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: 14-1327	Period: From 01/01/2018 To 12/31/2018	Worksheet S Parts I-III Date/Time Prepared: 5/29/2019 3:08 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 5/29/2019 Time: 3:08 pm
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by WABASH GENERAL HOSPITAL (14-1327) for the cost reporting period beginning 01/01/2018 and ending 12/31/2018 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

(Signed) KARISSA TURNER
Officer or Administrator of Provider(s)

CEO
Title

(Dated when report is electronically signed.)
Date

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	39,814	593,685	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	16,984	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
10.00	RURAL HEALTH CLINIC I	0		1,262		0	10.00
10.01	RURAL HEALTH CLINIC II	0		216,709		0	10.01
10.02	RURAL HEALTH CLINIC III	0		-63,785		0	10.02
200.00	Total	0	56,798	747,871	0	0	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1327 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part I Date/Time Prepared: 5/29/2019 3:08 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 1418 COLLEGE DRIVE	PO Box:			1.00
2.00	City: MT. CARMEL	State: IL	Zip Code: 62863-	County: WABASH	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	WABASH GENERAL HOSPITAL	141327	99914	1	06/01/2003	N	O	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	WABASH GENERAL HOSPITAL SWING BEDS	14Z327	14999		06/01/2003	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	WABASH GENERAL RHC	148501	14999		04/01/2009	N	O	N	15.00
15.01	Hospital-Based Health Clinic - RHC II	WABASH PRIMARY CARE	148568	14999		08/09/2016	N	O	N	15.01
15.02	Hospital-Based Health Clinic - RHC III	WABASH PRIMARY CARE - COLLEGE DR	148579	14999		10/01/2017	N	O	N	15.02
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

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

		1.00	2.00	3.00	
	Inpatient PPS Information				
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	N	N		22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	N	N		22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N		22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.	N	N	N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	2	N		23.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1327 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part I Date/Time Prepared: 5/29/2019 3:08 pm

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1327 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part I | Date/Time Prepared: 5/29/2019 3:08 pm

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 14-1327	Period: From 01/01/2018 To 12/31/2018	Worksheet S-2 Part I Date/Time Prepared: 5/29/2019 3:08 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: 14-1327	Period: From 01/01/2018 To 12/31/2018	Worksheet S-2 Part I Date/Time Prepared: 5/29/2019 3:08 pm

			1.00	
	Long Term Care Hospital PPS			
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.		N	80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.		N	81.00
	TEFRA Providers			
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.		N	85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.			86.00
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.		N	87.00
		V	XIX	
		1.00	2.00	
	Title V and XIX Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.06
	Rural Providers			
105.00	Does this hospital qualify as a CAH?	Y		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N		106.00
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II.	N		107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	Y		108.00

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

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

Line	Description	1.00	2.00	Line
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

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

Line	Description	Premiums 1.00	Losses 2.00	Insurance 3.00	Line
118.01	List amounts of malpractice premiums and paid losses:	187,101	0	0	118.01

Line	Description	1.00	2.00	Line
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)	Y		140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1327 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part I Date/Time Prepared: 5/29/2019 3:08 pm

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

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

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

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

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

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

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

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

		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	01/01/2017	12/31/2017	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: 14-1327	Period: From 01/01/2018 To 12/31/2018	Worksheet S-2 Part II Date/Time Prepared: 5/29/2019 3:08 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	C		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00

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

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

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	Y	03/29/2019	Y	03/29/2019	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: 14-1327	Period: From 01/01/2018 To 12/31/2018	Worksheet S-2 Part II Date/Time Prepared: 5/29/2019 3:08 pm

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 14-1327	Period: From 01/01/2018 To 12/31/2018	Worksheet S-2 Part II Date/Time Prepared: 5/29/2019 3:08 pm

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 14-1327 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-3 Part I Date/Time Prepared: 5/29/2019 3:08 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	21	7,665	52,080.00	0	1.00
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		21	7,665	52,080.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	4	1,460	1,560.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)		25	9,125	53,640.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	88.00				0	26.00
26.01	RURAL HEALTH CLINIC II	88.01				0	26.01
26.02	RURAL HEALTH CLINIC III	88.02				0	26.02
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: 14-1327 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-3 Part I Date/Time Prepared: 5/29/2019 3:08 pm

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	1,301	104	2,170			1.00
2.00	HMO and other (see instructions)	112	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	231	0	279			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,532	104	2,449			7.00
8.00	INTENSIVE CARE UNIT	19	0	65			8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	1,551	104	2,514	0.00	264.14	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	271	0	3,806	0.00	1.47	26.00
26.01	RURAL HEALTH CLINIC II	2,468	0	10,794	0.00	21.51	26.01
26.02	RURAL HEALTH CLINIC III	4,632	0	8,376	0.00	7.59	26.02
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	294.71	27.00
28.00	Observation Bed Days		0	160			28.00
29.00	Ambulance Trips	655					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

	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	428	47	676	1.00
2.00	HMO and other (see instructions)			37	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	428	47	676	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	0.00					26.00
26.01	RURAL HEALTH CLINIC II	0.00					26.01
26.02	RURAL HEALTH CLINIC III	0.00					26.02
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: 14-1327 Component CCN: 14-8501	Period: From 01/01/2018 To 12/31/2018	Worksheet S-8 Date/Time Prepared: 5/29/2019 3:08 pm
		RHC I	Cost

Line	Description		1.00	Line
	Clinic Address and Identification			
1.00	Street		1418 COLLEGE DRIVE	1.00

Line	Description	City 1.00	State 2.00	ZIP Code 3.00	Line
2.00	City, State, ZIP Code, County	MT.CARMEL	IL	62863	2.00

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

Line	Description	Grant Award 1.00	Date 2.00	Line
	Source of Federal Funds			
4.00	Community Health Center (Section 330(d), PHS Act)			4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)			5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)			6.00
7.00	Appalachian Regional Commission			7.00
8.00	Look-Alikes			8.00
9.00	OTHER (SPECIFY)			9.00
9.01				9.01
9.02				9.02
9.03				9.03
9.04				9.04
9.05				9.05
9.06				9.06
9.07				9.07
9.08				9.08
9.09				9.09
9.10				9.10

Line	Description	1.00	2.00	Line
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

Line	Description	Sunday from 1.00	Sunday to 2.00	Monday from 3.00	Monday to 4.00	Tuesday from 5.00	Line
	Facility hours of operations (1)						
11.00	CLINIC	10:00	22:00	15:00	21:00	15:00	11.00

Line	Description	1.00	2.00	Line
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

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

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

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-1327	Period: From 01/01/2018 To 12/31/2018
Component CCN: 14-8501	Worksheet S-8; Date/Time Prepared: 5/29/2019 3:08 pm
RHC I	Cost

		County	
		4.00	
2.00	City, State, ZIP Code, County	WABASH	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	21:00	18:00	21:00	18:00	21:00	11.00

		Friday		Saturday		
		from	to	from	to	
		11.00	12.00	13.00	14.00	
	Facility hours of operations (1)					
11.00	CLINIC	15:00	21:00	10:00	22:00	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 14-1327 | Component CCN: 14-8568 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-8 | Date/Time Prepared: 5/29/2019 3:08 pm

RHC II | Cost

		1.00	
	Clinic Address and Identification		
1.00	Street	1123 CHESTNUT STREET	1.00

		City	State	ZIP Code	
		1.00	2.00	3.00	
2.00	City, State, ZIP Code, County	MOUNT CARMEL	IL	62863-1212	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	WABASH	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	18:00	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 14-1327 | Component CCN: 14-8568 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-8 | Date/Time Prepared: 5/29/2019 3:08 pm

RHC II | Cost

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

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-1327 | Component CCN: 14-8579 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-8 | Date/Time Prepared: 5/29/2019 3:08 pm

RHC III | Cost

		1.00	
	Clinic Address and Identification		
1.00	Street	1418 COLLEGE DR	1.00

		City	State	ZIP Code	
		1.00	2.00	3.00	
2.00	City, State, ZIP Code, County	MOUNT CARMEL	IL	62863	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 from	Sunday to	Monday from	Monday to	Tuesday 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	WABASH	2.00

		Tuesday to	Wednesday from	Wednesday to	Thursday from	Thursday 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: 14-1327 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-8
Component CCN: 14-8579 | | Date/Time Prepared: 5/29/2019 3:08 pm

RHC III | 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	17:00				11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 14-1327	Period: From 01/01/2018 To 12/31/2018	Worksheet S-10 Date/Time Prepared: 5/29/2019 3:08 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)	0.395003	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	4,458,442	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	15,343,286	6.00
7.00	Medicaid cost (line 1 times line 6)	6,060,644	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)	1,602,202	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)	1,602,202	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)	84,313	0	84,313	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	33,304	0	33,304	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)	33,304	0	33,304	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)	3,979,630	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	241,259	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	371,167	27.01
28.00	Non-Medicare bad debt expense (see instructions)	3,608,463	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	1,555,262	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	1,588,566	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	3,190,768	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-1327 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A | Date/Time Prepared: 5/29/2019 3:08 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		1,118,454	1,118,454	0	1,118,454	1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		766,324	766,324	778,390	1,544,714	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	210,876	4,580,998	4,791,874	0	4,791,874	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,344,977	4,757,173	6,102,150	-96,292	6,005,858	5.00
7.00	00700	OPERATION OF PLANT	265,260	1,201,482	1,466,742	15,833	1,482,575	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	129,628	129,628	8.00
9.00	00900	HOUSEKEEPING	258,193	62,915	321,108	0	321,108	9.00
10.00	01000	DIETARY	359,037	224,499	583,536	-459,063	124,473	10.00
11.00	01100	CAFETERIA	0	0	0	457,993	457,993	11.00
13.00	01300	NURSING ADMINISTRATION	262,957	12,646	275,603	0	275,603	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	473,725	58,516	532,241	-1,672	530,569	16.00
17.00	01700	SOCIAL SERVICE	149,491	8,346	157,837	0	157,837	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	800,354	96,000	896,354	-6,321	890,033	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,323,023	993,705	2,316,728	-50,440	2,266,288	30.00
31.00	03100	INTENSIVE CARE UNIT	255,819	1,992	257,811	-1,550	256,261	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	824,864	3,431,353	4,256,217	-2,718,277	1,537,940	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	806,084	1,033,628	1,839,712	-131,248	1,708,464	54.00
60.00	06000	LABORATORY	786,856	831,920	1,618,776	-160,953	1,457,823	60.00
65.00	06500	RESPIRATORY THERAPY	572,389	153,050	725,439	-20,803	704,636	65.00
66.00	06600	PHYSICAL THERAPY	972,670	214,778	1,187,448	-3,439	1,184,009	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	214,106	467,640	681,746	177,029	858,775	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	2,614,168	2,614,168	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	407,480	2,255,677	2,663,157	-1,632	2,661,525	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	78,504	136,609	215,113	0	215,113	88.00
88.01	08802	RURAL HEALTH CLINIC II	1,624,002	332,066	1,956,068	0	1,956,068	88.01
88.02	08801	RURAL HEALTH CLINIC III	794,474	73,702	868,176	0	868,176	88.02
90.00	09000	CLINIC	254,786	240,003	494,789	-13,609	481,180	90.00
90.01	09001	ORTHOPAEDIC CLINIC	3,425,307	516,040	3,941,347	-64,426	3,876,921	90.01
90.02	09002	SURGICAL CLINIC	698,173	94,827	793,000	-8,115	784,885	90.02
90.03	09003	OP CLINIC	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	938,654	1,258,081	2,196,735	-51,553	2,145,182	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	612,924	135,304	748,228	-34,022	714,206	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		328,661	328,661	-328,661	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	18,714,985	25,386,389	44,101,374	20,965	44,122,339	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	406,650	310,690	717,340	-20,965	696,375	192.00
200.00		TOTAL (SUM OF LINES 118 through 199)	19,121,635	25,697,079	44,818,714	0	44,818,714	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-1327 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A | Date/Time Prepared: 5/29/2019 3:08 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
	GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	0	1,118,454	1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	-128,702	1,416,012	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-473,443	4,318,431	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-248,415	5,757,443	5.00
7.00	00700	OPERATION OF PLANT	0	1,482,575	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	129,628	8.00
9.00	00900	HOUSEKEEPING	0	321,108	9.00
10.00	01000	DIETARY	0	124,473	10.00
11.00	01100	CAFETERIA	-102,783	355,210	11.00
13.00	01300	NURSING ADMINISTRATION	0	275,603	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-20,410	510,159	16.00
17.00	01700	SOCIAL SERVICE	0	157,837	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	-800,354	89,679	19.00
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-886,351	1,379,937	30.00
31.00	03100	INTENSIVE CARE UNIT	0	256,261	31.00
	ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	1,537,940	50.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-2,742	1,705,722	54.00
60.00	06000	LABORATORY	-70,752	1,387,071	60.00
65.00	06500	RESPIRATORY THERAPY	-22,812	681,824	65.00
66.00	06600	PHYSICAL THERAPY	0	1,184,009	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	-1,410	857,365	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	2,614,168	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-1,158	2,660,367	73.00
	OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	215,113	88.00
88.01	08802	RURAL HEALTH CLINIC II	0	1,956,068	88.01
88.02	08801	RURAL HEALTH CLINIC III	0	868,176	88.02
90.00	09000	CLINIC	-165,500	315,680	90.00
90.01	09001	ORTHOPAEDIC CLINIC	-2,691,841	1,185,080	90.01
90.02	09002	SURGICAL CLINIC	-593,168	191,717	90.02
90.03	09003	OP CLINIC	0	0	90.03
91.00	09100	EMERGENCY	0	2,145,182	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
	OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0	714,206	95.00
	SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-6,209,841	37,912,498	118.00
	NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	696,375	192.00
200.00		TOTAL (SUM OF LINES 118 through 199)	-6,209,841	38,608,873	200.00

