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: 14-1342	Period: From 01/01/2018 To 12/31/2018	Worksheet S Parts I-III Date/Time Prepared: 5/29/2019 4:33 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 5/29/2019 Time: 4:33 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 UNION COUNTY HOSPITAL DISTRICT (14-1342) 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) MIKE HARBOR
Officer or Administrator of Provider(s)

CFO
Title

(Dated when report is electronically signed.)
Date

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	93,073	-140,465	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	20,376	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
10.00	RURAL HEALTH CLINIC I	0		17,824		0	10.00
200.00	Total	0	113,449	-122,641	0	0	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1342 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part I Date/Time Prepared: 5/29/2019 4:33 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 517 NORTH MAIN STREET	PO Box:			1.00
2.00	City: ANNA	State: IL	Zip Code: 62906	County: UNION	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	UNION COUNTY HOSPITAL DISTRICT	141342	99914	1	07/01/1966	N	O	P	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	UNION COUNTY HOSP DIST SWING BEDS	14Z342	99914		08/05/1992	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	UNION COUNTY HOSP DIST RHC	143975	99914		05/22/1991	N	O	N	15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

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

		1.00	2.00	3.00	
	Inpatient PPS Information				
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	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.	3	N		23.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1342 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part I | Date/Time Prepared: 5/29/2019 4:33 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: 14-1342 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part I Date/Time Prepared: 5/29/2019 4:33 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)				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: 14-1342 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part I | Date/Time Prepared: 5/29/2019 4:33 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: 14-1342	Period: From 01/01/2018 To 12/31/2018	Worksheet S-2 Part I Date/Time Prepared: 5/29/2019 4:33 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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1342 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part I | Date/Time Prepared: 5/29/2019 4:33 pm

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

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

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	9,307	0	0	118.01

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1342 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part I Date/Time Prepared: 5/29/2019 4:33 pm

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

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

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

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

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

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

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

		1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act		
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.	Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)	0	168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)		168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	1.00	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)	06/13/2017	09/10/2017	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: 14-1342 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part II | Date/Time Prepared: 5/29/2019 4:33 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)	Y			3.00
		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	N			4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00
			Y/N	Legal Oper.	
			1.00	2.00	
	Approved Educational Activities				
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?		N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.		N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.		N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.		N		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.		N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.		N		11.00
				Y/N	
				1.00	
	Bad Debts				
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.			Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.			N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.			N	14.00
	Bed Complement				
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			N	15.00
		Part A		Part B	
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
	PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	Y	03/18/2019	Y	03/18/2019
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N	
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N	
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N	

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 14-1342 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part II Date/Time Prepared: 5/29/2019 4:33 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.	N	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.	N	35.00

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

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	BRENT	WILSON	41.00
42.00	Enter the employer/company name of the cost report preparer.	QUORUM HEALTH		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	615-221-3647	BRENT	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 14-1342 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part II Date/Time Prepared: 5/29/2019 4:33 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.	REVENUE 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: 14-1342 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-3 Part I Date/Time Prepared: 5/29/2019 4:33 pm

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	25	9,125	42,120.00	0	1.00
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		25	9,125	42,120.00	0	7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)		25	9,125	42,120.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE	46.00	22	8,030			21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	88.00				0	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		47				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00
33.01	LTCH site neutral days and discharges						33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 14-1342 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-3 Part I | Date/Time Prepared: 5/29/2019 4:33 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)	1,266	33	1,755			1.00
2.00	HMO and other (see instructions)	222	48				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	390	0	563			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	27			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,656	33	2,345			7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	1,656	33	2,345	0.00	131.65	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			5,466	0.00	16.05	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	961	0	7,533	0.00	6.00	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	153.70	27.00
28.00	Observation Bed Days		0	263			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 14-1342 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-3 Part I Date/Time Prepared: 5/29/2019 4:33 pm

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	342	16	517	1.00
2.00	HMO and other (see instructions)			61	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	342	16	517	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE	0.00				0	21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	0.00					26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 14-1342 | Component CCN: 14-3975 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-8 | Date/Time Prepared: 5/29/2019 4:33 pm

RHC I | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			517 NORTH MAIN STREET		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	ANNA		IL	62906	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	12:00	17:00	08:00	20:00	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		UNION				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	20:00	08:00	20:00	08:00	20:00	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-1342
Component CCN: 14-3975

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

Worksheet S-8
Date/Time Prepared:
5/29/2019 4:33 pm

RHC I | Cost

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	CLINIC	08:00	20:00	08:00	20:00		11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 14-1342 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-10 | Date/Time Prepared: 5/29/2019 4:33 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)	0.222685	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	1,514,963	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?	N	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	852,006	5.00
6.00	Medicaid charges	17,711,723	6.00
7.00	Medicaid cost (line 1 times line 6)	3,944,135	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)	1,577,166	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)	1,577,166	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)	538,258	4,466	542,724	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	119,862	4,466	124,328	21.00
22.00	Payments received from patients for amounts previously written off as charity care	31,376	1,607	32,983	22.00
23.00	Cost of charity care (line 21 minus line 22)	88,486	2,859	91,345	23.00

		1.00	
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	2,467,160	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	871,609	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	1,340,936	27.01
28.00	Non-Medicare bad debt expense (see instructions)	1,126,224	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	720,120	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	811,465	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	2,388,631	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-1342 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A | Date/Time Prepared: 5/29/2019 4:33 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		170,269	170,269	101,055	271,324	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		1,385,842	1,385,842	117,927	1,503,769	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	106,819	31,216	138,035	1,587,558	1,725,593	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,308,214	5,050,077	6,358,291	-1,846,376	4,511,915	5.00
7.00	00700	OPERATION OF PLANT	268,545	682,922	951,467	7,286	958,753	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	27,880	1,262	29,142	0	29,142	8.00
9.00	00900	HOUSEKEEPING	248,906	81,212	330,118	26,355	356,473	9.00
10.00	01000	DIETARY	219,008	200,859	419,867	0	419,867	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	872,908	112,316	985,224	-154,896	830,328	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	79,016	133,998	213,014	-106,276	106,738	14.00
15.00	01500	PHARMACY	315,942	549,696	865,638	-487,408	378,230	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	89,037	123,615	212,652	-25,279	187,373	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	654,576	899,443	1,554,019	220,882	1,774,901	30.00
46.00	04600	OTHER LONG TERM CARE	678,319	124,763	803,082	-36,074	767,008	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	241,884	126,639	368,523	69,420	437,943	50.00
51.00	05100	RECOVERY ROOM	65,398	7,909	73,307	-73,307	0	51.00
53.00	05300	ANESTHESIOLOGY	0	274,685	274,685	0	274,685	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	348,450	194,743	543,193	431,484	974,677	54.00
54.01	05401	ULTRASOUND	67,783	22,218	90,001	-90,001	0	54.01
56.00	05600	RADIOISOTOPE	0	82,934	82,934	-82,934	0	56.00
57.00	05700	CT SCAN	0	76,102	76,102	-76,102	0	57.00
58.00	05800	MRI	76,483	105,964	182,447	-182,447	0	58.00
60.00	06000	LABORATORY	387,235	441,661	828,896	-42,367	786,529	60.00
65.00	06500	RESPIRATORY THERAPY	53,612	35,719	89,331	-29,964	59,367	65.00
66.00	06600	PHYSICAL THERAPY	498,643	53,083	551,726	-1,155	550,571	66.00
67.00	06700	OCCUPATIONAL THERAPY	145,657	11,648	157,305	0	157,305	67.00
68.00	06800	SPEECH PATHOLOGY	45,569	4,338	49,907	0	49,907	68.00
69.00	06900	ELECTROCARDIOLOGY	71,937	17,630	89,567	0	89,567	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	129,905	129,905	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	9,851	9,851	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	468,220	468,220	73.00
76.00	03020	SLEEP LAB	0	92,691	92,691	0	92,691	76.00
76.03	03950	WOUND CARE	23,721	29,205	52,926	0	52,926	76.03
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	636,028	348,816	984,844	-53,300	931,544	88.00
91.00	09100	EMERGENCY	860,660	1,211,924	2,072,584	-844	2,071,740	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	8,392,230	12,685,399	21,077,629	-118,787	20,958,842	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	43,820	43,820	0	43,820	192.00
194.00	07956	AREAS UNDER RENOVATION	0	0	0	0	0	194.00
194.01	07951	OTHER NONREIMBURSABLE - MARKETING	0	0	0	118,787	118,787	194.01
194.02	07952	OTHER NONREIMBURSABLE - SENIOR CIRC	0	3,184	3,184	0	3,184	194.02
194.03	07953	FREESTANDING HHA COSTS	0	0	0	0	0	194.03
194.04	07954	LEASED TO SPECIALTY CLINICS	0	0	0	0	0	194.04
194.05	07955	VACANT SPACE	0	0	0	0	0	194.05
200.00		TOTAL (SUM OF LINES 118 through 199)	8,392,230	12,732,403	21,124,633	0	21,124,633	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-1342 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A | Date/Time Prepared: 5/29/2019 4:33 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	484,115	755,439		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-882,793	620,976		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	1,725,593		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-1,049,744	3,462,171		5.00
7.00	00700	OPERATION OF PLANT	-1,182	957,571		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	29,142		8.00
9.00	00900	HOUSEKEEPING	0	356,473		9.00
10.00	01000	DIETARY	0	419,867		10.00
11.00	01100	CAFETERIA	-24,675	-24,675		11.00
13.00	01300	NURSING ADMINISTRATION	0	830,328		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	106,738		14.00
15.00	01500	PHARMACY	0	378,230		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-858	186,515		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-765,474	1,009,427		30.00
46.00	04600	OTHER LONG TERM CARE	0	767,008		46.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	437,943		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
53.00	05300	ANESTHESIOLOGY	0	274,685		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	974,677		54.00
54.01	05401	ULTRASOUND	0	0		54.01
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MRI	0	0		58.00
60.00	06000	LABORATORY	0	786,529		60.00
65.00	06500	RESPIRATORY THERAPY	0	59,367		65.00
66.00	06600	PHYSICAL THERAPY	0	550,571		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	157,305		67.00
68.00	06800	SPEECH PATHOLOGY	0	49,907		68.00
69.00	06900	ELECTROCARDIOLOGY	0	89,567		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	129,905		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	9,851		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	468,220		73.00
76.00	03020	SLEEP LAB	-2,250	90,441		76.00
76.03	03950	WOUND CARE	0	52,926		76.03
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	-225,542	706,002		88.00
91.00	09100	EMERGENCY	-648,720	1,423,020		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-3,117,123	17,841,719		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	43,820		192.00
194.00	07956	AREAS UNDER RENOVATION	0	0		194.00
194.01	07951	OTHER NONREIMBURSABLE - MARKETING	0	118,787		194.01
194.02	07952	OTHER NONREIMBURSABLE - SENIOR CIRC	0	3,184		194.02
194.03	07953	FREESTANDING HHA COSTS	0	0		194.03
194.04	07954	LEASED TO SPECIALTY CLINICS	0	0		194.04
194.05	07955	VACANT SPACE	0	0		194.05
200.00		TOTAL (SUM OF LINES 118 through 199)	-3,117,123	18,007,510		200.00

