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: 14-1348	Period: From 07/01/2017 To 06/30/2018	Worksheet S Parts I-III Date/Time Prepared: 11/29/2018 9:07 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 11/29/2018 Time: 9:07 am
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 RED BUD REGIONAL HOSPITAL (14-1348) for the cost reporting period beginning 07/01/2017 and ending 06/30/2018 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

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

_____
Title

_____
Date

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	-185,111	-2,867,425	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	-353,638	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
10.00	RURAL HEALTH CLINIC I	0		-173,057		0	10.00
200.00	Total	0	-538,749	-3,040,482	0	0	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1348 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-2 Part I | Date/Time Prepared: 11/29/2018 9:06 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: ST. CLEMENT BLVD	PO Box:			1.00
2.00	City: RED BUD	State: IL	Zip Code: 62278-	County: RANDOLPH	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	RED BUD REGIONAL HOSPITAL	141348	99914	1	07/01/2005	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	RED BUD HOSPITAL	14Z348	99914		08/10/2005	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	OLDER ADULT HEALTH CENTER	148514	99914		05/26/2011	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)	07/01/2017	06/30/2018	20.00
21.00	Type of Control (see instructions)	4		21.00
	Inpatient PPS Information			
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	N	N	22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	N	N	22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N	22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.	N	N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	3	N	23.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1348 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-2 Part I Date/Time Prepared: 11/29/2018 9:06 am

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

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

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

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

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1348 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-2 Part I | Date/Time Prepared: 11/29/2018 9:06 am

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

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

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

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1348 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-2 Part I | Date/Time Prepared: 11/29/2018 9:06 am

		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:	15,177	-11,015	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: 14-1348 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-2 Part I | Date/Time Prepared: 11/29/2018 9:06 am

	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	Contractor's Name: WPS	Contractor's Number: 52280	141.00
142.00	Street: 1573 MALLORY LANE SUITE 100	PO Box:		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)	0.00	169.00

		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	04/01/2017	06/29/2017	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: 14-1348 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-2 Part II | Date/Time Prepared: 11/29/2018 9:06 am

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

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

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

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

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

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	Y	08/17/2018	Y	08/17/2018	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 14-1348 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-2 Part II Date/Time Prepared: 11/29/2018 9:06 am

		Description		Y/N	Y/N	
		0		1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
	Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions				N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				N	27.00
	Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				N	31.00
	Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				N	33.00
	Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				Y	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.				Y	12/31/2017	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.	LUCIE		GREEN		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.	615-227-3747		LUCIE_GREENE@QUORUMHEALTH.COM		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 14-1348	Period: From 07/01/2017 To 06/30/2018	Worksheet S-2 Part II Date/Time Prepared: 11/29/2018 9:06 am

		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.	DIRECTOR, REIMBURSEMENT		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: 14-1348 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-3 Part I | Date/Time Prepared: 11/29/2018 9:06 am

	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	53,496.00	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	53,496.00	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	53,496.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	88.00				0	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		25				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00
33.01	LTCH site neutral days and discharges						33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 14-1348 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-3 Part I | Date/Time Prepared: 11/29/2018 9:06 am

	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)	1,560	130	2,268			1.00
2.00	HMO and other (see instructions)	245	0				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	2,893	0	3,864			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	4,453	130	6,132			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)	4,453	130	6,132	0.00	145.85	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	0	0	0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	6,330	0	12,330	0.00	4.88	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	150.73	27.00
28.00	Observation Bed Days		0	408			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: 14-1348 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-3 Part I | Date/Time Prepared: 11/29/2018 9:06 am

	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	478	45	713	1.00
2.00	HMO and other (see instructions)			0	0		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				0		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	478	45	713	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	0.00					26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01

HOSPITAL WAGE RELATED COSTS | Provider CCN: 14-1348 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-3 Part IV Date/Time Prepared: 11/29/2018 9:06 am

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	175,874	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	0	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)	0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	0	8.02
8.03	Health Insurance (Purchased)	1,291,537	8.03
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	13,750	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	10,551	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	-924	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	13,159	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	139,786	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	0	16.00
	TAXES		
17.00	FICA-Employers Portion Only	586,169	17.00
18.00	Medicare Taxes - Employers Portion Only	137,088	18.00
19.00	Unemployment Insurance	0	19.00
20.00	State or Federal Unemployment Taxes	66,340	20.00
	OTHER		
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	0	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	2,433,330	24.00
	Part B - Other than Core Related Cost		
25.00	OTHER BENEFITS	-30,753	25.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 14-1348 | Component CCN: 14-8514 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-8 | Date/Time Prepared: 11/29/2018 9:06 am

RHC I | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			325 SPRING STREET		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	RED BUD		IL	62278	2.00
					1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0	3.00
			Grant Award		Date	
			1.00		2.00	
	Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)					4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)					5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)					6.00
7.00	Appalachian Regional Commission					7.00
8.00	Look-Alikes					8.00
9.00	OTHER (SPECIFY)					9.00
				1.00	2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N	0	10.00

		Sunday		Monday		Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
	Facility hours of operations (1)						
11.00	CLINIC			08:00	05:00	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		RANDOLPH				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	05:00	08:00	05:00	08:00	05:00	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 14-1348 | Component CCN: 14-8514 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-8 | Date/Time Prepared: 11/29/2018 9:06 am

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	05:00				11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 14-1348 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-10 | Date/Time Prepared: 11/29/2018 9:06 am

		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)	0.145663	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	882,757	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	157,440	5.00
6.00	Medicaid charges	11,107,069	6.00
7.00	Medicaid cost (line 1 times line 6)	1,617,889	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)	577,692	8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone CHIP	13,430	9.00
10.00	Stand-alone CHIP charges	166,627	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	24,271	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)	10,841	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)	588,533	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)	1,556,663	7,266	1,563,929	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	226,748	7,266	234,014	21.00
22.00	Payments received from patients for amounts previously written off as charity care	15,412	0	15,412	22.00
23.00	Cost of charity care (line 21 minus line 22)	211,336	7,266	218,602	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)	1,320,106	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	480,447	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	739,149	27.01
28.00	Non-Medicare bad debt expense (see instructions)	580,957	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	343,326	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	561,928	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	1,150,461	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-1348 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A | Date/Time Prepared: 11/29/2018 9:06 am

		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		395,795	395,795	60,489	456,284	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		990,143	990,143	366,606	1,356,749	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	128,417	127,211	255,628	1,674,149	1,929,777	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,085,903	5,075,487	6,161,390	-1,883,528	4,277,862	5.00
7.00	00700	OPERATION OF PLANT	207,376	936,595	1,143,971	-40,380	1,103,591	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	87,271	87,271	0	87,271	8.00
9.00	00900	HOUSEKEEPING	157,726	32,574	190,300	-485	189,815	9.00
10.00	01000	DIETARY	0	808,993	808,993	-111,096	697,897	10.00
11.00	01100	CAFETERIA	0	0	0	111,096	111,096	11.00
13.00	01300	NURSING ADMINISTRATION	558,457	100,064	658,521	-23,244	635,277	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	45,418	316,486	361,904	-264,535	97,369	14.00
15.00	01500	PHARMACY	343,974	650,771	994,745	-594,245	400,500	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	227,937	103,008	330,945	-8,236	322,709	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,550,204	310,297	1,860,501	-11,278	1,849,223	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	302,344	167,298	469,642	-33,913	435,729	50.00
53.00	05300	ANESTHESIOLOGY	0	5,120	5,120	220,306	225,426	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	539,949	815,806	1,355,755	-172,597	1,183,158	54.00
60.00	06000	LABORATORY	448,219	505,157	953,376	-61,038	892,338	60.00
65.00	06500	RESPIRATORY THERAPY	103,518	41,394	144,912	-24,172	120,740	65.00
66.00	06600	PHYSICAL THERAPY	468,776	55,616	524,392	-1,050	523,342	66.00
67.00	06700	OCCUPATIONAL THERAPY	160,089	13,421	173,510	0	173,510	67.00
68.00	06800	SPEECH PATHOLOGY	53,318	4,922	58,240	0	58,240	68.00
69.00	06900	ELECTROCARDIOLOGY	31,368	7,169	38,537	0	38,537	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	198,012	198,012	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	92,367	92,367	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	574,289	574,289	73.00
76.00	03610	BLANK	0	0	0	0	0	76.00
76.01	03550	SLEEP LAB	0	0	0	0	0	76.01
76.02	03020	PSYCH SERVICES	0	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	2,303,557	458,787	2,762,344	719	2,763,063	88.00
91.00	09100	EMERGENCY	2,306,202	685,185	2,991,387	-380,678	2,610,709	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)	11,022,752	12,694,570	23,717,322	-312,442	23,404,880	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	-11,972	-11,972	0	-11,972	192.00
194.00	07950	HOME HEALTH	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	0	0	120,335	120,335	194.01
194.02	07952	SENIOR CIRCLE	42,330	10,195	52,525	-3,282	49,243	194.02
194.03	07953	RED BUD SPECIALTY CLINIC	0	0	0	0	0	194.03
194.04	07954	WATERLOO SPECIALTY CLINIC	0	0	0	0	0	194.04
194.05	07955	FREE STANDING NURSING HOME	0	0	0	195,389	195,389	194.05
194.06	07956	CLINIC CORPORATION	0	0	0	0	0	194.06
194.07	07957	VACANT SPACE	0	0	0	0	0	194.07
200.00		TOTAL (SUM OF LINES 118 through 199)	11,065,082	12,692,793	23,757,875	0	23,757,875	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-1348 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A | Date/Time Prepared: 11/29/2018 9:06 am

