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: 14-1308	Period: From 05/01/2017 To 04/30/2018	Worksheet S Parts I-III Date/Time Prepared: 9/26/2018 1:51 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 9/26/2018 Time: 1:51 pm
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by WASHINGTON COUNTY HOSPITAL (14-1308) for the cost reporting period beginning 05/01/2017 and ending 04/30/2018 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

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

_____
Title

_____
Date

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	99,562	94,076	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	-198,972	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
10.00	RURAL HEALTH CLINIC I	0		6,107		0	10.00
200.00	Total	0	-99,410	100,183	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: 14-1308 | Period: From 05/01/2017 To 04/30/2018 | Worksheet S-2 Part I | Date/Time Prepared: 9/26/2018 12:59 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 705 SOUTH GRAND AVENUE	PO Box:			1.00
2.00	City: NASHVILLE	State: IL	Zip Code: 62263	County: WASHINGTON	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	WASHINGTON COUNTY HOSPITAL	141308	99914	1	12/01/2000	N	O	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	WASHINGTON COUNTY SWING BED	14Z308	99914		08/18/2000	N	O	N	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC	WASHINTON COUNTY EXTENDED CARE								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	GRAND STREET RHC	143472	99914		08/01/2005	N	O	N	15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	05/01/2017	04/30/2018	20.00
21.00	Type of Control (see instructions)	11		21.00
	Inpatient PPS Information			
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	N	N	22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	N	N	22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N	22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.	N	N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	3	N	23.00

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	0	0	0	0	0	0	24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0		25.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1308 | Period: From 05/01/2017 To 04/30/2018 | Worksheet S-2 Part I Date/Time Prepared: 9/26/2018 12:59 pm

		Urban/Rural S	Date of Geogr	
		1.00	2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	2		26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	2		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0		35.00
		Beginning:	Ending:	
		1.00	2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.			36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.	0		37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)	N		37.01
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.			38.00
		Y/N	Y/N	
		1.00	2.00	
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i) or (ii)? Enter in column 1 “Y” for yes or “N” for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i) or (ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	N	N	39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	N	N	40.00

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

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

		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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1308 | Period: From 05/01/2017 To 04/30/2018 | Worksheet S-2 Part I | Date/Time Prepared: 9/26/2018 12:59 pm

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1308 | Period: From 05/01/2017 To 04/30/2018 | Worksheet S-2 Part I | Date/Time Prepared: 9/26/2018 12:59 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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1308 | Period: From 05/01/2017 To 04/30/2018 | Worksheet S-2 Part I | Date/Time Prepared: 9/26/2018 12:59 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.	Y			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1			118.00

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	21,712	0	0	118.01

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1308 | Period: From 05/01/2017 To 04/30/2018 | Worksheet S-2 Part I | Date/Time Prepared: 9/26/2018 12:59 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:	Contractor's Name:	Contractor's Number:	141.00
142.00	Street:	PO Box:		142.00
143.00	City:	State:	Zip Code:	143.00

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

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

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

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

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

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

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

		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	05/01/2017	04/30/2018	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: 14-1308 | Period: From 05/01/2017 To 04/30/2018 | Worksheet S-2 Part II | Date/Time Prepared: 9/26/2018 12:59 pm

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

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

		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	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)	N		N		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	08/24/2018	Y	08/24/2018	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 14-1308 | Period: From 05/01/2017 To 04/30/2018 | Worksheet S-2 Part II Date/Time Prepared: 9/26/2018 12:59 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.	Y	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	Y	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.		33.00
	Provider-Based Physicians		
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.	Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.	N	35.00

		Y/N	Date	
		1.00	2.00	
	Home Office Costs			
36.00	Were home office costs claimed on the cost report?	N		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			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.			38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			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.	VALERIE	TEPE	41.00
42.00	Enter the employer/company name of the cost report preparer.	WASHINGTON COUNTY HOSPITAL		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	618-327-2303	VTEPE@WASHINGTONCOUNTYHOSPITAL.ORG	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 14-1308	Period: From 05/01/2017 To 04/30/2018	Worksheet S-2 Part II Date/Time Prepared: 9/26/2018 12:59 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.	ACCOUNTING MANAGER		41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 14-1308 | Period: From 05/01/2017 To 04/30/2018 | Worksheet S-3 Part I Date/Time Prepared: 9/26/2018 12:59 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	22	8,030	5,813.00	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)		22	8,030	5,813.00	0	7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)		22	8,030	5,813.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE	46.00	28	10,220			21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)	115.00					23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	88.00				0	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		50				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: 14-1308 | Period: From 05/01/2017 To 04/30/2018 | Worksheet S-3 Part I | Date/Time Prepared: 9/26/2018 12:59 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)	189	12	246			1.00
2.00	HMO and other (see instructions)	0	0				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	1,195	0	1,316			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	58			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,384	12	1,620			7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	1,384	12	1,620	0.00	93.88	14.00
15.00	CAH visits	8,452	3,069	23,414			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			7,755	0.00	16.42	21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)				0.00	0.00	23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	0	0	0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	2,456	0	7,942	0.00	11.70	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	122.00	27.00
28.00	Observation Bed Days		0	30			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: 14-1308 | Period: From 05/01/2017 To 04/30/2018 | Worksheet S-3 Part I | Date/Time Prepared: 9/26/2018 12:59 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	60	4	83	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	60	4	83	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE	0.00				24	21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)	0.00					23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	0.00					26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 14-1308 | Component CCN: 14-3472 | Period: From 05/01/2017 To 04/30/2018 | Worksheet S-8 | Date/Time Prepared: 9/26/2018 12:59 pm

RHC I | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			705 SOUTH GRAND AVE		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	NASHVILLE		IL	62263	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			07:30	19:00	07:30	11.00

				1.00	2.00	
12.00	Have you received an approval for an exception to the productivity standard?			N		12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.			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		WASHINGTON				2.00
		Tuesday	Wednesday		Thursday		
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)						
11.00	CLINIC	19:00	07:30	19:00	07:30	19:00	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 14-1308 | Component CCN: 14-3472 | Period: From 05/01/2017 To 04/30/2018 | Worksheet S-8 | Date/Time Prepared: 9/26/2018 12:59 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	07:30	19:00	08:00	14:00		11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 14-1308 | Period: From 05/01/2017 To 04/30/2018 | Worksheet S-10 | Date/Time Prepared: 9/26/2018 12:59 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)	0.705475	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	1,382,278	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?	Y	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	2,192,719	6.00
7.00	Medicaid cost (line 1 times line 6)	1,546,908	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)	164,630	8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone CHIP	0	9.00
10.00	Stand-alone CHIP charges	0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	164,630	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)	12,778	26,808	39,586	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	9,015	26,808	35,823	21.00
22.00	Payments received from patients for amounts previously written off as charity care	536	1,463	1,999	22.00
23.00	Cost of charity care (line 21 minus line 22)	8,479	25,345	33,824	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)	533,551	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	66,318	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	102,026	27.01
28.00	Non-Medicare bad debt expense (see instructions)	431,525	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	340,138	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	373,962	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	538,592	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-1308 | Period: From 05/01/2017 To 04/30/2018 | Worksheet A | Date/Time Prepared: 9/26/2018 12:59 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		242,456	242,456	58,261	300,717	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		151,547	151,547	0	151,547	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	83,420	2,066,904	2,150,324	0	2,150,324	4.00
5.01	00550	INFORMATION SYSTEMS	222,046	289,265	511,311	-44,843	466,468	5.01
5.02	00591	OTHER ADMINISTRATIVE AND GENERAL	583,586	675,368	1,258,954	52,013	1,310,967	5.02
6.00	00600	MAINTENANCE & REPAIRS	104,166	411,849	516,015	0	516,015	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	102,060	102,060	0	102,060	8.00
9.00	00900	HOUSEKEEPING	201,676	25,944	227,620	0	227,620	9.00
10.00	01000	DIETARY	218,425	127,947	346,372	-31,035	315,337	10.00
11.00	01100	CAFETERIA	0	0	0	31,035	31,035	11.00
13.00	01300	NURSING ADMINISTRATION	68,144	315	68,459	0	68,459	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	56,784	16,303	73,087	0	73,087	14.00
15.00	01500	PHARMACY	121,567	34,641	156,208	0	156,208	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	175,946	32,276	208,222	0	208,222	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	5,084	5,084	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	84,700	84,700	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	582,569	43,511	626,080	-5,084	620,996	30.00
46.00	04600	OTHER LONG TERM CARE	520,746	23,328	544,074	0	544,074	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	133,273	94,309	227,582	0	227,582	50.00
53.00	05300	ANESTHESIOLOGY	0	91,620	91,620	-84,700	6,920	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	309,290	301,183	610,473	44,843	655,316	54.00
60.00	06000	LABORATORY	384,044	536,148	920,192	0	920,192	60.00
65.00	06500	RESPIRATORY THERAPY	0	46,930	46,930	0	46,930	65.00
66.00	06600	PHYSICAL THERAPY	780,343	40,871	821,214	0	821,214	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
68.01	06801	CARDIAC REHAB	62,796	7,084	69,880	0	69,880	68.01
69.00	06900	ELECTROCARDIOLOGY	5,304	9,316	14,620	0	14,620	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	83,010	83,010	-8,940	74,070	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	8,940	8,940	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	591,953	591,953	0	591,953	73.00
76.00	03480	ONCOLOGY	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	985,620	329,139	1,314,759	-52,013	1,262,746	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	429,733	1,304,378	1,734,111	0	1,734,111	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		59,076	59,076	-59,076	0	113.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	6,029,478	7,738,731	13,768,209	-815	13,767,394	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	5,846	5,846	815	6,661	190.00
190.01	19001	OUTPATIENT CLINIC	528	43	571	0	571	190.01
190.02	19003	NON-REIMBURSEABLE OUTPATIENT MEALS	0	0	0	0	0	190.02
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		TOTAL (SUM OF LINES 118 through 199)	6,030,006	7,744,620	13,774,626	0	13,774,626	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-1308 | Period: From 05/01/2017 To 04/30/2018 | Worksheet A | Date/Time Prepared: 9/26/2018 12:59 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	0	300,717		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-14,734	136,813		2.00
3.00	00300	OTHER CAP REL COSTS	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	2,150,324		4.00
5.01	00550	INFORMATION SYSTEMS	0	466,468		5.01
5.02	00591	OTHER ADMINISTRATIVE AND GENERAL	-50,217	1,260,750		5.02
6.00	00600	MAINTENANCE & REPAIRS	0	516,015		6.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	102,060		8.00
9.00	00900	HOUSEKEEPING	0	227,620		9.00
10.00	01000	DIETARY	0	315,337		10.00
11.00	01100	CAFETERIA	-18,774	12,261		11.00
13.00	01300	NURSING ADMINISTRATION	0	68,459		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	-300	72,787		14.00
15.00	01500	PHARMACY	0	156,208		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-9,617	198,605		16.00
17.00	01700	SOCIAL SERVICE	0	5,084		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	84,700		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	620,996		30.00
46.00	04600	OTHER LONG TERM CARE	0	544,074		46.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	227,582		50.00
53.00	05300	ANESTHESIOLOGY	0	6,920		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-5,535	649,781		54.00
60.00	06000	LABORATORY	-5,452	914,740		60.00
65.00	06500	RESPIRATORY THERAPY	-205	46,725		65.00
66.00	06600	PHYSICAL THERAPY	0	821,214		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
68.01	06801	CARDIAC REHAB	0	69,880		68.01
69.00	06900	ELECTROCARDIOLOGY	-9,304	5,316		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	74,070		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	8,940		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-38,305	553,648		73.00
76.00	03480	ONCOLOGY	0	0		76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	-42,205	1,220,541		88.00
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	-181,465	1,552,646		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0	0		93.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0	0		95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0		98.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0		115.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-376,113	13,391,281		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	6,661		190.00
190.01	19001	OUTPATIENT CLINIC	0	571		190.01
190.02	19003	NON-REIMBURSEABLE OUTPATIENT MEALS	0	0		190.02
191.00	19100	RESEARCH	0	0		191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0		192.00
193.00	19300	NONPAID WORKERS	0	0		193.00
200.00		TOTAL (SUM OF LINES 118 through 199)	-376,113	13,398,513		200.00

