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: 14-1323	Period: From 04/01/2017 To 03/31/2018	Worksheet S Parts I-III Date/Time Prepared: 8/30/2018 5:58 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 8/30/2018 Time: 5:58 pm
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

5. [1] Cost Report Status
   (1) As Submitted
   (2) Settled without Audit
   (3) Settled with Audit
   (4) Reopened
   (5) Amended
6. Date Received:
7. Contractor No. 15101
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 MASSAC MEMORIAL HOSPITAL (14-1323) for the cost reporting period beginning 04/01/2017 and ending 03/31/2018 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.

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

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

_____
Title

_____
Date

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	-1,265,635	398,715	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	-262,973	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
10.00	RURAL HEALTH CLINIC I	0		70,472		0	10.00
200.00	Total	0	-1,528,608	469,187	0	0	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1323 | Period: From 04/01/2017 To 03/31/2018 | Worksheet S-2 Part I | Date/Time Prepared: 8/30/2018 5:54 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 28 CHICK STREET	PO Box:			1.00
2.00	City: METROPOLIS	State: IL	Zip Code: 62960-	County: MASSAC	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	MASSAC MEMORIAL HOSPITAL	141323	99914	1	02/01/2003	N	O	N	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	MASSAC MEMORIAL HOSPITAL	14Z323	99916		02/01/2003	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	MASSAC MEMORIAL MEDICAL CLINIC	143478	99916		02/07/2006	N	O	N	15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	04/01/2017	03/31/2018	20.00
21.00	Type of Control (see instructions)	11		21.00
	Inpatient PPS Information			
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	N	N	22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	N	N	22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N	22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.	N	N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	3	N	23.00

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1323 | Period: From 04/01/2017 To 03/31/2018 | Worksheet S-2 Part I | Date/Time Prepared: 8/30/2018 5:54 pm

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1323 | Period: From 04/01/2017 To 03/31/2018 | Worksheet S-2 Part I Date/Time Prepared: 8/30/2018 5:54 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: 14-1323	Period: From 04/01/2017 To 03/31/2018	Worksheet S-2 Part I Date/Time Prepared: 8/30/2018 5:54 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)	Y		106.00
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II.	N		107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	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

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

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

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	171,816	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: 14-1323	Period: From 04/01/2017 To 03/31/2018	Worksheet S-2 Part I Date/Time Prepared: 8/30/2018 5:54 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)	1	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)	10/01/2013	09/30/2014	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: 14-1323 | Period: From 04/01/2017 To 03/31/2018 | Worksheet S-2 Part II | Date/Time Prepared: 8/30/2018 5:54 pm

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

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

		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	09/30/2017	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	08/13/2018	Y	08/13/2018	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 14-1323 | Period: From 04/01/2017 To 03/31/2018 | Worksheet S-2 Part II Date/Time Prepared: 8/30/2018 5:54 pm

		Description		Y/N	Y/N	
		0		1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
	Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions				N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				Y	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				Y	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				N	27.00
	Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				Y	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				Y	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				N	31.00
	Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				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.	KYLE		LEE		41.00
42.00	Enter the employer/company name of the cost report preparer.	MEDTRACK, INC				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	417-268-5953		KYLE.LEE@EDPTS.COM		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 14-1323	Period: From 04/01/2017 To 03/31/2018	Worksheet S-2 Part II Date/Time Prepared: 8/30/2018 5:54 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.	PRIN		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: 14-1323 | Period: From 04/01/2017 To 03/31/2018 | Worksheet S-3 Part I | Date/Time Prepared: 8/30/2018 5:54 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	79,251.61	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	79,251.61	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	79,251.61	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	88.00				0	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		25				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00
33.01	LTCH site neutral days and discharges						33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 14-1323 | Period: From 04/01/2017 To 03/31/2018 | Worksheet S-3 Part I | Date/Time Prepared: 8/30/2018 5:54 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)	2,779	521	4,048			1.00
2.00	HMO and other (see instructions)	254	0				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	741	0	741			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		99	99			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	3,520	620	4,888			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)	3,520	620	4,888	0.00	167.33	14.00
15.00	CAH visits	7,043	0	24,011			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	0	0	0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	3,058	0	13,968	0.00	12.50	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	179.83	27.00
28.00	Observation Bed Days		0	248			28.00
29.00	Ambulance Trips	876					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: 14-1323 | Period: From 04/01/2017 To 03/31/2018 | Worksheet S-3 Part I | Date/Time Prepared: 8/30/2018 5:54 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	679	247	1,056	1.00
2.00	HMO and other (see instructions)			56	0		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				0		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	679	247	1,056	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	0.00					26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 14-1323 | Component CCN: 14-3478 | Period: From 04/01/2017 To 03/31/2018 | Worksheet S-8 | Date/Time Prepared: 8/30/2018 5:54 pm

		RHC I	Cost
		1.00	
	Clinic Address and Identification		
1.00	Street	28 CHICK STREET	1.00

		City	State	ZIP Code	
		1.00	2.00	3.00	
2.00	City, State, ZIP Code, County	METROPOLIS	IL	62960	2.00

		1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban	0	3.00

		Grant Award	Date	
		1.00	2.00	
	Source of Federal Funds			
4.00	Community Health Center (Section 330(d), PHS Act)			4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)			5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)			6.00
7.00	Appalachian Regional Commission			7.00
8.00	Look-Alikes			8.00
9.00	OTHER (SPECIFY)			9.00

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

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

			County				
			4.00				
2.00	City, State, ZIP Code, County		MASSAC				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	17:00	08:00	17:00	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 14-1323 | Component CCN: 14-3478 | Period: From 04/01/2017 To 03/31/2018 | Worksheet S-8 | Date/Time Prepared: 8/30/2018 5:54 pm

RHC I | Cost

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

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 14-1323 | Period: From 04/01/2017 To 03/31/2018 | Worksheet S-10 | Date/Time Prepared: 8/30/2018 5:54 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)	0.425103	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	2,815,217	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	15,499,437	6.00
7.00	Medicaid cost (line 1 times line 6)	6,588,857	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)	3,773,640	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)	3,773,640	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)	415,918	0	415,918	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	176,808	0	176,808	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)	176,808	0	176,808	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)	981,431	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	404,041	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	621,602	27.01
28.00	Non-Medicare bad debt expense (see instructions)	359,829	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	370,525	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	547,333	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	4,320,973	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-1323 | Period: From 04/01/2017 To 03/31/2018 | Worksheet A | Date/Time Prepared: 8/30/2018 5:54 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		905,562	905,562	304,063	1,209,625	1.00
1.01	00101	NEW CAP REL COSTS-BLDG AMBULANCE		0	0	0	0	1.01
1.02	00102	NEW CAP REL COSTS-BLDG EKG		0	0	0	0	1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP		1,157,746	1,157,746	113,831	1,271,577	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	4,127,034	4,127,034	0	4,127,034	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,384,968	1,757,952	3,142,920	-49,837	3,093,083	5.00
7.00	00700	OPERATION OF PLANT	194,188	824,275	1,018,463	0	1,018,463	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	14,965	109,067	124,032	0	124,032	8.00
9.00	00900	HOUSEKEEPING	289,982	64,328	354,310	0	354,310	9.00
10.00	01000	DIETARY	291,143	209,808	500,951	-196,515	304,436	10.00
11.00	01100	CAFETERIA	0	0	0	196,018	196,018	11.00
13.00	01300	NURSING ADMINISTRATION	111,444	10,089	121,533	-1,797	119,736	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	238,875	44,686	283,561	-4,501	279,060	16.00
17.00	01700	SOCIAL SERVICE	169,180	8,413	177,593	0	177,593	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,470,018	148,159	1,618,177	675,693	2,293,870	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	291,065	254,327	545,392	-119,967	425,425	50.00
53.00	05300	ANESTHESIOLOGY	224,570	6,673	231,243	0	231,243	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	567,891	530,376	1,098,267	-13,255	1,085,012	54.00
60.00	06000	LABORATORY	560,462	994,829	1,555,291	-82,344	1,472,947	60.00
65.00	06500	RESPIRATORY THERAPY	394,185	140,076	534,261	-29,476	504,785	65.00
66.00	06600	PHYSICAL THERAPY	428,478	48,077	476,555	-2,580	473,975	66.00
69.00	06900	ELECTROCARDIOLOGY	59,571	241,617	301,188	24,652	325,840	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	46,649	-20,131	26,518	109,821	136,339	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	30,374	30,374	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	362,993	550,424	913,417	11,309	924,726	73.00
76.00	03020	GERIATRIC PSYCH	212,932	127,412	340,344	-2,531	337,813	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,733,244	267,260	2,000,504	-705,517	1,294,987	88.00
90.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	90.00
90.01	04951	WOUND CARE	0	81,725	81,725	0	81,725	90.01
90.02	09000	CLINIC	219,452	24,661	244,113	0	244,113	90.02
91.00	09100	EMERGENCY	713,986	933,086	1,647,072	-1,492	1,645,580	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0	0	0	17,903	17,903	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	618,141	101,372	719,513	0	719,513	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		281,689	281,689	-281,689	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	10,598,382	13,930,592	24,528,974	-7,837	24,521,137	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	7,837	7,837	192.00
192.01	19201	PROMOTION	0	0	0	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		TOTAL (SUM OF LINES 118 through 199)	10,598,382	13,930,592	24,528,974	0	24,528,974	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-1323 | Period: From 04/01/2017 To 03/31/2018 | Worksheet A | Date/Time Prepared: 8/30/2018 5:54 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	-100,179	1,109,446		1.00
1.01	00101	NEW CAP REL COSTS-BLDG AMBULANCE	0	0		1.01
1.02	00102	NEW CAP REL COSTS-BLDG EKG	0	0		1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-494,545	777,032		2.00
3.00	00300	OTHER CAP REL COSTS	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-243	4,126,791		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-43,322	3,049,761		5.00
7.00	00700	OPERATION OF PLANT	0	1,018,463		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	124,032		8.00
9.00	00900	HOUSEKEEPING	0	354,310		9.00
10.00	01000	DIETARY	-1,946	302,490		10.00
11.00	01100	CAFETERIA	0	196,018		11.00
13.00	01300	NURSING ADMINISTRATION	0	119,736		13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-1,936	277,124		16.00
17.00	01700	SOCIAL SERVICE	0	177,593		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-153,970	2,139,900		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	425,425		50.00
53.00	05300	ANESTHESIOLOGY	0	231,243		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,085,012		54.00
60.00	06000	LABORATORY	0	1,472,947		60.00
65.00	06500	RESPIRATORY THERAPY	0	504,785		65.00
66.00	06600	PHYSICAL THERAPY	0	473,975		66.00
69.00	06900	ELECTROCARDIOLOGY	-149,243	176,597		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	-5,570	130,769		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	30,374		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-6,050	918,676		73.00
76.00	03020	GERIATRIC PSYCH	-2,030	335,783		76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	-375	1,294,612		88.00
90.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0	0		90.00
90.01	04951	WOUND CARE	0	81,725		90.01
90.02	09000	CLINIC	0	244,113		90.02
91.00	09100	EMERGENCY	0	1,645,580		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0	17,903		93.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0	719,513		95.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-959,409	23,561,728		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	7,837		192.00
192.01	19201	PROMOTION	0	0		192.01
193.00	19300	NONPAID WORKERS	0	0		193.00
200.00		TOTAL (SUM OF LINES 118 through 199)	-959,409	23,569,565		200.00