		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	-71,668	384,616		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	215,315	1,572,064		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-686	1,929,091		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-935,050	3,342,812		5.00
7.00	00700	OPERATION OF PLANT	-18,023	1,085,568		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	87,271		8.00
9.00	00900	HOUSEKEEPING	0	189,815		9.00
10.00	01000	DIETARY	0	697,897		10.00
11.00	01100	CAFETERIA	-2,441	108,655		11.00
13.00	01300	NURSING ADMINISTRATION	0	635,277		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	97,369		14.00
15.00	01500	PHARMACY	0	400,500		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	322,709		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-194,734	1,654,489		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	435,729		50.00
53.00	05300	ANESTHESIOLOGY	-184,961	40,465		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,183,158		54.00
60.00	06000	LABORATORY	-69,207	823,131		60.00
65.00	06500	RESPIRATORY THERAPY	0	120,740		65.00
66.00	06600	PHYSICAL THERAPY	0	523,342		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	173,510		67.00
68.00	06800	SPEECH PATHOLOGY	0	58,240		68.00
69.00	06900	ELECTROCARDIOLOGY	0	38,537		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	198,012		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	92,367		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-32	574,257		73.00
76.00	03610	BLANK	0	0		76.00
76.01	03550	SLEEP LAB	0	0		76.01
76.02	03020	PSYCH SERVICES	0	0		76.02
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	-840,262	1,922,801		88.00
91.00	09100	EMERGENCY	-736,842	1,873,867		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)	-2,838,591	20,566,289		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	-11,972		192.00
194.00	07950	HOME HEALTH	0	0		194.00
194.01	07951	MARKETING	0	120,335		194.01
194.02	07952	SENIOR CIRCLE	0	49,243		194.02
194.03	07953	RED BUD SPECIALTY CLINIC	0	0		194.03
194.04	07954	WATERLOO SPECIALTY CLINIC	66,000	66,000		194.04
194.05	07955	FREE STANDING NURSING HOME	0	195,389		194.05
194.06	07956	CLINIC CORPORATION	0	0		194.06
194.07	07957	VACANT SPACE	0	0		194.07
200.00		TOTAL (SUM OF LINES 118 through 199)	-2,772,591	20,985,284		200.00

RECLASSIFICATIONS | Provider CCN: 14-1348 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-6 | Date/Time Prepared: 11/29/2018 9:06 am

		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	1,774,681	1.00
2.00	RURAL HEALTH CLINIC	88.00	0	88,069	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
	0		0	1,862,750	
	B - OXYGEN COSTS				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	10,775	1.00
	0		0	10,775	
	C - RENTAL EXPENSE				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	36,600	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	360,601	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
	0		0	397,201	
	D - OTHER CAPITAL COSTS				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	23,889	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	6,005	2.00
	0		0	29,894	
	E - MARKETING COSTS				
1.00	MARKETING	194.01	49,205	71,130	1.00
	0		49,205	71,130	
	F - MEDICAL SUPPLIES				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	187,237	1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	92,367	2.00
	0		0	279,604	
	G - RECLASS COST OF DRUGS/IV SOLUTIONS				
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	574,289	1.00
	0		0	574,289	
	H - CAFETERIA COSTS				
1.00	CAFETERIA	11.00	0	111,096	1.00
	0		0	111,096	
	I - ALLOCATE NUSRSING HOME COSTS				
1.00	FREE STANDING NURSING HOME	194.05	186,533	8,856	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
	0		186,533	8,856	
	K - RECLASS ANESTHESIA COSTS				
1.00	ANESTHESIOLOGY	53.00	51,408	169,066	1.00
	0		51,408	169,066	
	L - RECLASS MALPRACTICE EXPENSE				
1.00	ADMINISTRATIVE & GENERAL	5.00	0	46,817	1.00
	0		0	46,817	
500.00	Grand Total: Increases		287,146	3,561,478	500.00

RECLASSIFICATIONS | Provider CCN: 14-1348 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-6 | Date/Time Prepared: 11/29/2018 9:06 am

		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	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	55,557	0		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	1,646,890	0		2.00
3.00	ADULTS & PEDIATRICS	30.00	0	2,910	0		3.00
4.00	EMERGENCY	91.00	0	157,393	0		4.00
	0		0	1,862,750			
	B - OXYGEN COSTS						
1.00	RESPIRATORY THERAPY	65.00	0	10,775	0		1.00
	0		0	10,775			
	C - RENTAL EXPENSE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	50,785	10		1.00
2.00	OPERATION OF PLANT	7.00	0	948	10		2.00
3.00	HOUSEKEEPING	9.00	0	485	0		3.00
4.00	NURSING ADMINISTRATION	13.00	0	657	0		4.00
5.00	CENTRAL SERVICES & SUPPLY	14.00	0	10,510	0		5.00
6.00	PHARMACY	15.00	0	19,956	0		6.00
7.00	MEDICAL RECORDS & LIBRARY	16.00	0	2,282	0		7.00
8.00	ADULTS & PEDIATRICS	30.00	0	8,368	0		8.00
9.00	OPERATING ROOM	50.00	0	8,334	0		9.00
10.00	ANESTHESIOLOGY	53.00	0	168	0		10.00
11.00	RADIOLOGY-DIAGNOSTIC	54.00	0	172,597	0		11.00
12.00	LABORATORY	60.00	0	61,038	0		12.00
13.00	RESPIRATORY THERAPY	65.00	0	13,397	0		13.00
14.00	PHYSICAL THERAPY	66.00	0	1,050	0		14.00
15.00	RURAL HEALTH CLINIC	88.00	0	40,533	0		15.00
16.00	EMERGENCY	91.00	0	2,811	0		16.00
17.00	SENIOR CIRCLE	194.02	0	3,282	0		17.00
	0		0	397,201			
	D - OTHER CAPITAL COSTS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	29,894	12		1.00
2.00		0.00	0	0	12		2.00
	0		0	29,894			
	E - MARKETING COSTS						
1.00	ADMINISTRATIVE & GENERAL	5.00	49,205	71,130	0		1.00
	0		49,205	71,130			
	F - MEDICAL SUPPLIES						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	254,025	0		1.00
2.00	OPERATING ROOM	50.00	0	25,579	0		2.00
	0		0	279,604			
	G - RECLASS COST OF DRUGS/IV SOLUTIONS						
1.00	PHARMACY	15.00	0	574,289	0		1.00
	0		0	574,289			
	H - CAFETERIA COSTS						
1.00	DIETARY	10.00	0	111,096	0		1.00
	0		0	111,096			
	I - ALLOCATE NUSRSING HOME COSTS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	41,846	3,129	0		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	79,886	2,555	0		2.00
3.00	OPERATION OF PLANT	7.00	36,564	2,868	0		3.00
4.00	NURSING ADMINISTRATION	13.00	22,283	304	0		4.00
5.00	MEDICAL RECORDS & LIBRARY	16.00	5,954	0	0		5.00
	0		186,533	8,856			
	K - RECLASS ANESTHESIA COSTS						
1.00	EMERGENCY	91.00	51,408	169,066	0		1.00
	0		51,408	169,066			
	L - RECLASS MALPRACTICE EXPENSE						
1.00	RURAL HEALTH CLINIC	88.00	0	46,817	0		1.00
	0		0	46,817			
500.00	Grand Total: Decreases		287,146	3,561,478			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1348 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-7 Part I | Date/Time Prepared: 11/29/2018 9:06 am

		Beginning Balances	Acquisitions: Purchases	Acquisitions: Donation	Acquisitions: Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	0	0	0	0	0	1.00
2.00	Land Improvements	311,428	0	0	0	0	2.00
3.00	Buildings and Fixtures	5,086,876	6,839	0	6,839	17	3.00
4.00	Building Improvements	8,186,246	203,182	0	203,182	439,361	4.00
5.00	Fixed Equipment	2,459,167	150,700	0	150,700	0	5.00
6.00	Movable Equipment	9,384,189	165,292	0	165,292	378,699	6.00
7.00	HIT designated Assets	3,103,097	0	0	0	27,390	7.00
8.00	Subtotal (sum of lines 1-7)	28,531,003	526,013	0	526,013	845,467	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	28,531,003	526,013	0	526,013	845,467	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	311,428	0	2.00
3.00	Buildings and Fixtures	5,093,698	0	3.00
4.00	Building Improvements	7,950,067	0	4.00
5.00	Fixed Equipment	2,609,867	0	5.00
6.00	Movable Equipment	9,170,782	0	6.00
7.00	HIT designated Assets	3,075,707	0	7.00
8.00	Subtotal (sum of lines 1-7)	28,211,549	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	28,211,549	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1348 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-7 Part II | Date/Time Prepared: 11/29/2018 9:06 am

	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	395,795	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	990,143	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	1,385,938	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	395,795		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	990,143		2.00
3.00	Total (sum of lines 1-2)	0	1,385,938		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1348 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-7 Part III Date/Time Prepared: 11/29/2018 9:06 am

	Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	13,355,193	0	13,355,193	0.473395	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	14,856,356	0	14,856,356	0.526605	0	2.00
3.00	Total (sum of lines 1-2)	28,211,549	0	28,211,549	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	324,127	36,600	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	1,205,458	360,601	2.00
3.00	Total (sum of lines 1-2)	0	0	0	1,529,585	397,201	3.00

