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: 14-1320	Period: From 01/01/2018 To 12/31/2018	Worksheet S Parts I-III Date/Time Prepared: 5/29/2019 1:41 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 5/29/2019 Time: 1:41 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 PARIS COMMUNITY HOSPITAL (14-1320) for the cost reporting period beginning 01/01/2018 and ending 12/31/2018 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

(Signed) MARTIN ADAMS
Officer or Administrator of Provider(s)

VICE PRESIDENT OF FINANCE
Title

(Dated when report is electronically signed.)
Date

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	-289,209	504,612	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	-495,428	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
10.00	RURAL HEALTH CLINIC I	0		387,028		0	10.00
10.01	RURAL HEALTH CLINIC II	0		13,027		0	10.01
10.02	RURAL HEALTH CLINIC III	0		0		0	10.02
200.00	Total	0	-784,637	904,667	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: 14-1320 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part I | Date/Time Prepared: 5/29/2019 1:41 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 721 EAST COURT STREET	PO Box:			1.00
2.00	City: PARIS	State: IL	Zip Code: 61944-	County: EDGAR	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	PARIS COMMUNITY HOSPITAL	141320	99914	1	06/30/2002	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	PARIS COMMUNITY HOSPITAL	14Z320	99914		06/30/2002	N	O	N	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC	FMC	143987	99914		09/24/1994	N	O	N	15.00
15.01	Hospital-Based Health Clinic - RHC II	HATCH	143989	99914		01/01/1995	N	O	N	15.01
15.02	Hospital-Based Health Clinic - RHC III	FMC	143431	99914		02/16/1997	N	O	N	15.02
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From: 1.00	To: 2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	01/01/2018	12/31/2018	20.00
21.00	Type of Control (see instructions)	2		21.00

		1.00	2.00	3.00	
	Inpatient PPS Information				
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	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	N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	2	N		23.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1320 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part I | Date/Time Prepared: 5/29/2019 1:41 pm

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

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

		Beginning:	Ending:	
		1.00	2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.			36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.	0		37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)			37.01
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.			38.00

		Y/N	Y/N	
		1.00	2.00	
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 “Y” for yes or “N” for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	N	N	39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	N	N	40.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1320 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part I Date/Time Prepared: 5/29/2019 1:41 pm

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1320 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part I | Date/Time Prepared: 5/29/2019 1:41 pm

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 14-1320	Period: From 01/01/2018 To 12/31/2018	Worksheet S-2 Part I Date/Time Prepared: 5/29/2019 1:41 pm

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

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

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

		1.00	
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A 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: 14-1320 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part I | Date/Time Prepared: 5/29/2019 1:41 pm

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

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

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	225,110	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: 14-1320	Period: From 01/01/2018 To 12/31/2018	Worksheet S-2 Part I Date/Time Prepared: 5/29/2019 1:41 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)	01/01/2018	12/31/2018	170.00

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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 14-1320 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part II | Date/Time Prepared: 5/29/2019 1:41 pm

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

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

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

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

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

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	Y	03/29/2019	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)	N		Y	03/29/2019	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: 14-1320 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part II Date/Time Prepared: 5/29/2019 1:41 pm

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

		1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)		
	Capital Related Cost		
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions	N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.	N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions	N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.	N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.	N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.	N	27.00
	Interest Expense		
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.	N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions	N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.	N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.	N	31.00
	Purchased Services		
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.	N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.	N	33.00
	Provider-Based Physicians		
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.	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.	N		37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.	N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.	N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.	N		40.00

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	SHAWN	ADAMS	41.00
42.00	Enter the employer/company name of the cost report preparer.	ALLIANT MANAGEMENT SERVICES		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	5029923508	SADAMS@BLUEANDCO.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 14-1320 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part II Date/Time Prepared: 5/29/2019 1:41 pm

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 14-1320 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-3 Part I Date/Time Prepared: 5/29/2019 1:41 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	25	9,125	49,560.00	0	1.00
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		25	9,125	49,560.00	0	7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)		25	9,125	49,560.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	88.00				0	26.00
26.01	RURAL HEALTH CLINIC II	88.01				0	26.01
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		25				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00
33.01	LTCH site neutral days and discharges						33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 14-1320 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-3 Part I | Date/Time Prepared: 5/29/2019 1:41 pm

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	1,299	74	2,065			1.00
2.00	HMO and other (see instructions)	7	138				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	778	0	880			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	2,493			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	2,077	74	5,438			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)	2,077	74	5,438	0.00	327.16	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	9,756	0	31,370	0.00	58.94	26.00
26.01	RURAL HEALTH CLINIC II	427	0	2,270	0.00	3.35	26.01
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	389.45	27.00
28.00	Observation Bed Days		0	423			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: 14-1320 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-3 Part I | Date/Time Prepared: 5/29/2019 1:41 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	422	39	711	1.00
2.00	HMO and other (see instructions)			3	56		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	422	39	711	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	0.00					26.00
26.01	RURAL HEALTH CLINIC II	0.00					26.01
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 14-1320 | Component CCN: 14-3987 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-8 | Date/Time Prepared: 5/29/2019 1:41 pm

		RHC I	Cost
		1.00	
	Clinic Address and Identification		
1.00	Street	727 EAST COURT STREET	1.00

		City	State	ZIP Code	
		1.00	2.00	3.00	
2.00	City, State, ZIP Code, County	PARIS	IL	61944	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
9.01				9.01
9.02				9.02
9.03				9.03
9.04				9.04
9.05				9.05
9.06				9.06
9.07				9.07
9.08				9.08
9.09				9.09
9.10				9.10

		1.00	2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)	N	0	10.00

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

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

		Provider name	CCN number	
		1.00	2.00	
14.00	RHC/FQHC name, CCN number			14.00

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

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-1320
Component CCN: 14-3987

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

Worksheet S-8

Date/Time Prepared:
5/29/2019 1:41 pm

RHC I | Cost

			County				
			4.00				
2.00	City, State, ZIP Code, County		EDGAR				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	17:00	08:00	19:00	08:00	19:00	11.00
		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	CLINIC	08:00	19:00	08:00	11:30		11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-1320
Component CCN: 14-3989

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

Worksheet S-8

Date/Time Prepared: 5/29/2019 1:41 pm

RHC II | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			144 ILLINOIS		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	CHRISMAN		IL	61924	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
9.01						9.01
9.02						9.02
9.03						9.03
9.04						9.04
9.05						9.05
9.06						9.06
9.07						9.07
9.08						9.08
9.09						9.09
9.10						9.10
				1.00	2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N	0	10.00

		Sunday		Monday		Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
	Facility hours of operations (1)						
11.00	CLINIC			08:00	12:00	13:30	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

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-1320
Component CCN: 14-3989

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

Worksheet S-8

Date/Time Prepared:
5/29/2019 1:41 pm

RHC II | Cost

			County				
			4.00				
2.00	City, State, ZIP Code, County		EDGAR				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	19:30			08:00	12:00	11.00
		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	CLINIC	08:00	12:00				11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 14-1320 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-10 | Date/Time Prepared: 5/29/2019 1:41 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)	0.421061	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	7,129,525	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	22,422,631	6.00
7.00	Medicaid cost (line 1 times line 6)	9,441,295	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)	2,311,770	8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone CHIP	0	9.00
10.00	Stand-alone CHIP charges	0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	2,311,770	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)	542,161	0	542,161	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	228,283	0	228,283	21.00
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	228,283	0	228,283	23.00

		1.00	
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	4,549,080	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	593,265	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	912,716	27.01
28.00	Non-Medicare bad debt expense (see instructions)	3,636,364	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	1,850,582	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	2,078,865	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	4,390,635	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-1320 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A | Date/Time Prepared: 5/29/2019 1:41 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	NEW CAP REL COSTS-BLDG & FIXT		657,457	657,457	200,539	857,996	1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		1,377,934	1,377,934	213,431	1,591,365	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	116,710	1,465,453	1,582,163	1,320,030	2,902,193	4.00
5.01	00590	OTHER ADMINISTRATIVE AND GENERAL	2,803,064	5,211,698	8,014,762	-1,440,049	6,574,713	5.01
5.02	00560	ADMITTING	906,931	859,296	1,766,227	-313	1,765,914	5.02
7.00	00700	OPERATION OF PLANT	523,861	742,657	1,266,518	-248	1,266,270	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	139,683	139,683	0	139,683	8.00
9.00	00900	HOUSEKEEPING	283,348	162,722	446,070	-1,630	444,440	9.00
10.00	01000	DIETARY	430,948	306,017	736,965	-406,510	330,455	10.00
11.00	01100	CAFETERIA	0	0	0	406,510	406,510	11.00
13.00	01300	NURSING ADMINISTRATION	869,420	167,900	1,037,320	-28	1,037,292	13.00
15.00	01500	PHARMACY	316,004	1,169,336	1,485,340	-1,079,021	406,319	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	359,651	79,573	439,224	0	439,224	16.00
17.00	01700	SOCIAL SERVICE	60,384	10,220	70,604	0	70,604	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,406,390	568,397	2,974,787	-34,343	2,940,444	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,353,196	1,655,988	3,009,184	-2,082,836	926,348	50.00
53.00	05300	ANESTHESIOLOGY	1,377,508	302,540	1,680,048	-104,825	1,575,223	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,465,974	975,713	2,441,687	-223,116	2,218,571	54.00
60.00	06000	LABORATORY	774,581	1,288,234	2,062,815	-374,547	1,688,268	60.00
65.00	06500	RESPIRATORY THERAPY	488,952	94,276	583,228	-48,171	535,057	65.00
66.00	06600	PHYSICAL THERAPY	1,146,780	165,501	1,312,281	-1,211	1,311,070	66.00
69.00	06900	ELECTROCARDIOLOGY	0	41,071	41,071	45,252	86,323	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	3,692	3,692	0	3,692	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	75	75	1,910,247	1,910,322	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	882,643	882,643	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	53	53	1,114,139	1,114,192	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	4,051,447	2,532,073	6,583,520	0	6,583,520	88.00
88.01	08801	RURAL HEALTH CLINIC II	223,829	137,535	361,364	0	361,364	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	0	88.02
90.00	09000	CLINIC	107,616	40,575	148,191	-14,708	133,483	90.00
90.01	04951	CHEMO/PAIN	873,794	409,560	1,283,354	-82,405	1,200,949	90.01
90.02	09002	SENIOR CARE	4,137	562,932	567,069	-26,089	540,980	90.02
90.03	09003	SLEEP LAB	81,557	70,547	152,104	-540	151,564	90.03
91.00	09100	EMERGENCY	1,345,920	2,094,435	3,440,355	-54,272	3,386,083	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	482,247	149,553	631,800	-5,560	626,240	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		82,240	82,240	-82,240	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	22,854,249	23,524,936	46,379,185	30,129	46,409,314	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	3,762,116	963,687	4,725,803	-20,784	4,705,019	192.00
192.01	19202	OCCUPATIONAL MEDICINE	0	0	0	0	0	192.01
192.02	19201	NAL CLINIC	377,973	95,621	473,594	0	473,594	192.02
192.03	19203	EZ CARE	782,726	437,072	1,219,798	-9,345	1,210,453	192.03
200.00		TOTAL (SUM OF LINES 118 through 199)	27,777,064	25,021,316	52,798,380	0	52,798,380	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-1320 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A | Date/Time Prepared: 5/29/2019 1:41 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	-82,240	775,756		1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	-6,000	1,585,365		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-210,140	2,692,053		4.00
5.01	00590	OTHER ADMINISTRATIVE AND GENERAL	-376,740	6,197,973		5.01
5.02	00560	ADMITTING	-4,083	1,761,831		5.02
7.00	00700	OPERATION OF PLANT	-1,186	1,265,084		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	-133	139,550		8.00
9.00	00900	HOUSEKEEPING	-39	444,401		9.00
10.00	01000	DIETARY	-4,360	326,095		10.00
11.00	01100	CAFETERIA	-89,483	317,027		11.00
13.00	01300	NURSING ADMINISTRATION	-900	1,036,392		13.00
15.00	01500	PHARMACY	-1,372	404,947		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-5,250	433,974		16.00
17.00	01700	SOCIAL SERVICE	0	70,604		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-754,218	2,186,226		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-22,472	903,876		50.00
53.00	05300	ANESTHESIOLOGY	-1,498,440	76,783		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-653,987	1,564,584		54.00
60.00	06000	LABORATORY	-1,097	1,687,171		60.00
65.00	06500	RESPIRATORY THERAPY	0	535,057		65.00
66.00	06600	PHYSICAL THERAPY	-2,694	1,308,376		66.00
69.00	06900	ELECTROCARDIOLOGY	-41,071	45,252		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	-3,692	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,910,322		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	882,643		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-24,015	1,090,177		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	-113,850	6,469,670		88.00
88.01	08801	RURAL HEALTH CLINIC II	-6,259	355,105		88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0		88.02
90.00	09000	CLINIC	-21,319	112,164		90.00
90.01	04951	CHEMO/PAIN	-238,965	961,984		90.01
90.02	09002	SENIOR CARE	-40,312	500,668		90.02
90.03	09003	SLEEP LAB	-32,375	119,189		90.03
91.00	09100	EMERGENCY	-1,453,734	1,932,349		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	-7,525	618,715		95.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-5,697,951	40,711,363		118.00
		NONREIMBURSABLE COST CENTERS				
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	4,705,019		192.00
192.01	19202	OCCUPATIONAL MEDICINE	0	0		192.01
192.02	19201	NAL CLINIC	0	473,594		192.02
192.03	19203	EZ CARE	0	1,210,453		192.03
200.00		TOTAL (SUM OF LINES 118 through 199)	-5,697,951	47,100,429		200.00