RECLASSIFICATIONS | Provider CCN: 14-1308 | Period: From 05/01/2017 To 04/30/2018 | Worksheet A-6 | Date/Time Prepared: 9/26/2018 12:59 pm

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - RECLASSIFY CAFETERIA COSTS					
1.00	CAFETERIA	11.00	19,571	11,464		1.00
	TOTALS		19,571	11,464		
	B - RECLASS SOCIAL SERVICE COST					
1.00	SOCIAL SERVICE	17.00	5,084	0		1.00
	TOTALS		5,084	0		
	C - RECLASS PROFESSIONAL LIABILITY INSUR					
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.02	0	52,013		1.00
	TOTALS		0	52,013		
	D - RECLASSIFY XRAY DIRECTORS SALARY					
1.00	RADIOLOGY-DIAGNOSTIC	54.00	44,843	0		1.00
	TOTALS		44,843	0		
	E - RECLASSIFY ANESTHESIA PRO FEES					
1.00	NONPHYSICIAN ANESTHETISTS	19.00	0	84,700		1.00
	TOTALS		0	84,700		
	F - INTEREST EXPENSE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	59,076		1.00
	TOTALS		0	59,076		
	G - TO RECLASS INTEROCULAR LENS					
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	8,940		1.00
	TOTALS		0	8,940		
	H - TO RECLASS ANNEX BLDG DEPRECIATION					
1.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00	0	815		1.00
	TOTALS		0	815		
500.00	Grand Total: Increases		69,498	217,008		500.00

RECLASSIFICATIONS | Provider CCN: 14-1308 | Period: From 05/01/2017 To 04/30/2018 | Worksheet A-6 | Date/Time Prepared: 9/26/2018 12:59 pm

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - RECLASSIFY CAFETERIA COSTS						
1.00	DIETARY	10.00	19,571	11,464	0		1.00
	TOTALS		19,571	11,464			
	B - RECLASS SOCIAL SERVICE COST						
1.00	ADULTS & PEDIATRICS	30.00	5,084	0	0		1.00
	TOTALS		5,084	0			
	C - RECLASS PROFESSIONAL LIABILITY INSUR						
1.00	RURAL HEALTH CLINIC	88.00	0	52,013	0		1.00
	TOTALS		0	52,013			
	D - RECLASSIFY XRAY DIRECTORS SALARY						
1.00	INFORMATION SYSTEMS	5.01	44,843	0	0		1.00
	TOTALS		44,843	0			
	E - RECLASSIFY ANESTHESIA PRO FEES						
1.00	ANESTHESIOLOGY	53.00	0	84,700	0		1.00
	TOTALS		0	84,700			
	F - INTEREST EXPENSE						
1.00	INTEREST EXPENSE	113.00	0	59,076	9		1.00
	TOTALS		0	59,076			
	G - TO RECLASS INTEROCULAR LENS						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	8,940	0		1.00
	TOTALS		0	8,940			
	H - TO RECLASS ANNEX BLDG DEPRECIATION						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	815	9		1.00
	TOTALS		0	815			
500.00	Grand Total: Decreases		69,498	217,008			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1308 | Period: From 05/01/2017 To 04/30/2018 | Worksheet A-7 Part I | Date/Time Prepared: 9/26/2018 12:59 pm

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	62,855	0	0	0	0	1.00
2.00	Land Improvements	419,030	0	0	0	0	2.00
3.00	Buildings and Fixtures	9,479,465	3,038	0	3,038	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	5,421,579	269,795	0	269,795	450,000	6.00
7.00	HIT designated Assets	927,041	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	16,309,970	272,833	0	272,833	450,000	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	16,309,970	272,833	0	272,833	450,000	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	62,855	0	1.00
2.00	Land Improvements	419,030	0	2.00
3.00	Buildings and Fixtures	9,482,503	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	5,241,374	0	6.00
7.00	HIT designated Assets	927,041	0	7.00
8.00	Subtotal (sum of lines 1-7)	16,132,803	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	16,132,803	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1308 | Period: From 05/01/2017 To 04/30/2018 | Worksheet A-7 Part II Date/Time Prepared: 9/26/2018 12:59 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	242,456	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	151,547	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	394,003	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	242,456		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	151,547		2.00
3.00	Total (sum of lines 1-2)	0	394,003		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1308 | Period: From 05/01/2017 To 04/30/2018 | Worksheet A-7 Part III Date/Time Prepared: 9/26/2018 12:59 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	9,964,388	0	9,964,388	0.617648	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	6,168,415	0	6,168,415	0.382352	0	2.00
3.00	Total (sum of lines 1-2)	16,132,803	0	16,132,803	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	300,717	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	136,813	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	437,530	0	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	0	0	0	300,717	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	136,813	2.00
3.00	Total (sum of lines 1-2)	0	0	0	0	437,530	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-1308 | Period: From 05/01/2017 To 04/30/2018 | Worksheet A-8 | Date/Time Prepared: 9/26/2018 12:59 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)	B	-44,960	OTHER ADMINISTRATIVE AND GENERAL	5.02	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)	B	-300	CENTRAL SERVICES & SUPPLY	14.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-196,009			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)	B	-500	RADIOLOGY-DIAGNOSTIC	54.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	0			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-18,774	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	-9,617	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		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	NONPHYSICIAN ANESTHETISTS	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	A	-14,734	CAP REL COSTS-MVBLE EQUIP	2.00	9	32.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-1308 | Period: From 05/01/2017 To 04/30/2018 | Worksheet A-8 | Date/Time Prepared: 9/26/2018 12:59 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	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.00
33.01	MISCELLANEOUS REVENUE - OTHER	B	-1,057	OTHER ADMINISTRATIVE AND GENERAL	5.02	0	33.01
34.00	LAB FEES	A	-5,452	LABORATORY	60.00	0	34.00
35.00	EDUCATION FEES	B	-710	OTHER ADMINISTRATIVE AND GENERAL	5.02	0	35.00
36.00	NONALLOWABLE PUBLIC RELATIONS	A	-2,499	OTHER ADMINISTRATIVE AND GENERAL	5.02	0	36.00
37.00	HEALTHLINK ADMIN FEES	A	17,227	OTHER ADMINISTRATIVE AND GENERAL	5.02	0	37.00
38.00	LOBBYING PORTION OF DUES	A	-11,106	OTHER ADMINISTRATIVE AND GENERAL	5.02	0	38.00
39.00	NON-RHC SERVICES	A	-33,192	RURAL HEALTH CLINIC	88.00	0	39.00
40.00	NON-RHC BENEFITS	A	-9,013	RURAL HEALTH CLINIC	88.00	0	40.00
41.00	TELEPHONE SERVICE	B	-7,112	OTHER ADMINISTRATIVE AND GENERAL	5.02	0	41.00
42.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	42.00
43.00	340B PHARMACY	A	-38,305	DRUGS CHARGED TO PATIENTS	73.00	0	43.00
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-376,113				50.00