	Cost Center Description	SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	23,889	0	0	384,616	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	6,005	0	0	1,572,064	2.00
3.00	Total (sum of lines 1-2)	0	29,894	0	0	1,956,680	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-1348 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-8 | Date/Time Prepared: 11/29/2018 9:06 am

	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	-3,160	ADMINISTRATIVE & GENERAL	5.00	0	7.00
8.00	Television and radio service (chapter 21)	A	-1,079	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	-863,052			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)	B	0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	-12,307			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-2,441	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	B	-32	DRUGS CHARGED TO PATIENTS	73.00	0	17.00
18.00	Sale of medical records and abstracts		0		0.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT	A	-126,560	CAP REL COSTS-BLDG & FIXT	1.00	9	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP	A	214,029	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

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-1348 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-8 | Date/Time Prepared: 11/29/2018 9:06 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.00	PATIENT TELEPHONE BENEFITS EXPENSE	A	-686	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.00
36.00	OTHER MISC REVENUE	B	-11,685	ADMINISTRATIVE & GENERAL	5.00	0	36.00
38.00	NON RHC COSTS	A	-840,262	RURAL HEALTH CLINIC	88.00	0	38.00
38.03	TELEPHONE SERVICES	A	-16,216	ADMINISTRATIVE & GENERAL	5.00	0	38.03
38.04	TELEPHONE DEPRECIATION	A	-5,635	CAP REL COSTS-MVBLE EQUIP	2.00	9	38.04
39.00	ADVERTISING	A	-97,888	ADMINISTRATIVE & GENERAL	5.00	0	39.00
39.01	PROFESSIONAL FEE BENEFITS	A	-25,290	ADULTS & PEDIATRICS	30.00	0	39.01
41.00	PROFESSIONAL FEE BENEFITS	A	-101,799	EMERGENCY	91.00	0	41.00
42.00	LOBBYING EXPENSE IN ASSOCIATION DUES	A	-11,644	ADMINISTRATIVE & GENERAL	5.00	0	42.00
44.00	SPECIAL EVENTS	A	-2,366	ADMINISTRATIVE & GENERAL	5.00	0	44.00
45.01	CRNA COSTS	A	-176,716	ANESTHESIOLOGY	53.00	0	45.01
45.02	CRNA BENEFITS	A	-8,245	ANESTHESIOLOGY	53.00	0	45.02
45.03	ILLINOIS PROVIDER TAX	A	-715,878	ADMINISTRATIVE & GENERAL	5.00	0	45.03
45.04	ADD BACK NH CREDIT FOR DIETARY	A	0	DIETARY	10.00	0	45.04
45.06	HOSPICE REVENUE	A	-10,642	ADULTS & PEDIATRICS	30.00	0	45.06
45.07	CHARITABLE CONTRIBUTIONS	A	-1,014	ADMINISTRATIVE & GENERAL	5.00	0	45.07
45.08	REMOVAL OF LEASE REVENUE	A	66,000	WATERLOO SPECIALTY CLINIC	194.04	0	45.08
45.09	PATIENT TV - CABLE EXPENSE	A	-18,023	OPERATION OF PLANT	7.00	0	45.09
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-2,772,591				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: 14-1348 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-8-1 | Date/Time Prepared: 11/29/2018 9:06 am

	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	5.00	ADMINISTRATIVE & GENERAL	DIRECT ALLOCATION - QHR COST	39,600	0	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	POOLED ALLOCATION OF NON-CAP	153,366	0	2.00
3.00	1.00	CAP REL COSTS-BLDG & FIXT	NEW CAPITAL - BUILDING & FIX	54,892	0	3.00
4.00	2.00	CAP REL COSTS-MVBLE EQUIP	NEW CAPITAL - MOVABLE EQUIPM	8,000	0	4.00
4.01	5.00	ADMINISTRATIVE & GENERAL	NON-CAPITAL FUNCTIONAL ALLOC	325,670	0	4.01
4.02	5.00	ADMINISTRATIVE & GENERAL	MALPRACTICE COSTS	26,983	238,356	4.02
4.03	5.00	ADMINISTRATIVE & GENERAL	MANAGEMENT FEES	0	382,462	4.03
4.04	0.00			0	0	4.04
4.05	0.00			0	0	4.05
4.06	0.00			0	0	4.06
4.07	0.00			0	0	4.07
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			608,511	620,818	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	QUORUM HEALTH C	100.00	QUORUM HEALTH C	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: 14-1348 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-8-1 | Date/Time Prepared: 11/29/2018 9:06 am

	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	39,600	0		1.00
2.00	153,366	0		2.00
3.00	54,892	9		3.00
4.00	8,000	9		4.00
4.01	325,670	0		4.01
4.02	-211,373	0		4.02
4.03	-382,462	0		4.03
4.04	0	0		4.04
4.05	0	0		4.05
4.06	0	0		4.06
4.07	0	0		4.07
5.00	-12,307			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 CORP		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: 14-1348 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-8-2 | Date/Time Prepared: 11/29/2018 9:06 am

	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	158,802	158,802	0	0	0	1.00
2.00	60.00	LABORATORY	69,207	69,207	0	0	0	2.00
3.00	91.00	EMERGENCY	1,363,430	635,043	728,387	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			1,591,439	863,052	728,387		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	60.00	LABORATORY	0	0	0	0	0	2.00
3.00	91.00	EMERGENCY	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	158,802		1.00
2.00	60.00	LABORATORY	0	0	0	69,207		2.00
3.00	91.00	EMERGENCY	0	0	0	635,043		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	863,052		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1348 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B Part I Date/Time Prepared: 11/29/2018 9:06 am

		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	384,616	384,616				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	1,572,064		1,572,064			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,929,091	3,243	24,775	1,957,109		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	3,342,812	63,578	270,926	170,568	3,847,884	5.00
7.00	00700	OPERATION OF PLANT	1,085,568	93,353	414,902	30,450	1,624,273	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	87,271	855	3,741	0	91,867	8.00
9.00	00900	HOUSEKEEPING	189,815	6,174	27,011	28,117	251,117	9.00
10.00	01000	DIETARY	697,897	16,498	72,184	0	786,579	10.00
11.00	01100	CAFETERIA	108,655	9,721	42,530	0	160,906	11.00
13.00	01300	NURSING ADMINISTRATION	635,277	4,498	16,331	95,582	751,688	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	97,369	3,538	15,478	8,097	124,482	14.00
15.00	01500	PHARMACY	400,500	4,482	19,611	61,319	485,912	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	322,709	9,835	43,031	39,572	415,147	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,654,489	40,506	177,220	276,350	2,148,565	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	435,729	22,099	96,688	53,898	608,414	50.00
53.00	05300	ANESTHESIOLOGY	40,465	474	2,074	9,164	52,177	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,183,158	15,368	67,237	96,255	1,362,018	54.00
60.00	06000	LABORATORY	823,131	8,928	39,060	79,903	951,022	60.00
65.00	06500	RESPIRATORY THERAPY	120,740	1,115	4,879	18,454	145,188	65.00
66.00	06600	PHYSICAL THERAPY	523,342	12,509	54,727	83,567	674,145	66.00
67.00	06700	OCCUPATIONAL THERAPY	173,510	1,536	6,722	28,539	210,307	67.00
68.00	06800	SPEECH PATHOLOGY	58,240	0	0	9,505	67,745	68.00
69.00	06900	ELECTROCARDIOLOGY	38,537	3,057	13,377	5,592	60,563	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	198,012	0	0	0	198,012	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	92,367	0	0	0	92,367	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	574,257	0	0	0	574,257	73.00
76.00	03610	BLANK	0	0	0	0	0	76.00
76.01	03550	SLEEP LAB	0	0	0	0	0	76.01
76.02	03020	PSYCH SERVICES	0	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,922,801	19,070	83,433	410,651	2,435,955	88.00
91.00	09100	EMERGENCY	1,873,867	9,355	40,930	401,955	2,326,107	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)	20,566,289	349,792	1,536,867	1,907,538	20,446,697	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	-11,972	25,302	0	0	13,330	192.00
194.00	07950	HOME HEALTH	0	0	0	0	0	194.00
194.01	07951	MARKETING	120,335	1,341	5,868	8,772	136,316	194.01
194.02	07952	SENIOR CIRCLE	49,243	2,007	2,318	7,546	61,114	194.02
194.03	07953	RED BUD SPECIALTY CLINIC	0	0	0	0	0	194.03
194.04	07954	WATERLOO SPECIALTY CLINIC	66,000	0	0	0	66,000	194.04
194.05	07955	FREE STANDING NURSING HOME	195,389	0	0	33,253	228,642	194.05
194.06	07956	CLINIC CORPORATION	0	0	0	0	0	194.06
194.07	07957	VACANT SPACE	0	6,174	27,011	0	33,185	194.07
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)	20,985,284	384,616	1,572,064	1,957,109	20,985,284	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1348 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B Part I Date/Time Prepared: 11/29/2018 9:06 am