RECLASSIFICATIONS | Provider CCN: 14-1320 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-6 | Date/Time Prepared: 5/29/2019 1:41 pm

		Increases				
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - RENTAL EXPENSE					
1.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	213,431		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15.00
	0		0	213,431		
	B - CAFETERIA					
1.00	CAFETERIA	11.00	237,711	168,799		1.00
	0		237,711	168,799		
	C - EKG					
1.00	ELECTROCARDIOLOGY	69.00	30,790	0		1.00
2.00		0.00	0	0		2.00
	0		30,790	0		
	D - PROPERTY INSURANCE					
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	118,299		1.00
	0		0	118,299		
	E - OXYGEN/PATIENT SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	1,910,247		1.00
2.00	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	45,311		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
	0		0	1,955,558		
	F - DRUGS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	1,114,139		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
	0		0	1,114,139		
	I - STRESS TEST					
1.00	ELECTROCARDIOLOGY	69.00	10,520	3,942		1.00
	0		10,520	3,942		
	J - IMPLANT EXPENSE					
1.00	IMPL. DEV. CHARGED TO PATIENT	72.00	0	882,643		1.00
	0		0	882,643		
	K - INTEREST EXPENSE					
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	82,240		1.00
	0		0	82,240		

RECLASSIFICATIONS | Provider CCN: 14-1320 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-6 | Date/Time Prepared: 5/29/2019 1:41 pm

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	L - BENEFITS RECLASS				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	1,320,030	1.00
	0		0	1,320,030	
500.00	Grand Total: Increases		279,021	5,859,081	500.00

RECLASSIFICATIONS | Provider CCN: 14-1320 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-6 | Date/Time Prepared: 5/29/2019 1:41 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - RENTAL EXPENSE						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	46,622	10		1.00
2.00	ADMITTING	5.02	0	313	0		2.00
3.00	OPERATION OF PLANT	7.00	0	243	0		3.00
4.00	HOUSEKEEPING	9.00	0	1,526	0		4.00
5.00	ADULTS & PEDIATRICS	30.00	0	564	0		5.00
6.00	OPERATING ROOM	50.00	0	62,422	0		6.00
7.00	ANESTHESIOLOGY	53.00	0	1,686	0		7.00
8.00	RADIOLOGY-DIAGNOSTIC	54.00	0	28,000	0		8.00
9.00	LABORATORY	60.00	0	78	0		9.00
10.00	RESPIRATORY THERAPY	65.00	0	12,600	0		10.00
11.00	SENIOR CARE	90.02	0	26,089	0		11.00
12.00	SLEEP LAB	90.03	0	540	0		12.00
13.00	AMBULANCE SERVICES	95.00	0	2,619	0		13.00
14.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	20,784	0		14.00
15.00	EZ CARE	192.03	0	9,345	0		15.00
	0		0	213,431			
	B - CAFETERIA						
1.00	DIETARY	10.00	237,711	168,799	0		1.00
	0		237,711	168,799			
	C - EKG						
1.00	ADULTS & PEDIATRICS	30.00	9,762	0	0		1.00
2.00	RESPIRATORY THERAPY	65.00	21,028	0	0		2.00
	0		30,790	0			
	D - PROPERTY INSURANCE						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	118,299	12		1.00
	0		0	118,299			
	E - OXYGEN/PATIENT SUPPLIES						
1.00	HOUSEKEEPING	9.00	0	104	0		1.00
2.00	NURSING ADMINISTRATION	13.00	0	3	0		2.00
3.00	PHARMACY	15.00	0	12,957	0		3.00
4.00	ADULTS & PEDIATRICS	30.00	0	23,588	0		4.00
5.00	OPERATING ROOM	50.00	0	1,137,610	0		5.00
6.00	ANESTHESIOLOGY	53.00	0	103,112	0		6.00
7.00	RADIOLOGY-DIAGNOSTIC	54.00	0	188,774	0		7.00
8.00	LABORATORY	60.00	0	374,469	0		8.00
9.00	RESPIRATORY THERAPY	65.00	0	12,994	0		9.00
10.00	PHYSICAL THERAPY	66.00	0	310	0		10.00
11.00	CLINIC	90.00	0	102	0		11.00
12.00	CHEMO/PAIN	90.01	0	49,570	0		12.00
13.00	EMERGENCY	91.00	0	51,938	0		13.00
14.00	AMBULANCE SERVICES	95.00	0	27	0		14.00
	0		0	1,955,558			
	F - DRUGS						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	409	0		1.00
2.00	OPERATION OF PLANT	7.00	0	5	0		2.00
3.00	NURSING ADMINISTRATION	13.00	0	25	0		3.00
4.00	PHARMACY	15.00	0	1,066,064	0		4.00
5.00	ADULTS & PEDIATRICS	30.00	0	429	0		5.00
6.00	OPERATING ROOM	50.00	0	161	0		6.00
7.00	ANESTHESIOLOGY	53.00	0	27	0		7.00
8.00	RADIOLOGY-DIAGNOSTIC	54.00	0	6,342	0		8.00
9.00	RESPIRATORY THERAPY	65.00	0	1,549	0		9.00
10.00	PHYSICAL THERAPY	66.00	0	901	0		10.00
11.00	CLINIC	90.00	0	144	0		11.00
12.00	CHEMO/PAIN	90.01	0	32,835	0		12.00
13.00	EMERGENCY	91.00	0	2,334	0		13.00
14.00	AMBULANCE SERVICES	95.00	0	2,914	0		14.00
	0		0	1,114,139			
	I - STRESS TEST						
1.00	CLINIC	90.00	10,520	3,942	0		1.00
	0		10,520	3,942			
	J - IMPLANT EXPENSE						
1.00	OPERATING ROOM	50.00	0	882,643	0		1.00
	0		0	882,643			
	K - INTEREST EXPENSE						
1.00	INTEREST EXPENSE	113.00	0	82,240	9		1.00
	0		0	82,240			

RECLASSIFICATIONS | Provider CCN: 14-1320 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-6 | Date/Time Prepared: 5/29/2019 1:41 pm

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	L - BENEFITS RECLASS						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	1,320,030	0		1.00
	0		0	1,320,030			
500.00	Grand Total: Decreases		279,021	5,859,081			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1320 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-7 Part I Date/Time Prepared: 5/29/2019 1:41 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	403,842	30,333	0	30,333	0	1.00
2.00	Land Improvements	2,324,864	0	0	0	0	2.00
3.00	Buildings and Fixtures	24,822,186	4,333,689	0	4,333,689	0	3.00
4.00	Building Improvements	855,820	6,358,155	0	6,358,155	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	17,113,271	2,346,597	0	2,346,597	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	45,519,983	13,068,774	0	13,068,774	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	45,519,983	13,068,774	0	13,068,774	0	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	434,175	0	1.00
2.00	Land Improvements	2,324,864	0	2.00
3.00	Buildings and Fixtures	29,155,875	0	3.00
4.00	Building Improvements	7,213,975	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	19,459,868	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	58,588,757	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	58,588,757	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1320 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-7 Part II | Date/Time Prepared: 5/29/2019 1:41 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	NEW CAP REL COSTS-BLDG & FIXT	657,457	0	0	0	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	1,377,934	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	2,035,391	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	NEW CAP REL COSTS-BLDG & FIXT	0	657,457		1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	1,377,934		2.00
3.00	Total (sum of lines 1-2)	0	2,035,391		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1320 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-7 Part III | Date/Time Prepared: 5/29/2019 1:41 pm

	Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	39,128,889	0	39,128,889	0.667857	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	19,459,868	0	19,459,868	0.332143	0	2.00
3.00	Total (sum of lines 1-2)	58,588,757	0	58,588,757	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	657,457	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	1,371,934	213,431	2.00
3.00	Total (sum of lines 1-2)	0	0	0	2,029,391	213,431	3.00

