 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)	721,168	721,168	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.007000	0.016500	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	5,048	11,899	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	2,538	962	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	7,586	12,861	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	728,009	728,009	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	648,516	648,516	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.010420	0.017666	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	6,758	11,457	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	14,344	24,318	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	28	66	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	512.29	368.45	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	28	66	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	14,344	24,318	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)		38,662	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)		38,662	16.00

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

Provider CCN: 14-0294 | Component CCN: 14-8523 | Period: From 01/01/2018 To 12/31/2018 | Worksheet M-4 | Date/Time Prepared: 5/30/2019 12:58 pm

Title XVIII | RHC II | Cost

		Pneumococcal	Influenza	
		1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	196,002	196,002	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.027800	0.012000	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	5,449	2,352	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	1,618	4,350	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	7,067	6,702	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	207,222	207,222	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	255,719	255,719	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.034104	0.032342	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	8,721	8,270	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	15,788	14,972	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	111	48	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	142.23	311.92	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	111	48	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	15,788	14,972	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)		30,760	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)		30,760	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 14-0294 Component CCN: 14-8524	Period: From 01/01/2018 To 12/31/2018	Worksheet M-5 Date/Time Prepared: 5/30/2019 12:58 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		149,577	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)		149,577	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		39,818	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		189,395	7.00

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

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

Provider CCN: 14-0294 | Component CCN: 14-8523 | Period: From 01/01/2018 To 12/31/2018 | Worksheet M-5 | Date/Time Prepared: 5/30/2019 12:58 pm

RHC II | Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		93,454	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)		93,454	4.00
	TO BE COMPLETED BY CONTRACTOR			
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			5.00
	Program to Provider			
5.01			0	5.01
5.02			0	5.02
5.03			0	5.03
	Provider to Program			
5.50			0	5.50
5.51			0	5.51
5.52			0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00
6.01	SETTLEMENT TO PROVIDER		0	6.01
6.02	SETTLEMENT TO PROGRAM		3,859	6.02
7.00	Total Medicare program liability (see instructions)		89,595	7.00

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