		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	3,847,884					5.00
7.00	00700	OPERATION OF PLANT	371,374	1,995,647				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	21,004	7,602	120,473			8.00
9.00	00900	HOUSEKEEPING	57,415	54,894	27,060	390,486		9.00
10.00	01000	DIETARY	179,843	146,697	14,703	29,632	1,157,454	10.00
11.00	01100	CAFETERIA	36,790	86,432	0	17,459	0	11.00
13.00	01300	NURSING ADMINISTRATION	171,866	39,993	0	8,078	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	28,462	31,455	964	6,354	0	14.00
15.00	01500	PHARMACY	111,099	39,856	0	8,051	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	94,919	87,451	0	17,665	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	491,248	360,162	36,990	72,752	183,197	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	139,108	196,496	7,254	39,691	0	50.00
53.00	05300	ANESTHESIOLOGY	11,930	4,214	0	851	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	311,412	136,644	8,960	27,601	0	54.00
60.00	06000	LABORATORY	217,442	79,381	436	16,034	0	60.00
65.00	06500	RESPIRATORY THERAPY	33,196	9,916	0	2,003	0	65.00
66.00	06600	PHYSICAL THERAPY	154,137	111,221	7,107	22,466	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	48,085	13,662	0	2,760	0	67.00
68.00	06800	SPEECH PATHOLOGY	15,489	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	13,847	27,186	85	5,491	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	45,273	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	21,119	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	131,298	0	0	0	0	73.00
76.00	03610	BLANK	0	0	0	0	0	76.00
76.01	03550	SLEEP LAB	0	0	0	0	0	76.01
76.02	03020	PSYCH SERVICES	0	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	556,960	169,559	0	34,250	0	88.00
91.00	09100	EMERGENCY	531,841	83,182	15,063	16,802	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)	3,795,157	1,686,003	118,622	327,940	183,197	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	224,976	1,851	45,444	0	192.00
194.00	07950	HOME HEALTH	0	0	0	0	0	194.00
194.01	07951	MARKETING	31,167	11,926	0	2,409	0	194.01
194.02	07952	SENIOR CIRCLE	13,973	17,848	0	3,605	0	194.02
194.03	07953	RED BUD SPECIALTY CLINIC	0	0	0	0	0	194.03
194.04	07954	WATERLOO SPECIALTY CLINIC	0	0	0	0	0	194.04
194.05	07955	FREE STANDING NURSING HOME	0	0	0	0	974,257	194.05
194.06	07956	CLINIC CORPORATION	0	0	0	0	0	194.06
194.07	07957	VACANT SPACE	7,587	54,894	0	11,088	0	194.07
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)	3,847,884	1,995,647	120,473	390,486	1,157,454	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1348 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B Part I | Date/Time Prepared: 11/29/2018 9:06 am

		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	301,587					11.00
13.00	01300	NURSING ADMINISTRATION	19,012	990,637				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3,834	0	195,551			14.00
15.00	01500	PHARMACY	7,068	73,976	9,430	735,392		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	12,727	0	206	0	628,115	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	71,825	333,393	45,534	0	67,915	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	10,901	65,023	1,084	0	47,376	50.00
53.00	05300	ANESTHESIOLOGY	0	0	2,565	0	1,474	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	22,611	0	18,457	0	181,320	54.00
60.00	06000	LABORATORY	23,707	0	35,342	0	137,841	60.00
65.00	06500	RESPIRATORY THERAPY	4,381	22,263	743	0	8,292	65.00
66.00	06600	PHYSICAL THERAPY	17,682	0	21	0	36,117	66.00
67.00	06700	OCCUPATIONAL THERAPY	5,685	0	12	0	11,771	67.00
68.00	06800	SPEECH PATHOLOGY	1,643	0	0	0	2,025	68.00
69.00	06900	ELECTROCARDIOLOGY	1,434	0	298	0	14,526	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	22,281	0	13,784	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	27,516	0	3,528	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	735,392	29,146	73.00
76.00	03610	BLANK	0	0	0	0	0	76.00
76.01	03550	SLEEP LAB	0	0	0	0	0	76.01
76.02	03020	PSYCH SERVICES	0	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	56,828	0	12,578	0	15,529	88.00
91.00	09100	EMERGENCY	39,902	495,982	17,392	0	57,471	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)	299,240	990,637	193,459	735,392	628,115	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	07950	HOME HEALTH	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	0	1,795	0	0	194.01
194.02	07952	SENIOR CIRCLE	2,347	0	297	0	0	194.02
194.03	07953	RED BUD SPECIALTY CLINIC	0	0	0	0	0	194.03
194.04	07954	WATERLOO SPECIALTY CLINIC	0	0	0	0	0	194.04
194.05	07955	FREE STANDING NURSING HOME	0	0	0	0	0	194.05
194.06	07956	CLINIC CORPORATION	0	0	0	0	0	194.06
194.07	07957	VACANT SPACE	0	0	0	0	0	194.07
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)	301,587	990,637	195,551	735,392	628,115	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1348 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B Part I | Date/Time Prepared: 11/29/2018 9:06 am

		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	3,811,581	0	3,811,581		30.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	1,115,347	0	1,115,347		50.00
53.00	05300	ANESTHESIOLOGY	73,211	0	73,211		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,069,023	0	2,069,023		54.00
60.00	06000	LABORATORY	1,461,205	0	1,461,205		60.00
65.00	06500	RESPIRATORY THERAPY	225,982	0	225,982		65.00
66.00	06600	PHYSICAL THERAPY	1,022,896	0	1,022,896		66.00
67.00	06700	OCCUPATIONAL THERAPY	292,282	0	292,282		67.00
68.00	06800	SPEECH PATHOLOGY	86,902	0	86,902		68.00
69.00	06900	ELECTROCARDIOLOGY	123,430	0	123,430		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	279,350	0	279,350		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	144,530	0	144,530		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,470,093	0	1,470,093		73.00
76.00	03610	BLANK	0	0	0		76.00
76.01	03550	SLEEP LAB	0	0	0		76.01
76.02	03020	PSYCH SERVICES	0	0	0		76.02
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	3,281,659	0	3,281,659		88.00
91.00	09100	EMERGENCY	3,583,742	0	3,583,742		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)	19,041,233	0	19,041,233		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	285,601	0	285,601		192.00
194.00	07950	HOME HEALTH	0	0	0		194.00
194.01	07951	MARKETING	183,613	0	183,613		194.01
194.02	07952	SENIOR CIRCLE	99,184	0	99,184		194.02
194.03	07953	RED BUD SPECIALTY CLINIC	0	0	0		194.03
194.04	07954	WATERLOO SPECIALTY CLINIC	66,000	0	66,000		194.04
194.05	07955	FREE STANDING NURSING HOME	1,202,899	0	1,202,899		194.05
194.06	07956	CLINIC CORPORATION	0	0	0		194.06
194.07	07957	VACANT SPACE	106,754	0	106,754		194.07
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)	20,985,284	0	20,985,284		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1348 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B Part II Date/Time Prepared: 11/29/2018 9:06 am

		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	3,243	24,775	28,018	28,018	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	63,578	270,926	334,504	2,442	5.00
7.00	00700	OPERATION OF PLANT	0	93,353	414,902	508,255	436	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	855	3,741	4,596	0	8.00
9.00	00900	HOUSEKEEPING	0	6,174	27,011	33,185	403	9.00
10.00	01000	DIETARY	0	16,498	72,184	88,682	0	10.00
11.00	01100	CAFETERIA	0	9,721	42,530	52,251	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	4,498	16,331	20,829	1,368	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	3,538	15,478	19,016	116	14.00
15.00	01500	PHARMACY	0	4,482	19,611	24,093	878	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	9,835	43,031	52,866	567	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	40,506	177,220	217,726	3,956	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	22,099	96,688	118,787	772	50.00
53.00	05300	ANESTHESIOLOGY	0	474	2,074	2,548	131	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	15,368	67,237	82,605	1,378	54.00
60.00	06000	LABORATORY	0	8,928	39,060	47,988	1,144	60.00
65.00	06500	RESPIRATORY THERAPY	0	1,115	4,879	5,994	264	65.00
66.00	06600	PHYSICAL THERAPY	0	12,509	54,727	67,236	1,196	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,536	6,722	8,258	409	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	136	68.00
69.00	06900	ELECTROCARDIOLOGY	0	3,057	13,377	16,434	80	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	03610	BLANK	0	0	0	0	0	76.00
76.01	03550	SLEEP LAB	0	0	0	0	0	76.01
76.02	03020	PSYCH SERVICES	0	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	19,070	83,433	102,503	5,878	88.00
91.00	09100	EMERGENCY	0	9,355	40,930	50,285	5,754	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	349,792	1,536,867	1,886,659	27,308	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	25,302	0	25,302	0	192.00
194.00	07950	HOME HEALTH	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	1,341	5,868	7,209	126	194.01
194.02	07952	SENIOR CIRCLE	0	2,007	2,318	4,325	108	194.02
194.03	07953	RED BUD SPECIALTY CLINIC	0	0	0	0	0	194.03
194.04	07954	WATERLOO SPECIALTY CLINIC	0	0	0	0	0	194.04
194.05	07955	FREE STANDING NURSING HOME	0	0	0	0	476	194.05
194.06	07956	CLINIC CORPORATION	0	0	0	0	0	194.06
194.07	07957	VACANT SPACE	0	6,174	27,011	33,185	0	194.07
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	384,616	1,572,064	1,956,680	28,018	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1348 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B Part II Date/Time Prepared: 11/29/2018 9:06 am