RECLASSIFICATIONS | Provider CCN: 14-1342 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-6 | Date/Time Prepared: 5/29/2019 4:33 pm

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - EMPLOYEE BENEFITS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	1,587,558		1.00
	0		0	1,587,558		
	B - OXYGEN					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	29,964		1.00
	0		0	29,964		
	C - RENTAL AND LEASE					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	116,162		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
	0		0	116,162		
	D - OTHER CAPITAL COSTS					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	101,055		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	1,765		2.00
	0		0	102,820		
	E - MARKETING DEPT					
1.00	OTHER NONREIMBURSABLE - MARKETING	194.01	65,461	53,326		1.00
	0		65,461	53,326		
	F - MED SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	99,941		1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	9,851		2.00
	0		0	109,792		
	G - COST OF DRUGS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	468,220		1.00
	0		0	468,220		
	J - OTHER RADIOLOGY COSTS					
1.00	RADIOLOGY-DIAGNOSTIC	54.00	144,266	287,218		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
	0		144,266	287,218		
	K - RECOVERY ROOM					
1.00	OPERATING ROOM	50.00	65,398	7,909		1.00
	0		65,398	7,909		
	M - RHC SALARY TO ADMIN					
1.00	ADMINISTRATIVE & GENERAL	5.00	52,146	0		1.00
	0		52,146	0		
	N - INFECTION CONTROL					
1.00	NURSING ADMINISTRATION	13.00	63,601	13,323		1.00
	0		63,601	13,323		
	O - RECLASS COSTS TO HSKP AND MAINT					
1.00	OPERATION OF PLANT	7.00	9,206	0		1.00
2.00	HOUSEKEEPING	9.00	26,355	0		2.00
	0		35,561	0		
	P - HOUSE SUPVR TO ADULT AND PED					
1.00	ADULTS & PEDIATRICS	30.00	231,820	0		1.00
	0		231,820	0		
500.00	Grand Total: Increases		658,253	2,776,292		500.00

RECLASSIFICATIONS | Provider CCN: 14-1342 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-6 | Date/Time Prepared: 5/29/2019 4:33 pm

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - EMPLOYEE BENEFITS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	1,587,558	0		1.00
	0		0	1,587,558			
	B - OXYGEN						
1.00	RESPIRATORY THERAPY	65.00	0	29,964	0		1.00
	0		0	29,964			
	C - RENTAL AND LEASE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	12,433	10		1.00
2.00	OPERATION OF PLANT	7.00	0	1,920	0		2.00
3.00	PHARMACY	15.00	0	19,188	0		3.00
4.00	MEDICAL RECORDS & LIBRARY	16.00	0	25,279	0		4.00
5.00	ADULTS & PEDIATRICS	30.00	0	10,938	0		5.00
6.00	OTHER LONG TERM CARE	46.00	0	513	0		6.00
7.00	LABORATORY	60.00	0	42,367	0		7.00
8.00	PHYSICAL THERAPY	66.00	0	1,155	0		8.00
9.00	EMERGENCY	91.00	0	844	0		9.00
10.00	OPERATING ROOM	50.00	0	371	0		10.00
11.00	RURAL HEALTH CLINIC	88.00	0	1,154	0		11.00
	0		0	116,162			
	D - OTHER CAPITAL COSTS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	102,820	12		1.00
2.00		0.00	0	0	13		2.00
	0		0	102,820			
	E - MARKETING DEPT						
1.00	ADMINISTRATIVE & GENERAL	5.00	65,461	53,326	0		1.00
	0		65,461	53,326			
	F - MED SUPPLIES						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	106,276	0		1.00
2.00	OPERATING ROOM	50.00	0	3,516	0		2.00
	0		0	109,792			
	G - COST OF DRUGS						
1.00	PHARMACY	15.00	0	468,220	0		1.00
	0		0	468,220			
	J - OTHER RADIOLOGY COSTS						
1.00	ULTRASOUND	54.01	67,783	22,218	0		1.00
2.00	RADIOISOTOPE	56.00	0	82,934	0		2.00
3.00	CT SCAN	57.00	0	76,102	0		3.00
4.00	MRI	58.00	76,483	105,964	0		4.00
	0		144,266	287,218			
	K - RECOVERY ROOM						
1.00	RECOVERY ROOM	51.00	65,398	7,909	0		1.00
	0		65,398	7,909			
	M - RHC SALARY TO ADMIN						
1.00	RURAL HEALTH CLINIC	88.00	52,146	0	0		1.00
	0		52,146	0			
	N - INFECTION CONTROL						
1.00	ADMINISTRATIVE & GENERAL	5.00	63,601	13,323	0		1.00
	0		63,601	13,323			
	O - RECLASS COSTS TO HSKP AND MAINT						
1.00	OTHER LONG TERM CARE	46.00	35,561	0	0		1.00
2.00		0.00	0	0	0		2.00
	0		35,561	0			
	P - HOUSE SUPVR TO ADULT AND PED						
1.00	NURSING ADMINISTRATION	13.00	231,820	0	0		1.00
	0		231,820	0			
500.00	Grand Total: Decreases		658,253	2,776,292			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1342 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-7 Part I | Date/Time Prepared: 5/29/2019 4:33 pm

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	0	0	0	0	0	1.00
2.00	Land Improvements	124,306	0	0	0	0	2.00
3.00	Buildings and Fixtures	6,846,397	0	0	0	0	3.00
4.00	Building Improvements	9,748,105	190,877	0	190,877	0	4.00
5.00	Fixed Equipment	2,313,299	42,957	0	42,957	988	5.00
6.00	Movable Equipment	10,417,250	225,378	0	225,378	2,656	6.00
7.00	HIT designated Assets	3,248,805	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	32,698,162	459,212	0	459,212	3,644	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	32,698,162	459,212	0	459,212	3,644	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	0	0	1.00
2.00	Land Improvements	124,306	0	2.00
3.00	Buildings and Fixtures	6,846,397	0	3.00
4.00	Building Improvements	9,938,982	0	4.00
5.00	Fixed Equipment	2,355,268	0	5.00
6.00	Movable Equipment	10,639,972	0	6.00
7.00	HIT designated Assets	3,248,805	0	7.00
8.00	Subtotal (sum of lines 1-7)	33,153,730	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	33,153,730	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1342 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-7 Part II | Date/Time Prepared: 5/29/2019 4:33 pm

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	170,269	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	1,385,842	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	1,556,111	0	0	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL		
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
		14.00	15.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	170,269	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	1,385,842	2.00
3.00	Total (sum of lines 1-2)	0	1,556,111	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1342 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-7 Part III Date/Time Prepared: 5/29/2019 4:33 pm

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	COMPUTATION OF RATIOS: Capitalized Leases	COMPUTATION OF RATIOS: Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	ALLOCATION OF OTHER CAPITAL: Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	16,909,685	0	16,909,685	0.510039	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	16,244,045	0	16,244,045	0.489961	0	2.00
3.00	Total (sum of lines 1-2)	33,153,730	0	33,153,730	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	ALLOCATION OF OTHER CAPITAL: Other Capital-Related Costs	ALLOCATION OF OTHER CAPITAL: Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	SUMMARY OF CAPITAL: Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	654,384	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	503,049	116,162	2.00
3.00	Total (sum of lines 1-2)	0	0	0	1,157,433	116,162	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	SUMMARY OF CAPITAL: Insurance (see instructions)	SUMMARY OF CAPITAL: Taxes (see instructions)	SUMMARY OF CAPITAL: Other Capital-Related Costs (see instructions)	SUMMARY OF CAPITAL: Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	101,055	0	0	755,439	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	1,765	0	620,976	2.00
3.00	Total (sum of lines 1-2)	0	101,055	1,765	0	1,376,415	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-1342 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-8 | Date/Time Prepared: 5/29/2019 4:33 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-3,529	ADMINISTRATIVE & GENERAL	5.00	0	7.00
8.00	Television and radio service (chapter 21)	A	-528	CAP REL COSTS-MVBLE EQUIP	2.00	9	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-1,416,444			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	-19,071			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-24,675	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-858	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT	A	471,865	CAP REL COSTS-BLDG & FIXT	1.00	9	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP	A	-889,025	CAP REL COSTS-MVBLE EQUIP	2.00	9	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	FITNESS REVENUE	B	-12,530	ADMINISTRATIVE & GENERAL	5.00	0	33.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-1342 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-8 | Date/Time Prepared: 5/29/2019 4:33 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.02	IL PROVIDER TAX	B	-806,871	ADMINISTRATIVE & GENERAL	5.00	0	33.02
34.00	LOBBY EXPENSE	A	-8,250	ADMINISTRATIVE & GENERAL	5.00	0	34.00
34.01	CHARITABLE CONTRIBUTIONS	A	-1,000	ADMINISTRATIVE & GENERAL	5.00	0	34.01
35.00	PATIENT PHONES BENEFIT COST	A	-860	ADMINISTRATIVE & GENERAL	5.00	0	35.00
36.00	PATIENT PHONES DEPRECIATION COST	A	-1,066	CAP REL COSTS-MVBLE EQUIP	2.00	9	36.00
37.00	CABLE TV EXPENSE	A	-1,182	OPERATION OF PLANT	7.00	0	37.00
38.00	MARKETING EXPENSE - EXCLUDING MARKET	A	-66,109	ADMINISTRATIVE & GENERAL	5.00	0	38.00
39.00	RENTAL INCOME	B	-18,008	CAP REL COSTS-BLDG & FIXT	1.00	9	39.00
40.00	LOBBYING EXPENSE IN ASSOCIATION DUES	A	-11,031	ADMINISTRATIVE & GENERAL	5.00	0	40.00
41.00	MISCELLANEOUS INCOME	B	-1,804	ADMINISTRATIVE & GENERAL	5.00	0	41.00
41.01	PATIENT PHONE WAGES	A	-2,980	ADMINISTRATIVE & GENERAL	5.00	0	41.01
42.00	ADMIN SERVICES ALLOCATED TO RHC	A	-225,542	RURAL HEALTH CLINIC	88.00	0	42.00
43.00	MD AMORTIZATION	A	-77,625	ADMINISTRATIVE & GENERAL	5.00	0	43.00
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-3,117,123				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: 14-1342 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-8-1 | Date/Time Prepared: 5/29/2019 4:33 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	1.00	CAP REL COSTS-BLDG & FIXT	CAPITAL RELATED COSTS(INT &	30,258	0	1.00
2.00	2.00	CAP REL COSTS-MVBLE EQUIP	CAPITAL RELATED (MOVEABLE)	7,826	0	2.00
3.00	5.00	ADMINISTRATIVE & GENERAL	ALLOCATED COSTS	677,121	509,420	3.00
4.00	5.00	ADMINISTRATIVE & GENERAL	MALPRACTICE COSTS	9,307	234,163	4.00
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			724,512	743,583	5.00

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

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

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

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

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

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 14-1342 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-8-1 | Date/Time Prepared: 5/29/2019 4:33 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	30,258	9		1.00
2.00	7,826	9		2.00
3.00	167,701	0		3.00
4.00	-224,856	0		4.00
5.00	-19,071			5.00