RECLASSIFICATIONS | Provider CCN: 14-1323 | Period: From 04/01/2017 To 03/31/2018 | Worksheet A-6 | Date/Time Prepared: 8/30/2018 5:54 pm

		Increases				
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - INTEREST RECLASS					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	275,374		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	6,315		2.00
	TOTALS		0	281,689		
	B - CAFETERIA RECLASS					
1.00	CAFETERIA	11.00	113,922	82,096		1.00
	TOTALS		113,922	82,096		
	C - RENTAL EXPENSE RECLASS					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	107,516		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
	TOTALS		0	107,516		
	D - MED SUPPLIES RECLASS					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	112,250		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
	TOTALS		0	112,250		
	E - DRUGS CHARGED RECLASS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	11,309		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
	TOTALS		0	11,309		
	F - POB REAL ESTATE TAXES					
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	7,837		1.00
	TOTALS		0	7,837		
	G - IMPLANTABLE SUPPLIES					
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	30,374		1.00
	TOTALS		0	30,374		
	I - RECLASS EKG SALARIES					
1.00	ELECTROCARDIOLOGY	69.00	24,652	0		1.00
	TOTALS		24,652	0		
	J - RECLASS RHC BLDG DEPRECIATION					
1.00	RURAL HEALTH CLINIC	88.00	0	6,017		1.00
	TOTALS		0	6,017		
	K - PROPERTY INSURANCE RECLASS					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	34,706		1.00
	TOTALS		0	34,706		
	L - HOSPITALIST					
1.00	ADULTS & PEDIATRICS	30.00	704,897	0		1.00
	TOTALS		704,897	0		
	M - BLOOD TRANSFUSION					
1.00	OTHER OUTPATIENT SERVICES	93.00	17,903	0		1.00
2.00		0.00	0	0		2.00
	TOTALS		17,903	0		
500.00	Grand Total: Increases		861,374	673,794		500.00

RECLASSIFICATIONS | Provider CCN: 14-1323 | Period: From 04/01/2017 To 03/31/2018 | Worksheet A-6 | Date/Time Prepared: 8/30/2018 5:54 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - INTEREST RECLASS						
1.00	INTEREST EXPENSE	113.00	0	281,689	11		1.00
2.00		0.00	0	0	11		2.00
	TOTALS		0	281,689			
	B - CAFETERIA RECLASS						
1.00	DIETARY	10.00	113,922	82,096	0		1.00
	TOTALS		113,922	82,096			
	C - RENTAL EXPENSE RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	7,294	10		1.00
2.00	NURSING ADMINISTRATION	13.00	0	613	10		2.00
3.00	MEDICAL RECORDS & LIBRARY	16.00	0	4,501	0		3.00
4.00	ADULTS & PEDIATRICS	30.00	0	6,649	0		4.00
5.00	OPERATING ROOM	50.00	0	54,769	0		5.00
6.00	RADIOLOGY-DIAGNOSTIC	54.00	0	4,501	0		6.00
7.00	LABORATORY	60.00	0	10,662	0		7.00
8.00	RESPIRATORY THERAPY	65.00	0	4,501	0		8.00
9.00	PHYSICAL THERAPY	66.00	0	2,429	0		9.00
10.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	2,429	0		10.00
11.00	GERIATRIC PSYCH	76.00	0	2,531	0		11.00
12.00	RURAL HEALTH CLINIC	88.00	0	6,637	0		12.00
	TOTALS		0	107,516			
	D - MED SUPPLIES RECLASS						
1.00	NURSING ADMINISTRATION	13.00	0	2	0		1.00
2.00	ADULTS & PEDIATRICS	30.00	0	6,084	0		2.00
3.00	OPERATING ROOM	50.00	0	34,159	0		3.00
4.00	LABORATORY	60.00	0	71,682	0		4.00
5.00	RESPIRATORY THERAPY	65.00	0	323	0		5.00
	TOTALS		0	112,250			
	E - DRUGS CHARGED RECLASS						
1.00	DIETARY	10.00	0	497	0		1.00
2.00	NURSING ADMINISTRATION	13.00	0	1,182	0		2.00
3.00	ADULTS & PEDIATRICS	30.00	0	60	0		3.00
4.00	OPERATING ROOM	50.00	0	665	0		4.00
5.00	RADIOLOGY-DIAGNOSTIC	54.00	0	8,754	0		5.00
6.00	PHYSICAL THERAPY	66.00	0	151	0		6.00
	TOTALS		0	11,309			
	F - POB REAL ESTATE TAXES						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	7,837	0		1.00
	TOTALS		0	7,837			
	G - IMPLANTABLE SUPPLIES						
1.00	OPERATING ROOM	50.00	0	30,374	0		1.00
	TOTALS		0	30,374			
	I - RECLASS EKG SALARIES						
1.00	RESPIRATORY THERAPY	65.00	24,652	0	0		1.00
	TOTALS		24,652	0			
	J - RECLASS RHC BLDG DEPRECIATION						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	6,017	9		1.00
	TOTALS		0	6,017			
	K - PROPERTY INSURANCE RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	34,706	12		1.00
	TOTALS		0	34,706			
	L - HOSPITALIST						
1.00	RURAL HEALTH CLINIC	88.00	704,897	0	0		1.00
	TOTALS		704,897	0			
	M - BLOOD TRANSFUSION						
1.00	ADULTS & PEDIATRICS	30.00	16,411	0	0		1.00
2.00	EMERGENCY	91.00	1,492	0	0		2.00
	TOTALS		17,903	0			
500.00	Grand Total: Decreases		861,374	673,794			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1323 | Period: From 04/01/2017 To 03/31/2018 | Worksheet A-7 Part I | Date/Time Prepared: 8/30/2018 5:54 pm

		Beginning Balances	Acquisitions: Purchases	Acquisitions: Donation	Acquisitions: Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	65,980	0	0	0	0	1.00
2.00	Land Improvements	1,075,420	21,342	0	21,342	0	2.00
3.00	Buildings and Fixtures	16,978,332	95,324	0	95,324	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	7,471,752	689,868	0	689,868	0	6.00
7.00	HIT designated Assets	424,784	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	26,016,268	806,534	0	806,534	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	26,016,268	806,534	0	806,534	0	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	65,980	0	1.00
2.00	Land Improvements	1,096,762	0	2.00
3.00	Buildings and Fixtures	17,073,656	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	8,161,620	0	6.00
7.00	HIT designated Assets	424,784	0	7.00
8.00	Subtotal (sum of lines 1-7)	26,822,802	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	26,822,802	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1323 | Period: From 04/01/2017 To 03/31/2018 | Worksheet A-7 Part II Date/Time Prepared: 8/30/2018 5:54 pm

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	905,562	0	0	0	0	1.00
1.01	NEW CAP REL COSTS-BLDG AMBULANCE	0	0	0	0	0	1.01
1.02	NEW CAP REL COSTS-BLDG EKG	0	0	0	0	0	1.02
2.00	CAP REL COSTS-MVBLE EQUIP	1,157,746	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	2,063,308	0	0	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL			
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)		
		14.00	15.00		
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2				
1.00	CAP REL COSTS-BLDG & FIXT	0	905,562		1.00
1.01	NEW CAP REL COSTS-BLDG AMBULANCE	0	0		1.01
1.02	NEW CAP REL COSTS-BLDG EKG	0	0		1.02
2.00	CAP REL COSTS-MVBLE EQUIP	0	1,157,746		2.00
3.00	Total (sum of lines 1-2)	0	2,063,308		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1323 | Period: From 04/01/2017 To 03/31/2018 | Worksheet A-7 Part III Date/Time Prepared: 8/30/2018 5:54 pm

	Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	18,053,752	-53,822	18,107,574	0.711529	0	1.00
1.01	NEW CAP REL COSTS-BLDG AMBULANCE	0	0	0	0.000000	0	1.01
1.02	NEW CAP REL COSTS-BLDG EKG	0	0	0	0.000000	0	1.02
2.00	CAP REL COSTS-MVBLE EQUIP	7,471,752	130,503	7,341,249	0.288471	0	2.00
3.00	Total (sum of lines 1-2)	25,525,504	76,681	25,448,823	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	899,545	0	1.00
1.01	NEW CAP REL COSTS-BLDG AMBULANCE	0	0	0	0	0	1.01
1.02	NEW CAP REL COSTS-BLDG EKG	0	0	0	0	0	1.02
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	665,498	107,516	2.00
3.00	Total (sum of lines 1-2)	0	0	0	1,565,043	107,516	3.00

	Cost Center Description	SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	175,195	34,706	0	0	1,109,446	1.00
1.01	NEW CAP REL COSTS-BLDG AMBULANCE	0	0	0	0	0	1.01
1.02	NEW CAP REL COSTS-BLDG EKG	0	0	0	0	0	1.02
2.00	CAP REL COSTS-MVBLE EQUIP	4,018	0	0	0	777,032	2.00
3.00	Total (sum of lines 1-2)	179,213	34,706	0	0	1,886,478	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-1323 | Period: From 04/01/2017 To 03/31/2018 | Worksheet A-8 | Date/Time Prepared: 8/30/2018 5:54 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-100,179	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
1.01	Investment income - NEW CAP REL COSTS-BLDG AMBULANCE (chapter 2)		0	NEW CAP REL COSTS-BLDG AMBULANCE	1.01	0	1.01
1.02	Investment income - NEW CAP REL COSTS-BLDG EKG (chapter 2)		0	NEW CAP REL COSTS-BLDG EKG	1.02	0	1.02
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)	B	-2,297	CAP REL COSTS-MVBLE EQUIP	2.00	11	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-7,351	ADMINISTRATIVE & GENERAL	5.00	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	-303,213			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	0			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests		0		0.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients	A	-1,936	MEDICAL RECORDS & LIBRARY	16.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts		0		0.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
26.01	Depreciation - NEW CAP REL COSTS-BLDG AMBULANCE		0	NEW CAP REL COSTS-BLDG AMBULANCE	1.01	0	26.01
26.02	Depreciation - NEW CAP REL COSTS-BLDG EKG		0	NEW CAP REL COSTS-BLDG EKG	1.02	0	26.02
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-1323 | Period: From 04/01/2017 To 03/31/2018 | Worksheet A-8 | Date/Time Prepared: 8/30/2018 5:54 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	PHYSICIAN RECRUITMENT	A	-33,392	ADMINISTRATIVE & GENERAL	5.00	0	33.00
34.00	OTHER OPERATING REVENUE	B	-1,946	DIETARY	10.00	0	34.00
35.00	PHARMACY REBATES	B	-6,050	DRUGS CHARGED TO PATIENTS	73.00	0	35.00
36.00	OTHER REVENUE	B	9,688	ADMINISTRATIVE & GENERAL	5.00	0	36.00
37.00	ACCOUNTS PAYABLE DISCOUNT	B	-536	ADMINISTRATIVE & GENERAL	5.00	0	37.00
38.00	PURCHASING REBATES	B	-5,570	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	38.00
39.00	BILLING REC	B	-20	ADMINISTRATIVE & GENERAL	5.00	0	39.00
42.00	LOBBYING EXPENSE	A	-2,583	ADMINISTRATIVE & GENERAL	5.00	0	42.00
43.00	CRNA EXPENSES	A	0	ANESTHESIOLOGY	53.00	0	43.00
44.00	RHC MISC INCOME	B	-375	RURAL HEALTH CLINIC	88.00	0	44.00
45.00	COMMUNITY OUTREACH	A	-2,030	GERIATRIC PSYCH	76.00	0	45.00
45.01	PATIENT TV DEPRECIATION	A	-1,861	CAP REL COSTS-MVBLE EQUIP	2.00	9	45.01
45.02	PATIENT PHONE SALARY	A	-896	ADMINISTRATIVE & GENERAL	5.00	0	45.02
45.03	PATIENT PHONE BENEFITS	A	-243	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	45.03
45.04	PATIENT PHONE DEPRECIATION	A	-1,934	CAP REL COSTS-MVBLE EQUIP	2.00	9	45.04
45.05	MARKETING EXPENSE	A	-8,232	ADMINISTRATIVE & GENERAL	5.00	0	45.05
45.06	HITECH DEPRECIATION	A	-488,453	CAP REL COSTS-MVBLE EQUIP	2.00	9	45.06
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-959,409				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: 14-1323 | Period: From 04/01/2017 To 03/31/2018 | Worksheet A-8-2 | Date/Time Prepared: 8/30/2018 5:54 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	153,970	153,970	0	0	0	1.00
2.00	91.00	EMERGENCY	808,306	0	808,306	0	0	2.00
3.00	69.00	ELECTROCARDIOLOGY	149,243	149,243	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			1,111,519	303,213	808,306		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	91.00	EMERGENCY	0	0	0	0	0	2.00
3.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	153,970		1.00
2.00	91.00	EMERGENCY	0	0	0	0		2.00
3.00	69.00	ELECTROCARDIOLOGY	0	0	0	149,243		3.00
4.00	0.00		0	0	0	0		4.00
5.00	0.00		0	0	0	0		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	303,213		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1323 | Period: From 04/01/2017 To 03/31/2018 | Worksheet B Part I | Date/Time Prepared: 8/30/2018 5:54 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS				
				BLDG & FIXT	NEW BLDG AMBULANCE	NEW BLDG EKG	MVBLE EQUIP	
			0	1.00	1.01	1.02	2.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	1,109,446	1,109,446				1.00
1.01	00101	NEW CAP REL COSTS-BLDG AMBULANCE	0	0	0			1.01
1.02	00102	NEW CAP REL COSTS-BLDG EKG	0	0	0	0		1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP	777,032				777,032	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4,126,791	5,132	0	0	3,365	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	3,049,761	256,873	0	0	168,438	5.00
7.00	00700	OPERATION OF PLANT	1,018,463	98,597	0	0	64,653	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	124,032	20,528	0	0	13,461	8.00
9.00	00900	HOUSEKEEPING	354,310	7,559	0	0	4,957	9.00
10.00	01000	DIETARY	302,490	24,713	0	0	16,205	10.00
11.00	01100	CAFETERIA	196,018	10,340	0	0	6,780	11.00
13.00	01300	NURSING ADMINISTRATION	119,736	4,298	0	0	2,818	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	277,124	19,454	0	0	14,348	16.00
17.00	01700	SOCIAL SERVICE	177,593	2,288	0	0	1,500	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,139,900	185,969	0	0	121,946	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	425,425	114,133	0	0	74,840	50.00
53.00	05300	ANESTHESIOLOGY	231,243	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,085,012	61,901	0	0	40,591	54.00
60.00	06000	LABORATORY	1,472,947	15,055	0	0	9,872	60.00
65.00	06500	RESPIRATORY THERAPY	504,785	20,819	0	0	13,652	65.00
66.00	06600	PHYSICAL THERAPY	473,975	43,825	0	0	28,738	66.00
69.00	06900	ELECTROCARDIOLOGY	176,597	38,579	0	0	25,546	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	130,769	17,469	0	0	11,455	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	30,374	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	918,676	7,205	0	0	4,725	73.00
76.00	03020	GERIATRIC PSYCH	335,783	18,240	0	0	11,961	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,294,612	23,537	0	0	48,589	88.00
90.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	90.00
90.01	04951	WOUND CARE	81,725	17,697	0	0	0	90.01
90.02	09000	CLINIC	244,113	18,961	0	0	12,433	90.02
91.00	09100	EMERGENCY	1,645,580	74,150	0	0	48,623	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04040	OTHER OUTPATIENT SERVICES	17,903	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	719,513	0	0	0	26,143	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	23,561,728	1,107,322	0	0	775,639	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	2,124	0	0	1,393	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	7,837	0	0	0	0	192.00
192.01	19201	PROMOTION	0	0	0	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	23,569,565	1,109,446	0	0	777,032	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1323 | Period: From 04/01/2017 To 03/31/2018 | Worksheet B Part I | Date/Time Prepared: 8/30/2018 5:54 pm