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 14-1308 | Period: From 05/01/2017 To 04/30/2018 | Worksheet A-8-2 | Date/Time Prepared: 9/26/2018 12:59 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	54.00	RADIOLOGY-DIAGNOSTIC	5,035	5,035	0	0	0	1.00
2.00	60.00	LABORATORY	18,545	0	18,545	0	0	2.00
3.00	69.00	ELECTROCARDIOLOGY	9,304	9,304	0	0	0	3.00
4.00	91.00	EMERGENCY	1,289,441	181,465	1,107,976	0	0	4.00
5.00	65.00	RESPIRATORY THERAPY	205	205	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			1,322,530	196,009	1,126,521		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	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	1.00
2.00	60.00	LABORATORY	0	0	0	0	0	2.00
3.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	3.00
4.00	91.00	EMERGENCY	0	0	0	0	0	4.00
5.00	65.00	RESPIRATORY THERAPY	0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	5,035		1.00
2.00	60.00	LABORATORY	0	0	0	0		2.00
3.00	69.00	ELECTROCARDIOLOGY	0	0	0	9,304		3.00
4.00	91.00	EMERGENCY	0	0	0	181,465		4.00
5.00	65.00	RESPIRATORY THERAPY	0	0	0	205		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	196,009		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1308 | Period: From 05/01/2017 To 04/30/2018 | Worksheet B Part I Date/Time Prepared: 9/26/2018 12:59 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	INFORMATION SYSTEMS	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	4.00	5.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	300,717	300,717				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	136,813		136,813			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,150,324	551	0	2,150,875		4.00
5.01	00550	INFORMATION SYSTEMS	466,468	4,015	2,967	64,094	537,544	5.01
5.02	00591	OTHER ADMINISTRATIVE AND GENERAL	1,260,750	64,002	1,520	211,082	95,842	5.02
6.00	00600	MAINTENANCE & REPAIRS	516,015	47,965	1,257	37,677	8,334	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	102,060	3,781	0	0	0	8.00
9.00	00900	HOUSEKEEPING	227,620	1,732	0	72,946	8,334	9.00
10.00	01000	DIETARY	315,337	7,095	596	71,925	12,501	10.00
11.00	01100	CAFETERIA	12,261	3,485	0	7,079	0	11.00
13.00	01300	NURSING ADMINISTRATION	68,459	551	0	24,648	4,167	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	72,787	3,172	6,412	20,539	8,334	14.00
15.00	01500	PHARMACY	156,208	3,882	15,871	43,971	16,668	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	198,605	4,065	79	63,639	25,002	16.00
17.00	01700	SOCIAL SERVICE	5,084	367	0	1,839	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	84,700	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	620,996	26,771	6,864	208,876	50,004	30.00
46.00	04600	OTHER LONG TERM CARE	544,074	38,111	737	188,353	16,668	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	227,582	14,103	2,712	48,205	20,835	50.00
53.00	05300	ANESTHESIOLOGY	6,920	0	2,513	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	649,781	18,682	66,708	128,090	50,004	54.00
60.00	06000	LABORATORY	914,740	8,423	1,482	138,908	20,835	60.00
65.00	06500	RESPIRATORY THERAPY	46,725	1,987	2,963	0	0	65.00
66.00	06600	PHYSICAL THERAPY	821,214	8,235	6,149	282,249	66,672	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
68.01	06801	CARDIAC REHAB	69,880	1,757	9,575	22,713	4,167	68.01
69.00	06900	ELECTROCARDIOLOGY	5,316	242	1,816	1,918	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	74,070	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	8,940	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	553,648	0	0	0	0	73.00
76.00	03480	ONCOLOGY	0	989	0	0	4,167	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,220,541	10,063	56	356,499	79,173	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	1,552,646	14,383	6,373	155,434	25,002	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	13,391,281	288,409	136,650	2,150,684	516,709	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	6,661	0	0	0	0	190.00
190.01	19001	OUTPATIENT CLINIC	571	12,308	163	191	20,835	190.01
190.02	19003	NON-REIMBURSEABLE OUTPATIENT MEALS	0	0	0	0	0	190.02
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	13,398,513	300,717	136,813	2,150,875	537,544	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1308 | Period: From 05/01/2017 To 04/30/2018 | Worksheet B Part I | Date/Time Prepared: 9/26/2018 12:59 pm

		Cost Center Description	Subtotal	OTHER ADMINISTRATIVE AND GENERAL	MAINTENANCE & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5A.01	5.02	6.00	8.00	9.00	
		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
5.01	00550	INFORMATION SYSTEMS						5.01
5.02	00591	OTHER ADMINISTRATIVE AND GENERAL	1,633,196	1,633,196				5.02
6.00	00600	MAINTENANCE & REPAIRS	611,248	84,850	696,098			6.00
8.00	00800	LAUNDRY & LINEN SERVICE	105,841	14,692	14,291	134,824		8.00
9.00	00900	HOUSEKEEPING	310,632	43,120	6,546	0	360,298	9.00
10.00	01000	DIETARY	407,454	56,560	26,816	0	14,308	10.00
11.00	01100	CAFETERIA	22,825	3,168	13,171	0	7,028	11.00
13.00	01300	NURSING ADMINISTRATION	97,825	13,579	2,082	0	1,111	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	111,244	15,442	11,988	0	6,397	14.00
15.00	01500	PHARMACY	236,600	32,843	14,670	0	7,827	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	291,390	40,449	15,364	0	8,198	16.00
17.00	01700	SOCIAL SERVICE	7,290	1,012	1,388	0	741	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	84,700	11,758	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	913,511	126,808	101,175	14,162	53,984	30.00
46.00	04600	OTHER LONG TERM CARE	787,943	109,378	144,036	92,748	76,851	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	313,437	43,509	53,301	4,299	28,440	50.00
53.00	05300	ANESTHESIOLOGY	9,433	1,309	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	913,265	126,774	70,605	4,929	37,673	54.00
60.00	06000	LABORATORY	1,084,388	150,528	31,832	0	16,985	60.00
65.00	06500	RESPIRATORY THERAPY	51,675	7,173	7,509	78	4,006	65.00
66.00	06600	PHYSICAL THERAPY	1,184,519	164,428	31,122	9,345	16,606	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
68.01	06801	CARDIAC REHAB	108,092	15,005	6,641	0	3,543	68.01
69.00	06900	ELECTROCARDIOLOGY	9,292	1,290	915	0	488	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	74,070	10,282	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	8,940	1,241	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	553,648	76,854	0	0	0	73.00
76.00	03480	ONCOLOGY	5,156	716	3,738	0	1,995	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,666,332	231,310	38,032	432	20,292	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	1,753,838	243,464	54,358	8,460	29,004	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0					92.00
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	13,357,784	1,627,542	649,580	134,453	335,477	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	6,661	925	0	0	0	190.00
190.01	19001	OUTPATIENT CLINIC	34,068	4,729	46,518	371	24,821	190.01
190.02	19003	NON-REIMBURSEABLE OUTPATIENT MEALS	0	0	0	0	0	190.02
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments	0					200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	13,398,513	1,633,196	696,098	134,824	360,298	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1308 | Period: From 05/01/2017 To 04/30/2018 | Worksheet B Part I | Date/Time Prepared: 9/26/2018 12:59 pm

		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	INFORMATION SYSTEMS						5.01
5.02	00591	OTHER ADMINISTRATIVE AND GENERAL						5.02
6.00	00600	MAINTENANCE & REPAIRS						6.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	505,138					10.00
11.00	01100	CAFETERIA	0	46,192				11.00
13.00	01300	NURSING ADMINISTRATION	0	468	115,065			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	892	0	145,963		14.00
15.00	01500	PHARMACY	0	544	0	80	292,564	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	2,213	0	353	0	16.00
17.00	01700	SOCIAL SERVICE	0	54	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	95,446	6,129	50,175	32,947	368	30.00
46.00	04600	OTHER LONG TERM CARE	407,667	8,931	0	24,862	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	1,283	10,784	16,795	6	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	4,471	75	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	3,274	0	3,184	370	54.00
60.00	06000	LABORATORY	0	3,948	0	3,940	269	60.00
65.00	06500	RESPIRATORY THERAPY	0	5	16	1,262	0	65.00
66.00	06600	PHYSICAL THERAPY	0	6,618	0	2,101	384	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
68.01	06801	CARDIAC REHAB	0	0	3,954	2,110	0	68.01
69.00	06900	ELECTROCARDIOLOGY	0	647	535	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	18,866	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	15,461	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	290,720	73.00
76.00	03480	ONCOLOGY	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	6,363	11,594	3,632	133	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	4,818	38,007	15,899	239	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	503,113	46,187	115,065	145,963	292,564	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	OUTPATIENT CLINIC	0	5	0	0	0	190.01
190.02	19003	NON-REIMBURSEABLE OUTPATIENT MEALS	2,025	0	0	0	0	190.02
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
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)	505,138	46,192	115,065	145,963	292,564	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1308 | Period: From 05/01/2017 To 04/30/2018 | Worksheet B Part I | Date/Time Prepared: 9/26/2018 12:59 pm

		Cost Center Description	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			16.00	17.00	19.00	24.00	25.00	
		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
5.01	00550	INFORMATION SYSTEMS						5.01
5.02	00591	OTHER ADMINISTRATIVE AND GENERAL						5.02
6.00	00600	MAINTENANCE & REPAIRS						6.00
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	357,967					16.00
17.00	01700	SOCIAL SERVICE	0	10,485				17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	96,458			19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	19,976	9,436	0	1,424,117	-48,101	30.00
46.00	04600	OTHER LONG TERM CARE	21,141	1,049	0	1,674,606	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	29,151	0	0	501,005	0	50.00
53.00	05300	ANESTHESIOLOGY	1,469	0	96,458	113,215	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	92,337	0	0	1,252,411	0	54.00
60.00	06000	LABORATORY	67,426	0	0	1,359,316	0	60.00
65.00	06500	RESPIRATORY THERAPY	3,006	0	0	74,730	0	65.00
66.00	06600	PHYSICAL THERAPY	48,558	0	0	1,463,681	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
68.01	06801	CARDIAC REHAB	1,853	0	0	141,198	0	68.01
69.00	06900	ELECTROCARDIOLOGY	3,677	0	0	16,844	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,960	0	0	105,178	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	426	0	0	26,068	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	23,027	0	0	944,249	0	73.00
76.00	03480	ONCOLOGY	471	0	0	12,076	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	16,779	0	0	1,994,899	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	26,710	0	0	2,174,797	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	48,101	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	357,967	10,485	96,458	13,278,390	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	7,586	0	190.00
190.01	19001	OUTPATIENT CLINIC	0	0	0	110,512	0	190.01
190.02	19003	NON-REIMBURSEABLE OUTPATIENT MEALS	0	0	0	2,025	0	190.02
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments			0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	357,967	10,485	96,458	13,398,513	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1308 | Period: From 05/01/2017 To 04/30/2018 | Worksheet B Part I | Date/Time Prepared: 9/26/2018 12:59 pm