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

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

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

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

6.00	HOSPITAL MANAGE		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: 14-1342 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-8-2 | Date/Time Prepared: 5/29/2019 4:33 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	765,474	765,474	0	0	0	1.00
2.00	91.00	EMERGENCY	1,017,600	648,720	368,880	0	0	2.00
3.00	76.00	SLEEP LAB	2,250	2,250	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			1,785,324	1,416,444	368,880		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	91.00	EMERGENCY	0	0	0	0	0	2.00
3.00	76.00	SLEEP LAB	0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	765,474		1.00
2.00	91.00	EMERGENCY	0	0	0	648,720		2.00
3.00	76.00	SLEEP LAB	0	0	0	2,250		3.00
4.00	0.00		0	0	0	0		4.00
5.00	0.00		0	0	0	0		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	1,416,444		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1342 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part I | Date/Time Prepared: 5/29/2019 4:33 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	755,439	755,439				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	620,976		620,976			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,725,593	5,902	4,917	1,736,412		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	3,462,171	156,691	130,546	258,045	4,007,453	5.00
7.00	00700	OPERATION OF PLANT	957,571	108,474	90,373	58,210	1,214,628	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	29,142	12,741	10,615	5,843	58,341	8.00
9.00	00900	HOUSEKEEPING	356,473	9,737	8,113	57,688	432,011	9.00
10.00	01000	DIETARY	419,867	24,060	20,045	45,899	509,871	10.00
11.00	01100	CAFETERIA	-24,675	0	0	0	-24,675	11.00
13.00	01300	NURSING ADMINISTRATION	830,328	20,935	17,442	147,685	1,016,390	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	106,738	14,860	12,380	16,560	150,538	14.00
15.00	01500	PHARMACY	378,230	9,314	7,760	66,214	461,518	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	186,515	8,656	7,211	18,660	221,042	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,009,427	53,946	44,944	185,766	1,294,083	30.00
46.00	04600	OTHER LONG TERM CARE	767,008	44,950	37,449	134,706	984,113	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	437,943	29,666	24,716	64,399	556,724	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	274,685	0	0	0	274,685	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	974,677	47,764	39,794	103,261	1,165,496	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	786,529	13,218	11,012	81,155	891,914	60.00
65.00	06500	RESPIRATORY THERAPY	59,367	1,990	1,658	11,236	74,251	65.00
66.00	06600	PHYSICAL THERAPY	550,571	33,510	27,918	104,503	716,502	66.00
67.00	06700	OCCUPATIONAL THERAPY	157,305	7,566	6,303	30,526	201,700	67.00
68.00	06800	SPEECH PATHOLOGY	49,907	1,052	876	9,550	61,385	68.00
69.00	06900	ELECTROCARDIOLOGY	89,567	5,743	4,784	15,076	115,170	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	129,905	0	0	0	129,905	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	9,851	0	0	0	9,851	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	468,220	0	0	0	468,220	73.00
76.00	03020	SLEEP LAB	90,441	2,694	2,244	0	95,379	76.00
76.03	03950	WOUND CARE	52,926	7,279	6,064	4,971	71,240	76.03
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	706,002	25,157	20,959	122,367	874,485	88.00
91.00	09100	EMERGENCY	1,423,020	35,636	29,689	180,373	1,668,718	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	17,841,719	681,541	567,812	1,722,693	17,700,938	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	3,556	2,963	0	6,519	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	43,820	43,505	36,245	0	123,570	192.00
194.00	07956	AREAS UNDER RENOVATION	0	0	0	0	0	194.00
194.01	07951	OTHER NONREIMBURSABLE - MARKETING	118,787	2,958	2,465	13,719	137,929	194.01
194.02	07952	OTHER NONREIMBURSABLE - SENIOR CIRC	3,184	3,443	2,868	0	9,495	194.02
194.03	07953	FREESTANDING HHA COSTS	0	0	0	0	0	194.03
194.04	07954	LEASED TO SPECIALTY CLINICS	0	10,350	8,623	0	18,973	194.04
194.05	07955	VACANT SPACE	0	10,086	0	0	10,086	194.05
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)	18,007,510	755,439	620,976	1,736,412	18,007,510	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1342 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part I | Date/Time Prepared: 5/29/2019 4:33 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	4,007,453					5.00
7.00	00700	OPERATION OF PLANT	347,070	1,561,698				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	16,670	41,831	116,842			8.00
9.00	00900	HOUSEKEEPING	123,444	31,970	3,551	590,976		9.00
10.00	01000	DIETARY	145,692	78,993	567	31,471	766,594	10.00
11.00	01100	CAFETERIA	0	0	0	0	223,891	11.00
13.00	01300	NURSING ADMINISTRATION	290,425	68,734	0	27,384	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	43,015	48,787	0	19,437	0	14.00
15.00	01500	PHARMACY	131,875	30,579	0	12,183	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	63,161	28,418	0	11,322	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	369,774	177,111	20,681	70,560	173,171	30.00
46.00	04600	OTHER LONG TERM CARE	281,202	147,577	58,572	58,796	369,532	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	159,079	97,400	5,148	38,805	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	78,489	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	333,031	156,818	4,659	62,477	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	254,857	43,396	0	17,289	0	60.00
65.00	06500	RESPIRATORY THERAPY	21,217	6,533	0	2,603	0	65.00
66.00	06600	PHYSICAL THERAPY	204,735	110,019	8,859	43,832	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	57,634	28,467	0	9,897	0	67.00
68.00	06800	SPEECH PATHOLOGY	17,540	4,372	0	1,376	0	68.00
69.00	06900	ELECTROCARDIOLOGY	32,909	18,854	0	7,512	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	37,119	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,815	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	133,790	0	0	0	0	73.00
76.00	03020	SLEEP LAB	27,254	8,843	0	3,523	0	76.00
76.03	03950	WOUND CARE	20,356	23,897	0	9,521	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	249,877	82,595	956	32,906	0	88.00
91.00	09100	EMERGENCY	476,823	116,999	13,849	46,613	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	3,919,853	1,352,193	116,842	507,507	766,594	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,863	11,675	0	4,651	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	35,309	142,833	0	56,906	0	192.00
194.00	07956	AREAS UNDER RENOVATION	0	0	0	0	0	194.00
194.01	07951	OTHER NONREIMBURSABLE - MARKETING	39,412	9,713	0	3,870	0	194.01
194.02	07952	OTHER NONREIMBURSABLE - SENIOR CIRC	2,713	11,302	0	4,503	0	194.02
194.03	07953	FREESTANDING HHA COSTS	0	0	0	0	0	194.03
194.04	07954	LEASED TO SPECIALTY CLINICS	5,421	33,982	0	13,539	0	194.04
194.05	07955	VACANT SPACE	2,882	0	0	0	0	194.05
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)	4,007,453	1,561,698	116,842	590,976	766,594	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1342 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part I | Date/Time Prepared: 5/29/2019 4:33 pm

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	199,216					11.00
13.00	01300	NURSING ADMINISTRATION	17,969	1,420,902				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	4,044	0	265,821			14.00
15.00	01500	PHARMACY	5,797	0	3,715	645,667		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,861	0	2,054	0	330,858	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	28,866	477,442	38,056	0	17,367	30.00
46.00	04600	OTHER LONG TERM CARE	31,975	0	10,782	0	3,062	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	10,100	224,129	54,621	0	15,284	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	4,055	0	3,111	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	16,754	0	16,728	0	119,314	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	14,862	0	0	0	52,367	60.00
65.00	06500	RESPIRATORY THERAPY	1,992	39,104	1,256	0	1,161	65.00
66.00	06600	PHYSICAL THERAPY	15,160	0	7,365	0	13,168	66.00
67.00	06700	OCCUPATIONAL THERAPY	4,004	0	0	0	3,219	67.00
68.00	06800	SPEECH PATHOLOGY	956	0	0	0	853	68.00
69.00	06900	ELECTROCARDIOLOGY	2,112	52,470	840	0	6,545	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	60,641	0	5,090	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	5,223	0	409	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	645,667	33,335	73.00
76.00	03020	SLEEP LAB	0	0	4,729	0	1,300	76.00
76.03	03950	WOUND CARE	1,395	0	3,591	0	849	76.03
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	11,953	0	7,799	0	4,283	88.00
91.00	09100	EMERGENCY	24,464	627,757	44,366	0	50,141	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	197,264	1,420,902	265,821	645,667	330,858	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07956	AREAS UNDER RENOVATION	0	0	0	0	0	194.00
194.01	07951	OTHER NONREIMBURSABLE - MARKETING	1,952	0	0	0	0	194.01
194.02	07952	OTHER NONREIMBURSABLE - SENIOR CIRC	0	0	0	0	0	194.02
194.03	07953	FREESTANDING HHA COSTS	0	0	0	0	0	194.03
194.04	07954	LEASED TO SPECIALTY CLINICS	0	0	0	0	0	194.04
194.05	07955	VACANT SPACE	0	0	0	0	0	194.05
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)	199,216	1,420,902	265,821	645,667	330,858	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1342 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part I | Date/Time Prepared: 5/29/2019 4:33 pm