	Cost Center Description	SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	118,299	0	0	775,756	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	1,585,365	2.00
3.00	Total (sum of lines 1-2)	0	118,299	0	0	2,361,121	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-1320 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-8 | Date/Time Prepared: 5/29/2019 1:41 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 - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)	A	-82,240	NEW CAP REL COSTS-BLDG & FIXT	1.00	9	1.00
2.00	Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)	B	-1,384	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)	B	-3,581	OTHER ADMINISTRATIVE AND GENERAL	5.01	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	-3,195,356			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	0			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-89,483	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others	B	-6,000	NEW CAP REL COSTS-MVBLE EQUIP	2.00	9	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients	B	-24,015	DRUGS CHARGED TO PATIENTS	73.00	0	17.00
18.00	Sale of medical records and abstracts	B	-5,250	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 - NEW CAP REL COSTS-BLDG & FIXT		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - NEW CAP REL COSTS-MVBLE EQUIP		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	68.00		31.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-1320 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-8 | Date/Time Prepared: 5/29/2019 1:41 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	
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	PHYSICIAN RECRUTING	A	-19,001	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	33.00
34.00	ADVERTISING - EMPLOYEE BENEFITS	A	-3,006	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	34.00
34.01	ADVERTISING - ADMIN & GEN	A	-133,411	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	34.01
34.02	ADVERTISING - HOUSEKEEPING	A	-39	HOUSEKEEPING	9.00	0	34.02
34.03	ADVERTISING - NURSING ADMIN	A	-129	NURSING ADMINISTRATION	13.00	0	34.03
34.04	ADVERTISING - PHARMACY	A	-744	PHARMACY	15.00	0	34.04
34.05	ADVERTISING - ADULTS & PEDS	A	-71	ADULTS & PEDIATRICS	30.00	0	34.05
34.06	ADVERTISING - ANESTHESIOLOGY	A	-2,308	ANESTHESIOLOGY	53.00	0	34.06
34.07	ADVERTISING - RADIOLOGY	A	-2,350	RADIOLOGY-DIAGNOSTIC	54.00	0	34.07
34.08	ADVERTISING - RHC I	A	-89,502	RURAL HEALTH CLINIC	88.00	0	34.08
34.09	ADVERTISING - RHC II	A	-5,879	RURAL HEALTH CLINIC II	88.01	0	34.09
34.10	ADVERTISING - SENIOR CARE	A	-4,269	SENIOR CARE	90.02	0	34.10
34.11	ADVERTISING - EMERGENCY	A	-425	EMERGENCY	91.00	0	34.11
34.12	ADVERTISING - AMBULANCE	A	-6,675	AMBULANCE SERVICES	95.00	0	34.12
35.00	ANESTHESIA	A	-1,377,508	ANESTHESIOLOGY	53.00	0	35.00
36.00	ANESTHESIA BENEFITS	A	-118,620	ANESTHESIOLOGY	53.00	0	36.00
36.01	ANESTHESIA BENEFITS	A	-206,991	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	36.01
37.00	OTHER REVENUE - EMPLOYEE BENEFITS	B	-143	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	37.00
37.01	OTHER REVENUE - ADMIN & GEN	B	-204,600	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	37.01
37.02	OTHER REVENUE - ADMITTING	B	-4,083	ADMITTING	5.02	0	37.02
37.03	OTHER REVENUE - MAINTENANCE	B	-1,186	OPERATION OF PLANT	7.00	0	37.03
37.04	OTHER REVENUE - LAUNDRY	B	-133	LAUNDRY & LINEN SERVICE	8.00	0	37.04
37.05	OTHER REVENUE - DIETARY	B	-4,360	DIETARY	10.00	0	37.05
37.06	OTHER REVENUE - NURSING ADMIN	B	-771	NURSING ADMINISTRATION	13.00	0	37.06
37.07	OTHER REVENUE - PHARMACY	B	-628	PHARMACY	15.00	0	37.07
37.08	OTHER REVENUE - ADULTS & PEDS	B	-6	ADULTS & PEDIATRICS	30.00	0	37.08
37.09	OTHER REVENUE - OPERATING ROOM	B	-683	OPERATING ROOM	50.00	0	37.09
37.10	OTHER REVENUE - ANESTHESIA	B	-4	ANESTHESIOLOGY	53.00	0	37.10
37.11	OTHER REVENUE - RADIOLOGY	B	-187	RADIOLOGY-DIAGNOSTIC	54.00	0	37.11
37.12	OTHER REVENUE - LABORATORY	B	-1,097	LABORATORY	60.00	0	37.12
37.13	OTHER REVENUE - PHYSICAL THERAPY	B	-2,694	PHYSICAL THERAPY	66.00	0	37.13
37.14	OTHER REVENUE - RHC I	B	-24,348	RURAL HEALTH CLINIC	88.00	0	37.14
37.15	OTHER REVENUE - RHC II	B	-380	RURAL HEALTH CLINIC II	88.01	0	37.15
37.16	OTHER REVENUE - CHEMO/PAIN	B	-58,523	CHEMO/PAIN	90.01	0	37.16
37.17	OTHER REVENUE - SENIOR CARE	B	-43	SENIOR CARE	90.02	0	37.17
37.18	OTHER REVENUE - EMERGENCY	B	-232	EMERGENCY	91.00	0	37.18
37.19	OTHER REVENUE - AMBULANCE	B	-850	AMBULANCE SERVICES	95.00	0	37.19
38.00	LOBBYING DUES	A	-14,763	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	38.00
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-5,697,951				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: 14-1320 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-8-2 | Date/Time Prepared: 5/29/2019 1:41 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	ADULTS & PEDIATRICS	754,141	754,141	0	0	0	1.00
2.00	50.00	OPERATING ROOM	21,789	21,789	0	0	0	2.00
3.00	54.00	RADIOLOGY-DIAGNOSTIC	651,450	651,450	0	0	0	3.00
4.00	60.00	LABORATORY	70,000	0	70,000	0	0	4.00
5.00	69.00	ELECTROCARDIOLOGY	41,071	41,071	0	0	0	5.00
6.00	70.00	ELECTROENCEPHALOGRAPHY	3,692	3,692	0	0	0	6.00
7.00	90.00	CLINIC	21,319	21,319	0	0	0	7.00
8.00	90.01	CHEMO/PAIN	208,442	180,442	28,000	0	0	8.00
9.00	90.02	SENIOR CARE	36,000	36,000	0	0	0	9.00
10.00	90.03	SLEEP LAB	40,875	32,375	8,500	0	0	10.00
11.00	91.00	EMERGENCY	1,862,442	1,453,077	409,365	0	0	11.00
200.00			3,711,221	3,195,356	515,865		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	50.00	OPERATING ROOM	0	0	0	0	0	2.00
3.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	3.00
4.00	60.00	LABORATORY	0	0	0	0	0	4.00
5.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	5.00
6.00	70.00	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	6.00
7.00	90.00	CLINIC	0	0	0	0	0	7.00
8.00	90.01	CHEMO/PAIN	0	0	0	0	0	8.00
9.00	90.02	SENIOR CARE	0	0	0	0	0	9.00
10.00	90.03	SLEEP LAB	0	0	0	0	0	10.00
11.00	91.00	EMERGENCY	0	0	0	0	0	11.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	754,141		1.00
2.00	50.00	OPERATING ROOM	0	0	0	21,789		2.00
3.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	651,450		3.00
4.00	60.00	LABORATORY	0	0	0	0		4.00
5.00	69.00	ELECTROCARDIOLOGY	0	0	0	41,071		5.00
6.00	70.00	ELECTROENCEPHALOGRAPHY	0	0	0	3,692		6.00
7.00	90.00	CLINIC	0	0	0	21,319		7.00
8.00	90.01	CHEMO/PAIN	0	0	0	180,442		8.00
9.00	90.02	SENIOR CARE	0	0	0	36,000		9.00
10.00	90.03	SLEEP LAB	0	0	0	32,375		10.00
11.00	91.00	EMERGENCY	0	0	0	1,453,077		11.00
200.00			0	0	0	3,195,356		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1320 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part I | Date/Time Prepared: 5/29/2019 1:41 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
				NEW BLDG & FIXT	NEW MVBLE EQUIP			
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	775,756	775,756				1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	1,585,365		1,585,365			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,692,053	7,101	14,512	2,713,666		4.00
5.01	00590	OTHER ADMINISTRATIVE AND GENERAL	6,197,973	156,515	319,866	445,220	7,119,574	5.01
5.02	00560	ADMITTING	1,761,831	25,202	51,503	144,053	1,982,589	5.02
7.00	00700	OPERATION OF PLANT	1,265,084	90,856	185,676	83,208	1,624,824	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	139,550	7,438	15,200	0	162,188	8.00
9.00	00900	HOUSEKEEPING	444,401	5,232	10,692	45,006	505,331	9.00
10.00	01000	DIETARY	326,095	23,501	48,028	30,693	428,317	10.00
11.00	01100	CAFETERIA	317,027	10,693	21,854	37,757	387,331	11.00
13.00	01300	NURSING ADMINISTRATION	1,036,392	10,571	21,603	138,095	1,206,661	13.00
15.00	01500	PHARMACY	404,947	6,672	13,635	50,193	475,447	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	433,974	17,090	34,925	57,126	543,115	16.00
17.00	01700	SOCIAL SERVICE	70,604	1,195	2,442	9,591	83,832	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,186,226	107,287	219,255	380,671	2,893,439	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	903,876	77,788	158,970	214,936	1,355,570	50.00
53.00	05300	ANESTHESIOLOGY	76,783	912	1,863	0	79,558	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,564,584	56,416	115,294	232,849	1,969,143	54.00
60.00	06000	LABORATORY	1,687,171	23,509	48,043	123,031	1,881,754	60.00
65.00	06500	RESPIRATORY THERAPY	535,057	2,918	5,964	74,323	618,262	65.00
66.00	06600	PHYSICAL THERAPY	1,308,376	33,727	68,926	182,150	1,593,179	66.00
69.00	06900	ELECTROCARDIOLOGY	45,252	4,014	8,203	6,562	64,031	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,910,322	0	0	0	1,910,322	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	882,643	0	0	0	882,643	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,090,177	0	0	0	1,090,177	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	6,469,670	0	0	0	6,469,670	88.00
88.01	08801	RURAL HEALTH CLINIC II	355,105	0	0	0	355,105	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	0	88.02
90.00	09000	CLINIC	112,164	4,711	9,627	15,422	141,924	90.00
90.01	04951	CHEMO/PAIN	961,984	11,827	24,170	138,790	1,136,771	90.01
90.02	09002	SENIOR CARE	500,668	0	0	657	501,325	90.02
90.03	09003	SLEEP LAB	119,189	996	2,035	12,954	135,174	90.03
91.00	09100	EMERGENCY	1,932,349	39,480	80,683	213,781	2,266,293	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	618,715	0	0	76,598	695,313	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	40,711,363	725,651	1,482,969	2,713,666	40,558,862	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	4,705,019	33,674	68,817	0	4,807,510	192.00
192.01	19202	OCCUPATIONAL MEDICINE	0	16,431	33,579	0	50,010	192.01
192.02	19201	NAL CLINIC	473,594	0	0	0	473,594	192.02
192.03	19203	EZ CARE	1,210,453	0	0	0	1,210,453	192.03
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)	47,100,429	775,756	1,585,365	2,713,666	47,100,429	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1320 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part I Date/Time Prepared: 5/29/2019 1:41 pm

		Cost Center Description	OTHER ADMINISTRATIVE AND GENERAL	ADMITTING	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.01	5.02	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	OTHER ADMINISTRATIVE AND GENERAL	7,119,574					5.01
5.02	00560	ADMITTING	353,050	2,335,639				5.02
7.00	00700	OPERATION OF PLANT	289,341	0	1,914,165			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	28,882	0	28,700	219,770		8.00
9.00	00900	HOUSEKEEPING	89,987	0	20,187	0	615,505	9.00
10.00	01000	DIETARY	76,273	0	90,681	0	29,923	10.00
11.00	01100	CAFETERIA	68,974	0	41,261	0	13,615	11.00
13.00	01300	NURSING ADMINISTRATION	214,876	0	40,789	0	13,459	13.00
15.00	01500	PHARMACY	84,665	0	25,744	0	8,495	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	96,715	0	65,941	0	21,759	16.00
17.00	01700	SOCIAL SERVICE	14,928	0	4,611	0	1,521	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	515,249	362,837	413,975	219,770	136,604	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	241,393	230,975	300,150	0	99,044	50.00
53.00	05300	ANESTHESIOLOGY	14,167	0	3,517	0	1,161	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	350,655	278,023	217,687	0	71,832	54.00
60.00	06000	LABORATORY	335,093	207,546	90,710	0	29,933	60.00
65.00	06500	RESPIRATORY THERAPY	110,097	66,840	11,261	0	3,716	65.00
66.00	06600	PHYSICAL THERAPY	283,705	166,037	130,139	0	42,943	66.00
69.00	06900	ELECTROCARDIOLOGY	11,402	10,902	15,488	0	5,111	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	438	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	340,181	226,659	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	157,177	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	194,133	129,349	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,152,072	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	63,235	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	0	88.02
90.00	09000	CLINIC	25,273	16,932	18,178	0	5,998	90.00
90.01	04951	CHEMO/PAIN	202,430	142,433	45,636	0	15,059	90.01
90.02	09002	SENIOR CARE	89,273	63,703	0	0	0	90.02
90.03	09003	SLEEP LAB	24,071	18,615	3,842	0	1,268	90.03
91.00	09100	EMERGENCY	403,570	414,350	152,336	0	50,268	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	123,818	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	5,954,685	2,335,639	1,720,833	219,770	551,709	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	856,097	0	129,932	0	42,875	192.00
192.01	19202	OCCUPATIONAL MEDICINE	8,906	0	63,400	0	20,921	192.01
192.02	19201	NAL CLINIC	84,335	0	0	0	0	192.02
192.03	19203	EZ CARE	215,551	0	0	0	0	192.03
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)	7,119,574	2,335,639	1,914,165	219,770	615,505	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1320 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part I | Date/Time Prepared: 5/29/2019 1:41 pm