		Cost Center Description	Total		
			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
5.01	00550	INFORMATION SYSTEMS			5.01
5.02	00591	OTHER ADMINISTRATIVE AND GENERAL			5.02
6.00	00600	MAINTENANCE & REPAIRS			6.00
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
17.00	01700	SOCIAL SERVICE			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS			19.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	1,376,016		30.00
46.00	04600	OTHER LONG TERM CARE	1,674,606		46.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	501,005		50.00
53.00	05300	ANESTHESIOLOGY	113,215		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,252,411		54.00
60.00	06000	LABORATORY	1,359,316		60.00
65.00	06500	RESPIRATORY THERAPY	74,730		65.00
66.00	06600	PHYSICAL THERAPY	1,463,681		66.00
67.00	06700	OCCUPATIONAL THERAPY	0		67.00
68.00	06800	SPEECH PATHOLOGY	0		68.00
68.01	06801	CARDIAC REHAB	141,198		68.01
69.00	06900	ELECTROCARDIOLOGY	16,844		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	105,178		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	26,068		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	944,249		73.00
76.00	03480	ONCOLOGY	12,076		76.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	1,994,899		88.00
90.00	09000	CLINIC	0		90.00
91.00	09100	EMERGENCY	2,174,797		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	48,101		93.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0		95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0		98.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0		115.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	13,278,390		118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	7,586		190.00
190.01	19001	OUTPATIENT CLINIC	110,512		190.01
190.02	19003	NON-REIMBURSEABLE OUTPATIENT MEALS	2,025		190.02
191.00	19100	RESEARCH	0		191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0		192.00
193.00	19300	NONPAID WORKERS	0		193.00
200.00		Cross Foot Adjustments	0		200.00
201.00		Negative Cost Centers	0		201.00
202.00		TOTAL (sum lines 118 through 201)	13,398,513		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1308 | Period: From 05/01/2017 To 04/30/2018 | Worksheet B Part II Date/Time Prepared: 9/26/2018 12:59 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	551	0	551	551	4.00
5.01	00550	INFORMATION SYSTEMS	0	4,015	2,967	6,982	16	5.01
5.02	00591	OTHER ADMINISTRATIVE AND GENERAL	0	64,002	1,520	65,522	54	5.02
6.00	00600	MAINTENANCE & REPAIRS	0	47,965	1,257	49,222	10	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	3,781	0	3,781	0	8.00
9.00	00900	HOUSEKEEPING	0	1,732	0	1,732	19	9.00
10.00	01000	DIETARY	0	7,095	596	7,691	18	10.00
11.00	01100	CAFETERIA	0	3,485	0	3,485	2	11.00
13.00	01300	NURSING ADMINISTRATION	0	551	0	551	6	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	3,172	6,412	9,584	5	14.00
15.00	01500	PHARMACY	0	3,882	15,871	19,753	11	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	4,065	79	4,144	16	16.00
17.00	01700	SOCIAL SERVICE	0	367	0	367	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	26,771	6,864	33,635	54	30.00
46.00	04600	OTHER LONG TERM CARE	0	38,111	737	38,848	48	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	14,103	2,712	16,815	12	50.00
53.00	05300	ANESTHESIOLOGY	0	0	2,513	2,513	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	18,682	66,708	85,390	33	54.00
60.00	06000	LABORATORY	0	8,423	1,482	9,905	36	60.00
65.00	06500	RESPIRATORY THERAPY	0	1,987	2,963	4,950	0	65.00
66.00	06600	PHYSICAL THERAPY	0	8,235	6,149	14,384	73	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
68.01	06801	CARDIAC REHAB	0	1,757	9,575	11,332	6	68.01
69.00	06900	ELECTROCARDIOLOGY	0	242	1,816	2,058	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03480	ONCOLOGY	0	989	0	989	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	10,063	56	10,119	92	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	14,383	6,373	20,756	40	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	288,409	136,650	425,059	551	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	OUTPATIENT CLINIC	0	12,308	163	12,471	0	190.01
190.02	19003	NON-REIMBURSEABLE OUTPATIENT MEALS	0	0	0	0	0	190.02
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
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	300,717	136,813	437,530	551	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1308 | Period: From 05/01/2017 To 04/30/2018 | Worksheet B Part II | Date/Time Prepared: 9/26/2018 12:59 pm

		Cost Center Description	INFORMATION SYSTEMS	OTHER ADMINISTRATIVE AND GENERAL	MAINTENANCE & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.01	5.02	6.00	8.00	9.00	
		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
5.01	00550	INFORMATION SYSTEMS	6,998					5.01
5.02	00591	OTHER ADMINISTRATIVE AND GENERAL	1,251	66,827				5.02
6.00	00600	MAINTENANCE & REPAIRS	108	3,472	52,812			6.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	601	1,084	5,466		8.00
9.00	00900	HOUSEKEEPING	108	1,764	497	0	4,120	9.00
10.00	01000	DIETARY	163	2,314	2,034	0	164	10.00
11.00	01100	CAFETERIA	0	130	999	0	80	11.00
13.00	01300	NURSING ADMINISTRATION	54	556	158	0	13	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	108	632	910	0	73	14.00
15.00	01500	PHARMACY	217	1,344	1,113	0	90	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	325	1,655	1,166	0	94	16.00
17.00	01700	SOCIAL SERVICE	0	41	105	0	8	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	481	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	651	5,189	7,676	574	617	30.00
46.00	04600	OTHER LONG TERM CARE	217	4,476	10,928	3,761	877	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	271	1,780	4,044	174	325	50.00
53.00	05300	ANESTHESIOLOGY	0	54	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	651	5,187	5,357	200	431	54.00
60.00	06000	LABORATORY	271	6,159	2,415	0	194	60.00
65.00	06500	RESPIRATORY THERAPY	0	294	570	3	46	65.00
66.00	06600	PHYSICAL THERAPY	868	6,728	2,361	379	190	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
68.01	06801	CARDIAC REHAB	54	614	504	0	41	68.01
69.00	06900	ELECTROCARDIOLOGY	0	53	69	0	6	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	421	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	51	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,145	0	0	0	73.00
76.00	03480	ONCOLOGY	54	29	284	0	23	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,031	9,465	2,885	17	232	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	325	9,960	4,124	343	332	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	6,727	66,595	49,283	5,451	3,836	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	38	0	0	0	190.00
190.01	19001	OUTPATIENT CLINIC	271	194	3,529	15	284	190.01
190.02	19003	NON-REIMBURSEABLE OUTPATIENT MEALS	0	0	0	0	0	190.02
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
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)	6,998	66,827	52,812	5,466	4,120	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1308 | Period: From 05/01/2017 To 04/30/2018 | Worksheet B Part II Date/Time Prepared: 9/26/2018 12:59 pm

		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	INFORMATION SYSTEMS						5.01
5.02	00591	OTHER ADMINISTRATIVE AND GENERAL						5.02
6.00	00600	MAINTENANCE & REPAIRS						6.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	12,384					10.00
11.00	01100	CAFETERIA	0	4,696				11.00
13.00	01300	NURSING ADMINISTRATION	0	48	1,386			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	91	0	11,403		14.00
15.00	01500	PHARMACY	0	55	0	6	22,589	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	225	0	28	0	16.00
17.00	01700	SOCIAL SERVICE	0	6	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,340	623	604	2,573	28	30.00
46.00	04600	OTHER LONG TERM CARE	9,994	906	0	1,942	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	130	130	1,312	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	349	6	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	333	0	249	29	54.00
60.00	06000	LABORATORY	0	401	0	308	21	60.00
65.00	06500	RESPIRATORY THERAPY	0	1	0	99	0	65.00
66.00	06600	PHYSICAL THERAPY	0	673	0	164	30	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
68.01	06801	CARDIAC REHAB	0	0	48	165	0	68.01
69.00	06900	ELECTROCARDIOLOGY	0	66	6	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	1,474	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1,208	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	22,447	73.00
76.00	03480	ONCOLOGY	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	647	140	284	10	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	490	458	1,242	18	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	12,334	4,695	1,386	11,403	22,589	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	OUTPATIENT CLINIC	0	1	0	0	0	190.01
190.02	19003	NON-REIMBURSEABLE OUTPATIENT MEALS	50	0	0	0	0	190.02
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
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)	12,384	4,696	1,386	11,403	22,589	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1308 | Period: From 05/01/2017 To 04/30/2018 | Worksheet B Part II Date/Time Prepared: 9/26/2018 12:59 pm

		Cost Center Description	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			16.00	17.00	19.00	24.00	25.00	
		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
5.01	00550	INFORMATION SYSTEMS						5.01
5.02	00591	OTHER ADMINISTRATIVE AND GENERAL						5.02
6.00	00600	MAINTENANCE & REPAIRS						6.00
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	7,653					16.00
17.00	01700	SOCIAL SERVICE	0	527				17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	481			19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	427	474		55,465	0	30.00
46.00	04600	OTHER LONG TERM CARE	452	53		72,502	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	624	0		25,617	0	50.00
53.00	05300	ANESTHESIOLOGY	31	0		2,953	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,969	0		99,829	0	54.00
60.00	06000	LABORATORY	1,443	0		21,153	0	60.00
65.00	06500	RESPIRATORY THERAPY	64	0		6,027	0	65.00
66.00	06600	PHYSICAL THERAPY	1,039	0		26,889	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0		0	0	68.00
68.01	06801	CARDIAC REHAB	40	0		12,804	0	68.01
69.00	06900	ELECTROCARDIOLOGY	79	0		2,337	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	42	0		1,937	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	9	0		1,268	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	493	0		26,085	0	73.00
76.00	03480	ONCOLOGY	10	0		1,389	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	359	0		25,281	0	88.00
90.00	09000	CLINIC	0	0		0	0	90.00
91.00	09100	EMERGENCY	572	0		38,660	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0	0		0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0		0	0	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0		0	0	98.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0		0	0	115.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	7,653	527	0	420,196	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		38	0	190.00
190.01	19001	OUTPATIENT CLINIC	0	0		16,765	0	190.01
190.02	19003	NON-REIMBURSEABLE OUTPATIENT MEALS	0	0		50	0	190.02
191.00	19100	RESEARCH	0	0		0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0		0	0	192.00
193.00	19300	NONPAID WORKERS	0	0		0	0	193.00
200.00		Cross Foot Adjustments			481	481	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	7,653	527	481	437,530	0	202.00