		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	336,946					5.00
7.00	00700	OPERATION OF PLANT	32,520	541,211				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,839	2,062	8,497			8.00
9.00	00900	HOUSEKEEPING	5,028	14,887	1,909	55,412		9.00
10.00	01000	DIETARY	15,748	39,784	1,037	4,205	149,456	10.00
11.00	01100	CAFETERIA	3,221	23,440	0	2,477	0	11.00
13.00	01300	NURSING ADMINISTRATION	15,050	10,846	0	1,146	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,492	8,530	68	902	0	14.00
15.00	01500	PHARMACY	9,728	10,809	0	1,142	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	8,312	23,716	0	2,507	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	43,016	97,673	2,608	10,325	23,655	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	12,181	53,289	512	5,632	0	50.00
53.00	05300	ANESTHESIOLOGY	1,045	1,143	0	121	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	27,269	37,057	632	3,917	0	54.00
60.00	06000	LABORATORY	19,040	21,528	31	2,275	0	60.00
65.00	06500	RESPIRATORY THERAPY	2,907	2,689	0	284	0	65.00
66.00	06600	PHYSICAL THERAPY	13,497	30,163	501	3,188	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	4,211	3,705	0	392	0	67.00
68.00	06800	SPEECH PATHOLOGY	1,356	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	1,213	7,373	6	779	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,964	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,849	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	11,497	0	0	0	0	73.00
76.00	03610	BLANK	0	0	0	0	0	76.00
76.01	03550	SLEEP LAB	0	0	0	0	0	76.01
76.02	03020	PSYCH SERVICES	0	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	48,775	45,984	0	4,860	0	88.00
91.00	09100	EMERGENCY	46,571	22,559	1,062	2,384	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)	332,329	457,237	8,366	46,536	23,655	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	61,013	131	6,449	0	192.00
194.00	07950	HOME HEALTH	0	0	0	0	0	194.00
194.01	07951	MARKETING	2,729	3,234	0	342	0	194.01
194.02	07952	SENIOR CIRCLE	1,224	4,840	0	512	0	194.02
194.03	07953	RED BUD SPECIALTY CLINIC	0	0	0	0	0	194.03
194.04	07954	WATERLOO SPECIALTY CLINIC	0	0	0	0	0	194.04
194.05	07955	FREE STANDING NURSING HOME	0	0	0	0	125,801	194.05
194.06	07956	CLINIC CORPORATION	0	0	0	0	0	194.06
194.07	07957	VACANT SPACE	664	14,887	0	1,573	0	194.07
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)	336,946	541,211	8,497	55,412	149,456	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1348 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B Part II | Date/Time Prepared: 11/29/2018 9:06 am

		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	81,389					11.00
13.00	01300	NURSING ADMINISTRATION	5,131	54,370				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,035	0	32,159			14.00
15.00	01500	PHARMACY	1,907	4,060	1,551	54,168		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,435	0	34	0	91,437	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	19,384	18,299	7,490	0	9,880	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,942	3,569	178	0	6,892	50.00
53.00	05300	ANESTHESIOLOGY	0	0	422	0	214	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,102	0	3,035	0	26,442	54.00
60.00	06000	LABORATORY	6,398	0	5,812	0	20,052	60.00
65.00	06500	RESPIRATORY THERAPY	1,182	1,222	122	0	1,206	65.00
66.00	06600	PHYSICAL THERAPY	4,772	0	3	0	5,254	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,534	0	2	0	1,712	67.00
68.00	06800	SPEECH PATHOLOGY	443	0	0	0	295	68.00
69.00	06900	ELECTROCARDIOLOGY	387	0	49	0	2,113	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	3,664	0	2,005	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	4,525	0	513	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	54,168	4,240	73.00
76.00	03610	BLANK	0	0	0	0	0	76.00
76.01	03550	SLEEP LAB	0	0	0	0	0	76.01
76.02	03020	PSYCH SERVICES	0	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	15,336	0	2,068	0	2,259	88.00
91.00	09100	EMERGENCY	10,768	27,220	2,860	0	8,360	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)	80,756	54,370	31,815	54,168	91,437	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	07950	HOME HEALTH	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	0	295	0	0	194.01
194.02	07952	SENIOR CIRCLE	633	0	49	0	0	194.02
194.03	07953	RED BUD SPECIALTY CLINIC	0	0	0	0	0	194.03
194.04	07954	WATERLOO SPECIALTY CLINIC	0	0	0	0	0	194.04
194.05	07955	FREE STANDING NURSING HOME	0	0	0	0	0	194.05
194.06	07956	CLINIC CORPORATION	0	0	0	0	0	194.06
194.07	07957	VACANT SPACE	0	0	0	0	0	194.07
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)	81,389	54,370	32,159	54,168	91,437	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1348 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B Part II | Date/Time Prepared: 11/29/2018 9:06 am

		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	454,012	0	454,012		30.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	204,754	0	204,754		50.00
53.00	05300	ANESTHESIOLOGY	5,624	0	5,624		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	188,437	0	188,437		54.00
60.00	06000	LABORATORY	124,268	0	124,268		60.00
65.00	06500	RESPIRATORY THERAPY	15,870	0	15,870		65.00
66.00	06600	PHYSICAL THERAPY	125,810	0	125,810		66.00
67.00	06700	OCCUPATIONAL THERAPY	20,223	0	20,223		67.00
68.00	06800	SPEECH PATHOLOGY	2,230	0	2,230		68.00
69.00	06900	ELECTROCARDIOLOGY	28,434	0	28,434		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	9,633	0	9,633		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	6,887	0	6,887		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	69,905	0	69,905		73.00
76.00	03610	BLANK	0	0	0		76.00
76.01	03550	SLEEP LAB	0	0	0		76.01
76.02	03020	PSYCH SERVICES	0	0	0		76.02
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	227,663	0	227,663		88.00
91.00	09100	EMERGENCY	177,823	0	177,823		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)	1,661,573	0	1,661,573		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	92,895	0	92,895		192.00
194.00	07950	HOME HEALTH	0	0	0		194.00
194.01	07951	MARKETING	13,935	0	13,935		194.01
194.02	07952	SENIOR CIRCLE	11,691	0	11,691		194.02
194.03	07953	RED BUD SPECIALTY CLINIC	0	0	0		194.03
194.04	07954	WATERLOO SPECIALTY CLINIC	0	0	0		194.04
194.05	07955	FREE STANDING NURSING HOME	126,277	0	126,277		194.05
194.06	07956	CLINIC CORPORATION	0	0	0		194.06
194.07	07957	VACANT SPACE	50,309	0	50,309		194.07
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)	1,956,680	0	1,956,680		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1348 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B-1 | Date/Time Prepared: 11/29/2018 9:06 am

		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	124,161					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		115,993				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,047	1,828	10,978,511			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	20,524	19,990	956,812	-3,847,884	16,829,428	5.00
7.00	00700	OPERATION OF PLANT	30,136	30,613	170,812	0	1,624,273	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	276	276	0	0	91,867	8.00
9.00	00900	HOUSEKEEPING	1,993	1,993	157,726	0	251,117	9.00
10.00	01000	DIETARY	5,326	5,326	0	0	786,579	10.00
11.00	01100	CAFETERIA	3,138	3,138	0	0	160,906	11.00
13.00	01300	NURSING ADMINISTRATION	1,452	1,205	536,174	0	751,688	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,142	1,142	45,418	0	124,482	14.00
15.00	01500	PHARMACY	1,447	1,447	343,974	0	485,912	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,175	3,175	221,983	0	415,147	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	13,076	13,076	1,550,204	0	2,148,565	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	7,134	7,134	302,344	0	608,414	50.00
53.00	05300	ANESTHESIOLOGY	153	153	51,408	0	52,177	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,961	4,961	539,949	0	1,362,018	54.00
60.00	06000	LABORATORY	2,882	2,882	448,219	0	951,022	60.00
65.00	06500	RESPIRATORY THERAPY	360	360	103,518	0	145,188	65.00
66.00	06600	PHYSICAL THERAPY	4,038	4,038	468,776	0	674,145	66.00
67.00	06700	OCCUPATIONAL THERAPY	496	496	160,089	0	210,307	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	53,318	0	67,745	68.00
69.00	06900	ELECTROCARDIOLOGY	987	987	31,368	0	60,563	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	198,012	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	92,367	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	574,257	73.00
76.00	03610	BLANK	0	0	0	0	0	76.00
76.01	03550	SLEEP LAB	0	0	0	0	0	76.01
76.02	03020	PSYCH SERVICES	0	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	6,156	6,156	2,303,557	0	2,435,955	88.00
91.00	09100	EMERGENCY	3,020	3,020	2,254,794	0	2,326,107	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)	112,919	113,396	10,700,443	-3,847,884	16,598,813	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	8,168	0	0	-13,330	0	192.00
194.00	07950	HOME HEALTH	0	0	0	0	0	194.00
194.01	07951	MARKETING	433	433	49,205	0	136,316	194.01
194.02	07952	SENIOR CIRCLE	648	171	42,330	0	61,114	194.02
194.03	07953	RED BUD SPECIALTY CLINIC	0	0	0	0	0	194.03
194.04	07954	WATERLOO SPECIALTY CLINIC	0	0	0	-66,000	0	194.04
194.05	07955	FREE STANDING NURSING HOME	0	0	186,533	-228,642	0	194.05
194.06	07956	CLINIC CORPORATION	0	0	0	0	0	194.06
194.07	07957	VACANT SPACE	1,993	1,993	0	0	33,185	194.07
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)	384,616	1,572,064	1,957,109		3,847,884	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	3.097720	13.553094	0.178267		0.228640	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			28,018		336,946	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.002552		0.020021	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: 14-1348 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B-1 | Date/Time Prepared: 11/29/2018 9:06 am