		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	PHARMACY	MEDICAL RECORDS & LIBRARY	
			10.00	11.00	13.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	OTHER ADMINISTRATIVE AND GENERAL						5.01
5.02	00560	ADMITTING						5.02
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	625,194					10.00
11.00	01100	CAFETERIA	0	511,181				11.00
13.00	01300	NURSING ADMINISTRATION	0	32,887	1,508,672			13.00
15.00	01500	PHARMACY	0	11,953	0	606,304		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	13,604	0	0	741,134	16.00
17.00	01700	SOCIAL SERVICE	0	2,284	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	625,194	90,651	515,734	0	28,752	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	51,186	396,938	0	86,145	50.00
53.00	05300	ANESTHESIOLOGY	0	52,106	0	0	12,723	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	55,452	0	0	195,036	54.00
60.00	06000	LABORATORY	0	29,299	0	0	123,221	60.00
65.00	06500	RESPIRATORY THERAPY	0	17,700	0	0	5,655	65.00
66.00	06600	PHYSICAL THERAPY	0	43,378	0	0	89,042	66.00
69.00	06900	ELECTROCARDIOLOGY	0	1,563	0	0	13,005	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	209	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	35,260	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	13,558	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	606,304	62,596	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	0	88.02
90.00	09000	CLINIC	0	3,673	0	0	1,145	90.00
90.01	04951	CHEMO/PAIN	0	33,052	209,304	0	8,089	90.01
90.02	09002	SENIOR CARE	0	156	1,256	0	7,818	90.02
90.03	09003	SLEEP LAB	0	3,085	0	0	3,538	90.03
91.00	09100	EMERGENCY	0	50,911	385,440	0	55,342	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	18,241	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	625,194	511,181	1,508,672	606,304	741,134	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19202	OCCUPATIONAL MEDICINE	0	0	0	0	0	192.01
192.02	19201	NAL CLINIC	0	0	0	0	0	192.02
192.03	19203	EZ CARE	0	0	0	0	0	192.03
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)	625,194	511,181	1,508,672	606,304	741,134	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1320 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part I | Date/Time Prepared: 5/29/2019 1:41 pm

		Cost Center Description	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			17.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	OTHER ADMINISTRATIVE AND GENERAL						5.01
5.02	00560	ADMITTING						5.02
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE	107,176					17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	107,176	5,909,381	0	5,909,381		30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	2,761,401	0	2,761,401		50.00
53.00	05300	ANESTHESIOLOGY	0	163,232	0	163,232		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	3,137,828	0	3,137,828		54.00
60.00	06000	LABORATORY	0	2,697,556	0	2,697,556		60.00
65.00	06500	RESPIRATORY THERAPY	0	833,531	0	833,531		65.00
66.00	06600	PHYSICAL THERAPY	0	2,348,423	0	2,348,423		66.00
69.00	06900	ELECTROCARDIOLOGY	0	121,502	0	121,502		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	647	0	647		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2,512,422	0	2,512,422		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	1,053,378	0	1,053,378		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,082,559	0	2,082,559		73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	7,621,742	0	7,621,742		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	418,340	0	418,340		88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0		88.02
90.00	09000	CLINIC	0	213,123	0	213,123		90.00
90.01	04951	CHEMO/PAIN	0	1,792,774	0	1,792,774		90.01
90.02	09002	SENIOR CARE	0	663,531	0	663,531		90.02
90.03	09003	SLEEP LAB	0	189,593	0	189,593		90.03
91.00	09100	EMERGENCY	0	3,778,510	0	3,778,510		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0			92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	837,372	0	837,372		95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	107,176	39,136,845	0	39,136,845		118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	5,836,414	0	5,836,414		192.00
192.01	19202	OCCUPATIONAL MEDICINE	0	143,237	0	143,237		192.01
192.02	19201	NAL CLINIC	0	557,929	0	557,929		192.02
192.03	19203	EZ CARE	0	1,426,004	0	1,426,004		192.03
200.00		Cross Foot Adjustments		0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	107,176	47,100,429	0	47,100,429		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1320 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part II Date/Time Prepared: 5/29/2019 1:41 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS NEW BLDG & FIXT	CAPITAL RELATED COSTS NEW MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	7,101	14,512	21,613	21,613	4.00
5.01	00590	OTHER ADMINISTRATIVE AND GENERAL	0	156,515	319,866	476,381	3,547	5.01
5.02	00560	ADMITTING	0	25,202	51,503	76,705	1,147	5.02
7.00	00700	OPERATION OF PLANT	0	90,856	185,676	276,532	663	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	7,438	15,200	22,638	0	8.00
9.00	00900	HOUSEKEEPING	0	5,232	10,692	15,924	358	9.00
10.00	01000	DIETARY	0	23,501	48,028	71,529	244	10.00
11.00	01100	CAFETERIA	0	10,693	21,854	32,547	301	11.00
13.00	01300	NURSING ADMINISTRATION	0	10,571	21,603	32,174	1,100	13.00
15.00	01500	PHARMACY	0	6,672	13,635	20,307	400	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	17,090	34,925	52,015	455	16.00
17.00	01700	SOCIAL SERVICE	0	1,195	2,442	3,637	76	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	107,287	219,255	326,542	3,032	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	77,788	158,970	236,758	1,712	50.00
53.00	05300	ANESTHESIOLOGY	0	912	1,863	2,775	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	56,416	115,294	171,710	1,854	54.00
60.00	06000	LABORATORY	0	23,509	48,043	71,552	980	60.00
65.00	06500	RESPIRATORY THERAPY	0	2,918	5,964	8,882	592	65.00
66.00	06600	PHYSICAL THERAPY	0	33,727	68,926	102,653	1,451	66.00
69.00	06900	ELECTROCARDIOLOGY	0	4,014	8,203	12,217	52	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	0	88.02
90.00	09000	CLINIC	0	4,711	9,627	14,338	123	90.00
90.01	04951	CHEMO/PAIN	0	11,827	24,170	35,997	1,105	90.01
90.02	09002	SENIOR CARE	0	0	0	0	5	90.02
90.03	09003	SLEEP LAB	0	996	2,035	3,031	103	90.03
91.00	09100	EMERGENCY	0	39,480	80,683	120,163	1,703	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	610	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	725,651	1,482,969	2,208,620	21,613	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	33,674	68,817	102,491	0	192.00
192.01	19202	OCCUPATIONAL MEDICINE	0	16,431	33,579	50,010	0	192.01
192.02	19201	NAL CLINIC	0	0	0	0	0	192.02
192.03	19203	EZ CARE	0	0	0	0	0	192.03
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	775,756	1,585,365	2,361,121	21,613	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1320 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part II | Date/Time Prepared: 5/29/2019 1:41 pm

		Cost Center Description	OTHER ADMINISTRATIVE AND GENERAL	ADMITTING	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.01	5.02	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	OTHER ADMINISTRATIVE AND GENERAL	479,928					5.01
5.02	00560	ADMITTING	23,799	101,651				5.02
7.00	00700	OPERATION OF PLANT	19,504	0	296,699			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,947	0	4,449	29,034		8.00
9.00	00900	HOUSEKEEPING	6,066	0	3,129	0	25,477	9.00
10.00	01000	DIETARY	5,142	0	14,056	0	1,239	10.00
11.00	01100	CAFETERIA	4,650	0	6,396	0	564	11.00
13.00	01300	NURSING ADMINISTRATION	14,485	0	6,322	0	557	13.00
15.00	01500	PHARMACY	5,707	0	3,990	0	352	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	6,520	0	10,221	0	901	16.00
17.00	01700	SOCIAL SERVICE	1,006	0	715	0	63	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	34,733	15,791	64,164	29,034	5,652	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	16,272	10,052	46,524	0	4,100	50.00
53.00	05300	ANESTHESIOLOGY	955	0	545	0	48	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	23,638	12,100	33,742	0	2,973	54.00
60.00	06000	LABORATORY	22,589	9,033	14,060	0	1,239	60.00
65.00	06500	RESPIRATORY THERAPY	7,422	2,909	1,746	0	154	65.00
66.00	06600	PHYSICAL THERAPY	19,125	7,226	20,172	0	1,778	66.00
69.00	06900	ELECTROCARDIOLOGY	769	474	2,401	0	212	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	19	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	22,932	9,864	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	10,595	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	13,086	5,629	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	77,656	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	4,263	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	0	88.02
90.00	09000	CLINIC	1,704	737	2,818	0	248	90.00
90.01	04951	CHEMO/PAIN	13,646	6,199	7,074	0	623	90.01
90.02	09002	SENIOR CARE	6,018	2,772	0	0	0	90.02
90.03	09003	SLEEP LAB	1,623	810	596	0	52	90.03
91.00	09100	EMERGENCY	27,205	18,036	23,612	0	2,081	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	8,347	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	401,404	101,651	266,732	29,034	22,836	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	57,709	0	20,140	0	1,775	192.00
192.01	19202	OCCUPATIONAL MEDICINE	600	0	9,827	0	866	192.01
192.02	19201	NAL CLINIC	5,685	0	0	0	0	192.02
192.03	19203	EZ CARE	14,530	0	0	0	0	192.03
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)	479,928	101,651	296,699	29,034	25,477	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1320 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part II | Date/Time Prepared: 5/29/2019 1:41 pm

		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	PHARMACY	MEDICAL RECORDS & LIBRARY	
			10.00	11.00	13.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	OTHER ADMINISTRATIVE AND GENERAL						5.01
5.02	00560	ADMITTING						5.02
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	92,210					10.00
11.00	01100	CAFETERIA	0	44,458				11.00
13.00	01300	NURSING ADMINISTRATION	0	2,860	57,498			13.00
15.00	01500	PHARMACY	0	1,040	0	31,796		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,183	0	0	71,295	16.00
17.00	01700	SOCIAL SERVICE	0	199	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	92,210	7,882	19,655	0	2,764	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	4,452	15,128	0	8,282	50.00
53.00	05300	ANESTHESIOLOGY	0	4,532	0	0	1,223	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	4,823	0	0	18,792	54.00
60.00	06000	LABORATORY	0	2,548	0	0	11,847	60.00
65.00	06500	RESPIRATORY THERAPY	0	1,539	0	0	544	65.00
66.00	06600	PHYSICAL THERAPY	0	3,773	0	0	8,561	66.00
69.00	06900	ELECTROCARDIOLOGY	0	136	0	0	1,250	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	20	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	3,390	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	1,303	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	31,796	6,018	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	0	88.02
90.00	09000	CLINIC	0	319	0	0	110	90.00
90.01	04951	CHEMO/PAIN	0	2,875	7,977	0	778	90.01
90.02	09002	SENIOR CARE	0	14	48	0	752	90.02
90.03	09003	SLEEP LAB	0	268	0	0	340	90.03
91.00	09100	EMERGENCY	0	4,428	14,690	0	5,321	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	1,587	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	92,210	44,458	57,498	31,796	71,295	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19202	OCCUPATIONAL MEDICINE	0	0	0	0	0	192.01
192.02	19201	NAL CLINIC	0	0	0	0	0	192.02
192.03	19203	EZ CARE	0	0	0	0	0	192.03
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)	92,210	44,458	57,498	31,796	71,295	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1320 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part II | Date/Time Prepared: 5/29/2019 1:41 pm