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	2,667,111	0	2,667,111		30.00
46.00	04600	OTHER LONG TERM CARE	1,945,611	0	1,945,611		46.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	1,161,290	0	1,161,290		50.00
51.00	05100	RECOVERY ROOM	0	0	0		51.00
53.00	05300	ANESTHESIOLOGY	360,340	0	360,340		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,875,277	0	1,875,277		54.00
54.01	05401	ULTRASOUND	0	0	0		54.01
56.00	05600	RADIOISOTOPE	0	0	0		56.00
57.00	05700	CT SCAN	0	0	0		57.00
58.00	05800	MRI	0	0	0		58.00
60.00	06000	LABORATORY	1,274,685	0	1,274,685		60.00
65.00	06500	RESPIRATORY THERAPY	148,117	0	148,117		65.00
66.00	06600	PHYSICAL THERAPY	1,119,640	0	1,119,640		66.00
67.00	06700	OCCUPATIONAL THERAPY	304,921	0	304,921		67.00
68.00	06800	SPEECH PATHOLOGY	86,482	0	86,482		68.00
69.00	06900	ELECTROCARDIOLOGY	236,412	0	236,412		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	232,755	0	232,755		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	18,298	0	18,298		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,281,012	0	1,281,012		73.00
76.00	03020	SLEEP LAB	141,028	0	141,028		76.00
76.03	03950	WOUND CARE	130,849	0	130,849		76.03
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	1,264,854	0	1,264,854		88.00
91.00	09100	EMERGENCY	3,069,730	0	3,069,730		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0			92.00
		SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	17,318,412	0	17,318,412		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	24,708	0	24,708		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	358,618	0	358,618		192.00
194.00	07956	AREAS UNDER RENOVATION	0	0	0		194.00
194.01	07951	OTHER NONREIMBURSABLE - MARKETING	192,876	0	192,876		194.01
194.02	07952	OTHER NONREIMBURSABLE - SENIOR CIRC	28,013	0	28,013		194.02
194.03	07953	FREESTANDING HHA COSTS	0	0	0		194.03
194.04	07954	LEASED TO SPECIALTY CLINICS	71,915	0	71,915		194.04
194.05	07955	VACANT SPACE	12,968	0	12,968		194.05
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)	18,007,510	0	18,007,510		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1342 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part II Date/Time Prepared: 5/29/2019 4:33 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	5,902	4,917	10,819	10,819	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	156,691	130,546	287,237	1,608	5.00
7.00	00700	OPERATION OF PLANT	0	108,474	90,373	198,847	363	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	12,741	10,615	23,356	36	8.00
9.00	00900	HOUSEKEEPING	0	9,737	8,113	17,850	359	9.00
10.00	01000	DIETARY	0	24,060	20,045	44,105	286	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	20,935	17,442	38,377	920	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	14,860	12,380	27,240	103	14.00
15.00	01500	PHARMACY	0	9,314	7,760	17,074	413	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	8,656	7,211	15,867	116	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	53,946	44,944	98,890	1,158	30.00
46.00	04600	OTHER LONG TERM CARE	0	44,950	37,449	82,399	839	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	29,666	24,716	54,382	401	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	47,764	39,794	87,558	643	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	13,218	11,012	24,230	506	60.00
65.00	06500	RESPIRATORY THERAPY	0	1,990	1,658	3,648	70	65.00
66.00	06600	PHYSICAL THERAPY	0	33,510	27,918	61,428	651	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	7,566	6,303	13,869	190	67.00
68.00	06800	SPEECH PATHOLOGY	0	1,052	876	1,928	60	68.00
69.00	06900	ELECTROCARDIOLOGY	0	5,743	4,784	10,527	94	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	SLEEP LAB	0	2,694	2,244	4,938	0	76.00
76.03	03950	WOUND CARE	0	7,279	6,064	13,343	31	76.03
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	25,157	20,959	46,116	763	88.00
91.00	09100	EMERGENCY	0	35,636	29,689	65,325	1,124	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	681,541	567,812	1,249,353	10,734	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	3,556	2,963	6,519	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	43,505	36,245	79,750	0	192.00
194.00	07956	AREAS UNDER RENOVATION	0	0	0	0	0	194.00
194.01	07951	OTHER NONREIMBURSABLE - MARKETING	0	2,958	2,465	5,423	85	194.01
194.02	07952	OTHER NONREIMBURSABLE - SENIOR CIRC	0	3,443	2,868	6,311	0	194.02
194.03	07953	FREESTANDING HHA COSTS	0	0	0	0	0	194.03
194.04	07954	LEASED TO SPECIALTY CLINICS	0	10,350	8,623	18,973	0	194.04
194.05	07955	VACANT SPACE	0	10,086	0	10,086	0	194.05
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	755,439	620,976	1,376,415	10,819	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1342 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part II | Date/Time Prepared: 5/29/2019 4:33 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	288,845					5.00
7.00	00700	OPERATION OF PLANT	25,015	224,225				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,202	6,006	30,600			8.00
9.00	00900	HOUSEKEEPING	8,897	4,590	930	32,626		9.00
10.00	01000	DIETARY	10,501	11,342	149	1,737	68,120	10.00
11.00	01100	CAFETERIA	0	0	0	0	19,895	11.00
13.00	01300	NURSING ADMINISTRATION	20,933	9,869	0	1,512	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3,100	7,005	0	1,073	0	14.00
15.00	01500	PHARMACY	9,505	4,390	0	673	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,552	4,080	0	625	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	26,652	25,428	5,416	3,894	15,388	30.00
46.00	04600	OTHER LONG TERM CARE	20,268	21,189	15,340	3,246	32,837	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	11,466	13,984	1,348	2,142	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	5,657	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	24,003	22,516	1,220	3,449	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	18,369	6,231	0	954	0	60.00
65.00	06500	RESPIRATORY THERAPY	1,529	938	0	144	0	65.00
66.00	06600	PHYSICAL THERAPY	14,756	15,796	2,320	2,420	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	4,154	4,087	0	546	0	67.00
68.00	06800	SPEECH PATHOLOGY	1,264	628	0	76	0	68.00
69.00	06900	ELECTROCARDIOLOGY	2,372	2,707	0	415	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,675	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	203	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	9,643	0	0	0	0	73.00
76.00	03020	SLEEP LAB	1,964	1,270	0	195	0	76.00
76.03	03950	WOUND CARE	1,467	3,431	0	526	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	18,010	11,859	250	1,817	0	88.00
91.00	09100	EMERGENCY	34,373	16,798	3,627	2,573	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	282,530	194,144	30,600	28,017	68,120	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	134	1,676	0	257	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2,545	20,508	0	3,142	0	192.00
194.00	07956	AREAS UNDER RENOVATION	0	0	0	0	0	194.00
194.01	07951	OTHER NONREIMBURSABLE - MARKETING	2,841	1,395	0	214	0	194.01
194.02	07952	OTHER NONREIMBURSABLE - SENIOR CIRC	196	1,623	0	249	0	194.02
194.03	07953	FREESTANDING HHA COSTS	0	0	0	0	0	194.03
194.04	07954	LEASED TO SPECIALTY CLINICS	391	4,879	0	747	0	194.04
194.05	07955	VACANT SPACE	208	0	0	0	0	194.05
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)	288,845	224,225	30,600	32,626	68,120	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1342 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part II | Date/Time Prepared: 5/29/2019 4:33 pm

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	17,702					11.00
13.00	01300	NURSING ADMINISTRATION	1,597	73,208				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	359	0	38,880			14.00
15.00	01500	PHARMACY	515	0	543	33,113		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	432	0	300	0	25,972	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,565	24,599	5,566	0	1,364	30.00
46.00	04600	OTHER LONG TERM CARE	2,841	0	1,577	0	240	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	897	11,548	7,989	0	1,200	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	593	0	244	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,489	0	2,447	0	9,362	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	1,321	0	0	0	4,112	60.00
65.00	06500	RESPIRATORY THERAPY	177	2,015	184	0	91	65.00
66.00	06600	PHYSICAL THERAPY	1,347	0	1,077	0	1,034	66.00
67.00	06700	OCCUPATIONAL THERAPY	356	0	0	0	253	67.00
68.00	06800	SPEECH PATHOLOGY	85	0	0	0	67	68.00
69.00	06900	ELECTROCARDIOLOGY	188	2,703	123	0	514	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	8,870	0	400	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	764	0	32	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	33,113	2,617	73.00
76.00	03020	SLEEP LAB	0	0	692	0	102	76.00
76.03	03950	WOUND CARE	124	0	525	0	67	76.03
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,062	0	1,141	0	336	88.00
91.00	09100	EMERGENCY	2,174	32,343	6,489	0	3,937	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	17,529	73,208	38,880	33,113	25,972	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07956	AREAS UNDER RENOVATION	0	0	0	0	0	194.00
194.01	07951	OTHER NONREIMBURSABLE - MARKETING	173	0	0	0	0	194.01
194.02	07952	OTHER NONREIMBURSABLE - SENIOR CIRC	0	0	0	0	0	194.02
194.03	07953	FREESTANDING HHA COSTS	0	0	0	0	0	194.03
194.04	07954	LEASED TO SPECIALTY CLINICS	0	0	0	0	0	194.04
194.05	07955	VACANT SPACE	0	0	0	0	0	194.05
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	2,193	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	19,895	73,208	38,880	33,113	25,972	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1342 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part II | Date/Time Prepared: 5/29/2019 4:33 pm

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	210,920	0	210,920		30.00
46.00	04600	OTHER LONG TERM CARE	180,776	0	180,776		46.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	105,357	0	105,357		50.00
51.00	05100	RECOVERY ROOM	0	0	0		51.00
53.00	05300	ANESTHESIOLOGY	6,494	0	6,494		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	152,687	0	152,687		54.00
54.01	05401	ULTRASOUND	0	0	0		54.01
56.00	05600	RADIOISOTOPE	0	0	0		56.00
57.00	05700	CT SCAN	0	0	0		57.00
58.00	05800	MRI	0	0	0		58.00
60.00	06000	LABORATORY	55,723	0	55,723		60.00
65.00	06500	RESPIRATORY THERAPY	8,796	0	8,796		65.00
66.00	06600	PHYSICAL THERAPY	100,829	0	100,829		66.00
67.00	06700	OCCUPATIONAL THERAPY	23,455	0	23,455		67.00
68.00	06800	SPEECH PATHOLOGY	4,108	0	4,108		68.00
69.00	06900	ELECTROCARDIOLOGY	19,643	0	19,643		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	11,945	0	11,945		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	999	0	999		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	45,373	0	45,373		73.00
76.00	03020	SLEEP LAB	9,161	0	9,161		76.00
76.03	03950	WOUND CARE	19,514	0	19,514		76.03
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	81,354	0	81,354		88.00
91.00	09100	EMERGENCY	168,763	0	168,763		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0			92.00
		SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,205,897	0	1,205,897		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	8,586	0	8,586		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	105,945	0	105,945		192.00
194.00	07956	AREAS UNDER RENOVATION	0	0	0		194.00
194.01	07951	OTHER NONREIMBURSABLE - MARKETING	10,131	0	10,131		194.01
194.02	07952	OTHER NONREIMBURSABLE - SENIOR CIRC	8,379	0	8,379		194.02
194.03	07953	FREESTANDING HHA COSTS	0	0	0		194.03
194.04	07954	LEASED TO SPECIALTY CLINICS	24,990	0	24,990		194.04
194.05	07955	VACANT SPACE	10,294	0	10,294		194.05
200.00		Cross Foot Adjustments	0	0	0		200.00
201.00		Negative Cost Centers	2,193	0	2,193		201.00
202.00		TOTAL (sum lines 118 through 201)	1,376,415	0	1,376,415		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1342 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B-1 | Date/Time Prepared: 5/29/2019 4:33 pm

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	99,846					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		98,513				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	780	780	8,285,411			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	20,710	20,710	1,231,298	-4,007,453	14,024,732	5.00
7.00	00700	OPERATION OF PLANT	14,337	14,337	277,751	0	1,214,628	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,684	1,684	27,880	0	58,341	8.00
9.00	00900	HOUSEKEEPING	1,287	1,287	275,261	0	432,011	9.00
10.00	01000	DIETARY	3,180	3,180	219,008	0	509,871	10.00
11.00	01100	CAFETERIA	0	0	0	24,675	0	11.00
13.00	01300	NURSING ADMINISTRATION	2,767	2,767	704,689	0	1,016,390	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,964	1,964	79,016	0	150,538	14.00
15.00	01500	PHARMACY	1,231	1,231	315,942	0	461,518	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,144	1,144	89,037	0	221,042	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,130	7,130	886,396	0	1,294,083	30.00
46.00	04600	OTHER LONG TERM CARE	5,941	5,941	642,758	0	984,113	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,921	3,921	307,282	0	556,724	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	274,685	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,313	6,313	492,716	0	1,165,496	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	1,747	1,747	387,235	0	891,914	60.00
65.00	06500	RESPIRATORY THERAPY	263	263	53,612	0	74,251	65.00
66.00	06600	PHYSICAL THERAPY	4,429	4,429	498,643	0	716,502	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,000	1,000	145,657	0	201,700	67.00
68.00	06800	SPEECH PATHOLOGY	139	139	45,569	0	61,385	68.00
69.00	06900	ELECTROCARDIOLOGY	759	759	71,937	0	115,170	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	129,905	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	9,851	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	468,220	73.00
76.00	03020	SLEEP LAB	356	356	0	0	95,379	76.00
76.03	03950	WOUND CARE	962	962	23,721	0	71,240	76.03
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	3,325	3,325	583,882	0	874,485	88.00
91.00	09100	EMERGENCY	4,710	4,710	860,660	0	1,668,718	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	90,079	90,079	8,219,950	-3,982,778	13,718,160	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	470	470	0	0	6,519	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	5,750	5,750	0	0	123,570	192.00
194.00	07956	AREAS UNDER RENOVATION	0	0	0	0	0	194.00
194.01	07951	OTHER NONREIMBURSABLE - MARKETING	391	391	65,461	0	137,929	194.01
194.02	07952	OTHER NONREIMBURSABLE - SENIOR CIRC	455	455	0	0	9,495	194.02
194.03	07953	FREESTANDING HHA COSTS	0	0	0	0	0	194.03
194.04	07954	LEASED TO SPECIALTY CLINICS	1,368	1,368	0	0	18,973	194.04
194.05	07955	VACANT SPACE	1,333	0	0	0	10,086	194.05
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)	755,439	620,976	1,736,412		4,007,453	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	7.566042	6.303493	0.209575		0.285742	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			10,819		288,845	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.001306		0.020595	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: 14-1342 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B-1 | Date/Time Prepared: 5/29/2019 4:33 pm