		Cost Center Description	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
			4.00	4A	5.00	7.00	8.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-BLDG AMBULANCE						1.01
1.02	00102	NEW CAP REL COSTS-BLDG EKG						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4,135,288					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	540,388	4,015,460	4,015,460			5.00
7.00	00700	OPERATION OF PLANT	75,768	1,257,481	258,225	1,515,706		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	5,839	163,860	33,649	41,551	239,060	8.00
9.00	00900	HOUSEKEEPING	113,145	479,971	98,563	15,300	0	9.00
10.00	01000	DIETARY	69,148	412,556	84,719	50,020	2,264	10.00
11.00	01100	CAFETERIA	44,450	257,588	52,896	20,929	0	11.00
13.00	01300	NURSING ADMINISTRATION	43,483	170,335	34,978	8,699	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	93,204	404,130	82,988	39,376	0	16.00
17.00	01700	SOCIAL SERVICE	66,011	247,392	50,802	4,631	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	842,210	3,290,025	675,617	376,411	108,210	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	113,568	727,966	149,489	231,011	19,524	50.00
53.00	05300	ANESTHESIOLOGY	87,623	318,866	65,479	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	221,580	1,409,084	289,357	125,292	23,249	54.00
60.00	06000	LABORATORY	218,682	1,716,556	352,496	30,472	0	60.00
65.00	06500	RESPIRATORY THERAPY	144,185	683,441	140,345	42,139	0	65.00
66.00	06600	PHYSICAL THERAPY	167,184	713,722	146,564	88,705	18,185	66.00
69.00	06900	ELECTROCARDIOLOGY	32,862	273,584	56,181	78,087	4,309	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	18,202	177,895	36,531	35,359	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	30,374	6,237	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	141,633	1,072,239	220,185	14,584	0	73.00
76.00	03020	GERIATRIC PSYCH	83,082	449,066	92,216	36,920	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	401,241	1,767,979	363,056	47,640	657	88.00
90.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	90.00
90.01	04951	WOUND CARE	0	99,422	20,416	35,820	0	90.01
90.02	09000	CLINIC	85,626	361,133	74,159	38,378	0	90.02
91.00	09100	EMERGENCY	278,002	2,046,355	420,221	150,084	61,542	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0				92.00
93.00	04040	OTHER OUTPATIENT SERVICES	6,985	24,888	5,111	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	241,187	986,843	202,649	0	779	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	4,135,288	23,558,211	4,013,129	1,511,408	238,719	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	3,517	722	4,298	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	7,837	1,609	0	341	192.00
192.01	19201	PROMOTION	0	0	0	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments		0				200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	4,135,288	23,569,565	4,015,460	1,515,706	239,060	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1323 | Period: From 04/01/2017 To 03/31/2018 | Worksheet B Part I | Date/Time Prepared: 8/30/2018 5:54 pm

		Cost Center Description	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	
			9.00	10.00	11.00	13.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-BLDG AMBULANCE						1.01
1.02	00102	NEW CAP REL COSTS-BLDG EKG						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING	593,834					9.00
10.00	01000	DIETARY	29,660	579,219				10.00
11.00	01100	CAFETERIA	0	180,054	511,467			11.00
13.00	01300	NURSING ADMINISTRATION	0	0	12,537	226,549		13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	6,991	0	34,074	0	567,559	16.00
17.00	01700	SOCIAL SERVICE	0	0	11,028	9,960	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	237,071	332,169	136,190	123,000	338,334	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,316	0	25,646	23,162	17,675	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	43,329	0	50,876	0	104,093	54.00
60.00	06000	LABORATORY	22,312	0	55,974	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	24,401	0	37,351	0	0	65.00
66.00	06600	PHYSICAL THERAPY	18,381	0	35,114	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	938	0	8,687	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	9,104	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,786	0	16,387	0	0	73.00
76.00	03020	GERIATRIC PSYCH	0	20,407	20,808	18,793	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	56,529	0	0	0	0	88.00
90.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	90.00
90.01	04951	WOUND CARE	0	0	0	0	0	90.01
90.02	09000	CLINIC	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	98,083	0	57,171	51,634	107,457	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0	0	0	0	0	93.00
		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)	546,797	532,630	510,947	226,549	567,559	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	47,037	46,589	520	0	0	192.00
192.01	19201	PROMOTION	0	0	0	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	593,834	579,219	511,467	226,549	567,559	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1323 | Period: From 04/01/2017 To 03/31/2018 | Worksheet B Part I | Date/Time Prepared: 8/30/2018 5:54 pm

		Cost Center Description	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			17.00	19.00	24.00	25.00	26.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-BLDG AMBULANCE						1.01
1.02	00102	NEW CAP REL COSTS-BLDG EKG						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE	323,813					17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0				19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	323,813	0	5,940,840	0	5,940,840	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	1,199,789	0	1,199,789	50.00
53.00	05300	ANESTHESIOLOGY	0	0	384,345	0	384,345	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	2,045,280	0	2,045,280	54.00
60.00	06000	LABORATORY	0	0	2,177,810	0	2,177,810	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	927,677	0	927,677	65.00
66.00	06600	PHYSICAL THERAPY	0	0	1,020,671	0	1,020,671	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	421,786	0	421,786	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	258,889	0	258,889	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	36,611	0	36,611	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	1,327,181	0	1,327,181	73.00
76.00	03020	GERIATRIC PSYCH	0	0	638,210	0	638,210	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	2,235,861	0	2,235,861	88.00
90.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	90.00
90.01	04951	WOUND CARE	0	0	155,658	0	155,658	90.01
90.02	09000	CLINIC	0	0	473,670	0	473,670	90.02
91.00	09100	EMERGENCY	0	0	2,992,547	0	2,992,547	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0	0	29,999	0	29,999	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	1,190,271	0	1,190,271	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	323,813	0	23,457,095	0	23,457,095	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	8,537	0	8,537	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	103,933	0	103,933	192.00
192.01	19201	PROMOTION	0	0	0	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments		0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	323,813	0	23,569,565	0	23,569,565	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1323 | Period: From 04/01/2017 To 03/31/2018 | Worksheet B Part II | Date/Time Prepared: 8/30/2018 5:54 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	NEW BLDG AMBULANCE	NEW BLDG EKG	MVBLE EQUIP	
			0	1.00	1.01	1.02	2.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-BLDG AMBULANCE						1.01
1.02	00102	NEW CAP REL COSTS-BLDG EKG						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	5,132	0	0	3,365	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	256,873	0	0	168,438	5.00
7.00	00700	OPERATION OF PLANT	0	98,597	0	0	64,653	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	20,528	0	0	13,461	8.00
9.00	00900	HOUSEKEEPING	0	7,559	0	0	4,957	9.00
10.00	01000	DIETARY	0	24,713	0	0	16,205	10.00
11.00	01100	CAFETERIA	0	10,340	0	0	6,780	11.00
13.00	01300	NURSING ADMINISTRATION	0	4,298	0	0	2,818	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	19,454	0	0	14,348	16.00
17.00	01700	SOCIAL SERVICE	0	2,288	0	0	1,500	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	185,969	0	0	121,946	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	114,133	0	0	74,840	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	61,901	0	0	40,591	54.00
60.00	06000	LABORATORY	0	15,055	0	0	9,872	60.00
65.00	06500	RESPIRATORY THERAPY	0	20,819	0	0	13,652	65.00
66.00	06600	PHYSICAL THERAPY	0	43,825	0	0	28,738	66.00
69.00	06900	ELECTROCARDIOLOGY	0	38,579	0	0	25,546	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	17,469	0	0	11,455	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	7,205	0	0	4,725	73.00
76.00	03020	GERIATRIC PSYCH	0	18,240	0	0	11,961	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	23,537	0	0	48,589	88.00
90.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	90.00
90.01	04951	WOUND CARE	0	17,697	0	0	0	90.01
90.02	09000	CLINIC	0	18,961	0	0	12,433	90.02
91.00	09100	EMERGENCY	0	74,150	0	0	48,623	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	26,143	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	1,107,322	0	0	775,639	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	2,124	0	0	1,393	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	PROMOTION	0	0	0	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	1,109,446	0	0	777,032	202.00

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		Cost Center Description	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
			2A	4.00	5.00	7.00	8.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-BLDG AMBULANCE						1.01
1.02	00102	NEW CAP REL COSTS-BLDG EKG						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	8,497	8,497				4.00
5.00	00500	ADMINISTRATIVE & GENERAL	425,311	1,111	426,422			5.00
7.00	00700	OPERATION OF PLANT	163,250	156	27,422	190,828		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	33,989	12	3,573	5,231	42,805	8.00
9.00	00900	HOUSEKEEPING	12,516	233	10,467	1,926	0	9.00
10.00	01000	DIETARY	40,918	142	8,997	6,297	405	10.00
11.00	01100	CAFETERIA	17,120	91	5,617	2,635	0	11.00
13.00	01300	NURSING ADMINISTRATION	7,116	89	3,714	1,095	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	33,802	192	8,813	4,957	0	16.00
17.00	01700	SOCIAL SERVICE	3,788	136	5,395	583	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	307,915	1,729	71,751	47,393	19,376	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	188,973	233	15,875	29,084	3,496	50.00
53.00	05300	ANESTHESIOLOGY	0	180	6,954	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	102,492	455	30,728	15,774	4,163	54.00
60.00	06000	LABORATORY	24,927	449	37,433	3,836	0	60.00
65.00	06500	RESPIRATORY THERAPY	34,471	296	14,904	5,305	0	65.00
66.00	06600	PHYSICAL THERAPY	72,563	344	15,564	11,168	3,256	66.00
69.00	06900	ELECTROCARDIOLOGY	64,125	68	5,966	9,831	772	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	28,924	37	3,879	4,452	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	662	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	11,930	291	23,382	1,836	0	73.00
76.00	03020	GERIATRIC PSYCH	30,201	171	9,793	4,648	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	72,126	825	38,554	5,998	118	88.00
90.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	90.00
90.01	04951	WOUND CARE	17,697	0	2,168	4,510	0	90.01
90.02	09000	CLINIC	31,394	176	7,875	4,832	0	90.02
91.00	09100	EMERGENCY	122,773	571	44,625	18,896	11,019	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0					92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0	14	543	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	26,143	496	21,520	0	139	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,882,961	8,497	426,174	190,287	42,744	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	3,517	0	77	541	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	171	0	61	192.00
192.01	19201	PROMOTION	0	0	0	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments	0					200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,886,478	8,497	426,422	190,828	42,805	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1323 | Period: From 04/01/2017 To 03/31/2018 | Worksheet B Part II | Date/Time Prepared: 8/30/2018 5:54 pm