		Cost Center Description	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			17.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	OTHER ADMINISTRATIVE AND GENERAL						5.01
5.02	00560	ADMITTING						5.02
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE	5,696					17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,696	607,155	0	607,155		30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	343,280	0	343,280		50.00
53.00	05300	ANESTHESIOLOGY	0	10,078	0	10,078		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	269,632	0	269,632		54.00
60.00	06000	LABORATORY	0	133,848	0	133,848		60.00
65.00	06500	RESPIRATORY THERAPY	0	23,788	0	23,788		65.00
66.00	06600	PHYSICAL THERAPY	0	164,739	0	164,739		66.00
69.00	06900	ELECTROCARDIOLOGY	0	17,511	0	17,511		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	39	0	39		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	36,186	0	36,186		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	11,898	0	11,898		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	56,529	0	56,529		73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	77,656	0	77,656		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	4,263	0	4,263		88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0		88.02
90.00	09000	CLINIC	0	20,397	0	20,397		90.00
90.01	04951	CHEMO/PAIN	0	76,274	0	76,274		90.01
90.02	09002	SENIOR CARE	0	9,609	0	9,609		90.02
90.03	09003	SLEEP LAB	0	6,823	0	6,823		90.03
91.00	09100	EMERGENCY	0	217,239	0	217,239		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0			92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	10,544	0	10,544		95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	5,696	2,097,488	0	2,097,488		118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	182,115	0	182,115		192.00
192.01	19202	OCCUPATIONAL MEDICINE	0	61,303	0	61,303		192.01
192.02	19201	NAL CLINIC	0	5,685	0	5,685		192.02
192.03	19203	EZ CARE	0	14,530	0	14,530		192.03
200.00		Cross Foot Adjustments		0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	5,696	2,361,121	0	2,361,121		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1320 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B-1 | Date/Time Prepared: 5/29/2019 1:41 pm

		Cost Center Description	CAPITAL RELATED COSTS NEW BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS NEW MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A.01	5.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	101,273					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		101,273				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	927	927	17,084,756			4.00
5.01	00590	OTHER ADMINISTRATIVE AND GENERAL	20,433	20,433	2,803,064	-7,119,574	39,980,855	5.01
5.02	00560	ADMITTING	3,290	3,290	906,931	0	1,982,589	5.02
7.00	00700	OPERATION OF PLANT	11,861	11,861	523,861	0	1,624,824	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	971	971	0	0	162,188	8.00
9.00	00900	HOUSEKEEPING	683	683	283,348	0	505,331	9.00
10.00	01000	DIETARY	3,068	3,068	193,237	0	428,317	10.00
11.00	01100	CAFETERIA	1,396	1,396	237,711	0	387,331	11.00
13.00	01300	NURSING ADMINISTRATION	1,380	1,380	869,420	0	1,206,661	13.00
15.00	01500	PHARMACY	871	871	316,004	0	475,447	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,231	2,231	359,651	0	543,115	16.00
17.00	01700	SOCIAL SERVICE	156	156	60,384	0	83,832	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	14,006	14,006	2,396,628	0	2,893,439	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	10,155	10,155	1,353,196	0	1,355,570	50.00
53.00	05300	ANESTHESIOLOGY	119	119	0	0	79,558	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,365	7,365	1,465,974	0	1,969,143	54.00
60.00	06000	LABORATORY	3,069	3,069	774,581	0	1,881,754	60.00
65.00	06500	RESPIRATORY THERAPY	381	381	467,924	0	618,262	65.00
66.00	06600	PHYSICAL THERAPY	4,403	4,403	1,146,780	0	1,593,179	66.00
69.00	06900	ELECTROCARDIOLOGY	524	524	41,311	0	64,031	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	1,910,322	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	882,643	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	1,090,177	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	6,469,670	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	355,105	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	0	88.02
90.00	09000	CLINIC	615	615	97,096	0	141,924	90.00
90.01	04951	CHEMO/PAIN	1,544	1,544	873,794	0	1,136,771	90.01
90.02	09002	SENIOR CARE	0	0	4,137	0	501,325	90.02
90.03	09003	SLEEP LAB	130	130	81,557	0	135,174	90.03
91.00	09100	EMERGENCY	5,154	5,154	1,345,920	0	2,266,293	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	482,247	0	695,313	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	94,732	94,732	17,084,756	-7,119,574	33,439,288	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	4,396	4,396	0	0	4,807,510	192.00
192.01	19202	OCCUPATIONAL MEDICINE	2,145	2,145	0	0	50,010	192.01
192.02	19201	NAL CLINIC	0	0	0	0	473,594	192.02
192.03	19203	EZ CARE	0	0	0	0	1,210,453	192.03
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)	775,756	1,585,365	2,713,666		7,119,574	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	7.660048	15.654370	0.158836		0.178075	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			21,613		479,928	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.001265		0.012004	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: 14-1320 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B-1 | Date/Time Prepared: 5/29/2019 1:41 pm

		Cost Center Description	ADMITTING (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (PATIENT DAYS)	
			5.02	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	OTHER ADMINISTRATIVE AND GENERAL						5.01
5.02	00560	ADMITTING	23,900,558					5.02
7.00	00700	OPERATION OF PLANT	0	64,762				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	971	100			8.00
9.00	00900	HOUSEKEEPING	0	683	0	63,108		9.00
10.00	01000	DIETARY	0	3,068	0	3,068	100	10.00
11.00	01100	CAFETERIA	0	1,396	0	1,396	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	1,380	0	1,380	0	13.00
15.00	01500	PHARMACY	0	871	0	871	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	2,231	0	2,231	0	16.00
17.00	01700	SOCIAL SERVICE	0	156	0	156	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,712,915	14,006	100	14,006	100	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,363,572	10,155	0	10,155	0	50.00
53.00	05300	ANESTHESIOLOGY	0	119	0	119	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,845,015	7,365	0	7,365	0	54.00
60.00	06000	LABORATORY	2,123,824	3,069	0	3,069	0	60.00
65.00	06500	RESPIRATORY THERAPY	683,978	381	0	381	0	65.00
66.00	06600	PHYSICAL THERAPY	1,699,054	4,403	0	4,403	0	66.00
69.00	06900	ELECTROCARDIOLOGY	111,563	524	0	524	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	4,483	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,319,406	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,323,632	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	0	88.02
90.00	09000	CLINIC	173,261	615	0	615	0	90.00
90.01	04951	CHEMO/PAIN	1,457,519	1,544	0	1,544	0	90.01
90.02	09002	SENIOR CARE	651,870	0	0	0	0	90.02
90.03	09003	SLEEP LAB	190,489	130	0	130	0	90.03
91.00	09100	EMERGENCY	4,239,977	5,154	0	5,154	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	23,900,558	58,221	100	56,567	100	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	4,396	0	4,396	0	192.00
192.01	19202	OCCUPATIONAL MEDICINE	0	2,145	0	2,145	0	192.01
192.02	19201	NAL CLINIC	0	0	0	0	0	192.02
192.03	19203	EZ CARE	0	0	0	0	0	192.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	2,335,639	1,914,165	219,770	615,505	625,194	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.097723	29.556916	2,197.700000	9.753201	6,251.940000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	101,651	296,699	29,034	25,477	92,210	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.004253	4.581375	290.340000	0.403705	922.100000	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: 14-1320 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B-1 | Date/Time Prepared: 5/29/2019 1:41 pm