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - RENT				
1.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	363,036	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
	0		0	363,036	
	B - CAFETERIA				
1.00	CAFETERIA	11.00	282,311	175,682	1.00
	0		282,311	175,682	
	E - INTEREST				
1.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	328,661	1.00
	0		0	328,661	
	F - OXYGEN				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	4,155	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
	0		0	4,155	
	G - MED SUPPLIES				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	302,502	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
	0		0	302,502	
	H - UTILITIES				
1.00	OPERATION OF PLANT	7.00	0	17,545	1.00
2.00		0.00	0	0	2.00
	0		0	17,545	
	I - IMPLANTS				
1.00	IMPL. DEV. CHARGED TO PATIENT	72.00	0	2,614,168	1.00
	0		0	2,614,168	
	J - LINEN				
1.00	LAUNDRY & LINEN SERVICE	8.00	0	129,628	1.00
	0		0	129,628	
	L - INSURANCE				
1.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	86,693	1.00
	0		0	86,693	
500.00	Grand Total: Increases		282,311	4,022,070	500.00

RECLASSIFICATIONS

Provider CCN: 14-1327 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-6 | Date/Time Prepared: 5/29/2019 3:08 pm

	Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
	A - RENT					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	9,599	10	1.00
2.00	OPERATION OF PLANT	7.00	0	1,712	0	2.00
3.00	DIETARY	10.00	0	1,070	0	3.00
4.00	MEDICAL RECORDS & LIBRARY	16.00	0	1,672	0	4.00
5.00	ADULTS & PEDIATRICS	30.00	0	1,673	0	5.00
6.00	OPERATING ROOM	50.00	0	9,973	0	6.00
7.00	RADIOLOGY-DIAGNOSTIC	54.00	0	111,003	0	7.00
8.00	LABORATORY	60.00	0	126,425	0	8.00
9.00	RESPIRATORY THERAPY	65.00	0	14,535	0	9.00
10.00	DRUGS CHARGED TO PATIENTS	73.00	0	305	0	10.00
11.00	ORTHOPAEDIC CLINIC	90.01	0	46,935	0	11.00
12.00	AMBULANCE SERVICES	95.00	0	26,599	0	12.00
13.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	11,535	0	13.00
	0		0	363,036		
	B - CAFETERIA					
1.00	DIETARY	10.00	282,311	175,682	0	1.00
	0		282,311	175,682		
	E - INTEREST					
1.00	INTEREST EXPENSE	113.00	0	328,661	9	1.00
	0		0	328,661		
	F - OXYGEN					
1.00	OPERATING ROOM	50.00	0	21	0	1.00
2.00	RESPIRATORY THERAPY	65.00	0	3,632	0	2.00
3.00	AMBULANCE SERVICES	95.00	0	502	0	3.00
	0		0	4,155		
	G - MED SUPPLIES					
1.00	NONPHYSICIAN ANESTHETISTS	19.00	0	6,321	0	1.00
2.00	ADULTS & PEDIATRICS	30.00	0	48,767	0	2.00
3.00	INTENSIVE CARE UNIT	31.00	0	1,550	0	3.00
4.00	OPERATING ROOM	50.00	0	94,115	0	4.00
5.00	RADIOLOGY-DIAGNOSTIC	54.00	0	20,245	0	5.00
6.00	LABORATORY	60.00	0	34,528	0	6.00
7.00	RESPIRATORY THERAPY	65.00	0	2,636	0	7.00
8.00	PHYSICAL THERAPY	66.00	0	3,439	0	8.00
9.00	DRUGS CHARGED TO PATIENTS	73.00	0	1,327	0	9.00
10.00	CLINIC	90.00	0	13,609	0	10.00
11.00	ORTHOPAEDIC CLINIC	90.01	0	17,491	0	11.00
12.00	EMERGENCY	91.00	0	51,553	0	12.00
13.00	AMBULANCE SERVICES	95.00	0	6,921	0	13.00
	0		0	302,502		
	H - UTILITIES					
1.00	SURGICAL CLINIC	90.02	0	8,115	0	1.00
2.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	9,430	0	2.00
	0		0	17,545		
	I - IMPLANTS					
1.00	OPERATING ROOM	50.00	0	2,614,168	0	1.00
	0		0	2,614,168		
	J - LINEN					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	129,628	0	1.00
	0		0	129,628		
	L - INSURANCE					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	86,693	9	1.00
	0		0	86,693		
500.00	Grand Total: Decreases		282,311	4,022,070		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1327 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-7 Part I Date/Time Prepared: 5/29/2019 3:08 pm

		Beginning Balances	Acquisitions Purchases	Donation	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	467,367	0	0	0	0	1.00
2.00	Land Improvements	1,994,371	93,692	0	93,692	0	2.00
3.00	Buildings and Fixtures	23,010,209	2,414,052	0	2,414,052	0	3.00
4.00	Building Improvements	0	26,944	0	26,944	0	4.00
5.00	Fixed Equipment	4,658,917	207,521	0	207,521	0	5.00
6.00	Movable Equipment	13,853,963	1,316,952	0	1,316,952	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	43,984,827	4,059,161	0	4,059,161	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	43,984,827	4,059,161	0	4,059,161	0	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	467,367	0	1.00
2.00	Land Improvements	2,088,063	0	2.00
3.00	Buildings and Fixtures	25,424,261	0	3.00
4.00	Building Improvements	26,944	0	4.00
5.00	Fixed Equipment	4,866,438	0	5.00
6.00	Movable Equipment	15,170,915	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	48,043,988	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	48,043,988	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1327 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-7 Part II | Date/Time Prepared: 5/29/2019 3:08 pm

	Cost Center Description	SUMMARY OF CAPITAL Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1,118,454	0	0	0	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	766,324	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	1,884,778	0	0	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
		14.00	15.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2			
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	1,118,454	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	766,324	2.00
3.00	Total (sum of lines 1-2)	0	1,884,778	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1327 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-7 Part III Date/Time Prepared: 5/29/2019 3:08 pm

	Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	32,873,073	0	32,873,073	0.684229	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	15,170,915	0	15,170,915	0.315771	0	2.00
3.00	Total (sum of lines 1-2)	48,043,988	0	48,043,988	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	1,118,454	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	1,052,976	363,036	2.00
3.00	Total (sum of lines 1-2)	0	0	0	2,171,430	363,036	3.00

	Cost Center Description	SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	0	1,118,454	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	1,416,012	2.00
3.00	Total (sum of lines 1-2)	0	0	0	0	2,534,466	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-1327 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-8 | Date/Time Prepared: 5/29/2019 3:08 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)	B	-144,691	NEW CAP REL COSTS-MVBLE EQUIP	2.00	9	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)	B	-5,256	ADMINISTRATIVE & GENERAL	5.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-4,432,804			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	-362			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-102,783	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients	B	-1,410	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	16.00
17.00	Sale of drugs to other than patients	B	-1,158	DRUGS CHARGED TO PATIENTS	73.00	0	17.00
18.00	Sale of medical records and abstracts	B	-20,410	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - NEW CAP REL COSTS-BLDG & FIXT		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - NEW CAP REL COSTS-MVBLE EQUIP		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	68.00		31.00

ADJUSTMENTS TO EXPENSES	Provider CCN: 14-1327	Period: From 01/01/2018 To 12/31/2018	Worksheet A-8 Date/Time Prepared: 5/29/2019 3:08 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
				Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.00
34.00	A&G OTHER REVENUE	B	-44,405	ADMINISTRATIVE & GENERAL	5.00	0	34.00
35.00	PHYSICIAN RECRUITMENT	A	-184,251	ADMINISTRATIVE & GENERAL	5.00	0	35.00
36.00	PHYSICIAN RECRUITMENT	A	-165,807	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	36.00
36.01	PUBLIC RELATIONS	A	-198,548	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	36.01
37.00	LOBBYING DUES	A	-14,503	ADMINISTRATIVE & GENERAL	5.00	0	37.00
38.00	CRNA SALARY	A	-800,354	NONPHYSICIAN ANESTHETISTS	19.00	0	38.00
39.00	CRNA EMP BEN	A	-109,088	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	39.00
40.00	BOND INSURANCE	A	15,989	NEW CAP REL COSTS-MVBLE EQUIP	2.00	9	40.00
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-6,209,841				50.00

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	Provider CCN: 14-1327	Period: From 01/01/2018 To 12/31/2018	Worksheet A-8-1 Date/Time Prepared: 5/29/2019 3:08 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	54.00	RADIOLOGY-DIAGNOSTIC	DSS MRI	294,863	295,225	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		0	294,863	295,225	5.00

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

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

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

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

	Symbol (1)	Name	Percentage of Ownership	Name	Percentage of Ownership	
6.00	A	DSS MRI	100.00		0.00	6.00
7.00			0.00		0.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	Provider CCN: 14-1327	Period: From 01/01/2018 To 12/31/2018	Worksheet A-8-1 Date/Time Prepared: 5/29/2019 3:08 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.	
	6.00	7.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:		
1.00	-362	0	1.00
2.00	0	0	2.00
3.00	0	0	3.00
4.00	0	0	4.00
5.00	-362		5.00