		Cost Center Description	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	
			9.00	10.00	11.00	13.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-BLDG AMBULANCE						1.01
1.02	00102	NEW CAP REL COSTS-BLDG EKG						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING	25,142					9.00
10.00	01000	DIETARY	1,256	58,015				10.00
11.00	01100	CAFETERIA	0	18,034	43,497			11.00
13.00	01300	NURSING ADMINISTRATION	0	0	1,066	13,080		13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	296	0	2,898	0	50,958	16.00
17.00	01700	SOCIAL SERVICE	0	0	938	575	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	10,038	33,271	11,582	7,102	30,377	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	225	0	2,181	1,337	1,587	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,834	0	4,327	0	9,346	54.00
60.00	06000	LABORATORY	945	0	4,760	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	1,033	0	3,176	0	0	65.00
66.00	06600	PHYSICAL THERAPY	778	0	2,986	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	40	0	739	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	774	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	160	0	1,394	0	0	73.00
76.00	03020	GERIATRIC PSYCH	0	2,044	1,770	1,085	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	2,393	0	0	0	0	88.00
90.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	90.00
90.01	04951	WOUND CARE	0	0	0	0	0	90.01
90.02	09000	CLINIC	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	4,153	0	4,862	2,981	9,648	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0	0	0	0	0	93.00
		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)	23,151	53,349	43,453	13,080	50,958	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,991	4,666	44	0	0	192.00
192.01	19201	PROMOTION	0	0	0	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	25,142	58,015	43,497	13,080	50,958	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1323 | Period: From 04/01/2017 To 03/31/2018 | Worksheet B Part II | Date/Time Prepared: 8/30/2018 5:54 pm

		Cost Center Description	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			17.00	19.00	24.00	25.00	26.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-BLDG AMBULANCE						1.01
1.02	00102	NEW CAP REL COSTS-BLDG EKG						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE	11,415					17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0				19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	11,415		551,949	0	551,949	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0		242,991	0	242,991	50.00
53.00	05300	ANESTHESIOLOGY	0		7,134	0	7,134	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0		169,119	0	169,119	54.00
60.00	06000	LABORATORY	0		72,350	0	72,350	60.00
65.00	06500	RESPIRATORY THERAPY	0		59,185	0	59,185	65.00
66.00	06600	PHYSICAL THERAPY	0		106,659	0	106,659	66.00
69.00	06900	ELECTROCARDIOLOGY	0		81,541	0	81,541	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0		38,066	0	38,066	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0		662	0	662	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0		38,993	0	38,993	73.00
76.00	03020	GERIATRIC PSYCH	0		49,712	0	49,712	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0		120,014	0	120,014	88.00
90.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0		0	0	0	90.00
90.01	04951	WOUND CARE	0		24,375	0	24,375	90.01
90.02	09000	CLINIC	0		44,277	0	44,277	90.02
91.00	09100	EMERGENCY	0		219,528	0	219,528	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0		557	0	557	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0		48,298	0	48,298	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	11,415	0	1,875,410	0	1,875,410	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		4,135	0	4,135	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0		6,933	0	6,933	192.00
192.01	19201	PROMOTION	0		0	0	0	192.01
193.00	19300	NONPAID WORKERS	0		0	0	0	193.00
200.00		Cross Foot Adjustments		0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	11,415	0	1,886,478	0	1,886,478	202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1323 | Period: From 04/01/2017 To 03/31/2018 | Worksheet B-1 | Date/Time Prepared: 8/30/2018 5:54 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	NEW BLDG AMBULANCE (SQUARE FEET)	NEW BLDG EKG (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	
			1.00	1.01	1.02	2.00	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	87,768					1.00
1.01	00101	NEW CAP REL COSTS-BLDG AMBULANCE	0	0				1.01
1.02	00102	NEW CAP REL COSTS-BLDG EKG	0	0	0			1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP				93,744		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	406	0	0	406	10,598,382	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	20,321	0	0	20,321	1,384,968	5.00
7.00	00700	OPERATION OF PLANT	7,800	0	0	7,800	194,188	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,624	0	0	1,624	14,965	8.00
9.00	00900	HOUSEKEEPING	598	0	0	598	289,982	9.00
10.00	01000	DIETARY	1,955	0	0	1,955	177,221	10.00
11.00	01100	CAFETERIA	818	0	0	818	113,922	11.00
13.00	01300	NURSING ADMINISTRATION	340	0	0	340	111,444	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,539	0	0	1,731	238,875	16.00
17.00	01700	SOCIAL SERVICE	181	0	0	181	169,180	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	14,712	0	0	14,712	2,158,504	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	9,029	0	0	9,029	291,065	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	224,570	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,897	0	0	4,897	567,891	54.00
60.00	06000	LABORATORY	1,191	0	0	1,191	560,462	60.00
65.00	06500	RESPIRATORY THERAPY	1,647	0	0	1,647	369,533	65.00
66.00	06600	PHYSICAL THERAPY	3,467	0	0	3,467	428,478	66.00
69.00	06900	ELECTROCARDIOLOGY	3,052	0	0	3,082	84,223	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,382	0	0	1,382	46,649	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	570	0	0	570	362,993	73.00
76.00	03020	GERIATRIC PSYCH	1,443	0	0	1,443	212,932	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,862	0	0	5,862	1,028,347	88.00
90.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	90.00
90.01	04951	WOUND CARE	1,400	0	0	0	0	90.01
90.02	09000	CLINIC	1,500	0	0	1,500	219,452	90.02
91.00	09100	EMERGENCY	5,866	0	0	5,866	712,494	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0	0	0	0	17,903	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	3,154	618,141	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	87,600	0	0	93,576	10,598,382	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	168	0	0	168	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	PROMOTION	0	0	0	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,109,446	0	0	777,032	4,135,288	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	12.640666	0.000000	0.000000	8.288872	0.390181	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)					8,497	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)					0.000802	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: 14-1323 | Period: From 04/01/2017 To 03/31/2018 | Worksheet B-1 | Date/Time Prepared: 8/30/2018 5:54 pm

		Cost Center Description	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (TIME SPENT)	
			5A	5.00	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-BLDG AMBULANCE						1.01
1.02	00102	NEW CAP REL COSTS-BLDG EKG						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-4,015,460	19,554,105				5.00
7.00	00700	OPERATION OF PLANT	0	1,257,481	59,241			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	163,860	1,624	9,820		8.00
9.00	00900	HOUSEKEEPING	0	479,971	598	0	265,880	9.00
10.00	01000	DIETARY	0	412,556	1,955	93	13,280	10.00
11.00	01100	CAFETERIA	0	257,588	818	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	170,335	340	0	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	404,130	1,539	0	3,130	16.00
17.00	01700	SOCIAL SERVICE	0	247,392	181	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	3,290,025	14,712	4,445	106,145	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	727,966	9,029	802	2,380	50.00
53.00	05300	ANESTHESIOLOGY	0	318,866	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,409,084	4,897	955	19,400	54.00
60.00	06000	LABORATORY	0	1,716,556	1,191	0	9,990	60.00
65.00	06500	RESPIRATORY THERAPY	0	683,441	1,647	0	10,925	65.00
66.00	06600	PHYSICAL THERAPY	0	713,722	3,467	747	8,230	66.00
69.00	06900	ELECTROCARDIOLOGY	0	273,584	3,052	177	420	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	177,895	1,382	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	30,374	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,072,239	570	0	1,695	73.00
76.00	03020	GERIATRIC PSYCH	0	449,066	1,443	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	1,767,979	1,862	27	25,310	88.00
90.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	90.00
90.01	04951	WOUND CARE	0	99,422	1,400	0	0	90.01
90.02	09000	CLINIC	0	361,133	1,500	0	0	90.02
91.00	09100	EMERGENCY	0	2,046,355	5,866	2,528	43,915	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0	24,888	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	986,843	0	32	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-4,015,460	19,542,751	59,073	9,806	244,820	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	3,517	168	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	7,837	0	14	21,060	192.00
192.01	19201	PROMOTION	0	0	0	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)		4,015,460	1,515,706	239,060	593,834	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)		0.205351	25.585422	24.344196	2.233466	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)		426,422	190,828	42,805	25,142	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)		0.021807	3.221215	4.358961	0.094561	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: 14-1323 | Period: From 04/01/2017 To 03/31/2018 | Worksheet B-1 | Date/Time Prepared: 8/30/2018 5:54 pm