		Cost Center Description	CAFETERIA (GROSS SALARIES)	NURSING ADMINISTRATION (NRSNG SALARIES)	PHARMACY (COST REQU.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (PAT DAYS)	
			11.00	13.00	15.00	16.00	17.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	OTHER ADMINISTRATIVE AND GENERAL						5.01
5.02	00560	ADMITTING						5.02
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	13,514,112					11.00
13.00	01300	NURSING ADMINISTRATION	869,420	4,968,676				13.00
15.00	01500	PHARMACY	316,004	0	100			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	359,651	0	0	78,998,123		16.00
17.00	01700	SOCIAL SERVICE	60,384	0	0	0	100	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,396,628	1,698,526	0	3,064,644	100	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,353,196	1,307,278	0	9,181,912	0	50.00
53.00	05300	ANESTHESIOLOGY	1,377,508	0	0	1,356,090	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,465,974	0	0	20,791,162	0	54.00
60.00	06000	LABORATORY	774,581	0	0	13,133,812	0	60.00
65.00	06500	RESPIRATORY THERAPY	467,924	0	0	602,761	0	65.00
66.00	06600	PHYSICAL THERAPY	1,146,780	0	0	9,490,723	0	66.00
69.00	06900	ELECTROCARDIOLOGY	41,311	0	0	1,386,122	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	22,228	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	3,758,243	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	1,445,102	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	100	6,671,939	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	0	88.02
90.00	09000	CLINIC	97,096	0	0	122,025	0	90.00
90.01	04951	CHEMO/PAIN	873,794	689,323	0	862,214	0	90.01
90.02	09002	SENIOR CARE	4,137	4,137	0	833,246	0	90.02
90.03	09003	SLEEP LAB	81,557	0	0	377,133	0	90.03
91.00	09100	EMERGENCY	1,345,920	1,269,412	0	5,898,767	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	482,247	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	13,514,112	4,968,676	100	78,998,123	100	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19202	OCCUPATIONAL MEDICINE	0	0	0	0	0	192.01
192.02	19201	NAL CLINIC	0	0	0	0	0	192.02
192.03	19203	EZ CARE	0	0	0	0	0	192.03
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)	511,181	1,508,672	606,304	741,134	107,176	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.037826	0.303637	6,063.040000	0.009382	1,071.760000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	44,458	57,498	31,796	71,295	5,696	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.003290	0.011572	317.960000	0.000902	56.960000	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1320 | Period: From 01/01/2018 To 12/31/2018 | Worksheet C Part I Date/Time Prepared: 5/29/2019 1:41 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	5,909,381		5,909,381	0	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,761,401		2,761,401	0	0	50.00
53.00	05300	ANESTHESIOLOGY	163,232		163,232	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,137,828		3,137,828	0	0	54.00
60.00	06000	LABORATORY	2,697,556		2,697,556	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	833,531	0	833,531	0	0	65.00
66.00	06600	PHYSICAL THERAPY	2,348,423	0	2,348,423	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	121,502		121,502	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	647		647	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,512,422		2,512,422	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1,053,378		1,053,378	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,082,559		2,082,559	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	7,621,742		7,621,742	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	418,340		418,340	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0		0	0	0	88.02
90.00	09000	CLINIC	213,123		213,123	0	0	90.00
90.01	04951	CHEMO/PAIN	1,792,774		1,792,774	0	0	90.01
90.02	09002	SENIOR CARE	663,531		663,531	0	0	90.02
90.03	09003	SLEEP LAB	189,593		189,593	0	0	90.03
91.00	09100	EMERGENCY	3,778,510		3,778,510	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	692,096		692,096		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	837,372		837,372	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	39,828,941	0	39,828,941	0	0	200.00
201.00		Less Observation Beds	692,096		692,096		0	201.00
202.00		Total (see instructions)	39,136,845	0	39,136,845	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1320 | Period: From 01/01/2018 To 12/31/2018 | Worksheet C Part I Date/Time Prepared: 5/29/2019 1:41 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	2,715,994		2,715,994			30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	821,401	8,360,511	9,181,912	0.300744	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	172,644	1,183,446	1,356,090	0.120370	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	700,290	20,090,872	20,791,162	0.150921	0.000000	54.00
60.00	06000	LABORATORY	1,102,209	12,031,603	13,133,812	0.205390	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	277,424	325,337	602,761	1.382855	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	831,553	8,659,170	9,490,723	0.247444	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	32,960	1,353,162	1,386,122	0.087656	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	22,228	22,228	0.029107	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	564,730	3,193,513	3,758,243	0.668510	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	652,870	792,232	1,445,102	0.728930	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,429,872	5,242,067	6,671,939	0.312137	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	12,905,897	12,905,897			88.00
88.01	08801	RURAL HEALTH CLINIC II	0	471,636	471,636			88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0			88.02
90.00	09000	CLINIC	0	122,025	122,025	1.746552	0.000000	90.00
90.01	04951	CHEMO/PAIN	0	862,214	862,214	2.079268	0.000000	90.01
90.02	09002	SENIOR CARE	0	833,246	833,246	0.796321	0.000000	90.02
90.03	09003	SLEEP LAB	0	377,133	377,133	0.502722	0.000000	90.03
91.00	09100	EMERGENCY	31,404	5,867,363	5,898,767	0.640559	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	348,650	348,650	1.985074	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	572,605	572,605	1.462390	0.000000	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	9,333,351	83,614,910	92,948,261			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	9,333,351	83,614,910	92,948,261			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1320 | Period: From 01/01/2018 To 12/31/2018 | Worksheet C Part I Date/Time Prepared: 5/29/2019 1:41 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
		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
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC			88.00
88.01	08801	RURAL HEALTH CLINIC II			88.01
88.02	08802	RURAL HEALTH CLINIC III			88.02
90.00	09000	CLINIC	0.000000		90.00
90.01	04951	CHEMO/PAIN	0.000000		90.01
90.02	09002	SENIOR CARE	0.000000		90.02
90.03	09003	SLEEP LAB	0.000000		90.03
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0.000000		95.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1320 | Period: From 01/01/2018 To 12/31/2018 | Worksheet C Part I Date/Time Prepared: 5/29/2019 1:41 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	5,909,381		5,909,381	0	5,909,381	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,761,401		2,761,401	0	2,761,401	50.00
53.00	05300	ANESTHESIOLOGY	163,232		163,232	0	163,232	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,137,828		3,137,828	0	3,137,828	54.00
60.00	06000	LABORATORY	2,697,556		2,697,556	0	2,697,556	60.00
65.00	06500	RESPIRATORY THERAPY	833,531	0	833,531	0	833,531	65.00
66.00	06600	PHYSICAL THERAPY	2,348,423	0	2,348,423	0	2,348,423	66.00
69.00	06900	ELECTROCARDIOLOGY	121,502		121,502	0	121,502	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	647		647	0	647	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,512,422		2,512,422	0	2,512,422	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1,053,378		1,053,378	0	1,053,378	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,082,559		2,082,559	0	2,082,559	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	7,621,742		7,621,742	0	7,621,742	88.00
88.01	08801	RURAL HEALTH CLINIC II	418,340		418,340	0	418,340	88.01
88.02	08802	RURAL HEALTH CLINIC III	0		0	0	0	88.02
90.00	09000	CLINIC	213,123		213,123	0	213,123	90.00
90.01	04951	CHEMO/PAIN	1,792,774		1,792,774	0	1,792,774	90.01
90.02	09002	SENIOR CARE	663,531		663,531	0	663,531	90.02
90.03	09003	SLEEP LAB	189,593		189,593	0	189,593	90.03
91.00	09100	EMERGENCY	3,778,510		3,778,510	0	3,778,510	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	692,096		692,096		692,096	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	837,372		837,372	0	837,372	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	39,828,941	0	39,828,941	0	39,828,941	200.00
201.00		Less Observation Beds	692,096		692,096		692,096	201.00
202.00		Total (see instructions)	39,136,845	0	39,136,845	0	39,136,845	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1320 | Period: From 01/01/2018 To 12/31/2018 | Worksheet C Part I Date/Time Prepared: 5/29/2019 1:41 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	2,715,994		2,715,994			30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	821,401	8,360,511	9,181,912	0.300744	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	172,644	1,183,446	1,356,090	0.120370	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	700,290	20,090,872	20,791,162	0.150921	0.000000	54.00
60.00	06000	LABORATORY	1,102,209	12,031,603	13,133,812	0.205390	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	277,424	325,337	602,761	1.382855	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	831,553	8,659,170	9,490,723	0.247444	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	32,960	1,353,162	1,386,122	0.087656	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	22,228	22,228	0.029107	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	564,730	3,193,513	3,758,243	0.668510	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	652,870	792,232	1,445,102	0.728930	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,429,872	5,242,067	6,671,939	0.312137	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	12,905,897	12,905,897	0.590563	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	471,636	471,636	0.886998	0.000000	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0.000000	0.000000	88.02
90.00	09000	CLINIC	0	122,025	122,025	1.746552	0.000000	90.00
90.01	04951	CHEMO/PAIN	0	862,214	862,214	2.079268	0.000000	90.01
90.02	09002	SENIOR CARE	0	833,246	833,246	0.796321	0.000000	90.02
90.03	09003	SLEEP LAB	0	377,133	377,133	0.502722	0.000000	90.03
91.00	09100	EMERGENCY	31,404	5,867,363	5,898,767	0.640559	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	348,650	348,650	1.985074	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	572,605	572,605	1.462390	0.000000	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	9,333,351	83,614,910	92,948,261			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	9,333,351	83,614,910	92,948,261			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1320 | Period: From 01/01/2018 To 12/31/2018 | Worksheet C Part I Date/Time Prepared: 5/29/2019 1:41 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
		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
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	0.000000		88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000		88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000		88.02
90.00	09000	CLINIC	0.000000		90.00
90.01	04951	CHEMO/PAIN	0.000000		90.01
90.02	09002	SENIOR CARE	0.000000		90.02
90.03	09003	SLEEP LAB	0.000000		90.03
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0.000000		95.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 14-1320 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part II Date/Time Prepared: 5/29/2019 1:41 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	343,280	9,181,912	0.037387	804,565	30,080	50.00
53.00	05300	ANESTHESIOLOGY	10,078	1,356,090	0.007432	154,727	1,150	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	269,632	20,791,162	0.012969	392,356	5,088	54.00
60.00	06000	LABORATORY	133,848	13,133,812	0.010191	609,335	6,210	60.00
65.00	06500	RESPIRATORY THERAPY	23,788	602,761	0.039465	160,982	6,353	65.00
66.00	06600	PHYSICAL THERAPY	164,739	9,490,723	0.017358	205,342	3,564	66.00
69.00	06900	ELECTROCARDIOLOGY	17,511	1,386,122	0.012633	19,379	245	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	39	22,228	0.001755	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	36,186	3,758,243	0.009628	507,629	4,887	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	11,898	1,445,102	0.008233	537,213	4,423	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	56,529	6,671,939	0.008473	710,181	6,017	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	77,656	12,905,897	0.006017	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	4,263	471,636	0.009039	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0.000000	0	0	88.02
90.00	09000	CLINIC	20,397	122,025	0.167154	0	0	90.00
90.01	04951	CHEMO/PAIN	76,274	862,214	0.088463	0	0	90.01
90.02	09002	SENIOR CARE	9,609	833,246	0.011532	0	0	90.02
90.03	09003	SLEEP LAB	6,823	377,133	0.018092	0	0	90.03
91.00	09100	EMERGENCY	217,239	5,898,767	0.036828	2,070	76	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	71,109	348,650	0.203955	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	1,550,898	89,659,662		4,103,779	68,093	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 14-1320 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part IV Date/Time Prepared: 5/29/2019 1:41 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	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	0	88.02
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	04951	CHEMO/PAIN	0	0	0	0	0	90.01
90.02	09002	SENIOR CARE	0	0	0	0	0	90.02
90.03	09003	SLEEP LAB	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1320 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part IV Date/Time Prepared: 5/29/2019 1:41 pm

Title XVIII | Hospital | Cost

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	9,181,912	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	1,356,090	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	20,791,162	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	13,133,812	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	602,761	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	9,490,723	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	1,386,122	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	22,228	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	3,758,243	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	1,445,102	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	6,671,939	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	12,905,897	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	471,636	0.000000	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	0.000000	88.02
90.00	09000	CLINIC	0	0	0	122,025	0.000000	90.00
90.01	04951	CHEMO/PAIN	0	0	0	862,214	0.000000	90.01
90.02	09002	SENIOR CARE	0	0	0	833,246	0.000000	90.02
90.03	09003	SLEEP LAB	0	0	0	377,133	0.000000	90.03
91.00	09100	EMERGENCY	0	0	0	5,898,767	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	348,650	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	89,659,662		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1320 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part IV | Date/Time Prepared: 5/29/2019 1:41 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	804,565	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	154,727	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	392,356	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	609,335	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	160,982	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	205,342	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	19,379	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	507,629	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000	537,213	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	710,181	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000	0	0	0	0	88.02
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	04951	CHEMO/PAIN	0.000000	0	0	0	0	90.01
90.02	09002	SENIOR CARE	0.000000	0	0	0	0	90.02
90.03	09003	SLEEP LAB	0.000000	0	0	0	0	90.03
91.00	09100	EMERGENCY	0.000000	2,070	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)		4,103,779	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-1320 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part V Date/Time Prepared: 5/29/2019 1:41 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	0.300744	0	2,015,253	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.120370	0	249,397	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.150921	0	6,331,970	0	0	54.00
60.00	06000	LABORATORY	0.205390	0	5,185,734	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	1.382855	0	113,113	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.247444	0	2,984,053	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.087656	0	516,318	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.029107	0	7,613	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.668510	0	805,632	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.728930	0	135,525	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.312137	0	1,574,086	90	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000				0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000				0	88.02
90.00	09000	CLINIC	1.746552	0	60,290	0	0	90.00
90.01	04951	CHEMO/PAIN	2.079268	0	310,041	0	0	90.01
90.02	09002	SENIOR CARE	0.796321	0	831,958	0	0	90.02
90.03	09003	SLEEP LAB	0.502722	0	137,357	0	0	90.03
91.00	09100	EMERGENCY	0.640559	0	1,569,082	90	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.985074	0	155,107	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1.462390		0			95.00
200.00		Subtotal (see instructions)		0	22,982,529	180	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	22,982,529	180	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-1320 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part V Date/Time Prepared: 5/29/2019 1:41 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	606,075	0		50.00
53.00	05300	ANESTHESIOLOGY	30,020	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	955,627	0		54.00
60.00	06000	LABORATORY	1,065,098	0		60.00
65.00	06500	RESPIRATORY THERAPY	156,419	0		65.00
66.00	06600	PHYSICAL THERAPY	738,386	0		66.00
69.00	06900	ELECTROCARDIOLOGY	45,258	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	222	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	538,573	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	98,788	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	491,330	28		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0		88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0		88.02
90.00	09000	CLINIC	105,300	0		90.00
90.01	04951	CHEMO/PAIN	644,658	0		90.01
90.02	09002	SENIOR CARE	662,506	0		90.02
90.03	09003	SLEEP LAB	69,052	0		90.03
91.00	09100	EMERGENCY	1,005,090	58		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	307,899	0		92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	7,520,301	86		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	7,520,301	86		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1320 | Component CCN: 14-Z320 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part V Date/Time Prepared: 5/29/2019 1:41 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	0.300744	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.120370	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.150921	0	0	0	0	54.00
60.00	06000	LABORATORY	0.205390	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	1.382855	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.247444	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.087656	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.029107	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.668510	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.728930	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.312137	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000				0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000				0	88.02
90.00	09000	CLINIC	1.746552	0	0	0	0	90.00
90.01	04951	CHEMO/PAIN	2.079268	0	0	0	0	90.01
90.02	09002	SENIOR CARE	0.796321	0	0	0	0	90.02
90.03	09003	SLEEP LAB	0.502722	0	0	0	0	90.03
91.00	09100	EMERGENCY	0.640559	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.985074	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1.462390		0			95.00
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: 14-1320 | Component CCN: 14-Z320 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part V | Date/Time Prepared: 5/29/2019 1:41 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
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0		88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0		88.02
90.00	09000	CLINIC	0	0		90.00
90.01	04951	CHEMO/PAIN	0	0		90.01
90.02	09002	SENIOR CARE	0	0		90.02
90.03	09003	SLEEP LAB	0	0		90.03
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	0	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	0		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-1320 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part V Date/Time Prepared: 5/29/2019 1:41 pm