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (LBS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTES)	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	62,869					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,684	57,057				8.00
9.00	00900	HOUSEKEEPING	1,287	1,734	59,715			9.00
10.00	01000	DIETARY	3,180	277	3,180	33,750		10.00
11.00	01100	CAFETERIA	0	0	0	9,857	10,000	11.00
13.00	01300	NURSING ADMINISTRATION	2,767	0	2,767	0	902	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,964	0	1,964	0	203	14.00
15.00	01500	PHARMACY	1,231	0	1,231	0	291	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,144	0	1,144	0	244	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,130	10,099	7,130	7,624	1,449	30.00
46.00	04600	OTHER LONG TERM CARE	5,941	28,602	5,941	16,269	1,605	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,921	2,514	3,921	0	507	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,313	2,275	6,313	0	841	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	1,747	0	1,747	0	746	60.00
65.00	06500	RESPIRATORY THERAPY	263	0	263	0	100	65.00
66.00	06600	PHYSICAL THERAPY	4,429	4,326	4,429	0	761	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,146	0	1,000	0	201	67.00
68.00	06800	SPEECH PATHOLOGY	176	0	139	0	48	68.00
69.00	06900	ELECTROCARDIOLOGY	759	0	759	0	106	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	SLEEP LAB	356	0	356	0	0	76.00
76.03	03950	WOUND CARE	962	0	962	0	70	76.03
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	3,325	467	3,325	0	600	88.00
91.00	09100	EMERGENCY	4,710	6,763	4,710	0	1,228	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	54,435	57,057	51,281	33,750	9,902	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	470	0	470	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	5,750	0	5,750	0	0	192.00
194.00	07956	AREAS UNDER RENOVATION	0	0	0	0	0	194.00
194.01	07951	OTHER NONREIMBURSABLE - MARKETING	391	0	391	0	98	194.01
194.02	07952	OTHER NONREIMBURSABLE - SENIOR CIRC	455	0	455	0	0	194.02
194.03	07953	FREESTANDING HHA COSTS	0	0	0	0	0	194.03
194.04	07954	LEASED TO SPECIALTY CLINICS	1,368	0	1,368	0	0	194.04
194.05	07955	VACANT SPACE	0	0	0	0	0	194.05
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)	1,561,698	116,842	590,976	766,594	199,216	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	24.840510	2.047812	9.896609	22.713896	19.921600	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	224,225	30,600	32,626	68,120	19,895	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	3.566543	0.536306	0.546362	2.018370	1.770200	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: 14-1342 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B-1 | Date/Time Prepared: 5/29/2019 4:33 pm

		Cost Center Description	NURSING ADMINISTRATION (NURSING WAGES)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)		
			13.00	14.00	15.00	16.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	1,948,067					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	322,417				14.00
15.00	01500	PHARMACY	0	4,506	468,220			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	2,491	0	77,770,828		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	654,576	46,158	0	4,082,495		30.00
46.00	04600	OTHER LONG TERM CARE	0	13,078	0	719,872		46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	307,282	66,251	0	3,592,826		50.00
51.00	05100	RECOVERY ROOM	0	0	0	0		51.00
53.00	05300	ANESTHESIOLOGY	0	4,918	0	731,229		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	20,289	0	28,042,374		54.00
54.01	05401	ULTRASOUND	0	0	0	0		54.01
56.00	05600	RADIOISOTOPE	0	0	0	0		56.00
57.00	05700	CT SCAN	0	0	0	0		57.00
58.00	05800	MRI	0	0	0	0		58.00
60.00	06000	LABORATORY	0	0	0	12,309,961		60.00
65.00	06500	RESPIRATORY THERAPY	53,612	1,523	0	272,839		65.00
66.00	06600	PHYSICAL THERAPY	0	8,933	0	3,095,532		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	756,634		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	200,592		68.00
69.00	06900	ELECTROCARDIOLOGY	71,937	1,019	0	1,538,533		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	73,553	0	1,196,587		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	6,335	0	96,099		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	468,220	7,836,221		73.00
76.00	03020	SLEEP LAB	0	5,736	0	305,701		76.00
76.03	03950	WOUND CARE	0	4,356	0	199,557		76.03
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	9,459	0	1,006,876		88.00
91.00	09100	EMERGENCY	860,660	53,812	0	11,786,900		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,948,067	322,417	468,220	77,770,828		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192.00
194.00	07956	AREAS UNDER RENOVATION	0	0	0	0		194.00
194.01	07951	OTHER NONREIMBURSABLE - MARKETING	0	0	0	0		194.01
194.02	07952	OTHER NONREIMBURSABLE - SENIOR CIRC	0	0	0	0		194.02
194.03	07953	FREESTANDING HHA COSTS	0	0	0	0		194.03
194.04	07954	LEASED TO SPECIALTY CLINICS	0	0	0	0		194.04
194.05	07955	VACANT SPACE	0	0	0	0		194.05
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)	1,420,902	265,821	645,667	330,858		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.729391	0.824463	1.378982	0.004254		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	73,208	38,880	33,113	25,972		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.037580	0.120589	0.070721	0.000334		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: 14-1342 | Period: From 01/01/2018 To 12/31/2018 | Worksheet C Part I Date/Time Prepared: 5/29/2019 4:33 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	2,667,111		2,667,111	0	0	30.00
46.00	04600	OTHER LONG TERM CARE	1,945,611		1,945,611	0	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,161,290		1,161,290	0	0	50.00
51.00	05100	RECOVERY ROOM	0		0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	360,340		360,340	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,875,277		1,875,277	0	0	54.00
54.01	05401	ULTRASOUND	0		0	0	0	54.01
56.00	05600	RADIOISOTOPE	0		0	0	0	56.00
57.00	05700	CT SCAN	0		0	0	0	57.00
58.00	05800	MRI	0		0	0	0	58.00
60.00	06000	LABORATORY	1,274,685		1,274,685	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	148,117	0	148,117	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,119,640	0	1,119,640	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	304,921	0	304,921	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	86,482	0	86,482	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	236,412		236,412	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	232,755		232,755	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	18,298		18,298	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,281,012		1,281,012	0	0	73.00
76.00	03020	SLEEP LAB	141,028		141,028	0	0	76.00
76.03	03950	WOUND CARE	130,849		130,849	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,264,854		1,264,854	0	0	88.00
91.00	09100	EMERGENCY	3,069,730		3,069,730	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	271,369		271,369		0	92.00
200.00		Subtotal (see instructions)	17,589,781	0	17,589,781	0	0	200.00
201.00		Less Observation Beds	271,369		271,369		0	201.00
202.00		Total (see instructions)	17,318,412	0	17,318,412	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1342 | Period: From 01/01/2018 To 12/31/2018 | Worksheet C Part I Date/Time Prepared: 5/29/2019 4:33 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Charges: Inpatient	Charges: Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,369,418		3,369,418			30.00
46.00	04600	OTHER LONG TERM CARE	719,872		719,872			46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	103,744	3,489,082	3,592,826	0.323225	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0.000000	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	26,465	704,764	731,229	0.492787	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,050,930	26,991,444	28,042,374	0.066873	0.000000	54.00
54.01	05401	ULTRASOUND	0	0	0	0.000000	0.000000	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0.000000	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	0.000000	0.000000	57.00
58.00	05800	MRI	0	0	0	0.000000	0.000000	58.00
60.00	06000	LABORATORY	1,614,569	10,695,392	12,309,961	0.103549	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	192,548	80,291	272,839	0.542873	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	376,458	2,719,074	3,095,532	0.361696	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	317,421	439,213	756,634	0.402997	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	63,375	137,217	200,592	0.431134	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	30,230	1,508,303	1,538,533	0.153661	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	794,555	402,032	1,196,587	0.194516	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	40	96,059	96,099	0.190408	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,998,391	4,837,830	7,836,221	0.163473	0.000000	73.00
76.00	03020	SLEEP LAB	0	305,701	305,701	0.461327	0.000000	76.00
76.03	03950	WOUND CARE	0	199,557	199,557	0.655697	0.000000	76.03
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	1,006,876	1,006,876			88.00
91.00	09100	EMERGENCY	36,551	11,750,349	11,786,900	0.260436	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	12,138	700,939	713,077	0.380561	0.000000	92.00
200.00		Subtotal (see instructions)	11,706,705	66,064,123	77,770,828			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	11,706,705	66,064,123	77,770,828			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1342 | Period: From 01/01/2018 To 12/31/2018 | Worksheet C Part I Date/Time Prepared: 5/29/2019 4:33 pm

Title XVIII | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
46.00	04600	OTHER LONG TERM CARE		46.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.000000	50.00
51.00	05100	RECOVERY ROOM	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	54.00
54.01	05401	ULTRASOUND	0.000000	54.01
56.00	05600	RADIOISOTOPE	0.000000	56.00
57.00	05700	CT SCAN	0.000000	57.00
58.00	05800	MRI	0.000000	58.00
60.00	06000	LABORATORY	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	73.00
76.00	03020	SLEEP LAB	0.000000	76.00
76.03	03950	WOUND CARE	0.000000	76.03
		OUTPATIENT SERVICE COST CENTERS		
88.00	08800	RURAL HEALTH CLINIC		88.00
91.00	09100	EMERGENCY	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	92.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1342 | Period: From 01/01/2018 To 12/31/2018 | Worksheet C Part I Date/Time Prepared: 5/29/2019 4:33 pm