		Cost Center Description	DIETARY (MEALS SERVED)	CAFETERIA (FTE)	NURSING ADMINISTRATION (NURSING FTES)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (ASSIGNEDTIMES)	
			10.00	11.00	13.00	16.00	17.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-BLDG AMBULANCE						1.01
1.02	00102	NEW CAP REL COSTS-BLDG EKG						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	42,830					10.00
11.00	01100	CAFETERIA	13,314	9,832				11.00
13.00	01300	NURSING ADMINISTRATION	0	241	4,822			13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	655	0	232,000		16.00
17.00	01700	SOCIAL SERVICE	0	212	212	0	100	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	24,562	2,618	2,618	138,300	100	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	493	493	7,225	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	978	0	42,550	0	54.00
60.00	06000	LABORATORY	0	1,076	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	718	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	675	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	167	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	175	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	315	0	0	0	73.00
76.00	03020	GERIATRIC PSYCH	1,509	400	400	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	90.00
90.01	04951	WOUND CARE	0	0	0	0	0	90.01
90.02	09000	CLINIC	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	0	1,099	1,099	43,925	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0	0	0	0	0	93.00
		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)	39,385	9,822	4,822	232,000	100	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	3,445	10	0	0	0	192.00
192.01	19201	PROMOTION	0	0	0	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	579,219	511,467	226,549	567,559	323,813	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	13.523675	52.020647	46.982372	2.446375	3,238.130000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	58,015	43,497	13,080	50,958	11,415	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	1.354541	4.424024	2.712567	0.219647	114.150000	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: 14-1323 | Period: From 04/01/2017 To 03/31/2018 | Worksheet B-1 | Date/Time Prepared: 8/30/2018 5:54 pm

		Cost Center Description	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	
			19.00	
		GENERAL SERVICE COST CENTERS		
1.00	00100	CAP REL COSTS-BLDG & FIXT		1.00
1.01	00101	NEW CAP REL COSTS-BLDG AMBULANCE		1.01
1.02	00102	NEW CAP REL COSTS-BLDG EKG		1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT		4.00
5.00	00500	ADMINISTRATIVE & GENERAL		5.00
7.00	00700	OPERATION OF PLANT		7.00
8.00	00800	LAUNDRY & LINEN SERVICE		8.00
9.00	00900	HOUSEKEEPING		9.00
10.00	01000	DIETARY		10.00
11.00	01100	CAFETERIA		11.00
13.00	01300	NURSING ADMINISTRATION		13.00
16.00	01600	MEDICAL RECORDS & LIBRARY		16.00
17.00	01700	SOCIAL SERVICE		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS	0	30.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0	50.00
53.00	05300	ANESTHESIOLOGY	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	54.00
60.00	06000	LABORATORY	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	65.00
66.00	06600	PHYSICAL THERAPY	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	73.00
76.00	03020	GERIATRIC PSYCH	0	76.00
		OUTPATIENT SERVICE COST CENTERS		
88.00	08800	RURAL HEALTH CLINIC	0	88.00
90.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0	90.00
90.01	04951	WOUND CARE	0	90.01
90.02	09000	CLINIC	0	90.02
91.00	09100	EMERGENCY	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0	93.00
		OTHER REIMBURSABLE COST CENTERS		
95.00	09500	AMBULANCE SERVICES	0	95.00
		SPECIAL PURPOSE COST CENTERS		
113.00	11300	INTEREST EXPENSE		113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	118.00
		NONREIMBURSABLE COST CENTERS		
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	192.00
192.01	19201	PROMOTION	0	192.01
193.00	19300	NONPAID WORKERS	0	193.00
200.00		Cross Foot Adjustments		200.00
201.00		Negative Cost Centers		201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	0	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)		206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)		207.00

POST STEPDOWN ADJUSTMENTS | Provider CCN: 14-1323 | Period: From 04/01/2017 To 03/31/2018 | Worksheet B-2 | Date/Time Prepared: 8/30/2018 5:54 pm

		Description	Worksheet CODE	Worksheet Line No.	Amount	
		1.00	2.00	3.00	4.00	
1.00		ADJ FOR EPO COSTS IN RENAL DIALYSIS	1	74.00	0	1.00
2.00		ADJ FOR EPO COSTS IN HOME PROGRAM	1	94.00	0	2.00
3.00		ADJ FOR ARANESP COSTS IN RENAL DIALYSIS	1	74.00	0	3.00
4.00		ADJ FOR ARANESP COSTS IN HOME PROGRAM	1	94.00	0	4.00
5.00		ADJ FOR ESA COSTS IN RENAL DIALYSIS	1	74.00	0	5.00
6.00		ADJ FOR ESA COSTS IN HOME PROGRAM	1	94.00	0	6.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1323 | Period: From 04/01/2017 To 03/31/2018 | Worksheet C Part I Date/Time Prepared: 8/30/2018 5:54 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	5,940,840		5,940,840	0	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,199,789		1,199,789	0	0	50.00
53.00	05300	ANESTHESIOLOGY	384,345		384,345	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,045,280		2,045,280	0	0	54.00
60.00	06000	LABORATORY	2,177,810		2,177,810	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	927,677	0	927,677	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,020,671	0	1,020,671	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	421,786		421,786	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	258,889		258,889	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	36,611		36,611	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,327,181		1,327,181	0	0	73.00
76.00	03020	GERIATRIC PSYCH	638,210		638,210	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	2,235,861		2,235,861	0	0	88.00
90.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0		0	0	0	90.00
90.01	04951	WOUND CARE	155,658		155,658	0	0	90.01
90.02	09000	CLINIC	473,670		473,670	0	0	90.02
91.00	09100	EMERGENCY	2,992,547		2,992,547	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	291,854		291,854		0	92.00
93.00	04040	OTHER OUTPATIENT SERVICES	29,999		29,999	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1,190,271		1,190,271	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	23,748,949	0	23,748,949	0	0	200.00
201.00		Less Observation Beds	291,854		291,854		0	201.00
202.00		Total (see instructions)	23,457,095	0	23,457,095	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1323 | Period: From 04/01/2017 To 03/31/2018 | Worksheet C Part I Date/Time Prepared: 8/30/2018 5:54 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	3,800,913		3,800,913			30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	1,934,502	1,934,502	0.620206	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	420,460	420,460	0.914106	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,177,372	16,114,762	20,292,134	0.100792	0.000000	54.00
60.00	06000	LABORATORY	2,574,505	5,150,377	7,724,882	0.281921	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	2,226,120	274,041	2,500,161	0.371047	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	362,020	947,728	1,309,748	0.779288	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	933,399	1,831,160	2,764,559	0.152569	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	14,737	48,618	63,355	4.086323	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	52,000	52,000	0.704058	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,982,759	1,160,056	3,142,815	0.422291	0.000000	73.00
76.00	03020	GERIATRIC PSYCH	0	664,308	664,308	0.960714	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	2,528,470	2,528,470			88.00
90.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0.000000	0.000000	90.00
90.01	04951	WOUND CARE	3,052	216,416	219,468	0.709251	0.000000	90.01
90.02	09000	CLINIC	0	215,000	215,000	2.203116	0.000000	90.02
91.00	09100	EMERGENCY	930,489	4,410,334	5,340,823	0.560316	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	5,985	126,763	132,748	2.198557	0.000000	92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0	143,966	143,966	0.208376	0.000000	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	1,929,465	1,929,465	0.616892	0.000000	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	17,011,351	38,168,426	55,179,777			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	17,011,351	38,168,426	55,179,777			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1323 | Period: From 04/01/2017 To 03/31/2018 | Worksheet C Part I Date/Time Prepared: 8/30/2018 5:54 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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
76.00	03020	GERIATRIC PSYCH	0.000000		76.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC			88.00
90.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0.000000		90.00
90.01	04951	WOUND CARE	0.000000		90.01
90.02	09000	CLINIC	0.000000		90.02
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0.000000		93.00
		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: 14-1323 | Period: From 04/01/2017 To 03/31/2018 | Worksheet D Part II Date/Time Prepared: 8/30/2018 5:54 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	242,991	1,934,502	0.125609	0	0	50.00
53.00	05300	ANESTHESIOLOGY	7,134	420,460	0.016967	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	169,119	20,292,134	0.008334	1,094,345	9,120	54.00
60.00	06000	LABORATORY	72,350	7,724,882	0.009366	1,312,395	12,292	60.00
65.00	06500	RESPIRATORY THERAPY	59,185	2,500,161	0.023672	1,206,236	28,554	65.00
66.00	06600	PHYSICAL THERAPY	106,659	1,309,748	0.081435	84,312	6,866	66.00
69.00	06900	ELECTROCARDIOLOGY	81,541	2,764,559	0.029495	412,055	12,154	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	38,066	63,355	0.600837	9,642	5,793	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	662	52,000	0.012731	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	38,993	3,142,815	0.012407	1,154,801	14,328	73.00
76.00	03020	GERIATRIC PSYCH	49,712	664,308	0.074833	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	120,014	2,528,470	0.047465	0	0	88.00
90.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0.000000	0	0	90.00
90.01	04951	WOUND CARE	24,375	219,468	0.111064	1,414	157	90.01
90.02	09000	CLINIC	44,277	215,000	0.205940	0	0	90.02
91.00	09100	EMERGENCY	219,528	5,340,823	0.041104	8,276	340	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	27,116	132,748	0.204267	560	114	92.00
93.00	04040	OTHER OUTPATIENT SERVICES	557	143,966	0.003869	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	1,302,279	49,449,399		5,284,036	89,718	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1323 | Period: From 04/01/2017 To 03/31/2018 | Worksheet D Part IV | Date/Time Prepared: 8/30/2018 5:54 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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	GERIATRIC PSYCH	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	90.00
90.01	04951	WOUND CARE	0	0	0	0	0	90.01
90.02	09000	CLINIC	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0	0	0	0	0	93.00
		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: 14-1323 | Period: From 04/01/2017 To 03/31/2018 | Worksheet D Part IV | Date/Time Prepared: 8/30/2018 5:54 pm