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

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

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

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

6.00			6.00
7.00			7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 14-1327 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-8-2 Date/Time Prepared: 5/29/2019 3:08 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	886,351	886,351	0	0	0	1.00
2.00	54.00	RADIOLOGY-DIAGNOSTIC	2,380	2,380	0	0	0	2.00
3.00	60.00	LABORATORY	70,752	70,752	0	0	0	3.00
4.00	65.00	RESPIRATORY THERAPY	22,812	22,812	0	0	0	4.00
5.00	90.00	CLINIC	165,500	165,500	0	0	0	5.00
6.00	90.01	ORTHOPAEDIC CLINIC	2,912,386	2,691,841	220,545	0	0	6.00
7.00	90.02	SURGICAL CLINIC	612,895	593,168	19,727	0	0	7.00
8.00	91.00	EMERGENCY	1,129,000	0	1,129,000	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			5,802,076	4,432,804	1,369,272		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	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	2.00
3.00	60.00	LABORATORY	0	0	0	0	0	3.00
4.00	65.00	RESPIRATORY THERAPY	0	0	0	0	0	4.00
5.00	90.00	CLINIC	0	0	0	0	0	5.00
6.00	90.01	ORTHOPAEDIC CLINIC	0	0	0	0	0	6.00
7.00	90.02	SURGICAL CLINIC	0	0	0	0	0	7.00
8.00	91.00	EMERGENCY	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	886,351	1.00
2.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	2,380	2.00
3.00	60.00	LABORATORY	0	0	0	70,752	3.00
4.00	65.00	RESPIRATORY THERAPY	0	0	0	22,812	4.00
5.00	90.00	CLINIC	0	0	0	165,500	5.00
6.00	90.01	ORTHOPAEDIC CLINIC	0	0	0	2,691,841	6.00
7.00	90.02	SURGICAL CLINIC	0	0	0	593,168	7.00
8.00	91.00	EMERGENCY	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	4,432,804	200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1327 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part I Date/Time Prepared: 5/29/2019 3:08 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS NEW BLDG & FIXT	NEW MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	1,118,454	1,118,454				1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	1,416,012		1,416,012			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4,318,431	5,300	6,710	4,330,441		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5,757,443	72,377	91,632	321,601	6,243,053	5.00
7.00	00700	OPERATION OF PLANT	1,482,575	42,962	54,392	63,427	1,643,356	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	129,628	0	0	0	129,628	8.00
9.00	00900	HOUSEKEEPING	321,108	4,209	5,329	61,737	392,383	9.00
10.00	01000	DIETARY	124,473	32,874	41,619	18,346	217,312	10.00
11.00	01100	CAFETERIA	355,210	13,224	16,743	67,504	452,681	11.00
13.00	01300	NURSING ADMINISTRATION	275,603	2,488	3,150	62,876	344,117	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	510,159	14,537	18,404	113,274	656,374	16.00
17.00	01700	SOCIAL SERVICE	157,837	3,033	3,840	35,745	200,455	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	89,679	0	0	0	89,679	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,379,937	134,494	170,275	316,352	2,001,058	30.00
31.00	03100	INTENSIVE CARE UNIT	256,261	13,582	17,196	61,170	348,209	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,537,940	210,638	266,675	197,236	2,212,489	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,705,722	44,956	56,917	192,745	2,000,340	54.00
60.00	06000	LABORATORY	1,387,071	32,056	40,584	188,147	1,647,858	60.00
65.00	06500	RESPIRATORY THERAPY	681,824	14,077	17,822	136,866	850,589	65.00
66.00	06600	PHYSICAL THERAPY	1,184,009	69,531	88,029	232,578	1,574,147	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	857,365	40,065	50,724	51,196	999,350	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	2,614,168	0	0	0	2,614,168	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,660,367	9,458	11,975	97,434	2,779,234	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	215,113	15,917	20,152	18,771	269,953	88.00
88.01	08802	RURAL HEALTH CLINIC II	1,956,068	0	0	388,320	2,344,388	88.01
88.02	08801	RURAL HEALTH CLINIC III	868,176	68,167	86,303	189,969	1,212,615	88.02
90.00	09000	CLINIC	315,680	34,612	43,820	60,923	455,035	90.00
90.01	09001	ORTHOPAEDIC CLINIC	1,185,080	132,091	167,233	819,045	2,303,449	90.01
90.02	09002	SURGICAL CLINIC	191,717	0	0	166,942	358,659	90.02
90.03	09003	OP CLINIC	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	2,145,182	38,105	48,243	224,444	2,455,974	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	714,206	60,805	76,982	146,558	998,551	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	37,912,498	1,109,558	1,404,749	4,233,206	37,795,104	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	3,749	4,747	0	8,496	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	696,375	5,147	6,516	97,235	805,273	192.00
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	38,608,873	1,118,454	1,416,012	4,330,441	38,608,873	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1327 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part I Date/Time Prepared: 5/29/2019 3:08 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	6,243,053					5.00
7.00	00700	OPERATION OF PLANT	316,987	1,960,343				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	25,004	0	154,632			8.00
9.00	00900	HOUSEKEEPING	75,687	9,031	819	477,920		9.00
10.00	01000	DIETARY	41,917	70,528	2,188	17,274	349,219	10.00
11.00	01100	CAFETERIA	87,318	28,372	0	6,949	0	11.00
13.00	01300	NURSING ADMINISTRATION	66,377	5,338	0	1,307	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	126,608	31,187	0	7,638	0	16.00
17.00	01700	SOCIAL SERVICE	38,666	6,508	0	1,594	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	17,298	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	385,984	288,547	59,683	70,672	339,073	30.00
31.00	03100	INTENSIVE CARE UNIT	67,166	29,140	0	7,137	10,146	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	426,767	451,906	29,369	110,682	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	385,846	96,450	17,299	23,623	0	54.00
60.00	06000	LABORATORY	317,855	68,773	684	16,844	0	60.00
65.00	06500	RESPIRATORY THERAPY	164,070	30,200	3,404	7,397	0	65.00
66.00	06600	PHYSICAL THERAPY	303,637	149,173	11,242	36,536	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	192,765	85,957	0	21,053	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	504,247	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	536,095	20,292	0	4,970	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	52,071	0	0	0	0	88.00
88.01	08802	RURAL HEALTH CLINIC II	452,209	0	304	0	0	88.01
88.02	08801	RURAL HEALTH CLINIC III	233,901	0	0	0	0	88.02
90.00	09000	CLINIC	87,772	74,257	1,166	18,187	0	90.00
90.01	09001	ORTHOPAEDIC CLINIC	444,312	283,392	0	69,409	0	90.01
90.02	09002	SURGICAL CLINIC	69,182	0	0	0	0	90.02
90.03	09003	OP CLINIC	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	473,733	81,753	27,114	20,023	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	192,611	130,453	904	31,951	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	6,086,085	1,941,257	154,176	473,246	349,219	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,639	8,044	0	1,970	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	155,329	11,042	456	2,704	0	192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	6,243,053	1,960,343	154,632	477,920	349,219	202.00

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	
			11.00	13.00	16.00	17.00	19.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	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	575,320					11.00
13.00	01300	NURSING ADMINISTRATION	7,913	425,052				13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	36,243	0	858,050			16.00
17.00	01700	SOCIAL SERVICE	7,230	0	0	254,453		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	106,977	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	84,463	180,413	98,203	247,053	0	30.00
31.00	03100	INTENSIVE CARE UNIT	14,150	30,224	0	7,400	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	48,965	104,589	160,808	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	106,977	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	41,704	0	143,622	0	0	54.00
60.00	06000	LABORATORY	43,007	0	47,874	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	30,161	0	49,102	0	0	65.00
66.00	06600	PHYSICAL THERAPY	48,748	0	11,048	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	12,846	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	13,653	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	20,868	0	0	88.00
88.01	08802	RURAL HEALTH CLINIC II	0	0	119,071	0	0	88.01
88.02	08801	RURAL HEALTH CLINIC III	0	0	0	0	0	88.02
90.00	09000	CLINIC	14,553	0	40,509	0	0	90.00
90.01	09001	ORTHOPAEDIC CLINIC	104,412	0	0	0	0	90.01
90.02	09002	SURGICAL CLINIC	15,856	0	0	0	0	90.02
90.03	09003	OP CLINIC	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	51,416	109,826	150,987	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	15,958	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	575,320	425,052	858,050	254,453	106,977	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
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)	575,320	425,052	858,050	254,453	106,977	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1327 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part I | Date/Time Prepared: 5/29/2019 3:08 pm

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			24.00	25.00	26.00	
		GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	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				19.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	3,755,149	0	3,755,149	30.00
31.00	03100	INTENSIVE CARE UNIT	513,572	0	513,572	31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	3,545,575	0	3,545,575	50.00
53.00	05300	ANESTHESIOLOGY	106,977	0	106,977	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,708,884	0	2,708,884	54.00
60.00	06000	LABORATORY	2,142,895	0	2,142,895	60.00
65.00	06500	RESPIRATORY THERAPY	1,134,923	0	1,134,923	65.00
66.00	06600	PHYSICAL THERAPY	2,134,531	0	2,134,531	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,311,971	0	1,311,971	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	3,118,415	0	3,118,415	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,354,244	0	3,354,244	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	342,892	0	342,892	88.00
88.01	08802	RURAL HEALTH CLINIC II	2,915,972	0	2,915,972	88.01
88.02	08801	RURAL HEALTH CLINIC III	1,446,516	0	1,446,516	88.02
90.00	09000	CLINIC	691,479	0	691,479	90.00
90.01	09001	ORTHOPAEDIC CLINIC	3,204,974	0	3,204,974	90.01
90.02	09002	SURGICAL CLINIC	443,697	0	443,697	90.02
90.03	09003	OP CLINIC	0	0	0	90.03
91.00	09100	EMERGENCY	3,370,826	0	3,370,826	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0		92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	1,370,428	0	1,370,428	95.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE				113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	37,613,920	0	37,613,920	118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	20,149	0	20,149	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	974,804	0	974,804	192.00
200.00		Cross Foot Adjustments	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	38,608,873	0	38,608,873	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1327 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part II | Date/Time Prepared: 5/29/2019 3:08 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
				NEW BLDG & FIXT	NEW MVBLE EQUIP			
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	5,300	6,710	12,010	12,010	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	9,599	72,377	91,632	173,608	892	5.00
7.00	00700	OPERATION OF PLANT	1,712	42,962	54,392	99,066	176	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	0	4,209	5,329	9,538	171	9.00
10.00	01000	DIETARY	1,070	32,874	41,619	75,563	51	10.00
11.00	01100	CAFETERIA	0	13,224	16,743	29,967	187	11.00
13.00	01300	NURSING ADMINISTRATION	0	2,488	3,150	5,638	174	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,672	14,537	18,404	34,613	314	16.00
17.00	01700	SOCIAL SERVICE	0	3,033	3,840	6,873	99	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,673	134,494	170,275	306,442	877	30.00
31.00	03100	INTENSIVE CARE UNIT	0	13,582	17,196	30,778	170	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	9,973	210,638	266,675	487,286	547	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	111,003	44,956	56,917	212,876	534	54.00
60.00	06000	LABORATORY	126,425	32,056	40,584	199,065	522	60.00
65.00	06500	RESPIRATORY THERAPY	14,535	14,077	17,822	46,434	379	65.00
66.00	06600	PHYSICAL THERAPY	0	69,531	88,029	157,560	645	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	40,065	50,724	90,789	142	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	305	9,458	11,975	21,738	270	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	15,917	20,152	36,069	52	88.00
88.01	08802	RURAL HEALTH CLINIC II	1,848	0	0	1,848	1,077	88.01
88.02	08801	RURAL HEALTH CLINIC III	1,367	68,167	86,303	155,837	527	88.02
90.00	09000	CLINIC	0	34,612	43,820	78,432	169	90.00
90.01	09001	ORTHOPAEDIC CLINIC	46,935	132,091	167,233	346,259	2,274	90.01
90.02	09002	SURGICAL CLINIC	0	0	0	0	463	90.02
90.03	09003	OP CLINIC	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	0	38,105	48,243	86,348	622	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	26,599	60,805	76,982	164,386	406	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	354,716	1,109,558	1,404,749	2,869,023	11,740	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	3,749	4,747	8,496	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	11,535	5,147	6,516	23,198	270	192.00
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	366,251	1,118,454	1,416,012	2,900,717	12,010	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1327 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part II | Date/Time Prepared: 5/29/2019 3:08 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	174,500					5.00
7.00	00700	OPERATION OF PLANT	8,859	108,101				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	699	0	699			8.00
9.00	00900	HOUSEKEEPING	2,115	498	4	12,326		9.00
10.00	01000	DIETARY	1,172	3,889	10	446	81,131	10.00
11.00	01100	CAFETERIA	2,440	1,565	0	179	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,855	294	0	34	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,539	1,720	0	197	0	16.00
17.00	01700	SOCIAL SERVICE	1,081	359	0	41	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	483	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	10,788	15,912	270	1,823	78,774	30.00
31.00	03100	INTENSIVE CARE UNIT	1,877	1,607	0	184	2,357	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	11,928	24,919	133	2,855	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	10,784	5,319	78	609	0	54.00
60.00	06000	LABORATORY	8,884	3,792	3	434	0	60.00
65.00	06500	RESPIRATORY THERAPY	4,586	1,665	15	191	0	65.00
66.00	06600	PHYSICAL THERAPY	8,486	8,226	51	942	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	5,387	4,740	0	543	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	14,093	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	14,998	1,119	0	128	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,455	0	0	0	0	88.00
88.01	08802	RURAL HEALTH CLINIC II	12,639	0	1	0	0	88.01
88.02	08801	RURAL HEALTH CLINIC III	6,537	0	0	0	0	88.02
90.00	09000	CLINIC	2,453	4,095	5	469	0	90.00
90.01	09001	ORTHOPAEDIC CLINIC	12,418	15,627	0	1,790	0	90.01
90.02	09002	SURGICAL CLINIC	1,934	0	0	0	0	90.02
90.03	09003	OP CLINIC	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	13,240	4,508	123	516	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	5,383	7,194	4	824	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	170,113	107,048	697	12,205	81,131	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	46	444	0	51	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	4,341	609	2	70	0	192.00
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)	174,500	108,101	699	12,326	81,131	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1327 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part II Date/Time Prepared: 5/29/2019 3:08 pm