Title XIX | Hospital | PPS

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	Costs RCE Disallowance	Costs Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,667,111		2,667,111	0	2,667,111	30.00
46.00	04600	OTHER LONG TERM CARE	1,945,611		1,945,611	0	1,945,611	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,161,290		1,161,290	0	1,161,290	50.00
51.00	05100	RECOVERY ROOM	0		0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	360,340		360,340	0	360,340	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,875,277		1,875,277	0	1,875,277	54.00
54.01	05401	ULTRASOUND	0		0	0	0	54.01
56.00	05600	RADIOISOTOPE	0		0	0	0	56.00
57.00	05700	CT SCAN	0		0	0	0	57.00
58.00	05800	MRI	0		0	0	0	58.00
60.00	06000	LABORATORY	1,274,685		1,274,685	0	1,274,685	60.00
65.00	06500	RESPIRATORY THERAPY	148,117	0	148,117	0	148,117	65.00
66.00	06600	PHYSICAL THERAPY	1,119,640	0	1,119,640	0	1,119,640	66.00
67.00	06700	OCCUPATIONAL THERAPY	304,921	0	304,921	0	304,921	67.00
68.00	06800	SPEECH PATHOLOGY	86,482	0	86,482	0	86,482	68.00
69.00	06900	ELECTROCARDIOLOGY	236,412		236,412	0	236,412	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	232,755		232,755	0	232,755	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	18,298		18,298	0	18,298	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,281,012		1,281,012	0	1,281,012	73.00
76.00	03020	SLEEP LAB	141,028		141,028	0	141,028	76.00
76.03	03950	WOUND CARE	130,849		130,849	0	130,849	76.03
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,264,854		1,264,854	0	1,264,854	88.00
91.00	09100	EMERGENCY	3,069,730		3,069,730	0	3,069,730	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	271,369		271,369		271,369	92.00
200.00		Subtotal (see instructions)	17,589,781	0	17,589,781	0	17,589,781	200.00
201.00		Less Observation Beds	271,369		271,369		271,369	201.00
202.00		Total (see instructions)	17,318,412	0	17,318,412	0	17,318,412	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1342 | Period: From 01/01/2018 To 12/31/2018 | Worksheet C Part I Date/Time Prepared: 5/29/2019 4:33 pm

Title XIX | Hospital | PPS

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,369,418		3,369,418			30.00
46.00	04600	OTHER LONG TERM CARE	719,872		719,872			46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	103,744	3,489,082	3,592,826	0.323225	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0.000000	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	26,465	704,764	731,229	0.492787	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,050,930	26,991,444	28,042,374	0.066873	0.000000	54.00
54.01	05401	ULTRASOUND	0	0	0	0.000000	0.000000	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0.000000	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	0.000000	0.000000	57.00
58.00	05800	MRI	0	0	0	0.000000	0.000000	58.00
60.00	06000	LABORATORY	1,614,569	10,695,392	12,309,961	0.103549	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	192,548	80,291	272,839	0.542873	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	376,458	2,719,074	3,095,532	0.361696	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	317,421	439,213	756,634	0.402997	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	63,375	137,217	200,592	0.431134	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	30,230	1,508,303	1,538,533	0.153661	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	794,555	402,032	1,196,587	0.194516	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	40	96,059	96,099	0.190408	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,998,391	4,837,830	7,836,221	0.163473	0.000000	73.00
76.00	03020	SLEEP LAB	0	305,701	305,701	0.461327	0.000000	76.00
76.03	03950	WOUND CARE	0	199,557	199,557	0.655697	0.000000	76.03
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	1,006,876	1,006,876	1.256216	0.000000	88.00
91.00	09100	EMERGENCY	36,551	11,750,349	11,786,900	0.260436	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	12,138	700,939	713,077	0.380561	0.000000	92.00
200.00		Subtotal (see instructions)	11,706,705	66,064,123	77,770,828			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	11,706,705	66,064,123	77,770,828			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1342 | Period: From 01/01/2018 To 12/31/2018 | Worksheet C Part I Date/Time Prepared: 5/29/2019 4:33 pm

Title XIX | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
46.00	04600	OTHER LONG TERM CARE		46.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.323225	50.00
51.00	05100	RECOVERY ROOM	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	0.492787	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.066873	54.00
54.01	05401	ULTRASOUND	0.000000	54.01
56.00	05600	RADIOISOTOPE	0.000000	56.00
57.00	05700	CT SCAN	0.000000	57.00
58.00	05800	MRI	0.000000	58.00
60.00	06000	LABORATORY	0.103549	60.00
65.00	06500	RESPIRATORY THERAPY	0.542873	65.00
66.00	06600	PHYSICAL THERAPY	0.361696	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.402997	67.00
68.00	06800	SPEECH PATHOLOGY	0.431134	68.00
69.00	06900	ELECTROCARDIOLOGY	0.153661	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.194516	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.190408	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.163473	73.00
76.00	03020	SLEEP LAB	0.461327	76.00
76.03	03950	WOUND CARE	0.655697	76.03
		OUTPATIENT SERVICE COST CENTERS		
88.00	08800	RURAL HEALTH CLINIC	1.256216	88.00
91.00	09100	EMERGENCY	0.260436	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.380561	92.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY

Provider CCN: 14-1342 | Period: From 01/01/2018 To 12/31/2018 | Worksheet C Part II | Date/Time Prepared: 5/29/2019 4:33 pm

Title XIX | Hospital | PPS

		Cost Center Description	Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,161,290	105,357	1,055,933	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	360,340	6,494	353,846	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,875,277	152,687	1,722,590	0	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	1,274,685	55,723	1,218,962	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	148,117	8,796	139,321	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,119,640	100,829	1,018,811	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	304,921	23,455	281,466	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	86,482	4,108	82,374	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	236,412	19,643	216,769	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	232,755	11,945	220,810	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	18,298	999	17,299	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,281,012	45,373	1,235,639	0	0	73.00
76.00	03020	SLEEP LAB	141,028	9,161	131,867	0	0	76.00
76.03	03950	WOUND CARE	130,849	19,514	111,335	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,264,854	81,354	1,183,500	0	0	88.00
91.00	09100	EMERGENCY	3,069,730	168,763	2,900,967	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	271,369	21,460	249,909	0	0	92.00
200.00		Subtotal (sum of lines 50 thru 199)	12,977,059	835,661	12,141,398	0	0	200.00
201.00		Less Observation Beds	271,369	21,460	249,909	0	0	201.00
202.00		Total (line 200 minus line 201)	12,705,690	814,201	11,891,489	0	0	202.00

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY

Provider CCN: 14-1342 | Period: From 01/01/2018 To 12/31/2018 | Worksheet C Part II Date/Time Prepared: 5/29/2019 4:33 pm

Title XIX | Hospital | PPS

		Cost Center Description	Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)		
			6.00	7.00	8.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	1,161,290	3,592,826	0.323225		50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000		51.00
53.00	05300	ANESTHESIOLOGY	360,340	731,229	0.492787		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,875,277	28,042,374	0.066873		54.00
54.01	05401	ULTRASOUND	0	0	0.000000		54.01
56.00	05600	RADIOISOTOPE	0	0	0.000000		56.00
57.00	05700	CT SCAN	0	0	0.000000		57.00
58.00	05800	MRI	0	0	0.000000		58.00
60.00	06000	LABORATORY	1,274,685	12,309,961	0.103549		60.00
65.00	06500	RESPIRATORY THERAPY	148,117	272,839	0.542873		65.00
66.00	06600	PHYSICAL THERAPY	1,119,640	3,095,532	0.361696		66.00
67.00	06700	OCCUPATIONAL THERAPY	304,921	756,634	0.402997		67.00
68.00	06800	SPEECH PATHOLOGY	86,482	200,592	0.431134		68.00
69.00	06900	ELECTROCARDIOLOGY	236,412	1,538,533	0.153661		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	232,755	1,196,587	0.194516		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	18,298	96,099	0.190408		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,281,012	7,836,221	0.163473		73.00
76.00	03020	SLEEP LAB	141,028	305,701	0.461327		76.00
76.03	03950	WOUND CARE	130,849	199,557	0.655697		76.03
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	1,264,854	1,006,876	1.256216		88.00
91.00	09100	EMERGENCY	3,069,730	11,786,900	0.260436		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	271,369	713,077	0.380561		92.00
200.00		Subtotal (sum of lines 50 thru 199)	12,977,059	73,681,538			200.00
201.00		Less Observation Beds	271,369	0			201.00
202.00		Total (line 200 minus line 201)	12,705,690	73,681,538			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 14-1342 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part II Date/Time Prepared: 5/29/2019 4:33 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	105,357	3,592,826	0.029324	87,137	2,555	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0	0	51.00
53.00	05300	ANESTHESIOLOGY	6,494	731,229	0.008881	23,196	206	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	152,687	28,042,374	0.005445	754,525	4,108	54.00
54.01	05401	ULTRASOUND	0	0	0.000000	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0.000000	0	0	56.00
57.00	05700	CT SCAN	0	0	0.000000	0	0	57.00
58.00	05800	MRI	0	0	0.000000	0	0	58.00
60.00	06000	LABORATORY	55,723	12,309,961	0.004527	1,016,097	4,600	60.00
65.00	06500	RESPIRATORY THERAPY	8,796	272,839	0.032239	109,756	3,538	65.00
66.00	06600	PHYSICAL THERAPY	100,829	3,095,532	0.032572	62,992	2,052	66.00
67.00	06700	OCCUPATIONAL THERAPY	23,455	756,634	0.030999	35,518	1,101	67.00
68.00	06800	SPEECH PATHOLOGY	4,108	200,592	0.020479	32,411	664	68.00
69.00	06900	ELECTROCARDIOLOGY	19,643	1,538,533	0.012767	19,444	248	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	11,945	1,196,587	0.009983	543,175	5,423	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	999	96,099	0.010396	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	45,373	7,836,221	0.005790	1,990,086	11,523	73.00
76.00	03020	SLEEP LAB	9,161	305,701	0.029967	0	0	76.00
76.03	03950	WOUND CARE	19,514	199,557	0.097787	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	81,354	1,006,876	0.080798	0	0	88.00
91.00	09100	EMERGENCY	168,763	11,786,900	0.014318	6,331	91	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	21,460	713,077	0.030095	0	0	92.00
200.00		Total (lines 50 through 199)	835,661	73,681,538		4,680,668	36,109	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 14-1342 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part IV Date/Time Prepared: 5/29/2019 4:33 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
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	SLEEP LAB	0	0	0	0	0	76.00
76.03	03950	WOUND CARE	0	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1342 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part IV | Date/Time Prepared: 5/29/2019 4:33 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	3,592,826	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	731,229	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	28,042,374	0.000000	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0.000000	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	0	0.000000	57.00
58.00	05800	MRI	0	0	0	0	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	12,309,961	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	272,839	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	3,095,532	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	756,634	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	200,592	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	1,538,533	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	1,196,587	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	96,099	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	7,836,221	0.000000	73.00
76.00	03020	SLEEP LAB	0	0	0	305,701	0.000000	76.00
76.03	03950	WOUND CARE	0	0	0	199,557	0.000000	76.03
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	1,006,876	0.000000	88.00
91.00	09100	EMERGENCY	0	0	0	11,786,900	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	713,077	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	73,681,538		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 14-1342 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part IV Date/Time Prepared: 5/29/2019 4:33 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	87,137	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.000000	23,196	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	754,525	0	0	0	54.00
54.01	05401	ULTRASOUND	0.000000	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MRI	0.000000	0	0	0	0	58.00
60.00	06000	LABORATORY	0.000000	1,016,097	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	109,756	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	62,992	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	35,518	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	32,411	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	19,444	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	543,175	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	1,990,086	0	0	0	73.00
76.00	03020	SLEEP LAB	0.000000	0	0	0	0	76.00
76.03	03950	WOUND CARE	0.000000	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
91.00	09100	EMERGENCY	0.000000	6,331	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		4,680,668	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-1342 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part V Date/Time Prepared: 5/29/2019 4:33 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	0.323225	0	1,114,461	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.492787	0	145,212	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.066873	0	9,545,221	0	0	54.00
54.01	05401	ULTRASOUND	0.000000	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MRI	0.000000	0	0	0	0	58.00
60.00	06000	LABORATORY	0.103549	0	3,903,217	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.542873	0	35,532	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.361696	0	972,731	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.402997	0	172,534	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.431134	0	87,397	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.153661	0	605,589	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.194516	0	185,284	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.190408	0	40,953	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.163473	0	2,062,229	5,553	0	73.00
76.00	03020	SLEEP LAB	0.461327	0	43,690	0	0	76.00
76.03	03950	WOUND CARE	0.655697	0	108,741	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
91.00	09100	EMERGENCY	0.260436	0	3,839,506	2,388	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.380561	0	354,543	0	0	92.00
200.00		Subtotal (see instructions)		0	23,216,840	7,941	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	23,216,840	7,941	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-1342 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part V Date/Time Prepared: 5/29/2019 4:33 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	360,222	0		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
53.00	05300	ANESTHESIOLOGY	71,559	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	638,318	0		54.00
54.01	05401	ULTRASOUND	0	0		54.01
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MRI	0	0		58.00
60.00	06000	LABORATORY	404,174	0		60.00
65.00	06500	RESPIRATORY THERAPY	19,289	0		65.00
66.00	06600	PHYSICAL THERAPY	351,833	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	69,531	0		67.00
68.00	06800	SPEECH PATHOLOGY	37,680	0		68.00
69.00	06900	ELECTROCARDIOLOGY	93,055	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	36,041	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	7,798	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	337,119	908		73.00
76.00	03020	SLEEP LAB	20,155	0		76.00
76.03	03950	WOUND CARE	71,301	0		76.03
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
91.00	09100	EMERGENCY	999,946	622		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	134,925	0		92.00
200.00		Subtotal (see instructions)	3,652,946	1,530		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	3,652,946	1,530		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1342 | Component CCN: 14-Z342 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part V Date/Time Prepared: 5/29/2019 4:33 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	0.323225	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.492787	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.066873	0	0	0	0	54.00
54.01	05401	ULTRASOUND	0.000000	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MRI	0.000000	0	0	0	0	58.00
60.00	06000	LABORATORY	0.103549	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.542873	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.361696	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.402997	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.431134	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.153661	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.194516	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.190408	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.163473	0	0	0	0	73.00
76.00	03020	SLEEP LAB	0.461327	0	0	0	0	76.00
76.03	03950	WOUND CARE	0.655697	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
91.00	09100	EMERGENCY	0.260436	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.380561	0	0	0	0	92.00
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: 14-1342 | Component CCN: 14-Z342 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part V Date/Time Prepared: 5/29/2019 4:33 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
54.01	05401	ULTRASOUND	0	0		54.01
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MRI	0	0		58.00
60.00	06000	LABORATORY	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
76.00	03020	SLEEP LAB	0	0		76.00
76.03	03950	WOUND CARE	0	0		76.03
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
200.00		Subtotal (see instructions)	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 INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 14-1342 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part I Date/Time Prepared: 5/29/2019 4:33 pm