Title XIX | 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	0.300744	0	0	421,141	0	50.00
53.00	05300	ANESTHESIOLOGY	0.120370	0	0	58,100	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.150921	0	0	1,821,669	0	54.00
60.00	06000	LABORATORY	0.205390	0	0	468,338	0	60.00
65.00	06500	RESPIRATORY THERAPY	1.382855	0	0	22,364	0	65.00
66.00	06600	PHYSICAL THERAPY	0.247444	0	0	373	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.087656	0	0	135,953	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.029107	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.668510	0	0	172,739	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.728930	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.312137	0	0	135,791	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.590563				0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.886998				0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000				0	88.02
90.00	09000	CLINIC	1.746552	0	0	0	0	90.00
90.01	04951	CHEMO/PAIN	2.079268	0	0	24,513	0	90.01
90.02	09002	SENIOR CARE	0.796321	0	0	0	0	90.02
90.03	09003	SLEEP LAB	0.502722	0	0	0	0	90.03
91.00	09100	EMERGENCY	0.640559	0	0	732,873	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.985074	0	0	14,097	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1.462390	0	0			95.00
200.00		Subtotal (see instructions)		0	0	4,007,951	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	4,007,951	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-1320 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part V Date/Time Prepared: 5/29/2019 1:41 pm

Title XIX | 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	0	126,656		50.00
53.00	05300	ANESTHESIOLOGY	0	6,993		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	274,928		54.00
60.00	06000	LABORATORY	0	96,192		60.00
65.00	06500	RESPIRATORY THERAPY	0	30,926		65.00
66.00	06600	PHYSICAL THERAPY	0	92		66.00
69.00	06900	ELECTROCARDIOLOGY	0	11,917		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	115,478		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	42,385		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0		88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0		88.02
90.00	09000	CLINIC	0	0		90.00
90.01	04951	CHEMO/PAIN	0	50,969		90.01
90.02	09002	SENIOR CARE	0	0		90.02
90.03	09003	SLEEP LAB	0	0		90.03
91.00	09100	EMERGENCY	0	469,448		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	27,984		92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	0	1,253,968		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	1,253,968		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1320 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-1 | Date/Time Prepared: 5/29/2019 1:41 pm

Title XVIII | Hospital

	Cost Center Description	Cost	
		1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	5,861	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,488	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	2,065	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	880	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	2,493	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	1,299	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)	778	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	159.97	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	159.97	20.00
21.00	Total general inpatient routine service cost (see instructions)	5,909,381	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)	398,805	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	1,838,626	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	4,070,755	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)	4,070,755	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,636.16	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	2,125,372	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	2,125,372	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1320 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-1 | Date/Time Prepared: 5/29/2019 1:41 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)	1,674,029	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	3,799,401	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)	1,272,932	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	1,272,932	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)	423	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,636.16	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	692,096	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1320 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-1 | Date/Time Prepared: 5/29/2019 1:41 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	607,155	5,909,381	0.102744	692,096	71,109	90.00
91.00	Nursing School cost	0	5,909,381	0.000000	692,096	0	91.00
92.00	Allied health cost	0	5,909,381	0.000000	692,096	0	92.00
93.00	All other Medical Education	0	5,909,381	0.000000	692,096	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 14-1320 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-3 | Date/Time Prepared: 5/29/2019 1:41 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		1,171,855		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.300744	804,565	241,968	50.00
53.00	05300	ANESTHESIOLOGY	0.120370	154,727	18,624	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.150921	392,356	59,215	54.00
60.00	06000	LABORATORY	0.205390	609,335	125,151	60.00
65.00	06500	RESPIRATORY THERAPY	1.382855	160,982	222,615	65.00
66.00	06600	PHYSICAL THERAPY	0.247444	205,342	50,811	66.00
69.00	06900	ELECTROCARDIOLOGY	0.087656	19,379	1,699	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.029107	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.668510	507,629	339,355	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.728930	537,213	391,591	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.312137	710,181	221,674	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000		0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000		0	88.02
90.00	09000	CLINIC	1.746552	0	0	90.00
90.01	04951	CHEMO/PAIN	2.079268	0	0	90.01
90.02	09002	SENIOR CARE	0.796321	0	0	90.02
90.03	09003	SLEEP LAB	0.502722	0	0	90.03
91.00	09100	EMERGENCY	0.640559	2,070	1,326	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.985074	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		4,103,779	1,674,029	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)		4,103,779		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 14-1320 | Component CCN: 14-Z320 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-3 | Date/Time Prepared: 5/29/2019 1:41 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	0.300744	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.120370	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.150921	48,018	7,247	54.00
60.00	06000	LABORATORY	0.205390	83,737	17,199	60.00
65.00	06500	RESPIRATORY THERAPY	1.382855	47,099	65,131	65.00
66.00	06600	PHYSICAL THERAPY	0.247444	427,984	105,902	66.00
69.00	06900	ELECTROCARDIOLOGY	0.087656	1,370	120	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.029107	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.668510	38,032	25,425	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.728930	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.312137	260,899	81,436	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000		0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000		0	88.02
90.00	09000	CLINIC	1.746552	0	0	90.00
90.01	04951	CHEMO/PAIN	2.079268	0	0	90.01
90.02	09002	SENIOR CARE	0.796321	0	0	90.02
90.03	09003	SLEEP LAB	0.502722	0	0	90.03
91.00	09100	EMERGENCY	0.640559	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.985074	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		907,139	302,460	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)		907,139		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 14-1320 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-3 | Date/Time Prepared: 5/29/2019 1:41 pm

Title XIX | 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		72,070		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.300744	14,777	4,444	50.00
53.00	05300	ANESTHESIOLOGY	0.120370	3,359	404	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.150921	51,232	7,732	54.00
60.00	06000	LABORATORY	0.205390	69,204	14,214	60.00
65.00	06500	RESPIRATORY THERAPY	1.382855	7,699	10,647	65.00
66.00	06600	PHYSICAL THERAPY	0.247444	1,424	352	66.00
69.00	06900	ELECTROCARDIOLOGY	0.087656	5,404	474	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.029107	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.668510	19,069	12,748	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.728930	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.312137	45,683	14,259	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.590563	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.886998	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000	0	0	88.02
90.00	09000	CLINIC	1.746552	0	0	90.00
90.01	04951	CHEMO/PAIN	2.079268	0	0	90.01
90.02	09002	SENIOR CARE	0.796321	0	0	90.02
90.03	09003	SLEEP LAB	0.502722	0	0	90.03
91.00	09100	EMERGENCY	0.640559	29,334	18,790	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.985074	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		247,185	84,064	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)		247,185		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 14-1320 | Period: From 01/01/2018 To 12/31/2018 | Worksheet E Part B Date/Time Prepared: 5/29/2019 1:41 pm