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		Cost Center Description	Total		
			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
5.01	00550	INFORMATION SYSTEMS			5.01
5.02	00591	OTHER ADMINISTRATIVE AND GENERAL			5.02
6.00	00600	MAINTENANCE & REPAIRS			6.00
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
17.00	01700	SOCIAL SERVICE			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS			19.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	55,465		30.00
46.00	04600	OTHER LONG TERM CARE	72,502		46.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	25,617		50.00
53.00	05300	ANESTHESIOLOGY	2,953		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	99,829		54.00
60.00	06000	LABORATORY	21,153		60.00
65.00	06500	RESPIRATORY THERAPY	6,027		65.00
66.00	06600	PHYSICAL THERAPY	26,889		66.00
67.00	06700	OCCUPATIONAL THERAPY	0		67.00
68.00	06800	SPEECH PATHOLOGY	0		68.00
68.01	06801	CARDIAC REHAB	12,804		68.01
69.00	06900	ELECTROCARDIOLOGY	2,337		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,937		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,268		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	26,085		73.00
76.00	03480	ONCOLOGY	1,389		76.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	25,281		88.00
90.00	09000	CLINIC	0		90.00
91.00	09100	EMERGENCY	38,660		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0		93.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0		95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0		98.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0		115.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	420,196		118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	38		190.00
190.01	19001	OUTPATIENT CLINIC	16,765		190.01
190.02	19003	NON-REIMBURSEABLE OUTPATIENT MEALS	50		190.02
191.00	19100	RESEARCH	0		191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0		192.00
193.00	19300	NONPAID WORKERS	0		193.00
200.00		Cross Foot Adjustments	481		200.00
201.00		Negative Cost Centers	0		201.00
202.00		TOTAL (sum lines 118 through 201)	437,530		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1308 | Period: From 05/01/2017 To 04/30/2018 | Worksheet B-1 | Date/Time Prepared: 9/26/2018 12:59 pm

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	INFORMATION SYSTEMS (# OF COMPUTERS)	Reconciliation	
			1.00	2.00	4.00	5.01	5A.02	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	72,049					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		135,850				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	132	0	5,946,586			4.00
5.01	00550	INFORMATION SYSTEMS	962	2,946	177,203	129		5.01
5.02	00591	OTHER ADMINISTRATIVE AND GENERAL	15,334	1,509	583,586	23	-1,633,196	5.02
6.00	00600	MAINTENANCE & REPAIRS	11,492	1,248	104,166	2	0	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	906	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	415	0	201,676	2	0	9.00
10.00	01000	DIETARY	1,700	592	198,854	3	0	10.00
11.00	01100	CAFETERIA	835	0	19,571	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	132	0	68,144	1	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	760	6,367	56,784	2	0	14.00
15.00	01500	PHARMACY	930	15,759	121,567	4	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	974	78	175,946	6	0	16.00
17.00	01700	SOCIAL SERVICE	88	0	5,084	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,414	6,816	577,485	12	0	30.00
46.00	04600	OTHER LONG TERM CARE	9,131	732	520,746	4	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,379	2,693	133,273	5	0	50.00
53.00	05300	ANESTHESIOLOGY	0	2,495	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,476	66,238	354,133	12	0	54.00
60.00	06000	LABORATORY	2,018	1,472	384,044	5	0	60.00
65.00	06500	RESPIRATORY THERAPY	476	2,942	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,973	6,106	780,343	16	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
68.01	06801	CARDIAC REHAB	421	9,508	62,796	1	0	68.01
69.00	06900	ELECTROCARDIOLOGY	58	1,803	5,304	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03480	ONCOLOGY	237	0	0	1	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	2,411	56	985,620	19	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	3,446	6,328	429,733	6	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	69,100	135,688	5,946,058	124	-1,633,196	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	OUTPATIENT CLINIC	2,949	162	528	5	0	190.01
190.02	19003	NON-REIMBURSEABLE OUTPATIENT MEALS	0	0	0	0	0	190.02
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
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)	300,717	136,813	2,150,875	537,544		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	4.173785	1.007089	0.361699	4,167.007752		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			551	6,998		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000093	54.248062		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: 14-1308 | Period: From 05/01/2017 To 04/30/2018 | Worksheet B-1 | Date/Time Prepared: 9/26/2018 12:59 pm

		Cost Center Description	OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	
			5.02	6.00	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
5.01	00550	INFORMATION SYSTEMS						5.01
5.02	00591	OTHER ADMINISTRATIVE AND GENERAL	11,765,317					5.02
6.00	00600	MAINTENANCE & REPAIRS	611,248	44,129				6.00
8.00	00800	LAUNDRY & LINEN SERVICE	105,841	906	31,235			8.00
9.00	00900	HOUSEKEEPING	310,632	415	0	42,808		9.00
10.00	01000	DIETARY	407,454	1,700	0	1,700	33,178	10.00
11.00	01100	CAFETERIA	22,825	835	0	835	0	11.00
13.00	01300	NURSING ADMINISTRATION	97,825	132	0	132	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	111,244	760	0	760	0	14.00
15.00	01500	PHARMACY	236,600	930	0	930	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	291,390	974	0	974	0	16.00
17.00	01700	SOCIAL SERVICE	7,290	88	0	88	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	84,700	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	913,511	6,414	3,281	6,414	6,269	30.00
46.00	04600	OTHER LONG TERM CARE	787,943	9,131	21,487	9,131	26,776	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	313,437	3,379	996	3,379	0	50.00
53.00	05300	ANESTHESIOLOGY	9,433	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	913,265	4,476	1,142	4,476	0	54.00
60.00	06000	LABORATORY	1,084,388	2,018	0	2,018	0	60.00
65.00	06500	RESPIRATORY THERAPY	51,675	476	18	476	0	65.00
66.00	06600	PHYSICAL THERAPY	1,184,519	1,973	2,165	1,973	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
68.01	06801	CARDIAC REHAB	108,092	421	0	421	0	68.01
69.00	06900	ELECTROCARDIOLOGY	9,292	58	0	58	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	74,070	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	8,940	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	553,648	0	0	0	0	73.00
76.00	03480	ONCOLOGY	5,156	237	0	237	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,666,332	2,411	100	2,411	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	1,753,838	3,446	1,960	3,446	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	11,724,588	41,180	31,149	39,859	33,045	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	6,661	0	0	0	0	190.00
190.01	19001	OUTPATIENT CLINIC	34,068	2,949	86	2,949	0	190.01
190.02	19003	NON-REIMBURSEABLE OUTPATIENT MEALS	0	0	0	0	133	190.02
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
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)	1,633,196	696,098	134,824	360,298	505,138	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.138814	15.774162	4.316440	8.416604	15.225089	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	66,827	52,812	5,466	4,120	12,384	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.005680	1.196764	0.174996	0.096244	0.373259	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: 14-1308 | Period: From 05/01/2017 To 04/30/2018 | Worksheet B-1 | Date/Time Prepared: 9/26/2018 12:59 pm

		Cost Center Description	CAFETERIA (FTE'S)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	
			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
5.01	00550	INFORMATION SYSTEMS						5.01
5.02	00591	OTHER ADMINISTRATIVE AND GENERAL						5.02
6.00	00600	MAINTENANCE & REPAIRS						6.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	8,494					11.00
13.00	01300	NURSING ADMINISTRATION	86	49,681				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	164	0	84,399			14.00
15.00	01500	PHARMACY	100	0	46	557,158		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	407	0	204	0	18,821,919	16.00
17.00	01700	SOCIAL SERVICE	10	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,127	21,664	19,051	700	1,050,300	30.00
46.00	04600	OTHER LONG TERM CARE	1,642	0	14,376	0	1,111,597	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	236	4,656	9,711	11	1,532,756	50.00
53.00	05300	ANESTHESIOLOGY	0	0	2,585	142	77,248	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	602	0	1,841	705	4,855,330	54.00
60.00	06000	LABORATORY	726	0	2,278	512	3,545,194	60.00
65.00	06500	RESPIRATORY THERAPY	1	7	730	0	158,075	65.00
66.00	06600	PHYSICAL THERAPY	1,217	0	1,215	731	2,553,114	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
68.01	06801	CARDIAC REHAB	0	1,707	1,220	0	97,426	68.01
69.00	06900	ELECTROCARDIOLOGY	119	231	0	0	193,340	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	10,909	0	103,062	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	8,940	0	22,380	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	553,648	1,210,742	73.00
76.00	03480	ONCOLOGY	0	0	0	0	24,781	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,170	5,006	2,100	254	882,201	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	886	16,410	9,193	455	1,404,373	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	8,493	49,681	84,399	557,158	18,821,919	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	OUTPATIENT CLINIC	1	0	0	0	0	190.01
190.02	19003	NON-REIMBURSEABLE OUTPATIENT MEALS	0	0	0	0	0	190.02
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
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)	46,192	115,065	145,963	292,564	357,967	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	5.438192	2.316077	1.729440	0.525101	0.019019	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	4,696	1,386	11,403	22,589	7,653	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.552861	0.027898	0.135108	0.040543	0.000407	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: 14-1308 | Period: From 05/01/2017 To 04/30/2018 | Worksheet B-1 | Date/Time Prepared: 9/26/2018 12:59 pm

		Cost Center Description	SOCIAL SERVICE (TIME SPENT)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)		
			17.00	19.00		
		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
5.01	00550	INFORMATION SYSTEMS				5.01
5.02	00591	OTHER ADMINISTRATIVE AND GENERAL				5.02
6.00	00600	MAINTENANCE & REPAIRS				6.00
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
17.00	01700	SOCIAL SERVICE	100			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	100		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	90	0		30.00
46.00	04600	OTHER LONG TERM CARE	10	0		46.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
53.00	05300	ANESTHESIOLOGY	0	100		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
60.00	06000	LABORATORY	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
68.01	06801	CARDIAC REHAB	0	0		68.01
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
76.00	03480	ONCOLOGY	0	0		76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0	0		93.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0	0		95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0		98.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE				113.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0		115.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	100	100		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
190.01	19001	OUTPATIENT CLINIC	0	0		190.01
190.02	19003	NON-REIMBURSEABLE OUTPATIENT MEALS	0	0		190.02
191.00	19100	RESEARCH	0	0		191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0		192.00
193.00	19300	NONPAID WORKERS	0	0		193.00
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)	10,485	96,458		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	104.850000	964.580000		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	527	481		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	5.270000	4.810000		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

POST STEPDOWN ADJUSTMENTS | Provider CCN: 14-1308 | Period: From 05/01/2017 To 04/30/2018 | Worksheet B-2 | Date/Time Prepared: 9/26/2018 12:59 pm