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	
			11.00	13.00	16.00	17.00	19.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	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	34,338					11.00
13.00	01300	NURSING ADMINISTRATION	472	8,467				13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,163	0	42,546			16.00
17.00	01700	SOCIAL SERVICE	432	0	0	8,885		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	483	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,041	3,594	4,869	8,627		30.00
31.00	03100	INTENSIVE CARE UNIT	845	602	0	258		31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,922	2,083	7,973	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,489	0	7,121	0		54.00
60.00	06000	LABORATORY	2,567	0	2,374	0		60.00
65.00	06500	RESPIRATORY THERAPY	1,800	0	2,435	0		65.00
66.00	06600	PHYSICAL THERAPY	2,909	0	548	0		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	767	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	815	0	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	1,035	0		88.00
88.01	08802	RURAL HEALTH CLINIC II	0	0	5,904	0		88.01
88.02	08801	RURAL HEALTH CLINIC III	0	0	0	0		88.02
90.00	09000	CLINIC	869	0	2,009	0		90.00
90.01	09001	ORTHOPAEDIC CLINIC	6,232	0	0	0		90.01
90.02	09002	SURGICAL CLINIC	946	0	0	0		90.02
90.03	09003	OP CLINIC	0	0	0	0		90.03
91.00	09100	EMERGENCY	3,069	2,188	7,487	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	791	0		95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	34,338	8,467	42,546	8,885	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192.00
200.00		Cross Foot Adjustments					483	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	34,338	8,467	42,546	8,885	483	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1327 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part II | Date/Time Prepared: 5/29/2019 3:08 pm

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			24.00	25.00	26.00	
		GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	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				19.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	437,017	0	437,017	30.00
31.00	03100	INTENSIVE CARE UNIT	38,678	0	38,678	31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	540,646	0	540,646	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	239,810	0	239,810	54.00
60.00	06000	LABORATORY	217,641	0	217,641	60.00
65.00	06500	RESPIRATORY THERAPY	57,505	0	57,505	65.00
66.00	06600	PHYSICAL THERAPY	179,367	0	179,367	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	102,368	0	102,368	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	14,093	0	14,093	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	39,068	0	39,068	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	38,611	0	38,611	88.00
88.01	08802	RURAL HEALTH CLINIC II	21,469	0	21,469	88.01
88.02	08801	RURAL HEALTH CLINIC III	162,901	0	162,901	88.02
90.00	09000	CLINIC	88,501	0	88,501	90.00
90.01	09001	ORTHOPAEDIC CLINIC	384,600	0	384,600	90.01
90.02	09002	SURGICAL CLINIC	3,343	0	3,343	90.02
90.03	09003	OP CLINIC	0	0	0	90.03
91.00	09100	EMERGENCY	118,101	0	118,101	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0		92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	178,988	0	178,988	95.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE				113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,862,707	0	2,862,707	118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	9,037	0	9,037	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	28,490	0	28,490	192.00
200.00		Cross Foot Adjustments	483	0	483	200.00
201.00		Negative Cost Centers	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	2,900,717	0	2,900,717	202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1327 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B-1 | Date/Time Prepared: 5/29/2019 3:08 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	65,630					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		65,630				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	311	311	18,110,405			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	4,247	4,247	1,344,977	-6,243,053	32,365,820	5.00
7.00	00700	OPERATION OF PLANT	2,521	2,521	265,260	0	1,643,356	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	129,628	8.00
9.00	00900	HOUSEKEEPING	247	247	258,193	0	392,383	9.00
10.00	01000	DIETARY	1,929	1,929	76,726	0	217,312	10.00
11.00	01100	CAFETERIA	776	776	282,311	0	452,681	11.00
13.00	01300	NURSING ADMINISTRATION	146	146	262,957	0	344,117	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	853	853	473,725	0	656,374	16.00
17.00	01700	SOCIAL SERVICE	178	178	149,491	0	200,455	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	89,679	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,892	7,892	1,323,023	0	2,001,058	30.00
31.00	03100	INTENSIVE CARE UNIT	797	797	255,819	0	348,209	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	12,360	12,360	824,864	0	2,212,489	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,638	2,638	806,084	0	2,000,340	54.00
60.00	06000	LABORATORY	1,881	1,881	786,856	0	1,647,858	60.00
65.00	06500	RESPIRATORY THERAPY	826	826	572,389	0	850,589	65.00
66.00	06600	PHYSICAL THERAPY	4,080	4,080	972,670	0	1,574,147	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,351	2,351	214,106	0	999,350	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	2,614,168	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	555	555	407,480	0	2,779,234	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	934	934	78,504	0	269,953	88.00
88.01	08802	RURAL HEALTH CLINIC II	0	0	1,624,002	0	2,344,388	88.01
88.02	08801	RURAL HEALTH CLINIC III	4,000	4,000	794,474	0	1,212,615	88.02
90.00	09000	CLINIC	2,031	2,031	254,786	0	455,035	90.00
90.01	09001	ORTHOPAEDIC CLINIC	7,751	7,751	3,425,307	0	2,303,449	90.01
90.02	09002	SURGICAL CLINIC	0	0	698,173	0	358,659	90.02
90.03	09003	OP CLINIC	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	2,236	2,236	938,654	0	2,455,974	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	3,568	3,568	612,924	0	998,551	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	65,108	65,108	17,703,755	-6,243,053	31,552,051	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	220	220	0	0	8,496	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	302	302	406,650	0	805,273	192.00
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)	1,118,454	1,416,012	4,330,441		6,243,053	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	17.041810	21.575682	0.239113		0.192890	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			12,010		174,500	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000663		0.005391	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: 14-1327 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B-1 | Date/Time Prepared: 5/29/2019 3:08 pm

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	53,617					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	18,307				8.00
9.00	00900	HOUSEKEEPING	247	97	53,370			9.00
10.00	01000	DIETARY	1,929	259	1,929	6,574		10.00
11.00	01100	CAFETERIA	776	0	776	0	18,541	11.00
13.00	01300	NURSING ADMINISTRATION	146	0	146	0	255	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	853	0	853	0	1,168	16.00
17.00	01700	SOCIAL SERVICE	178	0	178	0	233	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,892	7,066	7,892	6,383	2,722	30.00
31.00	03100	INTENSIVE CARE UNIT	797	0	797	191	456	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	12,360	3,477	12,360	0	1,578	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,638	2,048	2,638	0	1,344	54.00
60.00	06000	LABORATORY	1,881	81	1,881	0	1,386	60.00
65.00	06500	RESPIRATORY THERAPY	826	403	826	0	972	65.00
66.00	06600	PHYSICAL THERAPY	4,080	1,331	4,080	0	1,571	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,351	0	2,351	0	414	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	555	0	555	0	440	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08802	RURAL HEALTH CLINIC II	0	36	0	0	0	88.01
88.02	08801	RURAL HEALTH CLINIC III	0	0	0	0	0	88.02
90.00	09000	CLINIC	2,031	138	2,031	0	469	90.00
90.01	09001	ORTHOPAEDIC CLINIC	7,751	0	7,751	0	3,365	90.01
90.02	09002	SURGICAL CLINIC	0	0	0	0	511	90.02
90.03	09003	OP CLINIC	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	2,236	3,210	2,236	0	1,657	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	3,568	107	3,568	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	53,095	18,253	52,848	6,574	18,541	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	220	0	220	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	302	54	302	0	0	192.00
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)	1,960,343	154,632	477,920	349,219	575,320	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	36.561967	8.446605	8.954844	53.121235	31.029610	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	108,101	699	12,326	81,131	34,338	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	2.016170	0.038182	0.230954	12.341193	1.852004	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: 14-1327 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B-1 | Date/Time Prepared: 5/29/2019 3:08 pm