Title XVIII | Hospital | Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	7,520,387	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)	7,520,387	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)	7,595,591	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 amounts (for CAH, see instructions)	54,287	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	3,526,884	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	4,014,420	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	4,014,420	30.00
31.00	Primary payer payments	3,153	31.00
32.00	Subtotal (line 30 minus line 31)	4,011,267	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)	785,237	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	510,404	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	202,682	36.00
37.00	Subtotal (see instructions)	4,521,671	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		39.50
39.97	Demonstration payment adjustment amount before sequestration	0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	4,521,671	40.00
40.01	Sequestration adjustment (see instructions)	90,433	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
41.00	Interim payments	3,926,626	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	504,612	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	274,833	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: 14-1320 | Period: From 01/01/2018 To 12/31/2018 | Worksheet E-1 Part I | Date/Time Prepared: 5/29/2019 1:41 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		4,028,516		3,963,918	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	07/12/2018	305,889	07/12/2018	37,292	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)		-305,889		-37,292	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)		3,722,627		3,926,626	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		504,612	6.01
6.02	SETTLEMENT TO PROGRAM		289,209		0	6.02
7.00	Total Medicare program liability (see instructions)		3,433,418		4,431,238	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: 14-1320 | Component CCN: 14-Z320 | Period: From 01/01/2018 To 12/31/2018 | Worksheet E-1 Part I | Date/Time Prepared: 5/29/2019 1:41 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		1,884,895		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	07/12/2018	160,992		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)		160,992		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		2,045,887		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		495,428		0	6.02
7.00	Total Medicare program liability (see instructions)		1,550,459		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: 14-1320	Period: From 01/01/2018 To 12/31/2018	Worksheet E-1 Part II Date/Time Prepared: 5/29/2019 1:41 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: 14-1320 | Component CCN: 14-Z320 | Period: From 01/01/2018 To 12/31/2018 | Worksheet E-2 | Date/Time Prepared: 5/29/2019 1:41 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)	1,285,661	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)	305,485	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	778	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)	1,591,146	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	1,591,146	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)	1,591,146	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	9,045	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)	1,582,101	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)	1,582,101	0	19.00
19.01	Sequestration adjustment (see instructions)	31,642	0	19.01
19.02	Demonstration payment adjustment amount after sequestration)	0	0	19.02
20.00	Interim payments	2,045,887	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)	-495,428	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: 14-1320	Period: From 01/01/2018 To 12/31/2018	Worksheet E-3 Part V Date/Time Prepared: 5/29/2019 1:41 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	3,799,401	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)	3,799,401	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	3,837,395	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)	3,837,395	19.00
20.00	Deductibles (exclude professional component)	416,768	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	3,420,627	22.00
23.00	Coinsurance	0	23.00
24.00	Subtotal (line 22 minus line 23)	3,420,627	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	127,479	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	82,861	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	3,503,488	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)	3,503,488	30.00
30.01	Sequestration adjustment (see instructions)	70,070	30.01
30.02	Demonstration payment adjustment amount after sequestration	0	30.02
31.00	Interim payments	3,722,627	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)	-289,209	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	44,618	34.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 14-1320 | Period: From 01/01/2018 To 12/31/2018 | Worksheet G | Date/Time Prepared: 5/29/2019 1:41 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	5,929,883	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	23,690,334	0	0	0	4.00
5.00	Other receivable	1,324,990	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-13,241,508	0	0	0	6.00
7.00	Inventory	1,617,010	0	0	0	7.00
8.00	Prepaid expenses	636,728	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)	19,957,437	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	434,175	0	0	0	12.00
13.00	Land improvements	2,324,864	0	0	0	13.00
14.00	Accumulated depreciation	-1,725,575	0	0	0	14.00
15.00	Buildings	29,155,875	0	0	0	15.00
16.00	Accumulated depreciation	-17,471,296	0	0	0	16.00
17.00	Leasehold improvements	7,213,975	0	0	0	17.00
18.00	Accumulated depreciation	-74,744	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	19,459,868	0	0	0	23.00
24.00	Accumulated depreciation	-14,315,572	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	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	25,001,570	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	21,014,136	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)	21,014,136	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	65,973,143	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	1,529,574	0	0	0	37.00
38.00	Salaries, wages, and fees payable	218,272	0	0	0	38.00
39.00	Payroll taxes payable	2,863,866	0	0	0	39.00
40.00	Notes and loans payable (short term)	6,405,484	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	75,870	0	0	0	43.00
44.00	Other current liabilities	0	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	11,093,066	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	192,095	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	192,095	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	11,285,161	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	54,687,982				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)	54,687,982	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	65,973,143	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 14-1320 | Period: From 01/01/2018 To 12/31/2018 | Worksheet G-1 | Date/Time Prepared: 5/29/2019 1:41 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		52,602,987		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		2,084,995				2.00
3.00	Total (sum of line 1 and line 2)		54,687,982		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)		54,687,982		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)		54,687,982		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: 14-1320 | Period: From 01/01/2018 To 12/31/2018 | Worksheet G-2 Parts I & II | Date/Time Prepared: 5/29/2019 1:41 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	4,144,556		4,144,556	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	4,144,556		4,144,556	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	4,144,556		4,144,556	17.00
18.00	Ancillary services	6,769,119	72,767,431	79,536,550	18.00
19.00	Outpatient services	1,017	8,680,194	8,681,211	19.00
20.00	RURAL HEALTH CLINIC	0	12,905,897	12,905,897	20.00
20.01	RURAL HEALTH CLINIC II	0	471,636	471,636	20.01
20.02	RURAL HEALTH CLINIC III	0	0	0	20.02
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES	0	572,605	572,605	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER OUTPATIENT	0	2,838,167	2,838,167	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	10,914,692	98,235,930	109,150,622	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		52,798,380		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)		52,798,380		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 14-1320	Period: From 01/01/2018 To 12/31/2018	Worksheet G-3 Date/Time Prepared: 5/29/2019 1:41 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	109,150,622	1.00
2.00	Less contractual allowances and discounts on patients' accounts	56,307,351	2.00
3.00	Net patient revenues (line 1 minus line 2)	52,843,271	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	52,798,380	4.00
5.00	Net income from service to patients (line 3 minus line 4)	44,891	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	127,278	6.00
7.00	Income from investments	465,993	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	5,057	10.00
11.00	Rebates and refunds of expenses	28,295	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	89,483	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	12,050	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	20,400	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER MISCELLANEOUS INCOME	544,054	24.00
24.01	PHARMACY	2,315,038	24.01
24.03	PHYSICIAN LICENSE	116,601	24.03
24.04	GAIN/LOSS ON SALE	-1,684,145	24.04
24.05	PRO FEES	0	24.05
25.00	Total other income (sum of lines 6-24)	2,040,104	25.00
26.00	Total (line 5 plus line 25)	2,084,995	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	2,084,995	29.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1320 | Component CCN: 14-3987 | Period: From 01/01/2018 To 12/31/2018 | Worksheet M-1 | Date/Time Prepared: 5/29/2019 1:41 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	1,401,913	0	1,401,913	0	1,401,913	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	575,337	0	575,337	0	575,337	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	1,151,194	0	1,151,194	0	1,151,194	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	107	0	107	0	107	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)	3,128,551	0	3,128,551	0	3,128,551	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	55,386	55,386	0	55,386	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	66,401	66,401	0	66,401	18.00
19.00	Other Health Care Costs	0	194,077	194,077	0	194,077	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	315,864	315,864	0	315,864	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	3,128,551	315,864	3,444,415	0	3,444,415	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	104,274	104,274	0	104,274	26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	104,274	104,274	0	104,274	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	297,027	297,027	0	297,027	29.00
30.00	Administrative Costs	922,896	1,814,908	2,737,804	0	2,737,804	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	922,896	2,111,935	3,034,831	0	3,034,831	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	4,051,447	2,532,073	6,583,520	0	6,583,520	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1320 | Component CCN: 14-3987 | Period: From 01/01/2018 To 12/31/2018 | Worksheet M-1 | Date/Time Prepared: 5/29/2019 1:41 pm

RHC I | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	1,401,913		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	575,337		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	1,151,194		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	107		8.00
9.00	Other Facility Health Care Staff Costs	0	0		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	3,128,551		10.00
11.00	Physician Services Under Agreement	0	0		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	0		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0		14.00
15.00	Medical Supplies	0	55,386		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	66,401		18.00
19.00	Other Health Care Costs	0	194,077		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	315,864		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	3,444,415		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	-89,502	14,772		26.00
27.00	Nonallowable GME costs				27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	-89,502	14,772		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	297,027		29.00
30.00	Administrative Costs	-24,348	2,713,456		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-24,348	3,010,483		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-113,850	6,469,670		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1320 | Component CCN: 14-3989 | Period: From 01/01/2018 To 12/31/2018 | Worksheet M-1 | Date/Time Prepared: 5/29/2019 1:41 pm

RHC II | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	0	0	0	0	0	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	124,937	0	124,937	0	124,937	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	55,680	0	55,680	0	55,680	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)	180,617	0	180,617	0	180,617	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	21,256	21,256	0	21,256	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	21,256	21,256	0	21,256	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	180,617	21,256	201,873	0	201,873	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	5,879	5,879	0	5,879	26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	5,879	5,879	0	5,879	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	17,311	17,311	0	17,311	29.00
30.00	Administrative Costs	43,212	93,089	136,301	0	136,301	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	43,212	110,400	153,612	0	153,612	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	223,829	137,535	361,364	0	361,364	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1320 | Component CCN: 14-3989 | Period: From 01/01/2018 To 12/31/2018 | Worksheet M-1 | Date/Time Prepared: 5/29/2019 1:41 pm

RHC II | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	0		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	124,937		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	55,680		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	0		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	180,617		10.00
11.00	Physician Services Under Agreement	0	0		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	0		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0		14.00
15.00	Medical Supplies	0	21,256		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	21,256		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	201,873		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	-5,879	0		26.00
27.00	Nonallowable GME costs				27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	-5,879	0		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	17,311		29.00
30.00	Administrative Costs	-380	135,921		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-380	153,232		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-6,259	355,105		32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1320 | Component CCN: 14-3987 | Period: From 01/01/2018 To 12/31/2018 | Worksheet M-2 | Date/Time Prepared: 5/29/2019 1:41 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	3.01	23,455	4,200	12,642		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	2.56	7,915	2,100	5,376		3.00
4.00	Subtotal (sum of lines 1 through 3)	5.57	31,370		18,018	31,370	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)	5.57	31,370			31,370	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)					3,444,415	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					14,772	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					3,459,187	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					0.995730	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					3,010,483	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					1,152,072	15.00
16.00	Total overhead (sum of lines 14 and 15)					4,162,555	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					4,162,555	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					4,144,781	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					7,589,196	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1320 | Component CCN: 14-3989 | Period: From 01/01/2018 To 12/31/2018 | Worksheet M-2 | Date/Time Prepared: 5/29/2019 1:41 pm

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	RHC II Minimum Visits (col. 1 x col. 3)	Cost Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	0.00	0	4,200	0		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	0.93	2,270	2,100	1,953		3.00
4.00	Subtotal (sum of lines 1 through 3)	0.93	2,270		1,953	2,270	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)	0.93	2,270			2,270	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)					201,873	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)					201,873	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)					153,232	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					63,235	15.00
16.00	Total overhead (sum of lines 14 and 15)					216,467	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					216,467	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					216,467	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					418,340	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 14-1320 Component CCN: 14-3987	Period: From 01/01/2018 To 12/31/2018	Worksheet M-3 Date/Time Prepared: 5/29/2019 1:41 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)		7,589,196	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)		445,017	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		7,144,179	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		31,370	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)		31,370	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		227.74	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)	227.74	227.74	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	9,756	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	2,221,831	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	2,221,831	16.00
16.01	Total program charges (see instructions)(from contractor's records)		1,489,079	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		47,350	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		70,650	16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)		1,599,973	16.04
16.05	Total program cost (see instructions)	0	1,670,623	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		151,215	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		258,103	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		1,670,623	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		175,522	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		1,846,145	22.00
23.00	Allowable bad debts (see instructions)		0	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		0	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	25.50
25.99	Demonstration payment adjustment amount before sequestration		0	25.99
26.00	Net reimbursable amount (see instructions)		1,846,145	26.00
26.01	Sequestration adjustment (see instructions)		36,923	26.01
26.02	Demonstration payment adjustment amount after sequestration		0	26.02
27.00	Interim payments		1,422,194	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)		387,028	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0	30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 14-1320 Component CCN: 14-3989	Period: From 01/01/2018 To 12/31/2018	Worksheet M-3 Date/Time Prepared: 5/29/2019 1:41 pm
	Title XVIII	RHC II	Cost

			1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES			
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)		418,340	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)		33,986	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		384,354	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		2,270	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)		2,270	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		169.32	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)	169.32	169.32	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	427	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	72,300	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	72,300	16.00
16.01	Total program charges (see instructions)(from contractor's records)		57,732	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		6,659	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		8,339	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.)		43,498	16.04
16.05	Total program cost (see instructions)	0	51,837	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		9,589	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		8,297	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		51,837	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		13,102	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		64,939	22.00
23.00	Allowable bad debts (see instructions)		0	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		0	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	25.50
25.99	Demonstration payment adjustment amount before sequestration		0	25.99
26.00	Net reimbursable amount (see instructions)		64,939	26.00
26.01	Sequestration adjustment (see instructions)		1,299	26.01
26.02	Demonstration payment adjustment amount after sequestration		0	26.02
27.00	Interim payments		50,613	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)		13,027	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: 14-1320 Component CCN: 14-3987	Period: From 01/01/2018 To 12/31/2018	Worksheet M-4 Date/Time Prepared: 5/29/2019 1:41 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)	3,128,551	3,128,551	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.009135	0.017636	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	28,579	55,175	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	97,428	20,793	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	126,007	75,968	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	3,444,415	3,444,415	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	4,144,781	4,144,781	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.036583	0.022055	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	151,629	91,413	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	277,636	167,381	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	635	1,226	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	437.22	136.53	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	250	485	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	109,305	66,217	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)		445,017	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)		175,522	16.00

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

Provider CCN: 14-1320 | Component CCN: 14-3989 | Period: From 01/01/2018 To 12/31/2018 | Worksheet M-4 | Date/Time Prepared: 5/29/2019 1:41 pm

Title XVIII | RHC II | Cost

		Pneumococcal	Influenza	
		1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	180,617	180,617	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.005860	0.013616	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	1,058	2,459	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	10,203	2,680	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	11,261	5,139	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	201,873	201,873	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	216,467	216,467	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.055783	0.025457	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	12,075	5,511	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	23,336	10,650	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	68	158	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	343.18	67.41	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	26	62	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	8,923	4,179	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)		33,986	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)		13,102	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 14-1320 Component CCN: 14-3987	Period: From 01/01/2018 To 12/31/2018	Worksheet M-5 Date/Time Prepared: 5/29/2019 1:41 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		1,308,468	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		07/12/2018	113,726	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)		113,726	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		1,422,194	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		387,028	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		1,809,222	7.00

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

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 14-1320 Component CCN: 14-3989	Period: From 01/01/2018 To 12/31/2018	Worksheet M-5 Date/Time Prepared: 5/29/2019 1:41 pm
		RHC II	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		66,033	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		07/12/2018	15,420	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)		-15,420	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		50,613	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		13,027	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		63,640	7.00

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