Title XVIII | Hospital | Cost

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	1,934,502	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	420,460	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	20,292,134	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	7,724,882	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	2,500,161	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	1,309,748	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	2,764,559	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	63,355	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	52,000	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	3,142,815	0.000000	73.00
76.00	03020	GERIATRIC PSYCH	0	0	0	664,308	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	2,528,470	0.000000	88.00
90.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0.000000	90.00
90.01	04951	WOUND CARE	0	0	0	219,468	0.000000	90.01
90.02	09000	CLINIC	0	0	0	215,000	0.000000	90.02
91.00	09100	EMERGENCY	0	0	0	5,340,823	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	132,748	0.000000	92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0	0	0	143,966	0.000000	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	49,449,399		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1323 | Period: From 04/01/2017 To 03/31/2018 | Worksheet D Part IV | Date/Time Prepared: 8/30/2018 5:54 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	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	1,094,345	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	1,312,395	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	1,206,236	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	84,312	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	412,055	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	9,642	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	1,154,801	0	0	0	73.00
76.00	03020	GERIATRIC PSYCH	0.000000	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
90.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	0	0	90.00
90.01	04951	WOUND CARE	0.000000	1,414	0	0	0	90.01
90.02	09000	CLINIC	0.000000	0	0	0	0	90.02
91.00	09100	EMERGENCY	0.000000	8,276	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	560	0	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0.000000	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)		5,284,036	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-1323 | Period: From 04/01/2017 To 03/31/2018 | Worksheet D Part V Date/Time Prepared: 8/30/2018 5:54 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	0.620206	0	844,325	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.914106	0	216,259	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.100792	0	6,221,588	0	0	54.00
60.00	06000	LABORATORY	0.281921	0	2,020,511	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.371047	0	95,905	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.779288	0	369,566	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.152569	0	751,548	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	4.086323	0	24,955	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.704058	0	45,314	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.422291	0	823,618	0	0	73.00
76.00	03020	GERIATRIC PSYCH	0.960714	0	538,129	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
90.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	0	0	90.00
90.01	04951	WOUND CARE	0.709251	0	113,706	0	0	90.01
90.02	09000	CLINIC	2.203116	0	45,000	0	0	90.02
91.00	09100	EMERGENCY	0.560316	0	1,452,550	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2.198557	0	30,505	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0.208376	0	141,195	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.616892		0			95.00
200.00		Subtotal (see instructions)		0	13,734,674	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	13,734,674	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-1323 | Period: From 04/01/2017 To 03/31/2018 | Worksheet D Part V Date/Time Prepared: 8/30/2018 5:54 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	523,655	0		50.00
53.00	05300	ANESTHESIOLOGY	197,684	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	627,086	0		54.00
60.00	06000	LABORATORY	569,624	0		60.00
65.00	06500	RESPIRATORY THERAPY	35,585	0		65.00
66.00	06600	PHYSICAL THERAPY	287,998	0		66.00
69.00	06900	ELECTROCARDIOLOGY	114,663	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	101,974	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	31,904	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	347,806	0		73.00
76.00	03020	GERIATRIC PSYCH	516,988	0		76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
90.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0	0		90.00
90.01	04951	WOUND CARE	80,646	0		90.01
90.02	09000	CLINIC	99,140	0		90.02
91.00	09100	EMERGENCY	813,887	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	67,067	0		92.00
93.00	04040	OTHER OUTPATIENT SERVICES	29,422	0		93.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	4,445,129	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	4,445,129	0		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1323 | Component CCN: 14-Z323 | Period: From 04/01/2017 To 03/31/2018 | Worksheet D Part V Date/Time Prepared: 8/30/2018 5:54 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	0.620206	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.914106	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.100792	0	0	0	0	54.00
60.00	06000	LABORATORY	0.281921	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.371047	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.779288	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.152569	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	4.086323	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.704058	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.422291	0	0	0	0	73.00
76.00	03020	GERIATRIC PSYCH	0.960714	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
90.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	0	0	90.00
90.01	04951	WOUND CARE	0.709251	0	0	0	0	90.01
90.02	09000	CLINIC	2.203116	0	0	0	0	90.02
91.00	09100	EMERGENCY	0.560316	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2.198557	0	0	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0.208376	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.616892		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: 14-1323 | Component CCN: 14-Z323 | Period: From 04/01/2017 To 03/31/2018 | Worksheet D Part V | Date/Time Prepared: 8/30/2018 5:54 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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
76.00	03020	GERIATRIC PSYCH	0	0		76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
90.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0	0		90.00
90.01	04951	WOUND CARE	0	0		90.01
90.02	09000	CLINIC	0	0		90.02
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0	0		93.00
		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

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1323 | Period: From 04/01/2017 To 03/31/2018 | Worksheet D-1 | Date/Time Prepared: 8/30/2018 5:54 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)	5,136	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	4,296	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)	4,048	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	243	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)	498	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	85	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)	14	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	2,779	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)	243	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)	498	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	132.61	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	132.61	20.00
21.00	Total general inpatient routine service cost (see instructions)	5,940,840	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)	11,272	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)	1,857	25.00
26.00	Total swing-bed cost (see instructions)	885,160	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	5,055,680	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	5,055,680	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)	1,176.83	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	3,270,411	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	3,270,411	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1323 | Period: From 04/01/2017 To 03/31/2018 | Worksheet D-1 | Date/Time Prepared: 8/30/2018 5:54 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)	1,590,366	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	4,860,777	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)	285,970	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	586,061	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	872,031	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)	248	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,176.83	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	291,854	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1323 | Period: From 04/01/2017 To 03/31/2018 | Worksheet D-1 | Date/Time Prepared: 8/30/2018 5:54 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	551,949	5,940,840	0.092908	291,854	27,116	90.00
91.00	Nursing School cost	0	5,940,840	0.000000	291,854	0	91.00
92.00	Allied health cost	0	5,940,840	0.000000	291,854	0	92.00
93.00	All other Medical Education	0	5,940,840	0.000000	291,854	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 14-1323 | Period: From 04/01/2017 To 03/31/2018 | Worksheet D-3 | Date/Time Prepared: 8/30/2018 5:54 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		2,111,483		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.620206	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.914106	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.100792	1,094,345	110,301	54.00
60.00	06000	LABORATORY	0.281921	1,312,395	369,992	60.00
65.00	06500	RESPIRATORY THERAPY	0.371047	1,206,236	447,570	65.00
66.00	06600	PHYSICAL THERAPY	0.779288	84,312	65,703	66.00
69.00	06900	ELECTROCARDIOLOGY	0.152569	412,055	62,867	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	4.086323	9,642	39,400	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.704058	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.422291	1,154,801	487,662	73.00
76.00	03020	GERIATRIC PSYCH	0.960714	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	90.00
90.01	04951	WOUND CARE	0.709251	1,414	1,003	90.01
90.02	09000	CLINIC	2.203116	0	0	90.02
91.00	09100	EMERGENCY	0.560316	8,276	4,637	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2.198557	560	1,231	92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0.208376	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		5,284,036	1,590,366	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)		5,284,036		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 14-1323 | Period: From 04/01/2017 To 03/31/2018 | Worksheet D-3

Component CCN: 14-Z323 | Date/Time Prepared: 8/30/2018 5:54 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	0.620206	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.914106	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.100792	106,327	10,717	54.00
60.00	06000	LABORATORY	0.281921	150,091	42,314	60.00
65.00	06500	RESPIRATORY THERAPY	0.371047	178,776	66,334	65.00
66.00	06600	PHYSICAL THERAPY	0.779288	213,329	166,245	66.00
69.00	06900	ELECTROCARDIOLOGY	0.152569	19,766	3,016	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	4.086323	1,021	4,172	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.704058	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.422291	218,726	92,366	73.00
76.00	03020	GERIATRIC PSYCH	0.960714	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	90.00
90.01	04951	WOUND CARE	0.709251	0	0	90.01
90.02	09000	CLINIC	2.203116	0	0	90.02
91.00	09100	EMERGENCY	0.560316	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2.198557	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0.208376	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		888,036	385,164	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)		888,036		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-1323	Period: From 04/01/2017 To 03/31/2018	Worksheet E Part B Date/Time Prepared: 8/30/2018 5:54 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	4,445,129	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)	4,445,129	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)	4,489,580	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	0	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	46,846	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	2,280,387	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	2,162,347	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	2,162,347	30.00
31.00	Primary payer payments	649	31.00
32.00	Subtotal (line 30 minus line 31)	2,161,698	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)	484,972	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	315,232	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	473,650	36.00
37.00	Subtotal (see instructions)	2,476,930	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		39.50
39.97	Demonstration payment adjustment amount before sequestration	0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	2,476,930	40.00
40.01	Sequestration adjustment (see instructions)	49,539	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
41.00	Interim payments	2,028,676	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	398,715	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-1323 | Period: From 04/01/2017 To 03/31/2018 | Worksheet E-1 Part I | Date/Time Prepared: 8/30/2018 5:54 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		5,114,535		2,090,375	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	11/08/2017	309,466		0	3.01
3.02		03/27/2018	149,652		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	11/08/2017	60,578	3.50
3.51			0	03/27/2018	1,121	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)		459,118		-61,699	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		5,573,653		2,028,676	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		398,715	6.01
6.02	SETTLEMENT TO PROGRAM		1,265,635		0	6.02
7.00	Total Medicare program liability (see instructions)		4,308,018		2,427,391	7.00