		Cost Center Description	NURSING ADMINISTRATION (NURSE FTE'S)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (TOTAL PATIENT DAYS)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)		
			13.00	16.00	17.00	19.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	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	6,413					13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	699				16.00
17.00	01700	SOCIAL SERVICE	0	0	2,235			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	100		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,722	80	2,170	0		30.00
31.00	03100	INTENSIVE CARE UNIT	456	0	65	0		31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,578	131	0	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	100		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	117	0	0		54.00
60.00	06000	LABORATORY	0	39	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	40	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	9	0	0		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	17	0	0		88.00
88.01	08802	RURAL HEALTH CLINIC II	0	97	0	0		88.01
88.02	08801	RURAL HEALTH CLINIC III	0	0	0	0		88.02
90.00	09000	CLINIC	0	33	0	0		90.00
90.01	09001	ORTHOPAEDIC CLINIC	0	0	0	0		90.01
90.02	09002	SURGICAL CLINIC	0	0	0	0		90.02
90.03	09003	OP CLINIC	0	0	0	0		90.03
91.00	09100	EMERGENCY	1,657	123	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	13	0	0		95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	6,413	699	2,235	100		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192.00
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)	425,052	858,050	254,453	106,977		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	66.279744	1,227.539342	113.849217	1,069.770000		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	8,467	42,546	8,885	483		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	1.320287	60.866953	3.975391	4.830000		205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1327 | Period: From 01/01/2018 To 12/31/2018 | Worksheet C Part I Date/Time Prepared: 5/29/2019 3:08 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	3,755,149		3,755,149	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	513,572		513,572	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,545,575		3,545,575	0	0	50.00
53.00	05300	ANESTHESIOLOGY	106,977		106,977	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,708,884		2,708,884	0	0	54.00
60.00	06000	LABORATORY	2,142,895		2,142,895	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	1,134,923	0	1,134,923	0	0	65.00
66.00	06600	PHYSICAL THERAPY	2,134,531	0	2,134,531	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,311,971		1,311,971	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	3,118,415		3,118,415	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,354,244		3,354,244	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	342,892		342,892	0	0	88.00
88.01	08802	RURAL HEALTH CLINIC II	2,915,972		2,915,972	0	0	88.01
88.02	08801	RURAL HEALTH CLINIC III	1,446,516		1,446,516	0	0	88.02
90.00	09000	CLINIC	691,479		691,479	0	0	90.00
90.01	09001	ORTHOPAEDIC CLINIC	3,204,974		3,204,974	0	0	90.01
90.02	09002	SURGICAL CLINIC	443,697		443,697	0	0	90.02
90.03	09003	OP CLINIC	0		0	0	0	90.03
91.00	09100	EMERGENCY	3,370,826		3,370,826	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	230,290		230,290		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1,370,428		1,370,428	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	37,844,210	0	37,844,210	0	0	200.00
201.00		Less Observation Beds	230,290		230,290		0	201.00
202.00		Total (see instructions)	37,613,920	0	37,613,920	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1327 | Period: From 01/01/2018 To 12/31/2018 | Worksheet C Part I | Date/Time Prepared: 5/29/2019 3:08 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Charges Inpatient	Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,576,785		2,576,785			30.00
31.00	03100	INTENSIVE CARE UNIT	64,611		64,611			31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	10,114,998	7,515,337	17,630,335	0.201107	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	1,229,130	1,782,284	3,011,414	0.035524	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	686,662	15,539,241	16,225,903	0.166948	0.000000	54.00
60.00	06000	LABORATORY	1,075,915	12,253,540	13,329,455	0.160764	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	290,062	2,063,932	2,353,994	0.482127	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	998,502	4,876,041	5,874,543	0.363353	0.000000	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,900,480	472,070	3,372,550	0.389015	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	9,849,012	332,035	10,181,047	0.306296	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,274,446	7,573,572	8,848,018	0.379096	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	483,355	483,355			88.00
88.01	08802	RURAL HEALTH CLINIC II	0	2,088,633	2,088,633			88.01
88.02	08801	RURAL HEALTH CLINIC III	0	1,191,584	1,191,584			88.02
90.00	09000	CLINIC	532	686,357	686,889	1.006682	0.000000	90.00
90.01	09001	ORTHOPAEDIC CLINIC	494	1,810,075	1,810,569	1.770147	0.000000	90.01
90.02	09002	SURGICAL CLINIC	0	213,962	213,962	2.073719	0.000000	90.02
90.03	09003	OP CLINIC	0	0	0	0.000000	0.000000	90.03
91.00	09100	EMERGENCY	15,581	3,195,960	3,211,541	1.049598	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	6,104	187,252	193,356	1.191016	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	1,875,809	1,875,809	0.730580	0.000000	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	31,083,314	64,141,039	95,224,353			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	31,083,314	64,141,039	95,224,353			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1327 | Period: From 01/01/2018 To 12/31/2018 | Worksheet C Part I Date/Time Prepared: 5/29/2019 3:08 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
31.00	03100	INTENSIVE CARE UNIT		31.00
		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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS		
88.00	08800	RURAL HEALTH CLINIC		88.00
88.01	08802	RURAL HEALTH CLINIC II		88.01
88.02	08801	RURAL HEALTH CLINIC III		88.02
90.00	09000	CLINIC	0.000000	90.00
90.01	09001	ORTHOPAEDIC CLINIC	0.000000	90.01
90.02	09002	SURGICAL CLINIC	0.000000	90.02
90.03	09003	OP CLINIC	0.000000	90.03
91.00	09100	EMERGENCY	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS		
95.00	09500	AMBULANCE SERVICES	0.000000	95.00
		SPECIAL PURPOSE COST CENTERS		
113.00	11300	INTEREST EXPENSE		113.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1327 | Period: From 01/01/2018 To 12/31/2018 | Worksheet C Part I Date/Time Prepared: 5/29/2019 3:08 pm

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,755,149		3,755,149	0	3,755,149	30.00
31.00	03100	INTENSIVE CARE UNIT	513,572		513,572	0	513,572	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,545,575		3,545,575	0	3,545,575	50.00
53.00	05300	ANESTHESIOLOGY	106,977		106,977	0	106,977	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,708,884		2,708,884	0	2,708,884	54.00
60.00	06000	LABORATORY	2,142,895		2,142,895	0	2,142,895	60.00
65.00	06500	RESPIRATORY THERAPY	1,134,923	0	1,134,923	0	1,134,923	65.00
66.00	06600	PHYSICAL THERAPY	2,134,531	0	2,134,531	0	2,134,531	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,311,971		1,311,971	0	1,311,971	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	3,118,415		3,118,415	0	3,118,415	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,354,244		3,354,244	0	3,354,244	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	342,892		342,892	0	342,892	88.00
88.01	08802	RURAL HEALTH CLINIC II	2,915,972		2,915,972	0	2,915,972	88.01
88.02	08801	RURAL HEALTH CLINIC III	1,446,516		1,446,516	0	1,446,516	88.02
90.00	09000	CLINIC	691,479		691,479	0	691,479	90.00
90.01	09001	ORTHOPAEDIC CLINIC	3,204,974		3,204,974	0	3,204,974	90.01
90.02	09002	SURGICAL CLINIC	443,697		443,697	0	443,697	90.02
90.03	09003	OP CLINIC	0		0	0	0	90.03
91.00	09100	EMERGENCY	3,370,826		3,370,826	0	3,370,826	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	230,290		230,290		230,290	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1,370,428		1,370,428	0	1,370,428	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	37,844,210	0	37,844,210	0	37,844,210	200.00
201.00		Less Observation Beds	230,290		230,290		230,290	201.00
202.00		Total (see instructions)	37,613,920	0	37,613,920	0	37,613,920	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1327 | Period: From 01/01/2018 To 12/31/2018 | Worksheet C Part I Date/Time Prepared: 5/29/2019 3:08 pm

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,576,785		2,576,785			30.00
31.00	03100	INTENSIVE CARE UNIT	64,611		64,611			31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	10,114,998	7,515,337	17,630,335	0.201107	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	1,229,130	1,782,284	3,011,414	0.035524	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	686,662	15,539,241	16,225,903	0.166948	0.000000	54.00
60.00	06000	LABORATORY	1,075,915	12,253,540	13,329,455	0.160764	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	290,062	2,063,932	2,353,994	0.482127	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	998,502	4,876,041	5,874,543	0.363353	0.000000	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,900,480	472,070	3,372,550	0.389015	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	9,849,012	332,035	10,181,047	0.306296	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,274,446	7,573,572	8,848,018	0.379096	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	483,355	483,355	0.709400	0.000000	88.00
88.01	08802	RURAL HEALTH CLINIC II	0	2,088,633	2,088,633	1.396115	0.000000	88.01
88.02	08801	RURAL HEALTH CLINIC III	0	1,191,584	1,191,584	1.213944	0.000000	88.02
90.00	09000	CLINIC	532	686,357	686,889	1.006682	0.000000	90.00
90.01	09001	ORTHOPAEDIC CLINIC	494	1,810,075	1,810,569	1.770147	0.000000	90.01
90.02	09002	SURGICAL CLINIC	0	213,962	213,962	2.073719	0.000000	90.02
90.03	09003	OP CLINIC	0	0	0	0.000000	0.000000	90.03
91.00	09100	EMERGENCY	15,581	3,195,960	3,211,541	1.049598	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	6,104	187,252	193,356	1.191016	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	1,875,809	1,875,809	0.730580	0.000000	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	31,083,314	64,141,039	95,224,353			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	31,083,314	64,141,039	95,224,353			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES	Provider CCN: 14-1327	Period: From 01/01/2018 To 12/31/2018	Worksheet C Part I Date/Time Prepared: 5/29/2019 3:08 pm
	Title XIX	Hospital	Cost

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
		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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS		
88.00	08800	RURAL HEALTH CLINIC	0.000000	88.00
88.01	08802	RURAL HEALTH CLINIC II	0.000000	88.01
88.02	08801	RURAL HEALTH CLINIC III	0.000000	88.02
90.00	09000	CLINIC	0.000000	90.00
90.01	09001	ORTHOPAEDIC CLINIC	0.000000	90.01
90.02	09002	SURGICAL CLINIC	0.000000	90.02
90.03	09003	OP CLINIC	0.000000	90.03
91.00	09100	EMERGENCY	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS		
95.00	09500	AMBULANCE SERVICES	0.000000	95.00
		SPECIAL PURPOSE COST CENTERS		
113.00	11300	INTEREST EXPENSE		113.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 14-1327 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part II Date/Time Prepared: 5/29/2019 3:08 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	540,646	17,630,335	0.030666	5,567,827	170,743	50.00
53.00	05300	ANESTHESIOLOGY	0	3,011,414	0.000000	662,833	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	239,810	16,225,903	0.014779	491,612	7,266	54.00
60.00	06000	LABORATORY	217,641	13,329,455	0.016328	739,355	12,072	60.00
65.00	06500	RESPIRATORY THERAPY	57,505	2,353,994	0.024429	183,072	4,472	65.00
66.00	06600	PHYSICAL THERAPY	179,367	5,874,543	0.030533	539,497	16,472	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	102,368	3,372,550	0.030353	1,125,981	34,177	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	14,093	10,181,047	0.001384	5,541,850	7,670	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	39,068	8,848,018	0.004415	747,129	3,299	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	38,611	483,355	0.079881	0	0	88.00
88.01	08802	RURAL HEALTH CLINIC II	21,469	2,088,633	0.010279	0	0	88.01
88.02	08801	RURAL HEALTH CLINIC III	162,901	1,191,584	0.136710	0	0	88.02
90.00	09000	CLINIC	88,501	686,889	0.128843	532	69	90.00
90.01	09001	ORTHOPAEDIC CLINIC	384,600	1,810,569	0.212419	247	52	90.01
90.02	09002	SURGICAL CLINIC	3,343	213,962	0.015624	0	0	90.02
90.03	09003	OP CLINIC	0	0	0.000000	0	0	90.03
91.00	09100	EMERGENCY	118,101	3,211,541	0.036774	767	28	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	26,801	193,356	0.138610	2,896	401	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	2,234,825	90,707,148		15,603,598	256,721	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 14-1327 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part IV Date/Time Prepared: 5/29/2019 3:08 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	106,977	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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08802	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
88.02	08801	RURAL HEALTH CLINIC III	0	0	0	0	0	88.02
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	ORTHOPAEDIC CLINIC	0	0	0	0	0	90.01
90.02	09002	SURGICAL CLINIC	0	0	0	0	0	90.02
90.03	09003	OP CLINIC	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	106,977	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1327 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part IV | Date/Time Prepared: 5/29/2019 3:08 pm