Title XIX | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	210,920	46,008	164,912	2,018	81.72	30.00
200.00	Total (lines 30 through 199)	210,920		164,912	2,018		200.00

	Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)	
		6.00	7.00	
	INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	ADULTS & PEDIATRICS	33	2,697	30.00
200.00	Total (lines 30 through 199)	33	2,697	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 14-1342 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part II Date/Time Prepared: 5/29/2019 4:33 pm

Title XIX | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	105,357	3,592,826	0.029324	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0	0	51.00
53.00	05300	ANESTHESIOLOGY	6,494	731,229	0.008881	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	152,687	28,042,374	0.005445	0	0	54.00
54.01	05401	ULTRASOUND	0	0	0.000000	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0.000000	0	0	56.00
57.00	05700	CT SCAN	0	0	0.000000	0	0	57.00
58.00	05800	MRI	0	0	0.000000	0	0	58.00
60.00	06000	LABORATORY	55,723	12,309,961	0.004527	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	8,796	272,839	0.032239	0	0	65.00
66.00	06600	PHYSICAL THERAPY	100,829	3,095,532	0.032572	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	23,455	756,634	0.030999	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	4,108	200,592	0.020479	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	19,643	1,538,533	0.012767	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	11,945	1,196,587	0.009983	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	999	96,099	0.010396	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	45,373	7,836,221	0.005790	0	0	73.00
76.00	03020	SLEEP LAB	9,161	305,701	0.029967	0	0	76.00
76.03	03950	WOUND CARE	19,514	199,557	0.097787	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	81,354	1,006,876	0.080798	0	0	88.00
91.00	09100	EMERGENCY	168,763	11,786,900	0.014318	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	21,492	713,077	0.030140	0	0	92.00
200.00		Total (lines 50 through 199)	835,693	73,681,538		0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 14-1342 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part III Date/Time Prepared: 5/29/2019 4:33 pm

Title XIX | Hospital | PPS

		Cost Center Description	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
			1A	1.00	2A	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
200.00		Total (lines 30 through 199)	0	0	0	0	0	200.00

		Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
			4.00	5.00	6.00	7.00	8.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	2,018	0.00	33	30.00
200.00		Total (lines 30 through 199)		0	2,018		33	200.00

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

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 14-1342 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part IV Date/Time Prepared: 5/29/2019 4:33 pm

Title XIX | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	SLEEP LAB	0	0	0	0	0	76.00
76.03	03950	WOUND CARE	0	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1342 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part IV Date/Time Prepared: 5/29/2019 4:33 pm

Title XIX | Hospital | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	3,592,826	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	731,229	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	28,042,374	0.000000	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0.000000	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	0	0.000000	57.00
58.00	05800	MRI	0	0	0	0	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	12,309,961	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	272,839	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	3,095,532	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	756,634	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	200,592	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	1,538,533	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	1,196,587	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	96,099	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	7,836,221	0.000000	73.00
76.00	03020	SLEEP LAB	0	0	0	305,701	0.000000	76.00
76.03	03950	WOUND CARE	0	0	0	199,557	0.000000	76.03
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	1,006,876	0.000000	88.00
91.00	09100	EMERGENCY	0	0	0	11,786,900	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	713,077	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	73,681,538		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1342 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part IV | Date/Time Prepared: 5/29/2019 4:33 pm

Title XIX | Hospital | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	0	0	0	0	54.00
54.01	05401	ULTRASOUND	0.000000	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MRI	0.000000	0	0	0	0	58.00
60.00	06000	LABORATORY	0.000000	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	0	0	0	0	73.00
76.00	03020	SLEEP LAB	0.000000	0	0	0	0	76.00
76.03	03950	WOUND CARE	0.000000	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
91.00	09100	EMERGENCY	0.000000	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		0	0	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1342 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-1 | Date/Time Prepared: 5/29/2019 4:33 pm

Title XVIII | Hospital

	Cost Center Description	Cost	
		1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	2,608	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,018	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)	1,755	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	563	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	27	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)	1,266	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)	390	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	147.52	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	2,667,111	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)	3,983	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)	584,898	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	2,082,213	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)	2,082,213	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)	1,031.82	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,306,284	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)	1,306,284	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1342 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-1 | Date/Time Prepared: 5/29/2019 4:33 pm

Title XVIII | Hospital | Cost

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	741,542	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	2,047,826	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)	402,410	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)	402,410	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)	263	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,031.82	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	271,369	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1342 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-1 | Date/Time Prepared: 5/29/2019 4:33 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	210,920	2,667,111	0.079082	271,369	21,460	90.00
91.00	Nursing School cost	0	2,667,111	0.000000	271,369	0	91.00
92.00	Allied health cost	0	2,667,111	0.000000	271,369	0	92.00
93.00	All other Medical Education	0	2,667,111	0.000000	271,369	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1342 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-1 | Date/Time Prepared: 5/29/2019 4:33 pm

Title XIX | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	2,608	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,018	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)	1,755	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	563	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	27	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)	33	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		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	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	2,667,111	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)	581,782	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	2,085,329	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)	2,085,329	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)	1,033.36	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	34,101	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)	34,101	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1342 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-1 | Date/Time Prepared: 5/29/2019 4:33 pm

Title XIX | Hospital | PPS

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	0	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	34,101	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)	2,697	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)	2,697	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	31,404	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	263	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,033.36	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	271,774	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1342 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-1 | Date/Time Prepared: 5/29/2019 4:33 pm

Title XIX | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	210,920	2,667,111	0.079082	271,774	21,492	90.00
91.00	Nursing School cost	0	2,667,111	0.000000	271,774	0	91.00
92.00	Allied health cost	0	2,667,111	0.000000	271,774	0	92.00
93.00	All other Medical Education	0	2,667,111	0.000000	271,774	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 14-1342 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-3 | Date/Time Prepared: 5/29/2019 4:33 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		1,908,652		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.323225	87,137	28,165	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.492787	23,196	11,431	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.066873	754,525	50,457	54.00
54.01	05401	ULTRASOUND	0.000000	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	57.00
58.00	05800	MRI	0.000000	0	0	58.00
60.00	06000	LABORATORY	0.103549	1,016,097	105,216	60.00
65.00	06500	RESPIRATORY THERAPY	0.542873	109,756	59,584	65.00
66.00	06600	PHYSICAL THERAPY	0.361696	62,992	22,784	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.402997	35,518	14,314	67.00
68.00	06800	SPEECH PATHOLOGY	0.431134	32,411	13,973	68.00
69.00	06900	ELECTROCARDIOLOGY	0.153661	19,444	2,988	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.194516	543,175	105,656	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.190408	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.163473	1,990,086	325,325	73.00
76.00	03020	SLEEP LAB	0.461327	0	0	76.00
76.03	03950	WOUND CARE	0.655697	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
91.00	09100	EMERGENCY	0.260436	6,331	1,649	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.380561	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		4,680,668	741,542	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		4,680,668		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 14-1342 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-3