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FULL TIME EQUIVALENT)	
			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	72,454					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	276	184,232				8.00
9.00	00900	HOUSEKEEPING	1,993	41,381	70,185			9.00
10.00	01000	DIETARY	5,326	22,484	5,326	123,462		10.00
11.00	01100	CAFETERIA	3,138	0	3,138	0	11,564	11.00
13.00	01300	NURSING ADMINISTRATION	1,452	0	1,452	0	729	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,142	1,474	1,142	0	147	14.00
15.00	01500	PHARMACY	1,447	0	1,447	0	271	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,175	0	3,175	0	488	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	13,076	56,568	13,076	19,541	2,754	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	7,134	11,093	7,134	0	418	50.00
53.00	05300	ANESTHESIOLOGY	153	0	153	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,961	13,702	4,961	0	867	54.00
60.00	06000	LABORATORY	2,882	666	2,882	0	909	60.00
65.00	06500	RESPIRATORY THERAPY	360	0	360	0	168	65.00
66.00	06600	PHYSICAL THERAPY	4,038	10,868	4,038	0	678	66.00
67.00	06700	OCCUPATIONAL THERAPY	496	0	496	0	218	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	63	68.00
69.00	06900	ELECTROCARDIOLOGY	987	130	987	0	55	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	03610	BLANK	0	0	0	0	0	76.00
76.01	03550	SLEEP LAB	0	0	0	0	0	76.01
76.02	03020	PSYCH SERVICES	0	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	6,156	0	6,156	0	2,179	88.00
91.00	09100	EMERGENCY	3,020	23,035	3,020	0	1,530	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)	61,212	181,401	58,943	19,541	11,474	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	8,168	2,831	8,168	0	0	192.00
194.00	07950	HOME HEALTH	0	0	0	0	0	194.00
194.01	07951	MARKETING	433	0	433	0	0	194.01
194.02	07952	SENIOR CIRCLE	648	0	648	0	90	194.02
194.03	07953	RED BUD SPECIALTY CLINIC	0	0	0	0	0	194.03
194.04	07954	WATERLOO SPECIALTY CLINIC	0	0	0	0	0	194.04
194.05	07955	FREE STANDING NURSING HOME	0	0	0	103,921	0	194.05
194.06	07956	CLINIC CORPORATION	0	0	0	0	0	194.06
194.07	07957	VACANT SPACE	1,993	0	1,993	0	0	194.07
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)	1,995,647	120,473	390,486	1,157,454	301,587	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	27.543641	0.653920	5.563667	9.374982	26.079817	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	541,211	8,497	55,412	149,456	81,389	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	7.469719	0.046121	0.789513	1.210543	7.038136	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: 14-1348 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B-1 | Date/Time Prepared: 11/29/2018 9:06 am

		Cost Center Description	NURSING ADMINISTRATION (NURSING SALARIE)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS REVENUE)		
			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	4,606,242					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	783,739				14.00
15.00	01500	PHARMACY	343,974	37,794	574,289			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	825	0	130,721,012		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,550,204	182,487	0	14,134,270		30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	302,344	4,345	0	9,859,813		50.00
53.00	05300	ANESTHESIOLOGY	0	10,280	0	306,776		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	73,972	0	37,735,300		54.00
60.00	06000	LABORATORY	0	141,644	0	28,686,993		60.00
65.00	06500	RESPIRATORY THERAPY	103,518	2,979	0	1,725,736		65.00
66.00	06600	PHYSICAL THERAPY	0	84	0	7,516,504		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	50	0	2,449,823		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	421,530		68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,196	0	3,023,113		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	89,301	0	2,868,591		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	110,281	0	734,333		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	574,289	6,065,717		73.00
76.00	03610	BLANK	0	0	0	0		76.00
76.01	03550	SLEEP LAB	0	0	0	0		76.01
76.02	03020	PSYCH SERVICES	0	0	0	0		76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	50,410	0	3,231,910		88.00
91.00	09100	EMERGENCY	2,306,202	69,706	0	11,960,603		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)	4,606,242	775,354	574,289	130,721,012		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	07950	HOME HEALTH	0	0	0	0		194.00
194.01	07951	MARKETING	0	7,194	0	0		194.01
194.02	07952	SENIOR CIRCLE	0	1,191	0	0		194.02
194.03	07953	RED BUD SPECIALTY CLINIC	0	0	0	0		194.03
194.04	07954	WATERLOO SPECIALTY CLINIC	0	0	0	0		194.04
194.05	07955	FREE STANDING NURSING HOME	0	0	0	0		194.05
194.06	07956	CLINIC CORPORATION	0	0	0	0		194.06
194.07	07957	VACANT SPACE	0	0	0	0		194.07
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)	990,637	195,551	735,392	628,115		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.215064	0.249510	1.280526	0.004805		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	54,370	32,159	54,168	91,437		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.011804	0.041033	0.094322	0.000699		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: 14-1348 | Period: From 07/01/2017 To 06/30/2018 | Worksheet C Part I Date/Time Prepared: 11/29/2018 9:06 am

Title XVIII | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,811,581		3,811,581	0	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,115,347		1,115,347	0	0	50.00
53.00	05300	ANESTHESIOLOGY	73,211		73,211	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,069,023		2,069,023	0	0	54.00
60.00	06000	LABORATORY	1,461,205		1,461,205	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	225,982	0	225,982	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,022,896	0	1,022,896	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	292,282	0	292,282	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	86,902	0	86,902	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	123,430		123,430	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	279,350		279,350	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	144,530		144,530	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,470,093		1,470,093	0	0	73.00
76.00	03610	BLANK	0		0	0	0	76.00
76.01	03550	SLEEP LAB	0		0	0	0	76.01
76.02	03020	PSYCH SERVICES	0		0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	3,281,659		3,281,659	0	0	88.00
91.00	09100	EMERGENCY	3,583,742		3,583,742	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	237,786		237,786		0	92.00
200.00		Subtotal (see instructions)	19,279,019	0	19,279,019	0	0	200.00
201.00		Less Observation Beds	237,786		237,786		0	201.00
202.00		Total (see instructions)	19,041,233	0	19,041,233	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1348 | Period: From 07/01/2017 To 06/30/2018 | Worksheet C Part I Date/Time Prepared: 11/29/2018 9:06 am

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	12,885,453		12,885,453			30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,918,709	7,941,104	9,859,813	0.113121	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	89,330	217,446	306,776	0.238646	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,875,117	34,860,183	37,735,300	0.054830	0.000000	54.00
60.00	06000	LABORATORY	6,562,576	22,124,417	28,686,993	0.050936	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	1,607,215	118,521	1,725,736	0.130948	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	4,038,320	3,478,184	7,516,504	0.136087	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,198,549	251,274	2,449,823	0.119307	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	308,836	112,694	421,530	0.206159	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	201,676	2,821,437	3,023,113	0.040829	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,201,829	666,762	2,868,591	0.097382	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	451,156	283,177	734,333	0.196818	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,806,947	3,258,770	6,065,717	0.242361	0.000000	73.00
76.00	03610	BLANK	0	0	0	0.000000	0.000000	76.00
76.01	03550	SLEEP LAB	0	0	0	0.000000	0.000000	76.01
76.02	03020	PSYCH SERVICES	0	0	0	0.000000	0.000000	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	3,231,910	3,231,910			88.00
91.00	09100	EMERGENCY	490,424	11,470,179	11,960,603	0.299629	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	113,707	1,135,110	1,248,817	0.190409	0.000000	92.00
200.00		Subtotal (see instructions)	38,749,844	91,971,168	130,721,012			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	38,749,844	91,971,168	130,721,012			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1348 | Period: From 07/01/2017 To 06/30/2018 | Worksheet C Part I Date/Time Prepared: 11/29/2018 9:06 am

Title XVIII | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	06000	LABORATORY	0.000000		60.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
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	03610	BLANK	0.000000		76.00
76.01	03550	SLEEP LAB	0.000000		76.01
76.02	03020	PSYCH SERVICES	0.000000		76.02
		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: 14-1348 | Period: From 07/01/2017 To 06/30/2018 | Worksheet C Part I Date/Time Prepared: 11/29/2018 9:06 am

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	3,811,581		3,811,581	0	3,811,581	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,115,347		1,115,347	0	1,115,347	50.00
53.00	05300	ANESTHESIOLOGY	73,211		73,211	0	73,211	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,069,023		2,069,023	0	2,069,023	54.00
60.00	06000	LABORATORY	1,461,205		1,461,205	0	1,461,205	60.00
65.00	06500	RESPIRATORY THERAPY	225,982	0	225,982	0	225,982	65.00
66.00	06600	PHYSICAL THERAPY	1,022,896	0	1,022,896	0	1,022,896	66.00
67.00	06700	OCCUPATIONAL THERAPY	292,282	0	292,282	0	292,282	67.00
68.00	06800	SPEECH PATHOLOGY	86,902	0	86,902	0	86,902	68.00
69.00	06900	ELECTROCARDIOLOGY	123,430		123,430	0	123,430	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	279,350		279,350	0	279,350	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	144,530		144,530	0	144,530	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,470,093		1,470,093	0	1,470,093	73.00
76.00	03610	BLANK	0		0	0	0	76.00
76.01	03550	SLEEP LAB	0		0	0	0	76.01
76.02	03020	PSYCH SERVICES	0		0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	3,281,659		3,281,659	0	3,281,659	88.00
91.00	09100	EMERGENCY	3,583,742		3,583,742	0	3,583,742	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	237,786		237,786		237,786	92.00
200.00		Subtotal (see instructions)	19,279,019	0	19,279,019	0	19,279,019	200.00
201.00		Less Observation Beds	237,786		237,786		237,786	201.00
202.00		Total (see instructions)	19,041,233	0	19,041,233	0	19,041,233	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1348 | Period: From 07/01/2017 To 06/30/2018 | Worksheet C Part I Date/Time Prepared: 11/29/2018 9:06 am