		Description	Worksheet CODE	Worksheet Line No.	Amount	
		1.00	2.00	3.00	4.00	
1.00		ADJ FOR EPO COSTS IN RENAL DIALYSIS	1	74.00	0	1.00
2.00		ADJ FOR EPO COSTS IN HOME PROGRAM	1	94.00	0	2.00
3.00		ADJ FOR ARANESP COSTS IN RENAL DIALYSIS	1	74.00	0	3.00
4.00		ADJ FOR ARANESP COSTS IN HOME PROGRAM	1	94.00	0	4.00
5.00		ADJ FOR ESA COSTS IN RENAL DIALYSIS	1	74.00	0	5.00
6.00		ADJ FOR ESA COSTS IN HOME PROGRAM	1	94.00	0	6.00
7.00		ADULTS AND PEDIATRICS	1	30.00	-48,101	7.00
8.00		OTHER OUTPATIENT SERVICES	1	93.00	48,101	8.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1308 | Period: From 05/01/2017 To 04/30/2018 | Worksheet C Part I Date/Time Prepared: 9/26/2018 12:59 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,376,016		1,376,016	0	0	30.00
46.00	04600	OTHER LONG TERM CARE	1,674,606		1,674,606	0	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	501,005		501,005	0	0	50.00
53.00	05300	ANESTHESIOLOGY	113,215		113,215	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,252,411		1,252,411	0	0	54.00
60.00	06000	LABORATORY	1,359,316		1,359,316	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	74,730	0	74,730	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,463,681	0	1,463,681	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
68.01	06801	CARDIAC REHAB	141,198	0	141,198	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	16,844		16,844	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	105,178		105,178	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	26,068		26,068	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	944,249		944,249	0	0	73.00
76.00	03480	ONCOLOGY	12,076		12,076	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,994,899		1,994,899	0	0	88.00
90.00	09000	CLINIC	0		0	0	0	90.00
91.00	09100	EMERGENCY	2,174,797		2,174,797	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	25,763		25,763		0	92.00
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	48,101		48,101	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0		0	0	0	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0		0	0	0	98.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0		0		0	115.00
200.00		Subtotal (see instructions)	13,304,153	0	13,304,153	0	0	200.00
201.00		Less Observation Beds	25,763		25,763		0	201.00
202.00		Total (see instructions)	13,278,390	0	13,278,390	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1308 | Period: From 05/01/2017 To 04/30/2018 | Worksheet C Part I Date/Time Prepared: 9/26/2018 12:59 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Charges: Inpatient	Charges: Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	578,042		578,042			30.00
46.00	04600	OTHER LONG TERM CARE	1,111,597		1,111,597			46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,503	1,528,253	1,532,756	0.326865	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	1,821	75,427	77,248	1.465604	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	50,195	4,805,135	4,855,330	0.257946	0.000000	54.00
60.00	06000	LABORATORY	133,508	3,411,686	3,545,194	0.383425	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	44,487	113,588	158,075	0.472750	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	436,689	2,116,425	2,553,114	0.573292	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	0.000000	68.00
68.01	06801	CARDIAC REHAB	0	97,426	97,426	1.449285	0.000000	68.01
69.00	06900	ELECTROCARDIOLOGY	2,280	191,060	193,340	0.087121	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	10,046	93,016	103,062	1.020531	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	22,380	22,380	1.164790	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	246,480	964,262	1,210,742	0.779893	0.000000	73.00
76.00	03480	ONCOLOGY	0	24,781	24,781	0.487309	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	882,201	882,201			88.00
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
91.00	09100	EMERGENCY	251	1,404,122	1,404,373	1.548589	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	27,470	27,470	0.937859	0.000000	92.00
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	8,381	436,407	444,788	0.108144	0.000000	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0.000000	0.000000	98.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0			115.00
200.00		Subtotal (see instructions)	2,628,280	16,193,639	18,821,919			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	2,628,280	16,193,639	18,821,919			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1308 | Period: From 05/01/2017 To 04/30/2018 | Worksheet C Part I Date/Time Prepared: 9/26/2018 12:59 pm

Title XVIII | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
46.00	04600	OTHER LONG TERM CARE			46.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	06000	LABORATORY	0.000000		60.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
68.01	06801	CARDIAC REHAB	0.000000		68.01
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
76.00	03480	ONCOLOGY	0.000000		76.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC			88.00
90.00	09000	CLINIC	0.000000		90.00
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0.000000		93.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0.000000		95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0.000000		98.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)			115.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1308 | Period: From 05/01/2017 To 04/30/2018 | Worksheet C Part I Date/Time Prepared: 9/26/2018 12:59 pm

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,376,016		1,376,016	0	1,376,016	30.00
46.00	04600	OTHER LONG TERM CARE	1,674,606		1,674,606	0	1,674,606	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	501,005		501,005	0	501,005	50.00
53.00	05300	ANESTHESIOLOGY	113,215		113,215	0	113,215	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,252,411		1,252,411	0	1,252,411	54.00
60.00	06000	LABORATORY	1,359,316		1,359,316	0	1,359,316	60.00
65.00	06500	RESPIRATORY THERAPY	74,730	0	74,730	0	74,730	65.00
66.00	06600	PHYSICAL THERAPY	1,463,681	0	1,463,681	0	1,463,681	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
68.01	06801	CARDIAC REHAB	141,198	0	141,198	0	141,198	68.01
69.00	06900	ELECTROCARDIOLOGY	16,844		16,844	0	16,844	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	105,178		105,178	0	105,178	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	26,068		26,068	0	26,068	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	944,249		944,249	0	944,249	73.00
76.00	03480	ONCOLOGY	12,076		12,076	0	12,076	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,994,899		1,994,899	0	1,994,899	88.00
90.00	09000	CLINIC	0		0	0	0	90.00
91.00	09100	EMERGENCY	2,174,797		2,174,797	0	2,174,797	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	25,763		25,763		25,763	92.00
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	48,101		48,101	0	48,101	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0		0	0	0	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0		0	0	0	98.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0		0		0	115.00
200.00		Subtotal (see instructions)	13,304,153	0	13,304,153	0	13,304,153	200.00
201.00		Less Observation Beds	25,763		25,763		25,763	201.00
202.00		Total (see instructions)	13,278,390	0	13,278,390	0	13,278,390	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1308 | Period: From 05/01/2017 To 04/30/2018 | Worksheet C Part I Date/Time Prepared: 9/26/2018 12:59 pm

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	578,042		578,042			30.00
46.00	04600	OTHER LONG TERM CARE	1,111,597		1,111,597			46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,503	1,528,253	1,532,756	0.326865	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	1,821	75,427	77,248	1.465604	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	50,195	4,805,135	4,855,330	0.257946	0.000000	54.00
60.00	06000	LABORATORY	133,508	3,411,686	3,545,194	0.383425	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	44,487	113,588	158,075	0.472750	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	436,689	2,116,425	2,553,114	0.573292	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	0.000000	68.00
68.01	06801	CARDIAC REHAB	0	97,426	97,426	1.449285	0.000000	68.01
69.00	06900	ELECTROCARDIOLOGY	2,280	191,060	193,340	0.087121	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	10,046	93,016	103,062	1.020531	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	22,380	22,380	1.164790	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	246,480	964,262	1,210,742	0.779893	0.000000	73.00
76.00	03480	ONCOLOGY	0	24,781	24,781	0.487309	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	882,201	882,201	2.261275	0.000000	88.00
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
91.00	09100	EMERGENCY	251	1,404,122	1,404,373	1.548589	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	27,470	27,470	0.937859	0.000000	92.00
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	8,381	436,407	444,788	0.108144	0.000000	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0.000000	0.000000	98.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0			115.00
200.00		Subtotal (see instructions)	2,628,280	16,193,639	18,821,919			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	2,628,280	16,193,639	18,821,919			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1308 | Period: From 05/01/2017 To 04/30/2018 | Worksheet C Part I Date/Time Prepared: 9/26/2018 12:59 pm

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
46.00	04600	OTHER LONG TERM CARE			46.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	06000	LABORATORY	0.000000		60.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
68.01	06801	CARDIAC REHAB	0.000000		68.01
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
76.00	03480	ONCOLOGY	0.000000		76.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	0.000000		88.00
90.00	09000	CLINIC	0.000000		90.00
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0.000000		93.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0.000000		95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0.000000		98.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)			115.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 14-1308 | Period: From 05/01/2017 To 04/30/2018 | Worksheet D Part II Date/Time Prepared: 9/26/2018 12:59 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	25,617	1,532,756	0.016713	1,174	20	50.00
53.00	05300	ANESTHESIOLOGY	2,953	77,248	0.038228	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	99,829	4,855,330	0.020561	25,099	516	54.00
60.00	06000	LABORATORY	21,153	3,545,194	0.005967	41,208	246	60.00
65.00	06500	RESPIRATORY THERAPY	6,027	158,075	0.038127	7,087	270	65.00
66.00	06600	PHYSICAL THERAPY	26,889	2,553,114	0.010532	3,232	34	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0	0	68.00
68.01	06801	CARDIAC REHAB	12,804	97,426	0.131423	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	2,337	193,340	0.012088	1,520	18	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,937	103,062	0.018795	1,835	34	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,268	22,380	0.056658	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	26,085	1,210,742	0.021545	41,378	891	73.00
76.00	03480	ONCOLOGY	1,389	24,781	0.056051	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	25,281	882,201	0.028657	0	0	88.00
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
91.00	09100	EMERGENCY	38,660	1,404,373	0.027528	251	7	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,038	27,470	0.037787	0	0	92.00
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0	444,788	0.000000	3,936	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0.000000	0	0	98.00
200.00		Total (lines 50 through 199)	293,267	17,132,280		126,720	2,036	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1308 | Period: From 05/01/2017 To 04/30/2018 | Worksheet D Part IV | Date/Time Prepared: 9/26/2018 12:59 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	96,458	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
68.01	06801	CARDIAC REHAB	0	0	0	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03480	ONCOLOGY	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0		0	92.00
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
200.00		Total (lines 50 through 199)	96,458	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1308 | Period: From 05/01/2017 To 04/30/2018 | Worksheet D Part IV | Date/Time Prepared: 9/26/2018 12:59 pm