Title XVIII | Hospital | Cost

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	17,630,335	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	106,977	0	3,011,414	0.035524	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	16,225,903	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	13,329,455	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	2,353,994	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	5,874,543	0.000000	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	3,372,550	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	10,181,047	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	8,848,018	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	483,355	0.000000	88.00
88.01	08802	RURAL HEALTH CLINIC II	0	0	0	2,088,633	0.000000	88.01
88.02	08801	RURAL HEALTH CLINIC III	0	0	0	1,191,584	0.000000	88.02
90.00	09000	CLINIC	0	0	0	686,889	0.000000	90.00
90.01	09001	ORTHOPAEDIC CLINIC	0	0	0	1,810,569	0.000000	90.01
90.02	09002	SURGICAL CLINIC	0	0	0	213,962	0.000000	90.02
90.03	09003	OP CLINIC	0	0	0	0	0.000000	90.03
91.00	09100	EMERGENCY	0	0	0	3,211,541	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	193,356	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	106,977	0	90,707,148		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1327 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part IV | Date/Time Prepared: 5/29/2019 3:08 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	5,567,827	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	662,833	23,546	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	491,612	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	739,355	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	183,072	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	539,497	0	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	1,125,981	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000	5,541,850	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	747,129	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
88.01	08802	RURAL HEALTH CLINIC II	0.000000	0	0	0	0	88.01
88.02	08801	RURAL HEALTH CLINIC III	0.000000	0	0	0	0	88.02
90.00	09000	CLINIC	0.000000	532	0	0	0	90.00
90.01	09001	ORTHOPAEDIC CLINIC	0.000000	247	0	0	0	90.01
90.02	09002	SURGICAL CLINIC	0.000000	0	0	0	0	90.02
90.03	09003	OP CLINIC	0.000000	0	0	0	0	90.03
91.00	09100	EMERGENCY	0.000000	767	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	2,896	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)		15,603,598	23,546	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-1327 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part V Date/Time Prepared: 5/29/2019 3:08 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	0.201107	0	2,103,892	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.035524	0	469,141	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.166948	0	5,962,327	0	0	54.00
60.00	06000	LABORATORY	0.160764	0	5,001,476	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.482127	0	871,814	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.363353	0	1,818,858	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.389015	0	314,199	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.306296	0	332,035	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.379096	0	3,907,092	1,410	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
88.01	08802	RURAL HEALTH CLINIC II	0.000000				0	88.01
88.02	08801	RURAL HEALTH CLINIC III	0.000000				0	88.02
90.00	09000	CLINIC	1.006682	0	326,913	275	0	90.00
90.01	09001	ORTHOPAEDIC CLINIC	1.770147	0	665,658	0	0	90.01
90.02	09002	SURGICAL CLINIC	2.073719	0	78,672	0	0	90.02
90.03	09003	OP CLINIC	0.000000	0	0	0	0	90.03
91.00	09100	EMERGENCY	1.049598	0	1,003,306	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.191016	0	113,655	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.730580		0			95.00
200.00		Subtotal (see instructions)		0	22,969,038	1,685	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	22,969,038	1,685	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 14-1327	Period: From 01/01/2018 To 12/31/2018	Worksheet D Part V Date/Time Prepared: 5/29/2019 3:08 pm
	Title XVIII	Hospital	Cost

		Cost Center Description	Costs		
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
			6.00	7.00	
	ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	423,107	0	50.00
53.00	05300	ANESTHESIOLOGY	16,666	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	995,399	0	54.00
60.00	06000	LABORATORY	804,057	0	60.00
65.00	06500	RESPIRATORY THERAPY	420,325	0	65.00
66.00	06600	PHYSICAL THERAPY	660,888	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	122,228	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	101,701	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,481,163	535	73.00
	OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0	88.00
88.01	08802	RURAL HEALTH CLINIC II	0	0	88.01
88.02	08801	RURAL HEALTH CLINIC III	0	0	88.02
90.00	09000	CLINIC	329,097	277	90.00
90.01	09001	ORTHOPAEDIC CLINIC	1,178,313	0	90.01
90.02	09002	SURGICAL CLINIC	163,144	0	90.02
90.03	09003	OP CLINIC	0	0	90.03
91.00	09100	EMERGENCY	1,053,068	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	135,365	0	92.00
	OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0		95.00
200.00		Subtotal (see instructions)	7,884,521	812	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	7,884,521	812	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1327 | Component CCN: 14-Z327 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part V | Date/Time Prepared: 5/29/2019 3:08 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	0.201107	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.035524	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.166948	0	0	0	0	54.00
60.00	06000	LABORATORY	0.160764	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.482127	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.363353	0	0	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.389015	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.306296	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.379096	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
88.01	08802	RURAL HEALTH CLINIC II	0.000000				0	88.01
88.02	08801	RURAL HEALTH CLINIC III	0.000000				0	88.02
90.00	09000	CLINIC	1.006682	0	0	0	0	90.00
90.01	09001	ORTHOPAEDIC CLINIC	1.770147	0	0	0	0	90.01
90.02	09002	SURGICAL CLINIC	2.073719	0	0	0	0	90.02
90.03	09003	OP CLINIC	0.000000	0	0	0	0	90.03
91.00	09100	EMERGENCY	1.049598	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.191016	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.730580		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: 14-1327 | Component CCN: 14-Z327 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part V | Date/Time Prepared: 5/29/2019 3:08 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Costs		
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	0	0	88.00
88.01	08802	RURAL HEALTH CLINIC II	0	0	88.01
88.02	08801	RURAL HEALTH CLINIC III	0	0	88.02
90.00	09000	CLINIC	0	0	90.00
90.01	09001	ORTHOPAEDIC CLINIC	0	0	90.01
90.02	09002	SURGICAL CLINIC	0	0	90.02
90.03	09003	OP CLINIC	0	0	90.03
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0		95.00
200.00		Subtotal (see instructions)	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-1327 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part V Date/Time Prepared: 5/29/2019 3:08 pm

Title XIX | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0.201107	0	0	674,810	0	50.00
53.00	05300	ANESTHESIOLOGY	0.035524	0	0	160,679	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.166948	0	0	1,000,902	0	54.00
60.00	06000	LABORATORY	0.160764	0	0	524,690	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.482127	0	0	49,875	0	65.00
66.00	06600	PHYSICAL THERAPY	0.363353	0	0	548	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.389015	0	0	157,871	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.306296	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.379096	0	0	200,781	0	73.00
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0.709400				0	88.00
88.01	08802	RURAL HEALTH CLINIC II	1.396115				0	88.01
88.02	08801	RURAL HEALTH CLINIC III	1.213944				0	88.02
90.00	09000	CLINIC	1.006682	0	0	0	0	90.00
90.01	09001	ORTHOPAEDIC CLINIC	1.770147	0	0	4,001	0	90.01
90.02	09002	SURGICAL CLINIC	2.073719	0	0	0	0	90.02
90.03	09003	OP CLINIC	0.000000	0	0	0	0	90.03
91.00	09100	EMERGENCY	1.049598	0	0	336,476	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.191016	0	0	16,316	0	92.00
	OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0.730580	0	0			95.00
200.00		Subtotal (see instructions)		0	0	3,126,949	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	3,126,949	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-1327 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part V Date/Time Prepared: 5/29/2019 3:08 pm

Title XIX | Hospital | Cost

		Cost Center Description	Costs		
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
			6.00	7.00	
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0	135,709	50.00
53.00	05300	ANESTHESIOLOGY	0	5,708	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	167,099	54.00
60.00	06000	LABORATORY	0	84,351	60.00
65.00	06500	RESPIRATORY THERAPY	0	24,046	65.00
66.00	06600	PHYSICAL THERAPY	0	199	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	61,414	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	76,115	73.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	0	0	88.00
88.01	08802	RURAL HEALTH CLINIC II	0	0	88.01
88.02	08801	RURAL HEALTH CLINIC III	0	0	88.02
90.00	09000	CLINIC	0	0	90.00
90.01	09001	ORTHOPAEDIC CLINIC	0	7,082	90.01
90.02	09002	SURGICAL CLINIC	0	0	90.02
90.03	09003	OP CLINIC	0	0	90.03
91.00	09100	EMERGENCY	0	353,165	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	19,433	92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0		95.00
200.00		Subtotal (see instructions)	0	934,321	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	0	934,321	202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1327 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-1 | Date/Time Prepared: 5/29/2019 3:08 pm

Title XVIII | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	2,609	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,330	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	2,170	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	279	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	1,301	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)	231	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	159.97	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	159.97	20.00
21.00	Total general inpatient routine service cost (see instructions)	3,755,149	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	401,567	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	3,353,582	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)	3,353,582	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)	1,439.31	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,872,542	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)	1,872,542	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1327 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-1 | Date/Time Prepared: 5/29/2019 3:08 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	513,572	65	7,901.11	19	150,121	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	4,052,433	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	6,075,096	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)	332,481	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	332,481	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)	160	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,439.31	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	230,290	89.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 14-1327	Period: From 01/01/2018 To 12/31/2018	Worksheet D-1 Date/Time Prepared: 5/29/2019 3:08 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	437,017	3,755,149	0.116378	230,290	26,801	90.00
91.00	Nursing School cost	0	3,755,149	0.000000	230,290	0	91.00
92.00	Allied health cost	0	3,755,149	0.000000	230,290	0	92.00
93.00	All other Medical Education	0	3,755,149	0.000000	230,290	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 14-1327 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-3 | Date/Time Prepared: 5/29/2019 3:08 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		1,790,457		30.00
31.00	03100	INTENSIVE CARE UNIT		42,484		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.201107	5,567,827	1,119,729	50.00
53.00	05300	ANESTHESIOLOGY	0.035524	662,833	23,546	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.166948	491,612	82,074	54.00
60.00	06000	LABORATORY	0.160764	739,355	118,862	60.00
65.00	06500	RESPIRATORY THERAPY	0.482127	183,072	88,264	65.00
66.00	06600	PHYSICAL THERAPY	0.363353	539,497	196,028	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.389015	1,125,981	438,023	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.306296	5,541,850	1,697,446	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.379096	747,129	283,234	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08802	RURAL HEALTH CLINIC II	0.000000		0	88.01
88.02	08801	RURAL HEALTH CLINIC III	0.000000		0	88.02
90.00	09000	CLINIC	1.006682	532	536	90.00
90.01	09001	ORTHOPAEDIC CLINIC	1.770147	247	437	90.01
90.02	09002	SURGICAL CLINIC	2.073719	0	0	90.02
90.03	09003	OP CLINIC	0.000000	0	0	90.03
91.00	09100	EMERGENCY	1.049598	767	805	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.191016	2,896	3,449	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		15,603,598	4,052,433	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)		15,603,598		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 14-1327 | Component CCN: 14-Z327 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-3 | Date/Time Prepared: 5/29/2019 3:08 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
31.00	03100	INTENSIVE CARE UNIT		0		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.201107	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.035524	4,197	149	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.166948	24,181	4,037	54.00
60.00	06000	LABORATORY	0.160764	50,290	8,085	60.00
65.00	06500	RESPIRATORY THERAPY	0.482127	28,780	13,876	65.00
66.00	06600	PHYSICAL THERAPY	0.363353	138,600	50,361	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.389015	46,888	18,240	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.306296	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.379096	120,027	45,502	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08802	RURAL HEALTH CLINIC II	0.000000		0	88.01
88.02	08801	RURAL HEALTH CLINIC III	0.000000		0	88.02
90.00	09000	CLINIC	1.006682	0	0	90.00
90.01	09001	ORTHOPAEDIC CLINIC	1.770147	0	0	90.01
90.02	09002	SURGICAL CLINIC	2.073719	0	0	90.02
90.03	09003	OP CLINIC	0.000000	0	0	90.03
91.00	09100	EMERGENCY	1.049598	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.191016	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		412,963	140,250	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)		412,963		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 14-1327 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-3 Date/Time Prepared: 5/29/2019 3:08 pm