Title XIX | Hospital | PPS

		Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
			Inpatient	Outpatient	Total (col. 6 + col. 7)			
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	12,885,453		12,885,453			30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,918,709	7,941,104	9,859,813	0.113121	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	89,330	217,446	306,776	0.238646	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,875,117	34,860,183	37,735,300	0.054830	0.000000	54.00
60.00	06000	LABORATORY	6,562,576	22,124,417	28,686,993	0.050936	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	1,607,215	118,521	1,725,736	0.130948	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	4,038,320	3,478,184	7,516,504	0.136087	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,198,549	251,274	2,449,823	0.119307	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	308,836	112,694	421,530	0.206159	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	201,676	2,821,437	3,023,113	0.040829	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,201,829	666,762	2,868,591	0.097382	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	451,156	283,177	734,333	0.196818	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,806,947	3,258,770	6,065,717	0.242361	0.000000	73.00
76.00	03610	BLANK	0	0	0	0.000000	0.000000	76.00
76.01	03550	SLEEP LAB	0	0	0	0.000000	0.000000	76.01
76.02	03020	PSYCH SERVICES	0	0	0	0.000000	0.000000	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	3,231,910	3,231,910	1.015393	0.000000	88.00
91.00	09100	EMERGENCY	490,424	11,470,179	11,960,603	0.299629	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	113,707	1,135,110	1,248,817	0.190409	0.000000	92.00
200.00		Subtotal (see instructions)	38,749,844	91,971,168	130,721,012			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	38,749,844	91,971,168	130,721,012			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1348 | Period: From 07/01/2017 To 06/30/2018 | Worksheet C Part I Date/Time Prepared: 11/29/2018 9:06 am

Title XIX | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.113121		50.00
53.00	05300	ANESTHESIOLOGY	0.238646		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.054830		54.00
60.00	06000	LABORATORY	0.050936		60.00
65.00	06500	RESPIRATORY THERAPY	0.130948		65.00
66.00	06600	PHYSICAL THERAPY	0.136087		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.119307		67.00
68.00	06800	SPEECH PATHOLOGY	0.206159		68.00
69.00	06900	ELECTROCARDIOLOGY	0.040829		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.097382		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.196818		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.242361		73.00
76.00	03610	BLANK	0.000000		76.00
76.01	03550	SLEEP LAB	0.000000		76.01
76.02	03020	PSYCH SERVICES	0.000000		76.02
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	1.015393		88.00
91.00	09100	EMERGENCY	0.299629		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.190409		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: 14-1348 | Period: From 07/01/2017 To 06/30/2018 | Worksheet C Part II | Date/Time Prepared: 11/29/2018 9:06 am

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	1,115,347	204,754	910,593	0	0	50.00
53.00	05300	ANESTHESIOLOGY	73,211	5,624	67,587	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,069,023	188,437	1,880,586	0	0	54.00
60.00	06000	LABORATORY	1,461,205	124,268	1,336,937	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	225,982	15,870	210,112	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,022,896	125,810	897,086	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	292,282	20,223	272,059	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	86,902	2,230	84,672	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	123,430	28,434	94,996	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	279,350	9,633	269,717	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	144,530	6,887	137,643	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,470,093	69,905	1,400,188	0	0	73.00
76.00	03610	BLANK	0	0	0	0	0	76.00
76.01	03550	SLEEP LAB	0	0	0	0	0	76.01
76.02	03020	PSYCH SERVICES	0	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	3,281,659	227,663	3,053,996	0	0	88.00
91.00	09100	EMERGENCY	3,583,742	177,823	3,405,919	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	237,786	28,324	209,462	0	0	92.00
200.00		Subtotal (sum of lines 50 thru 199)	15,467,438	1,235,885	14,231,553	0	0	200.00
201.00		Less Observation Beds	237,786	28,324	209,462	0	0	201.00
202.00		Total (line 200 minus line 201)	15,229,652	1,207,561	14,022,091	0	0	202.00

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

Provider CCN: 14-1348 | Period: From 07/01/2017 To 06/30/2018 | Worksheet C Part II Date/Time Prepared: 11/29/2018 9:06 am

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	1,115,347	9,859,813	0.113121		50.00
53.00	05300	ANESTHESIOLOGY	73,211	306,776	0.238646		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,069,023	37,735,300	0.054830		54.00
60.00	06000	LABORATORY	1,461,205	28,686,993	0.050936		60.00
65.00	06500	RESPIRATORY THERAPY	225,982	1,725,736	0.130948		65.00
66.00	06600	PHYSICAL THERAPY	1,022,896	7,516,504	0.136087		66.00
67.00	06700	OCCUPATIONAL THERAPY	292,282	2,449,823	0.119307		67.00
68.00	06800	SPEECH PATHOLOGY	86,902	421,530	0.206159		68.00
69.00	06900	ELECTROCARDIOLOGY	123,430	3,023,113	0.040829		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	279,350	2,868,591	0.097382		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	144,530	734,333	0.196818		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,470,093	6,065,717	0.242361		73.00
76.00	03610	BLANK	0	0	0.000000		76.00
76.01	03550	SLEEP LAB	0	0	0.000000		76.01
76.02	03020	PSYCH SERVICES	0	0	0.000000		76.02
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	3,281,659	3,231,910	1.015393		88.00
91.00	09100	EMERGENCY	3,583,742	11,960,603	0.299629		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	237,786	1,248,817	0.190409		92.00
200.00		Subtotal (sum of lines 50 thru 199)	15,467,438	117,835,559			200.00
201.00		Less Observation Beds	237,786	0			201.00
202.00		Total (line 200 minus line 201)	15,229,652	117,835,559			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 14-1348 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part II Date/Time Prepared: 11/29/2018 9:06 am

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	204,754	9,859,813	0.020767	786,254	16,328	50.00
53.00	05300	ANESTHESIOLOGY	5,624	306,776	0.018333	25,681	471	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	188,437	37,735,300	0.004994	1,186,962	5,928	54.00
60.00	06000	LABORATORY	124,268	28,686,993	0.004332	2,679,158	11,606	60.00
65.00	06500	RESPIRATORY THERAPY	15,870	1,725,736	0.009196	640,144	5,887	65.00
66.00	06600	PHYSICAL THERAPY	125,810	7,516,504	0.016738	671,808	11,245	66.00
67.00	06700	OCCUPATIONAL THERAPY	20,223	2,449,823	0.008255	152,061	1,255	67.00
68.00	06800	SPEECH PATHOLOGY	2,230	421,530	0.005290	68,916	365	68.00
69.00	06900	ELECTROCARDIOLOGY	28,434	3,023,113	0.009406	85,820	807	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	9,633	2,868,591	0.003358	858,414	2,883	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	6,887	734,333	0.009379	215,530	2,021	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	69,905	6,065,717	0.011525	843,729	9,724	73.00
76.00	03610	BLANK	0	0	0.000000	0	0	76.00
76.01	03550	SLEEP LAB	0	0	0.000000	0	0	76.01
76.02	03020	PSYCH SERVICES	0	0	0.000000	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	227,663	3,231,910	0.070442	0	0	88.00
91.00	09100	EMERGENCY	177,823	11,960,603	0.014867	9,582	142	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	28,324	1,248,817	0.022681	0	0	92.00
200.00		Total (lines 50 through 199)	1,235,885	117,835,559		8,224,059	68,662	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1348 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part IV | Date/Time Prepared: 11/29/2018 9:06 am

Title XVIII | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
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	03610	BLANK	0	0	0	0	0	76.00
76.01	03550	SLEEP LAB	0	0	0	0	0	76.01
76.02	03020	PSYCH SERVICES	0	0	0	0	0	76.02
		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: 14-1348 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part IV | Date/Time Prepared: 11/29/2018 9:06 am

Title XVIII | Hospital | Cost

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	9,859,813	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	306,776	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	37,735,300	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	28,686,993	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	1,725,736	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	7,516,504	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	2,449,823	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	421,530	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	3,023,113	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	2,868,591	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	734,333	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	6,065,717	0.000000	73.00
76.00	03610	BLANK	0	0	0	0	0.000000	76.00
76.01	03550	SLEEP LAB	0	0	0	0	0.000000	76.01
76.02	03020	PSYCH SERVICES	0	0	0	0	0.000000	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	3,231,910	0.000000	88.00
91.00	09100	EMERGENCY	0	0	0	11,960,603	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	1,248,817	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	117,835,559		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1348 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part IV | Date/Time Prepared: 11/29/2018 9:06 am