Title XVIII | Hospital | Cost

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	1,532,756	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	96,458	0	77,248	1.248680	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	4,855,330	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	3,545,194	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	158,075	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	2,553,114	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0.000000	68.00
68.01	06801	CARDIAC REHAB	0	0	0	97,426	0.000000	68.01
69.00	06900	ELECTROCARDIOLOGY	0	0	0	193,340	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	103,062	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	22,380	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,210,742	0.000000	73.00
76.00	03480	ONCOLOGY	0	0	0	24,781	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	882,201	0.000000	88.00
90.00	09000	CLINIC	0	0	0	0	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	1,404,373	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	27,470	0.000000	92.00
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	444,788	0.000000	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0.000000	98.00
200.00		Total (lines 50 through 199)	0	96,458	0	17,132,280		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1308 | Period: From 05/01/2017 To 04/30/2018 | Worksheet D Part IV | Date/Time Prepared: 9/26/2018 12:59 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	1,174	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	25,099	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	41,208	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	7,087	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	3,232	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
68.01	06801	CARDIAC REHAB	0.000000	0	0	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	0.000000	1,520	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	1,835	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	41,378	0	0	0	73.00
76.00	03480	ONCOLOGY	0.000000	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.000000	251	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0	92.00
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	3,936	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0.000000	0	0	0	0	98.00
200.00		Total (lines 50 through 199)		126,720	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-1308 | Period: From 05/01/2017 To 04/30/2018 | Worksheet D Part V Date/Time Prepared: 9/26/2018 12:59 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.326865	0	693,157	0	0	50.00
53.00	05300	ANESTHESIOLOGY	1.465604	0	38,439	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.257946	0	1,788,610	0	0	54.00
60.00	06000	LABORATORY	0.383425	0	1,452,356	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.472750	0	34,433	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.573292	0	823,623	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
68.01	06801	CARDIAC REHAB	1.449285	0	62,698	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	0.087121	0	97,848	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.020531	0	64,390	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1.164790	0	14,174	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.779893	0	475,585	10,127	0	73.00
76.00	03480	ONCOLOGY	0.487309	0	16,760	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	1.548589	0	462,895	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.937859	0	16,935	0	0	92.00
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0.108144	0	225,661	5,694	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.000000		0			95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0.000000	0	0	0	0	98.00
200.00		Subtotal (see instructions)		0	6,267,564	15,821	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	6,267,564	15,821	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-1308 | Period: From 05/01/2017 To 04/30/2018 | Worksheet D Part V Date/Time Prepared: 9/26/2018 12:59 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	226,569	0		50.00
53.00	05300	ANESTHESIOLOGY	56,336	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	461,365	0		54.00
60.00	06000	LABORATORY	556,870	0		60.00
65.00	06500	RESPIRATORY THERAPY	16,278	0		65.00
66.00	06600	PHYSICAL THERAPY	472,176	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
68.01	06801	CARDIAC REHAB	90,867	0		68.01
69.00	06900	ELECTROCARDIOLOGY	8,525	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	65,712	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	16,510	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	370,905	7,898		73.00
76.00	03480	ONCOLOGY	8,167	0		76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	716,834	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	15,883	0		92.00
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	24,404	616		93.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0		98.00
200.00		Subtotal (see instructions)	3,107,401	8,514		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	3,107,401	8,514		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1308 | Component CCN: 14-Z308 | Period: From 05/01/2017 To 04/30/2018 | Worksheet D Part V Date/Time Prepared: 9/26/2018 12:59 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.326865	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	1.465604	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.257946	0	0	0	0	54.00
60.00	06000	LABORATORY	0.383425	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.472750	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.573292	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
68.01	06801	CARDIAC REHAB	1.449285	0	0	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	0.087121	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.020531	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1.164790	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.779893	0	0	0	0	73.00
76.00	03480	ONCOLOGY	0.487309	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	1.548589	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.937859	0	0	0	0	92.00
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0.108144	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.000000		0			95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0.000000	0	0	0	0	98.00
200.00		Subtotal (see instructions)		0	0	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-1308 | Component CCN: 14-Z308 | Period: From 05/01/2017 To 04/30/2018 | Worksheet D Part V Date/Time Prepared: 9/26/2018 12:59 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
60.00	06000	LABORATORY	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
68.01	06801	CARDIAC REHAB	0	0		68.01
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
76.00	03480	ONCOLOGY	0	0		76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0	0		93.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0		98.00
200.00		Subtotal (see instructions)	0	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	0		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1308 | Period: From 05/01/2017 To 04/30/2018 | Worksheet D-1 | Date/Time Prepared: 9/26/2018 12:59 pm

Title XVIII | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	1,650	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	276	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)	246	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	740	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)	576	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	54	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)	4	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	189	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)	692	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)	503	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	151.93	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	156.49	20.00
21.00	Total general inpatient routine service cost (see instructions)	1,376,016	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)	8,204	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)	626	25.00
26.00	Total swing-bed cost (see instructions)	1,138,998	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	237,018	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)	237,018	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)	858.79	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	162,311	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)	162,311	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1308 | Period: From 05/01/2017 To 04/30/2018 | Worksheet D-1 | Date/Time Prepared: 9/26/2018 12:59 pm

Title XVIII | Hospital | Cost

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	62,951	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	225,262	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	594,283	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	431,971	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	1,026,254	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)	30	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	858.76	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	25,763	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1308 | Period: From 05/01/2017 To 04/30/2018 | Worksheet D-1 | Date/Time Prepared: 9/26/2018 12:59 pm

Title XVIII | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	55,465	1,376,016	0.040308	25,763	1,038	90.00
91.00	Nursing School cost	0	1,376,016	0.000000	25,763	0	91.00
92.00	Allied health cost	0	1,376,016	0.000000	25,763	0	92.00
93.00	All other Medical Education	0	1,376,016	0.000000	25,763	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 14-1308 | Period: From 05/01/2017 To 04/30/2018 | Worksheet D-3 | Date/Time Prepared: 9/26/2018 12:59 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		151,518		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.326865	1,174	384	50.00
53.00	05300	ANESTHESIOLOGY	1.465604	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.257946	25,099	6,474	54.00
60.00	06000	LABORATORY	0.383425	41,208	15,800	60.00
65.00	06500	RESPIRATORY THERAPY	0.472750	7,087	3,350	65.00
66.00	06600	PHYSICAL THERAPY	0.573292	3,232	1,853	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	68.00
68.01	06801	CARDIAC REHAB	1.449285	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	0.087121	1,520	132	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.020531	1,835	1,873	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1.164790	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.779893	41,378	32,270	73.00
76.00	03480	ONCOLOGY	0.487309	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000	CLINIC	0.000000	0	0	90.00
91.00	09100	EMERGENCY	1.548589	251	389	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.937859	0	0	92.00
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0.108144	3,936	426	93.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0.000000	0	0	98.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		126,720	62,951	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)		126,720		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 14-1308 | Component CCN: 14-Z308 | Period: From 05/01/2017 To 04/30/2018 | Worksheet D-3 | Date/Time Prepared: 9/26/2018 12:59 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.326865	0	0	50.00
53.00	05300	ANESTHESIOLOGY	1.465604	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.257946	14,887	3,840	54.00
60.00	06000	LABORATORY	0.383425	76,347	29,273	60.00
65.00	06500	RESPIRATORY THERAPY	0.472750	20,979	9,918	65.00
66.00	06600	PHYSICAL THERAPY	0.573292	371,974	213,250	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	68.00
68.01	06801	CARDIAC REHAB	1.449285	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	0.087121	570	50	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.020531	5,432	5,544	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1.164790	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.779893	166,962	130,212	73.00
76.00	03480	ONCOLOGY	0.487309	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000	CLINIC	0.000000	0	0	90.00
91.00	09100	EMERGENCY	1.548589	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.937859	0	0	92.00
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0.108144	764	83	93.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0.000000	0	0	98.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		657,915	392,170	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)		657,915		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-1308	Period: From 05/01/2017 To 04/30/2018	Worksheet E Part B Date/Time Prepared: 9/26/2018 12:59 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	3,115,915	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	OPPS payments	0	3.00
4.00	Outlier payment (see instructions)	0	4.00
4.01	Outlier reconciliation amount (see instructions)	0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	3,115,915	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	0	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (see instructions)	3,147,074	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	0	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	24,080	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	953,073	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)	2,169,921	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)	2,169,921	30.00
31.00	Primary payer payments	492	31.00
32.00	Subtotal (line 30 minus line 31)	2,169,429	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)	93,127	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	60,533	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	93,127	36.00
37.00	Subtotal (see instructions)	2,229,962	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)	2,229,962	40.00
40.01	Sequestration adjustment (see instructions)	44,599	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
41.00	Interim payments	2,091,287	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	94,076	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: 14-1308 | Period: From 05/01/2017 To 04/30/2018 | Worksheet E-1 Part I | Date/Time Prepared: 9/26/2018 12:59 pm

Title XVIII | Hospital | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		192,379		2,061,969	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	04/30/2018	47,932	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	04/05/2018	133,000	04/05/2018	18,614	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)		-133,000		29,318	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)		59,379		2,091,287	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		99,562		94,076	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		158,941		2,185,363	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: 14-1308 | Component CCN: 14-Z308 | Period: From 05/01/2017 To 04/30/2018 | Worksheet E-1 Part I | Date/Time Prepared: 9/26/2018 12:59 pm

Title XVIII | Swing Beds - SNF | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,577,052		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)		1,577,052		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		198,972		0	6.02
7.00	Total Medicare program liability (see instructions)		1,378,080		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: 14-1308	Period: From 05/01/2017 To 04/30/2018	Worksheet E-1 Part II Date/Time Prepared: 9/26/2018 12:59 pm
	Title XVIII	Hospital	Cost

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

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS | Provider CCN: 14-1308 | Component CCN: 14-Z308 | Period: From 05/01/2017 To 04/30/2018 | Worksheet E-2 | Date/Time Prepared: 9/26/2018 12:59 pm