			Title XIX	Hospital	Cost	
		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		79,849		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.201107	269,068	54,111	50.00
53.00	05300	ANESTHESIOLOGY	0.035524	26,005	924	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.166948	10,988	1,834	54.00
60.00	06000	LABORATORY	0.160764	33,725	5,422	60.00
65.00	06500	RESPIRATORY THERAPY	0.482127	17,274	8,328	65.00
66.00	06600	PHYSICAL THERAPY	0.363353	19,656	7,142	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.389015	251,243	97,737	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.306296	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.379096	34,851	13,212	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.709400	0	0	88.00
88.01	08802	RURAL HEALTH CLINIC II	1.396115	0	0	88.01
88.02	08801	RURAL HEALTH CLINIC III	1.213944	0	0	88.02
90.00	09000	CLINIC	1.006682	0	0	90.00
90.01	09001	ORTHOPAEDIC CLINIC	1.770147	247	437	90.01
90.02	09002	SURGICAL CLINIC	2.073719	0	0	90.02
90.03	09003	OP CLINIC	0.000000	0	0	90.03
91.00	09100	EMERGENCY	1.049598	191	200	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.191016	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		663,248	189,347	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)		663,248		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 14-1327 | Period: From 01/01/2018 To 12/31/2018 | Worksheet E Part B Date/Time Prepared: 5/29/2019 3:08 pm

Title XVIII | Hospital | Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	7,885,333	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	OPPS payments	0	3.00
4.00	Outlier payment (see instructions)	0	4.00
4.01	Outlier reconciliation amount (see instructions)	0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	7,885,333	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	0	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (see instructions)	7,964,186	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	0	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)	71,131	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	3,594,915	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	4,298,140	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	4,298,140	30.00
31.00	Primary payer payments	230	31.00
32.00	Subtotal (line 30 minus line 31)	4,297,910	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)	309,718	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	201,317	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	303,007	36.00
37.00	Subtotal (see instructions)	4,499,227	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		39.50
39.97	Demonstration payment adjustment amount before sequestration	0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	4,499,227	40.00
40.01	Sequestration adjustment (see instructions)	89,985	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
41.00	Interim payments	3,815,557	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	593,685	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: 14-1327	Period: From 01/01/2018 To 12/31/2018	Worksheet E-1 Part I Date/Time Prepared: 5/29/2019 3:08 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		5,531,738		4,015,876	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	08/01/2018	5,658	08/01/2018	118,676	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0	11/21/2018	318,995	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)		5,658		-200,319	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)		5,537,396		3,815,557	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		39,814		593,685	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		5,577,210		4,409,242	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-1327 | Component CCN: 14-Z327 | Period: From 01/01/2018 To 12/31/2018 | Worksheet E-1 Part I | Date/Time Prepared: 5/29/2019 3:08 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		535,393		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM	08/01/2018	85,367		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)		-85,367		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)		450,026		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		16,984		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		467,010		0	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 14-1327	Period: From 01/01/2018 To 12/31/2018	Worksheet E-1 Part II Date/Time Prepared: 5/29/2019 3:08 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: 14-1327 | Component CCN: 14-Z327 | Period: From 01/01/2018 To 12/31/2018 | Worksheet E-2 | Date/Time Prepared: 5/29/2019 3:08 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)	335,806	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)	141,653	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	231	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)	477,459	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	477,459	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)	477,459	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	1,675	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)	475,784	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)	1,164	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	757	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	1,164	0	18.00
19.00	Total (see instructions)	476,541	0	19.00
19.01	Sequestration adjustment (see instructions)	9,531	0	19.01
19.02	Demonstration payment adjustment amount after sequestration)	0	0	19.02
20.00	Interim payments	450,026	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)	16,984	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: 14-1327	Period: From 01/01/2018 To 12/31/2018	Worksheet E-3 Part V Date/Time Prepared: 5/29/2019 3:08 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	6,075,096	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)	6,075,096	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	6,135,847	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)	6,135,847	19.00
20.00	Deductibles (exclude professional component)	479,644	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	5,656,203	22.00
23.00	Coinsurance	0	23.00
24.00	Subtotal (line 22 minus line 23)	5,656,203	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	53,581	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	34,828	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	52,265	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	5,691,031	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)	5,691,031	30.00
30.01	Sequestration adjustment (see instructions)	113,821	30.01
30.02	Demonstration payment adjustment amount after sequestration	0	30.02
31.00	Interim payments	5,537,396	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)	39,814	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: 14-1327 | Period: From 01/01/2018 To 12/31/2018 | Worksheet G | Date/Time Prepared: 5/29/2019 3:08 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	5,519,439	0	0	0	1.00
2.00	Temporary investments	5,551,226	0	0	0	2.00
3.00	Notes receivable	78,437	0	0	0	3.00
4.00	Accounts receivable	21,430,664	0	0	0	4.00
5.00	Other receivable	104,000	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-12,142,860	0	0	0	6.00
7.00	Inventory	926,187	0	0	0	7.00
8.00	Prepaid expenses	0	0	0	0	8.00
9.00	Other current assets	497,366	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)	21,964,459	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	467,367	0	0	0	12.00
13.00	Land improvements	2,088,063	0	0	0	13.00
14.00	Accumulated depreciation	-1,132,550	0	0	0	14.00
15.00	Buildings	25,424,261	0	0	0	15.00
16.00	Accumulated depreciation	-11,146,347	0	0	0	16.00
17.00	Leasehold improvements	26,944	0	0	0	17.00
18.00	Accumulated depreciation	-2,645,971	0	0	0	18.00
19.00	Fixed equipment	4,866,438	0	0	0	19.00
20.00	Accumulated depreciation	-12,429,062	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	15,170,915	0	0	0	23.00
24.00	Accumulated depreciation	0	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	20,690,058	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	1,409,084	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	1,409,084	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	44,063,601	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	928,867	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,728,362	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	5,525,522	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	269,126	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	8,451,877	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	2,789,449	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	2,789,449	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	11,241,326	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	32,822,275				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)	32,822,275	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	44,063,601	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 14-1327 | Period: From 01/01/2018 To 12/31/2018 | Worksheet G-1 | Date/Time Prepared: 5/29/2019 3:08 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		30,378,173		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		2,444,102				2.00
3.00	Total (sum of line 1 and line 2)		32,822,275		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		32,822,275		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)		32,822,275		0		19.00

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

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 14-1327 | Period: From 01/01/2018 To 12/31/2018 | Worksheet G-2 Parts I & II Date/Time Prepared: 5/29/2019 3:08 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	3,330,084		3,330,084	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	3,330,084		3,330,084	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	70,914		70,914	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)	70,914		70,914	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	3,400,998		3,400,998	17.00
18.00	Ancillary services	30,000,891	53,161,188	83,162,079	18.00
19.00	Outpatient services	57,904	13,202,450	13,260,354	19.00
20.00	RURAL HEALTH CLINIC	0	483,355	483,355	20.00
20.01	RURAL HEALTH CLINIC II	0	2,088,633	2,088,633	20.01
20.02	RURAL HEALTH CLINIC III	0	1,191,584	1,191,584	20.02
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES	0	1,875,809	1,875,809	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PRO FEES	0	541,275	541,275	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	33,459,793	72,544,294	106,004,087	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		44,818,714		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		44,818,714		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 14-1327 | Period: From 01/01/2018 To 12/31/2018 | Worksheet G-3 | Date/Time Prepared: 5/29/2019 3:08 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	106,004,087	1.00
2.00	Less contractual allowances and discounts on patients' accounts	60,557,240	2.00
3.00	Net patient revenues (line 1 minus line 2)	45,446,847	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	44,818,714	4.00
5.00	Net income from service to patients (line 3 minus line 4)	628,133	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	5,256	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	110,472	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	1,410	16.00
17.00	Revenue from sale of drugs to other than patients	453,588	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	6,275	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER OPERATING INCOME	493,765	24.00
25.00	Total other income (sum of lines 6-24)	1,070,766	25.00
26.00	Total (line 5 plus line 25)	1,698,899	26.00
27.00	NON-OPERATING G/L	-745,204	27.00
27.01	ROUNDING	1	27.01
28.00	Total other expenses (sum of line 27 and subscripts)	-745,203	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	2,444,102	29.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1327 | Component CCN: 14-8501 | Period: From 01/01/2018 To 12/31/2018 | Worksheet M-1 | Date/Time Prepared: 5/29/2019 3:08 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	0	0	0	0	0	1.00
2.00	Physician Assistant	0	126,787	126,787	16,698	143,485	2.00
3.00	Nurse Practitioner	0	0	0	0	0	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	78,504	0	78,504	-23,691	54,813	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	189	189	9.00
10.00	Subtotal (sum of lines 1 through 9)	78,504	126,787	205,291	-6,804	198,487	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	9,822	9,822	0	9,822	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	9,822	9,822	0	9,822	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	78,504	136,609	215,113	-6,804	208,309	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	0	0	0	0	29.00
30.00	Administrative Costs	0	0	0	6,804	6,804	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	0	0	6,804	6,804	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	78,504	136,609	215,113	0	215,113	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS	Provider CCN: 14-1327 Component CCN: 14-8501	Period: From 01/01/2018 To 12/31/2018	Worksheet M-1 Date/Time Prepared: 5/29/2019 3:08 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	0	1.00
2.00	Physician Assistant	0	143,485	2.00
3.00	Nurse Practitioner	0	0	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	54,813	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	189	9.00
10.00	Subtotal (sum of lines 1 through 9)	0	198,487	10.00
11.00	Physician Services Under Agreement	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	12.00
13.00	Other Costs Under Agreement	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	14.00
15.00	Medical Supplies	0	9,822	15.00
16.00	Transportation (Health Care Staff)	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	17.00
18.00	Professional Liability Insurance	0	0	18.00
19.00	Other Health Care Costs	0	0	19.00
20.00	Allowable GME Costs			20.00
21.00	Subtotal (sum of lines 15 through 20)	0	9,822	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	208,309	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	0	29.00
30.00	Administrative Costs	0	6,804	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	6,804	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	215,113	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1327 | Period: From 01/01/2018 To 12/31/2018 | Worksheet M-1

Component CCN: 14-8568 | Date/Time Prepared: 5/29/2019 3:08 pm

RHC II | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	0	0	0	782,435	782,435	1.00
2.00	Physician Assistant	0	27,785	27,785	94,700	122,485	2.00
3.00	Nurse Practitioner	0	0	0	70,880	70,880	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	1,624,002	0	1,624,002	-1,223,084	400,918	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	21,053	21,053	9.00
10.00	Subtotal (sum of lines 1 through 9)	1,624,002	27,785	1,651,787	-254,016	1,397,771	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	228,079	228,079	0	228,079	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	228,079	228,079	0	228,079	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	1,624,002	255,864	1,879,866	-254,016	1,625,850	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	0	0	0	0	29.00
30.00	Administrative Costs	0	76,202	76,202	254,016	330,218	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	76,202	76,202	254,016	330,218	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	1,624,002	332,066	1,956,068	0	1,956,068	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1327 | Period: From 01/01/2018 To 12/31/2018 | Worksheet M-1
Component CCN: 14-8568 | Date/Time Prepared: 5/29/2019 3:08 pm