Component CCN: 14-Z342 | Date/Time Prepared: 5/29/2019 4:33 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.323225	9,645	3,118	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.492787	601	296	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.066873	39,670	2,653	54.00
54.01	05401	ULTRASOUND	0.000000	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	57.00
58.00	05800	MRI	0.000000	0	0	58.00
60.00	06000	LABORATORY	0.103549	115,129	11,921	60.00
65.00	06500	RESPIRATORY THERAPY	0.542873	5,907	3,207	65.00
66.00	06600	PHYSICAL THERAPY	0.361696	183,885	66,510	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.402997	171,452	69,095	67.00
68.00	06800	SPEECH PATHOLOGY	0.431134	6,661	2,872	68.00
69.00	06900	ELECTROCARDIOLOGY	0.153661	924	142	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.194516	29,074	5,655	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.190408	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.163473	188,500	30,815	73.00
76.00	03020	SLEEP LAB	0.461327	0	0	76.00
76.03	03950	WOUND CARE	0.655697	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
91.00	09100	EMERGENCY	0.260436	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.380561	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		751,448	196,284	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)		751,448		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-1342	Period: From 01/01/2018 To 12/31/2018	Worksheet E Part B Date/Time Prepared: 5/29/2019 4:33 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	3,654,476	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	OPPS payments	0	3.00
4.00	Outlier payment (see instructions)	0	4.00
4.01	Outlier reconciliation amount (see instructions)	0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	3,654,476	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	0	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (see instructions)	3,691,021	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)	53,880	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	3,851,055	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)	-213,914	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)	-213,914	30.00
31.00	Primary payer payments	4	31.00
32.00	Subtotal (line 30 minus line 31)	-213,918	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)	1,245,644	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	809,669	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	1,189,302	36.00
37.00	Subtotal (see instructions)	595,751	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)	595,751	40.00
40.01	Sequestration adjustment (see instructions)	11,915	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
41.00	Interim payments	724,301	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	-140,465	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: 14-1342 | Period: From 01/01/2018 To 12/31/2018 | Worksheet E-1 Part I Date/Time Prepared: 5/29/2019 4:33 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		1,600,393		724,301	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER	07/10/2018	101,400		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		101,400		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,701,793		724,301	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		93,073		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		140,465	6.02
7.00	Total Medicare program liability (see instructions)		1,794,866		583,836	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: 14-1342 | Component CCN: 14-Z342 | Period: From 01/01/2018 To 12/31/2018 | Worksheet E-1 Part I | Date/Time Prepared: 5/29/2019 4:33 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		567,452		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		567,452		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		20,376		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		587,828		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: 14-1342	Period: From 01/01/2018 To 12/31/2018	Worksheet E-1 Part II Date/Time Prepared: 5/29/2019 4:33 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: 14-1342 | Component CCN: 14-Z342 | Period: From 01/01/2018 To 12/31/2018 | Worksheet E-2 | Date/Time Prepared: 5/29/2019 4:33 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)	406,434	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)	198,247	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	390	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)	604,681	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	604,681	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)	604,681	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	4,857	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)	599,824	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)			16.50
16.55	Rural community hospital demonstration project (§410A Demonstration) payment adjustment (see instructions)	0		16.55
16.99	Demonstration payment adjustment amount before sequestration	0	0	16.99
17.00	Allowable bad debts (see instructions)	0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (see instructions)	599,824	0	19.00
19.01	Sequestration adjustment (see instructions)	11,996	0	19.01
19.02	Demonstration payment adjustment amount after sequestration)	0	0	19.02
20.00	Interim payments	567,452	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)	20,376	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: 14-1342	Period: From 01/01/2018 To 12/31/2018	Worksheet E-3 Part V Date/Time Prepared: 5/29/2019 4:33 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	2,047,826	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)	2,047,826	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	2,068,304	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)	2,068,304	19.00
20.00	Deductibles (exclude professional component)	297,408	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	1,770,896	22.00
23.00	Coinsurance	1,340	23.00
24.00	Subtotal (line 22 minus line 23)	1,769,556	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	95,292	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	61,940	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	92,295	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	1,831,496	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)	1,831,496	30.00
30.01	Sequestration adjustment (see instructions)	36,630	30.01
30.02	Demonstration payment adjustment amount after sequestration	0	30.02
31.00	Interim payments	1,701,793	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)	93,073	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: 14-1342 | Period: From 01/01/2018 To 12/31/2018 | Worksheet G | Date/Time Prepared: 5/29/2019 4:33 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	-295,214	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	6,607,811	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-1,281,451	0	0	0	6.00
7.00	Inventory	382,893	0	0	0	7.00
8.00	Prepaid expenses	214,016	0	0	0	8.00
9.00	Other current assets	17,550	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)	5,645,605	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	0	0	0	0	12.00
13.00	Land improvements	76,833	0	0	0	13.00
14.00	Accumulated depreciation	-31,721	0	0	0	14.00
15.00	Buildings	3,304,483	0	0	0	15.00
16.00	Accumulated depreciation	-1,966,616	0	0	0	16.00
17.00	Leasehold improvements	9,636,865	0	0	0	17.00
18.00	Accumulated depreciation	-4,199,438	0	0	0	18.00
19.00	Fixed equipment	1,464,497	0	0	0	19.00
20.00	Accumulated depreciation	-658,053	0	0	0	20.00
21.00	Automobiles and trucks	57,058	0	0	0	21.00
22.00	Accumulated depreciation	-57,058	0	0	0	22.00
23.00	Major movable equipment	4,912,620	0	0	0	23.00
24.00	Accumulated depreciation	-4,133,327	0	0	0	24.00
25.00	Minor equipment depreciable	3,320,672	0	0	0	25.00
26.00	Accumulated depreciation	-3,134,189	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)	8,592,626	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	1,233,394	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	1,233,394	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	15,471,625	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	822,018	0	0	0	37.00
38.00	Salaries, wages, and fees payable	661,252	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	-9,650,844	0	0	0	43.00
44.00	Other current liabilities	92,890	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	-8,074,684	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	0	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	-8,074,684	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	23,546,309				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)	23,546,309	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	15,471,625	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 14-1342 | Period: From 01/01/2018 To 12/31/2018 | Worksheet G-1 | Date/Time Prepared: 5/29/2019 4:33 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		22,486,522		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		1,059,789				2.00
3.00	Total (sum of line 1 and line 2)		23,546,311		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)		23,546,311		0		11.00
12.00	MISC ADJUSTMENT	2		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)		2		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		23,546,309		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	MISC ADJUSTMENT		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: 14-1342 | Period: From 01/01/2018 To 12/31/2018 | Worksheet G-2 Parts I & II Date/Time Prepared: 5/29/2019 4:33 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	3,369,418		3,369,418	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	0		0	9.00
10.00	Total general inpatient care services (sum of lines 1-9)	3,369,418		3,369,418	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	3,369,418		3,369,418	17.00
18.00	Ancillary services	8,337,749	0	8,337,749	18.00
19.00	Outpatient services	0	65,056,785	65,056,785	19.00
20.00	RURAL HEALTH CLINIC	0	1,006,876	1,006,876	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	11,707,167	66,063,661	77,770,828	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		21,124,633		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)		21,124,633		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 14-1342 | Period: From 01/01/2018 To 12/31/2018 | Worksheet G-3 | Date/Time Prepared: 5/29/2019 4:33 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	77,770,828	1.00
2.00	Less contractual allowances and discounts on patients' accounts	55,698,694	2.00
3.00	Net patient revenues (line 1 minus line 2)	22,072,134	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	21,124,633	4.00
5.00	Net income from service to patients (line 3 minus line 4)	947,501	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER REVENUE	112,303	24.00
25.00	Total other income (sum of lines 6-24)	112,303	25.00
26.00	Total (line 5 plus line 25)	1,059,804	26.00
27.00	OTHER MISC EXPENSE	15	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	15	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	1,059,789	29.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1342 | Component CCN: 14-3975 | Period: From 01/01/2018 To 12/31/2018 | Worksheet M-1 | Date/Time Prepared: 5/29/2019 4:33 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	150,882	0	150,882	0	150,882	1.00
2.00	Physician Assistant	264,225	0	264,225	0	264,225	2.00
3.00	Nurse Practitioner	25,921	0	25,921	0	25,921	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	142,854	0	142,854	0	142,854	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	583,882	0	583,882	0	583,882	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	51,175	51,175	0	51,175	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	51,175	51,175	0	51,175	14.00
15.00	Medical Supplies	0	9,459	9,459	0	9,459	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	9,459	9,459	0	9,459	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	583,882	60,634	644,516	0	644,516	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	1,813	1,813	-1,154	659	29.00
30.00	Administrative Costs	52,146	286,369	338,515	-52,146	286,369	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	52,146	288,182	340,328	-53,300	287,028	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	636,028	348,816	984,844	-53,300	931,544	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1342 | Component CCN: 14-3975 | Period: From 01/01/2018 To 12/31/2018 | Worksheet M-1 | Date/Time Prepared: 5/29/2019 4:33 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	150,882		1.00
2.00	Physician Assistant	0	264,225		2.00
3.00	Nurse Practitioner	0	25,921		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	142,854		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	0		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	583,882		10.00
11.00	Physician Services Under Agreement	0	0		11.00
12.00	Physician Supervision Under Agreement	0	51,175		12.00
13.00	Other Costs Under Agreement	0	0		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	51,175		14.00
15.00	Medical Supplies	0	9,459		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	9,459		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	644,516		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	659		29.00
30.00	Administrative Costs	-225,542	60,827		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-225,542	61,486		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-225,542	706,002		32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1342 | Component CCN: 14-3975 | Period: From 01/01/2018 To 12/31/2018 | Worksheet M-2 | Date/Time Prepared: 5/29/2019 4:33 pm

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	RHC I Minimum Visits (col. 1 x col. 3)	Cost Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	0.46	740	4,200	1,932		1.00
2.00	Physician Assistant	2.10	5,564	2,100	4,410		2.00
3.00	Nurse Practitioner	0.23	1,229	2,100	483		3.00
4.00	Subtotal (sum of lines 1 through 3)	2.79	7,533		6,825	7,533	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	2.79	7,533			7,533	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)					644,516	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)					644,516	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)					61,486	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					558,852	15.00
16.00	Total overhead (sum of lines 14 and 15)					620,338	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					620,338	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					620,338	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					1,264,854	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1342 | Component CCN: 14-3975 | Period: From 01/01/2018 To 12/31/2018 | Worksheet M-3 | Date/Time Prepared: 5/29/2019 4:33 pm

Title XVIII | RHC I | Cost

		1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES		
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)	1,264,854	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)	328	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)	1,264,526	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)	7,533	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)	7,533	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)	167.86	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)	0.00	83.45	8.00
9.00	Rate for Program covered visits (see instructions)	167.86	167.86	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	961	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	161,313	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	161,313	16.00
16.01	Total program charges (see instructions)(from contractor's records)		136,176	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.)		110,086	16.04
16.05	Total program cost (see instructions)	0	110,086	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		23,706	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		22,494	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		110,086	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		211	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		110,297	22.00
23.00	Allowable bad debts (see instructions)		0	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		0	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	25.50
25.99	Demonstration payment adjustment amount before sequestration		0	25.99
26.00	Net reimbursable amount (see instructions)		110,297	26.00
26.01	Sequestration adjustment (see instructions)		2,206	26.01
26.02	Demonstration payment adjustment amount after sequestration		0	26.02
27.00	Interim payments		90,267	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)		17,824	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: 14-1342 | Component CCN: 14-3975 | Period: From 01/01/2018 To 12/31/2018 | Worksheet M-4 | Date/Time Prepared: 5/29/2019 4:33 pm

Title XVIII | RHC I | Cost

		Pneumococcal	Influenza	
		1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	583,882	583,882	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000224	0.000000	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	131	0	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	36	0	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	167	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	644,516	644,516	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	620,338	620,338	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.000259	0.000000	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	161	0	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	328	0	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	14	0	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	23.43	0.00	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	9	0	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	211	0	14.00
15.00	Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2)		328	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)		211	16.00

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

Provider CCN: 14-1342 | Component CCN: 14-3975 | Period: From 01/01/2018 To 12/31/2018 | Worksheet M-5 | Date/Time Prepared: 5/29/2019 4:33 pm

RHC I | Cost

		Part B mm/dd/yyyy	Part B Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		90,267	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00
	Program to Provider			
3.01			0	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
	Provider to Program			
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		90,267	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		17,824	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		108,091	7.00

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