			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor	CGS	15101		8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-1323 | Component CCN: 14-Z323 | Period: From 04/01/2017 To 03/31/2018 | Worksheet E-1 Part I | Date/Time Prepared: 8/30/2018 5:54 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		1,367,486		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	11/08/2017	84,931		0	3.01
3.02		03/27/2018	40,509		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)		125,440		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,492,926		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		262,973		0	6.02
7.00	Total Medicare program liability (see instructions)		1,229,953		0	7.00

			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor	CGS	15101		8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 14-1323	Period: From 04/01/2017 To 03/31/2018	Worksheet E-1 Part II Date/Time Prepared: 8/30/2018 5:54 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: 14-1323 | Component CCN: 14-Z323 | Period: From 04/01/2017 To 03/31/2018 | Worksheet E-2 | Date/Time Prepared: 8/30/2018 5:54 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)	880,751	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)	389,016	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	741	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)	1,269,767	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	1,269,767	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)	1,269,767	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	14,713	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)	1,255,054	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)	1,255,054	0	19.00
19.01	Sequestration adjustment (see instructions)	25,101	0	19.01
19.02	Demonstration payment adjustment amount after sequestration)	0	0	19.02
20.00	Interim payments	1,492,926	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)	-262,973	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: 14-1323	Period: From 04/01/2017 To 03/31/2018	Worksheet E-3 Part V Date/Time Prepared: 8/30/2018 5:54 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	4,860,777	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)	4,860,777	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	4,909,385	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)	4,909,385	19.00
20.00	Deductibles (exclude professional component)	589,220	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	4,320,165	22.00
23.00	Coinsurance	1,340	23.00
24.00	Subtotal (line 22 minus line 23)	4,318,825	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	118,634	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	77,112	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	112,996	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	4,395,937	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)	4,395,937	30.00
30.01	Sequestration adjustment (see instructions)	87,919	30.01
30.02	Demonstration payment adjustment amount after sequestration	0	30.02
31.00	Interim payments	5,573,653	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)	-1,265,635	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	34.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only)

Provider CCN: 14-1323 | Period: From 04/01/2017 To 03/31/2018 | Worksheet G | Date/Time Prepared: 8/30/2018 5:54 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	16,300,566	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	12,124,168	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-6,045,767	0	0	0	6.00
7.00	Inventory	410,792	0	0	0	7.00
8.00	Prepaid expenses	358,837	0	0	0	8.00
9.00	Other current assets	69,771	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)	23,218,367	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	65,980	0	0	0	12.00
13.00	Land improvements	1,103,982	0	0	0	13.00
14.00	Accumulated depreciation	-803,315	0	0	0	14.00
15.00	Buildings	17,370,221	0	0	0	15.00
16.00	Accumulated depreciation	-8,382,741	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	9,484,955	0	0	0	23.00
24.00	Accumulated depreciation	-6,900,044	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	89,307	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	12,028,345	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	366,842	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	366,842	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	35,613,554	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	333,090	0	0	0	37.00
38.00	Salaries, wages, and fees payable	0	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	1,743,958	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	2,513,453	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	4,590,501	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	9,031,597	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	301,532	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	9,333,129	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	13,923,630	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	21,689,924				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)	21,689,924	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	35,613,554	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 14-1323 | Period: From 04/01/2017 To 03/31/2018 | Worksheet G-1 | Date/Time Prepared: 8/30/2018 5:54 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		20,222,310		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		930,731				2.00
3.00	Total (sum of line 1 and line 2)		21,153,041		0		3.00
4.00	NON OPERATING EQUITY ADJ	536,883		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)		536,883		0		10.00
11.00	Subtotal (line 3 plus line 10)		21,689,924		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)		21,689,924		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	NON OPERATING EQUITY ADJ		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: 14-1323 | Period: From 04/01/2017 To 03/31/2018 | Worksheet G-2 Parts I & II Date/Time Prepared: 8/30/2018 5:54 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	3,461,873		3,461,873	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	339,040		339,040	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)	3,800,913		3,800,913	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)	3,800,913		3,800,913	17.00
18.00	Ancillary services	13,210,438	33,710,491	46,920,929	18.00
19.00	Outpatient services	0	0	0	19.00
20.00	RURAL HEALTH CLINIC	0	2,528,470	2,528,470	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES	0	1,929,465	1,929,465	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	17,011,351	38,168,426	55,179,777	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		24,528,974		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	OTHER	292,258			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)		292,258		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		24,236,716		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 14-1323 | Period: From 04/01/2017 To 03/31/2018 | Worksheet G-3 | Date/Time Prepared: 8/30/2018 5:54 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	55,179,777	1.00
2.00	Less contractual allowances and discounts on patients' accounts	30,518,315	2.00
3.00	Net patient revenues (line 1 minus line 2)	24,661,462	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	24,236,716	4.00
5.00	Net income from service to patients (line 3 minus line 4)	424,746	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	103,536	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER OPERATING REVENUE	402,449	24.00
25.00	Total other income (sum of lines 6-24)	505,985	25.00
26.00	Total (line 5 plus line 25)	930,731	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)	930,731	29.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1323 | Component CCN: 14-3478 | Period: From 04/01/2017 To 03/31/2018 | Worksheet M-1 | Date/Time Prepared: 8/30/2018 5:54 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	293,099	0	293,099	0	293,099	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	179,848	0	179,848	0	179,848	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	0	0	0	0	0	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	472,947	0	472,947	0	472,947	10.00
11.00	Physician Services Under Agreement	361,308	0	361,308	0	361,308	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	96,737	96,737	0	96,737	13.00
14.00	Subtotal (sum of lines 11 through 13)	361,308	96,737	458,045	0	458,045	14.00
15.00	Medical Supplies	0	39,074	39,074	0	39,074	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	61,061	61,061	0	61,061	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	100,135	100,135	0	100,135	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	834,255	196,872	1,031,127	0	1,031,127	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
25.01	Telehealth	0	0	0	0	0	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	19,870	19,870	0	19,870	29.00
30.00	Administrative Costs	200,729	42,886	243,615	0	243,615	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	200,729	62,756	263,485	0	263,485	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	1,034,984	259,628	1,294,612	0	1,294,612	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1323 | Component CCN: 14-3478 | Period: From 04/01/2017 To 03/31/2018 | Worksheet M-1 | Date/Time Prepared: 8/30/2018 5:54 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	293,099		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	179,848		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	0		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	0		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	472,947		10.00
11.00	Physician Services Under Agreement	0	361,308		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	96,737		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	458,045		14.00
15.00	Medical Supplies	0	39,074		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	61,061		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	100,135		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	1,031,127		22.00
	COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
25.01	Telehealth	0	0		25.01
25.02	Chronic Care Management	0	0		25.02
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs				27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	19,870		29.00
30.00	Administrative Costs	0	243,615		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	263,485		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	1,294,612		32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1323 | Component CCN: 14-3478 | Period: From 04/01/2017 To 03/31/2018 | Worksheet M-2 | Date/Time Prepared: 8/30/2018 5:54 pm

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	RHC I 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	1.90	6,435	4,200	7,980		1.00
2.00	Physician Assistant	1.70	7,533	2,100	3,570		2.00
3.00	Nurse Practitioner	0.00	0	2,100	0		3.00
4.00	Subtotal (sum of lines 1 through 3)	3.60	13,968		11,550	13,968	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	3.60	13,968			13,968	8.00
9.00	Physician Services Under Agreements		0			0	9.00
						1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)					1,031,127	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					1,031,127	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)					263,485	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					941,249	15.00
16.00	Total overhead (sum of lines 14 and 15)					1,204,734	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					1,204,734	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					1,204,734	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					2,235,861	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 14-1323 Component CCN: 14-3478	Period: From 04/01/2017 To 03/31/2018	Worksheet M-3 Date/Time Prepared: 8/30/2018 5:54 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)				2,235,861	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)				0	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)				2,235,861	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)				13,968	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)				13,968	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)				160.07	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	0.00	8.00
9.00	Rate for Program covered visits (see instructions)	160.07	160.07	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	3,058	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	489,494	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	489,494	16.00
16.01	Total program charges (see instructions)(from contractor's records)		244,228	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		0	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		0	16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)		373,228	16.04
16.05	Total program cost (see instructions)	0	373,228	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		22,959	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		44,254	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		373,228	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		0	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		373,228	22.00
23.00	Allowable bad debts (see instructions)		17,996	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		11,697	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		13,926	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)		384,925	26.00
26.01	Sequestration adjustment (see instructions)		7,699	26.01
26.02	Demonstration payment adjustment amount after sequestration		0	26.02
27.00	Interim payments		306,754	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)		70,472	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0	30.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 14-1323 Component CCN: 14-3478	Period: From 04/01/2017 To 03/31/2018	Worksheet M-5 Date/Time Prepared: 8/30/2018 5:54 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			345,150	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			11/08/2017	32,582	3.50
3.51			03/27/2018	5,814	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)			-38,396	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)			306,754	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			70,472	6.01
6.02	SETTLEMENT TO PROGRAM			0	6.02
7.00	Total Medicare program liability (see instructions)			377,226	7.00

			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor	CGS	15101		8.00