RHC II | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
		6.00	7.00	
	FACILITY HEALTH CARE STAFF COSTS			
1.00	Physician	0	782,435	1.00
2.00	Physician Assistant	0	122,485	2.00
3.00	Nurse Practitioner	0	70,880	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	400,918	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	21,053	9.00
10.00	Subtotal (sum of lines 1 through 9)	0	1,397,771	10.00
11.00	Physician Services Under Agreement	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	12.00
13.00	Other Costs Under Agreement	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	14.00
15.00	Medical Supplies	0	228,079	15.00
16.00	Transportation (Health Care Staff)	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	17.00
18.00	Professional Liability Insurance	0	0	18.00
19.00	Other Health Care Costs	0	0	19.00
20.00	Allowable GME Costs			20.00
21.00	Subtotal (sum of lines 15 through 20)	0	228,079	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	1,625,850	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	0	29.00
30.00	Administrative Costs	0	330,218	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	330,218	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	1,956,068	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1327 | Period: From 01/01/2018 To 12/31/2018 | Worksheet M-1

Component CCN: 14-8579 | Date/Time Prepared: 5/29/2019 3:08 pm

RHC III | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	0	0	0	459,376	459,376	1.00
2.00	Physician Assistant	0	1,566	1,566	98,124	99,690	2.00
3.00	Nurse Practitioner	0	0	0	0	0	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	794,474	0	794,474	-733,012	61,462	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	35,807	35,807	9.00
10.00	Subtotal (sum of lines 1 through 9)	794,474	1,566	796,040	-139,705	656,335	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	56,499	56,499	0	56,499	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	56,499	56,499	0	56,499	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	794,474	58,065	852,539	-139,705	712,834	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	0	0	0	0	29.00
30.00	Administrative Costs	0	15,637	15,637	139,705	155,342	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	15,637	15,637	139,705	155,342	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	794,474	73,702	868,176	0	868,176	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1327 | Component CCN: 14-8579 | Period: From 01/01/2018 To 12/31/2018 | Worksheet M-1 | Date/Time Prepared: 5/29/2019 3:08 pm

RHC III | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
		6.00	7.00	
	FACILITY HEALTH CARE STAFF COSTS			
1.00	Physician	0	459,376	1.00
2.00	Physician Assistant	0	99,690	2.00
3.00	Nurse Practitioner	0	0	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	61,462	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	35,807	9.00
10.00	Subtotal (sum of lines 1 through 9)	0	656,335	10.00
11.00	Physician Services Under Agreement	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	12.00
13.00	Other Costs Under Agreement	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	14.00
15.00	Medical Supplies	0	56,499	15.00
16.00	Transportation (Health Care Staff)	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	17.00
18.00	Professional Liability Insurance	0	0	18.00
19.00	Other Health Care Costs	0	0	19.00
20.00	Allowable GME Costs			20.00
21.00	Subtotal (sum of lines 15 through 20)	0	56,499	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	712,834	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	0	29.00
30.00	Administrative Costs	0	155,342	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	155,342	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	868,176	32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 14-1327 Component CCN: 14-8501	Period: From 01/01/2018 To 12/31/2018	Worksheet M-2 Date/Time Prepared: 5/29/2019 3:08 pm
		RHC I	Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	0.00	0	4,200	0		1.00
2.00	Physician Assistant	0.45	2,202	2,100	945		2.00
3.00	Nurse Practitioner	0.35	1,604	2,100	735		3.00
4.00	Subtotal (sum of lines 1 through 3)	0.80	3,806		1,680	3,806	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	0.80	3,806			3,806	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)	208,309	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)	208,309	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)	6,804	14.00
15.00	Parent provider overhead allocated to facility (see instructions)	127,779	15.00
16.00	Total overhead (sum of lines 14 and 15)	134,583	16.00
17.00	Allowable GME overhead (see instructions)	0	17.00
18.00	Enter the amount from line 16	134,583	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)	134,583	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)	342,892	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 14-1327 Component CCN: 14-8568	Period: From 01/01/2018 To 12/31/2018	Worksheet M-2 Date/Time Prepared: 5/29/2019 3:08 pm
		RHC II	Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	2.20	7,404	4,200	9,240		1.00
2.00	Physician Assistant	1.13	2,034	2,100	2,373		2.00
3.00	Nurse Practitioner	0.68	1,356	2,100	1,428		3.00
4.00	Subtotal (sum of lines 1 through 3)	4.01	10,794		13,041	13,041	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)	4.01	10,794			13,041	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)	1,625,850	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)	1,625,850	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)	330,218	14.00
15.00	Parent provider overhead allocated to facility (see instructions)	959,904	15.00
16.00	Total overhead (sum of lines 14 and 15)	1,290,122	16.00
17.00	Allowable GME overhead (see instructions)	0	17.00
18.00	Enter the amount from line 16	1,290,122	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)	1,290,122	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)	2,915,972	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1327 | Component CCN: 14-8579 | Period: From 01/01/2018 To 12/31/2018 | Worksheet M-2 | Date/Time Prepared: 5/29/2019 3:08 pm

RHC III | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	0.78	5,134	4,200	3,276		1.00
2.00	Physician Assistant	0.85	3,242	2,100	1,785		2.00
3.00	Nurse Practitioner	0.00	0	2,100	0		3.00
4.00	Subtotal (sum of lines 1 through 3)	1.63	8,376		5,061	8,376	4.00
5.00	Visiting Nurse	1.15	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	2.78	8,376			8,376	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)	712,834	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)	712,834	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)	155,342	14.00
15.00	Parent provider overhead allocated to facility (see instructions)	578,340	15.00
16.00	Total overhead (sum of lines 14 and 15)	733,682	16.00
17.00	Allowable GME overhead (see instructions)	0	17.00
18.00	Enter the amount from line 16	733,682	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)	733,682	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)	1,446,516	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 14-1327 Component CCN: 14-8501	Period: From 01/01/2018 To 12/31/2018	Worksheet M-3 Date/Time Prepared: 5/29/2019 3:08 pm
	Title XVIII	RHC I	Cost

Line	Description		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)		342,892	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)		342,892	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		3,806	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)		3,806	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		90.09	7.00
		Calculation of Limit (1)		
		Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	82.30	83.45	8.00
9.00	Rate for Program covered visits (see instructions)	90.09	90.09	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	271	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	24,414	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	24,414	16.00
16.01	Total program charges (see instructions)(from contractor's records)		43,298	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.)		14,267	16.04
16.05	Total program cost (see instructions)	0	14,267	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		6,580	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		7,343	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		14,267	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)		14,267	22.00
23.00	Allowable bad debts (see instructions)		377	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		245	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		258	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)		14,512	26.00
26.01	Sequestration adjustment (see instructions)		290	26.01
26.02	Demonstration payment adjustment amount after sequestration		0	26.02
27.00	Interim payments		12,960	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)		1,262	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0	30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 14-1327 Component CCN: 14-8568	Period: From 01/01/2018 To 12/31/2018	Worksheet M-3 Date/Time Prepared: 5/29/2019 3:08 pm
	Title XVIII	RHC II	Cost

			1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES			
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)		2,915,972	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)		297,403	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		2,618,569	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		13,041	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)		13,041	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		200.80	7.00
		Calculation of Limit (1)		
		Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	82.30	83.45	8.00
9.00	Rate for Program covered visits (see instructions)	200.80	200.80	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	2,468	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	495,574	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	495,574	16.00
16.01	Total program charges (see instructions)(from contractor's records)		403,980	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		10,954	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		13,437	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.)		351,154	16.04
16.05	Total program cost (see instructions)	0	364,591	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		43,195	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		69,965	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		364,591	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		175,658	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		540,249	22.00
23.00	Allowable bad debts (see instructions)		5,134	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		3,337	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		5,097	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)		543,586	26.00
26.01	Sequestration adjustment (see instructions)		10,872	26.01
26.02	Demonstration payment adjustment amount after sequestration		0	26.02
27.00	Interim payments		316,005	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)		216,709	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0	30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 14-1327 Component CCN: 14-8579	Period: From 01/01/2018 To 12/31/2018	Worksheet M-3 Date/Time Prepared: 5/29/2019 3:08 pm
	Title XVIII	RHC III	Cost

			1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES			
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)		1,446,516	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)		204,010	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		1,242,506	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		8,376	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)		8,376	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		148.34	7.00
		Calculation of Limit (1)		
		Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	82.30	83.45	8.00
9.00	Rate for Program covered visits (see instructions)	148.34	148.34	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	4,632	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	687,111	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	687,111	16.00
16.01	Total program charges (see instructions)(from contractor's records)		641,033	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		3,067	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		3,287	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.)		502,938	16.04
16.05	Total program cost (see instructions)	0	506,225	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		55,151	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		116,559	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		506,225	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		149,477	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		655,702	22.00
23.00	Allowable bad debts (see instructions)		1,193	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		775	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		1,193	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)		656,477	26.00
26.01	Sequestration adjustment (see instructions)		13,130	26.01
26.02	Demonstration payment adjustment amount after sequestration		0	26.02
27.00	Interim payments		707,132	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)		-63,785	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0	30.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA VACCINE COST	Provider CCN: 14-1327 Component CCN: 14-8568	Period: From 01/01/2018 To 12/31/2018	Worksheet M-4 Date/Time Prepared: 5/29/2019 3:08 pm
	Title XVIII	RHC II	Cost

		Pneumococcal	Influenza	
		1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	1,397,771	1,397,771	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.014514	0.007248	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	20,287	10,131	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	130,365	5,039	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	150,652	15,170	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	1,625,850	1,625,850	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	1,290,122	1,290,122	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.092660	0.009331	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	119,543	12,038	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	270,195	27,208	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	797	398	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	339.02	68.36	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	477	204	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	161,713	13,945	14.00
15.00	Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2)		297,403	15.00
16.00	Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3, line 21)		175,658	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA VACCINE COST	Provider CCN: 14-1327 Component CCN: 14-8579	Period: From 01/01/2018 To 12/31/2018	Worksheet M-4 Date/Time Prepared: 5/29/2019 3:08 pm

		Title XVIII	RHC III	Cost
		Pneumococcal	Influenza	
		1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	656,335	656,335	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.011313	0.020843	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	7,425	13,680	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	69,517	9,913	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	76,942	23,593	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	712,834	712,834	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	733,682	733,682	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.107938	0.033097	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	79,192	24,283	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	156,134	47,876	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	425	783	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	367.37	61.14	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	326	486	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	119,763	29,714	14.00
15.00	Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2)		204,010	15.00
16.00	Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3, line 21)		149,477	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 14-1327 Component CCN: 14-8501	Period: From 01/01/2018 To 12/31/2018	Worksheet M-5 Date/Time Prepared: 5/29/2019 3:08 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		15,089	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		08/01/2018	2,129	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		-2,129	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		12,960	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		1,262	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		14,222	7.00

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

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 14-1327 Component CCN: 14-8568	Period: From 01/01/2018 To 12/31/2018	Worksheet M-5 Date/Time Prepared: 5/29/2019 3:08 pm
		RHC II	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		322,803	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		08/01/2018	6,798	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		-6,798	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		316,005	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		216,709	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		532,714	7.00

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

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 14-1327 Component CCN: 14-8579	Period: From 01/01/2018 To 12/31/2018	Worksheet M-5 Date/Time Prepared: 5/29/2019 3:08 pm
		RHC III	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		391,315	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		08/01/2018	315,817	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
	Provider to Program			
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		315,817	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		707,132	4.00
	TO BE COMPLETED BY CONTRACTOR			
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			5.00
	Program to Provider			
5.01			0	5.01
5.02			0	5.02
5.03			0	5.03
	Provider to Program			
5.50			0	5.50
5.51			0	5.51
5.52			0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00
6.01	SETTLEMENT TO PROVIDER		0	6.01
6.02	SETTLEMENT TO PROGRAM		63,785	6.02
7.00	Total Medicare program liability (see instructions)		643,347	7.00

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