Title XVIII | Swing Beds - SNF | Cost

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	1,036,517	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)	396,092	0	3.00
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)		0.00	4.00
5.00	Program days	1,195	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)		0	6.00
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	1,432,609	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	1,432,609	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0	0	11.00
12.00	Subtotal (line 10 minus line 11)	1,432,609	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	26,405	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)	1,406,204	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)			16.50
16.55	Rural community hospital demonstration project (§410A Demonstration) payment adjustment (see instructions)	0		16.55
16.99	Demonstration payment adjustment amount before sequestration	0	0	16.99
17.00	Allowable bad debts (see instructions)	0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (see instructions)	1,406,204	0	19.00
19.01	Sequestration adjustment (see instructions)	28,124	0	19.01
19.02	Demonstration payment adjustment amount after sequestration)	0	0	19.02
20.00	Interim payments	1,577,052	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)	-198,972	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	23.00
	Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment			
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
	Cost Reimbursement			
201.00	Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital))			201.00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))			202.00
203.00	Total (sum of lines 201 and 202)			203.00
204.00	Medicare swing-bed SNF discharges (see instructions)			204.00
	Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)			
205.00	Medicare swing-bed SNF target amount			205.00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)			206.00
	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement			
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)			208.00
209.00	Adjustment to Medicare swing-bed SNF PPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
	Comparision of PPS versus Cost Reimbursement			
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see instructions)			215.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-1308	Period: From 05/01/2017 To 04/30/2018	Worksheet E-3 Part V Date/Time Prepared: 9/26/2018 12:59 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	225,262	1.00
2.00	Nursing and Allied Health Managed Care payment (see instructions)	0	2.00
3.00	Organ acquisition	0	3.00
4.00	Subtotal (sum of lines 1 through 3)	225,262	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	227,515	6.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
7.00	Routine service charges	0	7.00
8.00	Ancillary service charges	0	8.00
9.00	Organ acquisition charges, net of revenue	0	9.00
10.00	Total reasonable charges	0	10.00
	Customary charges		
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)	0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)	0.000000	13.00
14.00	Total customary charges (see instructions)	0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)	0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)	0	16.00
17.00	Cost of physicians' services in a teaching hospital (see instructions)	0	17.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)	0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)	227,515	19.00
20.00	Deductibles (exclude professional component)	66,131	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	161,384	22.00
23.00	Coinsurance	0	23.00
24.00	Subtotal (line 22 minus line 23)	161,384	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	1,232	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	801	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	1,232	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	162,185	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	29.50
29.99	Demonstration payment adjustment amount before sequestration	0	29.99
30.00	Subtotal (see instructions)	162,185	30.00
30.01	Sequestration adjustment (see instructions)	3,244	30.01
30.02	Demonstration payment adjustment amount after sequestration	0	30.02
31.00	Interim payments	59,379	31.00
32.00	Tentative settlement (for contractor use only)	0	32.00
33.00	Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32)	99,562	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	34.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 14-1308 | Period: From 05/01/2017 To 04/30/2018 | Worksheet G | Date/Time Prepared: 9/26/2018 12:59 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	382,528	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	1,935,014	0	0	0	4.00
5.00	Other receivable	158,209	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-320,000	0	0	0	6.00
7.00	Inventory	310,444	0	0	0	7.00
8.00	Prepaid expenses	90,380	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	2,556,575	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	62,855	0	0	0	12.00
13.00	Land improvements	419,030	0	0	0	13.00
14.00	Accumulated depreciation	-394,548	0	0	0	14.00
15.00	Buildings	9,482,503	0	0	0	15.00
16.00	Accumulated depreciation	-7,806,091	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	5,241,374	0	0	0	23.00
24.00	Accumulated depreciation	-4,781,733	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	927,041	0	0	0	27.00
28.00	Accumulated depreciation	-915,051	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)	2,235,380	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	648,682	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	0	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	648,682	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	5,440,637	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	268,024	0	0	0	37.00
38.00	Salaries, wages, and fees payable	608,197	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	218,542	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	0	0	0	0	43.00
44.00	Other current liabilities	643,139	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	1,737,902	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	1,039,598	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)	1,039,598	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	2,777,500	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	2,663,137				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)	2,663,137	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	5,440,637	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 14-1308 | Period: From 05/01/2017 To 04/30/2018 | Worksheet G-1 | Date/Time Prepared: 9/26/2018 12:59 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		3,394,833		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-731,696				2.00
3.00	Total (sum of line 1 and line 2)		2,663,137		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)		2,663,137		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		2,663,137		0		19.00

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

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 14-1308 | Period: From 05/01/2017 To 04/30/2018 | Worksheet G-2 Parts I & II | Date/Time Prepared: 9/26/2018 12:59 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	208,400		208,400	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	369,642		369,642	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	1,111,597		1,111,597	9.00
10.00	Total general inpatient care services (sum of lines 1-9)	1,689,639		1,689,639	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	1,689,639		1,689,639	17.00
18.00	Ancillary services	928,760	15,897,902	16,826,662	18.00
19.00	Outpatient services	0	444,788	444,788	19.00
20.00	RURAL HEALTH CLINIC	0	1,396,788	1,396,788	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES	0	0	0	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	25.00
26.00	HOSPICE				26.00
27.00	CHARITY CARE	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	2,618,399	17,739,478	20,357,877	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		13,774,626		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)		13,774,626		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 14-1308	Period: From 05/01/2017 To 04/30/2018	Worksheet G-3 Date/Time Prepared: 9/26/2018 12:59 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	20,357,877	1.00
2.00	Less contractual allowances and discounts on patients' accounts	7,982,383	2.00
3.00	Net patient revenues (line 1 minus line 2)	12,375,494	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	13,774,626	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-1,399,132	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	2,715	6.00
7.00	Income from investments	49,804	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	4,745	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	21,155	22.00
23.00	Governmental appropriations	367,963	23.00
24.00	GRANT INCOME	13,146	24.00
24.01	MEDICARE AND MEDICAID INCENTIVE REV	8,500	24.01
24.02	GAIN ON DISPOSAL OF FIXED ASSETS	1	24.02
24.03	OTHER MISCELLANEOUS INCOME	46,885	24.03
24.04	340B	152,522	24.04
25.00	Total other income (sum of lines 6-24)	667,436	25.00
26.00	Total (line 5 plus line 25)	-731,696	26.00
27.00	OTHER EXPENSES	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-731,696	29.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1308 | Component CCN: 14-3472 | Period: From 05/01/2017 To 04/30/2018 | Worksheet M-1 | Date/Time Prepared: 9/26/2018 12:59 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	629,925	0	629,925	0	629,925	1.00
2.00	Physician Assistant	91,000	0	91,000	0	91,000	2.00
3.00	Nurse Practitioner	0	0	0	0	0	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	264,695	0	264,695	0	264,695	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	985,620	0	985,620	0	985,620	10.00
11.00	Physician Services Under Agreement	0	238,260	238,260	0	238,260	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	27,408	27,408	0	27,408	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	265,668	265,668	0	265,668	14.00
15.00	Medical Supplies	0	3,658	3,658	0	3,658	15.00
16.00	Transportation (Health Care Staff)	0	150	150	0	150	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	52,013	52,013	-52,013	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	55,821	55,821	-52,013	3,808	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	985,620	321,489	1,307,109	-52,013	1,255,096	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	931	931	0	931	29.00
30.00	Administrative Costs	0	6,719	6,719	0	6,719	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	7,650	7,650	0	7,650	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	985,620	329,139	1,314,759	-52,013	1,262,746	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1308 | Component CCN: 14-3472 | Period: From 05/01/2017 To 04/30/2018 | Worksheet M-1 | Date/Time Prepared: 9/26/2018 12:59 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	-42,205	587,720		1.00
2.00	Physician Assistant	0	91,000		2.00
3.00	Nurse Practitioner	0	0		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	264,695		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	0		9.00
10.00	Subtotal (sum of lines 1 through 9)	-42,205	943,415		10.00
11.00	Physician Services Under Agreement	0	238,260		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	27,408		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	265,668		14.00
15.00	Medical Supplies	0	3,658		15.00
16.00	Transportation (Health Care Staff)	0	150		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	3,808		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-42,205	1,212,891		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	931		29.00
30.00	Administrative Costs	0	6,719		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	7,650		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-42,205	1,220,541		32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1308 | Component CCN: 14-3472 | Period: From 05/01/2017 To 04/30/2018 | Worksheet M-2 | Date/Time Prepared: 9/26/2018 12:59 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	2.12	5,765	4,200	8,904		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	0.84	2,177	2,100	1,764		3.00
4.00	Subtotal (sum of lines 1 through 3)	2.96	7,942		10,668	10,668	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	2.96	7,942			10,668	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)					1,212,891	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)					1,212,891	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)					7,650	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					774,358	15.00
16.00	Total overhead (sum of lines 14 and 15)					782,008	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					782,008	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					782,008	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					1,994,899	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 14-1308 Component CCN: 14-3472	Period: From 05/01/2017 To 04/30/2018	Worksheet M-3 Date/Time Prepared: 9/26/2018 12:59 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)			1,994,899	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			24,455	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			1,970,444	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			10,668	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)			10,668	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			184.71	7.00
		Calculation of Limit (1)			
		Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)		
		1.00	2.00		
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	82.30	83.45		8.00
9.00	Rate for Program covered visits (see instructions)	184.71	184.71		9.00
	CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	0	2,456		10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	453,648		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	453,648		16.00
16.01	Total program charges (see instructions)(from contractor's records)		306,447		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		0		16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		0		16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)		332,202		16.04
16.05	Total program cost (see instructions)	0	332,202		16.05
17.00	Primary payer amounts		0		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		38,396		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		53,610		19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		332,202		20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		246		21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		332,448		22.00
23.00	Allowable bad debts (see instructions)		7,667		23.00
23.01	Adjusted reimbursable bad debts (see instructions)		4,984		23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		7,667		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)		337,432		26.00
26.01	Sequestration adjustment (see instructions)		6,749		26.01
26.02	Demonstration payment adjustment amount after sequestration		0		26.02
27.00	Interim payments		324,576		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)		6,107		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: 14-1308 Component CCN: 14-3472	Period: From 05/01/2017 To 04/30/2018	Worksheet M-4 Date/Time Prepared: 9/26/2018 12:59 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)	943,415	943,415	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000336	0.000508	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	317	479	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	11,031	3,042	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	11,348	3,521	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	1,212,891	1,212,891	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	782,008	782,008	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.009356	0.002903	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	7,316	2,270	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	18,664	5,791	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	76	115	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	245.58	50.36	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	1	0	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	246	0	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)		24,455	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)		246	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 14-1308 Component CCN: 14-3472	Period: From 05/01/2017 To 04/30/2018	Worksheet M-5 Date/Time Prepared: 9/26/2018 12:59 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		324,576	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)		324,576	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		6,107	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		330,683	7.00

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