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	786,254	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	25,681	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	1,186,962	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	2,679,158	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	640,144	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	671,808	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	152,061	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	68,916	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	85,820	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	858,414	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	215,530	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	843,729	0	0	0	73.00
76.00	03610	BLANK	0.000000	0	0	0	0	76.00
76.01	03550	SLEEP LAB	0.000000	0	0	0	0	76.01
76.02	03020	PSYCH SERVICES	0.000000	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
91.00	09100	EMERGENCY	0.000000	9,582	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)		8,224,059	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-1348 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part V Date/Time Prepared: 11/29/2018 9:06 am

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	0.113121	0	2,562,410	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.238646	0	67,080	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.054830	0	11,972,983	0	0	54.00
60.00	06000	LABORATORY	0.050936	0	8,614,564	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.130948	0	50,314	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.136087	0	1,275,773	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.119307	0	30,977	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.206159	0	31,972	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.040829	0	2,565,991	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.097382	0	213,819	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.196818	0	147,955	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.242361	0	969,518	0	0	73.00
76.00	03610	BLANK	0.000000	0	0	0	0	76.00
76.01	03550	SLEEP LAB	0.000000	0	0	0	0	76.01
76.02	03020	PSYCH SERVICES	0.000000	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
91.00	09100	EMERGENCY	0.299629	0	3,444,875	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.190409	0	502,331	0	0	92.00
200.00		Subtotal (see instructions)		0	32,450,562	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	32,450,562	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-1348 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part V Date/Time Prepared: 11/29/2018 9:06 am

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	289,862	0		50.00
53.00	05300	ANESTHESIOLOGY	16,008	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	656,479	0		54.00
60.00	06000	LABORATORY	438,791	0		60.00
65.00	06500	RESPIRATORY THERAPY	6,589	0		65.00
66.00	06600	PHYSICAL THERAPY	173,616	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	3,696	0		67.00
68.00	06800	SPEECH PATHOLOGY	6,591	0		68.00
69.00	06900	ELECTROCARDIOLOGY	104,767	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	20,822	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	29,120	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	234,973	0		73.00
76.00	03610	BLANK	0	0		76.00
76.01	03550	SLEEP LAB	0	0		76.01
76.02	03020	PSYCH SERVICES	0	0		76.02
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
91.00	09100	EMERGENCY	1,032,184	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	95,648	0		92.00
200.00		Subtotal (see instructions)	3,109,146	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	3,109,146	0		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1348 | Component CCN: 14-Z348 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part V Date/Time Prepared: 11/29/2018 9:06 am

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	0.113121	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.238646	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.054830	0	0	0	0	54.00
60.00	06000	LABORATORY	0.050936	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.130948	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.136087	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.119307	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.206159	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.040829	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.097382	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.196818	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.242361	0	0	0	0	73.00
76.00	03610	BLANK	0.000000	0	0	0	0	76.00
76.01	03550	SLEEP LAB	0.000000	0	0	0	0	76.01
76.02	03020	PSYCH SERVICES	0.000000	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
91.00	09100	EMERGENCY	0.299629	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.190409	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: 14-1348 | Component CCN: 14-Z348 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part V | Date/Time Prepared: 11/29/2018 9:06 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
60.00	06000	LABORATORY	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
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	03610	BLANK	0	0		76.00
76.01	03550	SLEEP LAB	0	0		76.01
76.02	03020	PSYCH SERVICES	0	0		76.02
		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: 14-1348 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part I Date/Time Prepared: 11/29/2018 9:06 am

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	454,012	268,242	185,770	2,676	69.42	30.00
200.00	Total (lines 30 through 199)	454,012		185,770	2,676		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	130	9,025	30.00
200.00	Total (lines 30 through 199)	130	9,025	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 14-1348 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part II Date/Time Prepared: 11/29/2018 9:06 am

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	204,754	9,859,813	0.020767	0	0	50.00
53.00	05300	ANESTHESIOLOGY	5,624	306,776	0.018333	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	188,437	37,735,300	0.004994	0	0	54.00
60.00	06000	LABORATORY	124,268	28,686,993	0.004332	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	15,870	1,725,736	0.009196	0	0	65.00
66.00	06600	PHYSICAL THERAPY	125,810	7,516,504	0.016738	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	20,223	2,449,823	0.008255	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	2,230	421,530	0.005290	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	28,434	3,023,113	0.009406	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	9,633	2,868,591	0.003358	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	6,887	734,333	0.009379	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	69,905	6,065,717	0.011525	0	0	73.00
76.00	03610	BLANK	0	0	0.000000	0	0	76.00
76.01	03550	SLEEP LAB	0	0	0.000000	0	0	76.01
76.02	03020	PSYCH SERVICES	0	0	0.000000	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	227,663	3,231,910	0.070442	0	0	88.00
91.00	09100	EMERGENCY	177,823	11,960,603	0.014867	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	28,324	1,248,817	0.022681	0	0	92.00
200.00		Total (lines 50 through 199)	1,235,885	117,835,559		0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 14-1348 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part III Date/Time Prepared: 11/29/2018 9:06 am

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	2,676	0.00	130	30.00
200.00		Total (lines 30 through 199)		0	2,676		130	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: 14-1348 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part IV Date/Time Prepared: 11/29/2018 9:06 am

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
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
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	03610	BLANK	0	0	0	0	0	76.00
76.01	03550	SLEEP LAB	0	0	0	0	0	76.01
76.02	03020	PSYCH SERVICES	0	0	0	0	0	76.02
		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: 14-1348 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part IV Date/Time Prepared: 11/29/2018 9:06 am

Title XIX | Hospital | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	9,859,813	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	306,776	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	37,735,300	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	28,686,993	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	1,725,736	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	7,516,504	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	2,449,823	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	421,530	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	3,023,113	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	2,868,591	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	734,333	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	6,065,717	0.000000	73.00
76.00	03610	BLANK	0	0	0	0	0.000000	76.00
76.01	03550	SLEEP LAB	0	0	0	0	0.000000	76.01
76.02	03020	PSYCH SERVICES	0	0	0	0	0.000000	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	3,231,910	0.000000	88.00
91.00	09100	EMERGENCY	0	0	0	11,960,603	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	1,248,817	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	117,835,559		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1348 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part IV Date/Time Prepared: 11/29/2018 9:06 am

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
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
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	03610	BLANK	0.000000	0	0	0	0	76.00
76.01	03550	SLEEP LAB	0.000000	0	0	0	0	76.01
76.02	03020	PSYCH SERVICES	0.000000	0	0	0	0	76.02
		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: 14-1348 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D-1 | Date/Time Prepared: 11/29/2018 9:06 am

Title XVIII | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	6,540	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,676	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	2,268	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	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)	3,864	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	1,560	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)	2,893	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	147.52	20.00
21.00	Total general inpatient routine service cost (see instructions)	3,811,581	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)	2,251,978	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	1,559,603	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)	1,559,603	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)	582.81	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	909,184	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)	909,184	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1348 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D-1 | Date/Time Prepared: 11/29/2018 9:06 am

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)	841,094	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	1,750,278	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)	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)	1,686,069	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	1,686,069	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)	408	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	582.81	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	237,786	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1348 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D-1 | Date/Time Prepared: 11/29/2018 9:06 am

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	454,012	3,811,581	0.119114	237,786	28,324	90.00
91.00	Nursing School cost	0	3,811,581	0.000000	237,786	0	91.00
92.00	Allied health cost	0	3,811,581	0.000000	237,786	0	92.00
93.00	All other Medical Education	0	3,811,581	0.000000	237,786	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1348 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D-1 | Date/Time Prepared: 11/29/2018 9:06 am

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)	6,540	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,676	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	2,268	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	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)	3,864	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	130	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)	3,811,581	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)	2,251,978	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	1,559,603	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)	1,559,603	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)	582.81	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	75,765	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)	75,765	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1348 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D-1 | Date/Time Prepared: 11/29/2018 9:06 am

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)	75,765	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)	9,025	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)	9,025	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	66,740	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)	408	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	582.81	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	237,786	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1348 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D-1 | Date/Time Prepared: 11/29/2018 9:06 am

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	454,012	3,811,581	0.119114	237,786	28,324	90.00
91.00	Nursing School cost	0	3,811,581	0.000000	237,786	0	91.00
92.00	Allied health cost	0	3,811,581	0.000000	237,786	0	92.00
93.00	All other Medical Education	0	3,811,581	0.000000	237,786	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 14-1348 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D-3 | Date/Time Prepared: 11/29/2018 9:06 am

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		4,787,314		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.113121	786,254	88,942	50.00
53.00	05300	ANESTHESIOLOGY	0.238646	25,681	6,129	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.054830	1,186,962	65,081	54.00
60.00	06000	LABORATORY	0.050936	2,679,158	136,466	60.00
65.00	06500	RESPIRATORY THERAPY	0.130948	640,144	83,826	65.00
66.00	06600	PHYSICAL THERAPY	0.136087	671,808	91,424	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.119307	152,061	18,142	67.00
68.00	06800	SPEECH PATHOLOGY	0.206159	68,916	14,208	68.00
69.00	06900	ELECTROCARDIOLOGY	0.040829	85,820	3,504	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.097382	858,414	83,594	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.196818	215,530	42,420	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.242361	843,729	204,487	73.00
76.00	03610	BLANK	0.000000	0	0	76.00
76.01	03550	SLEEP LAB	0.000000	0	0	76.01
76.02	03020	PSYCH SERVICES	0.000000	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
91.00	09100	EMERGENCY	0.299629	9,582	2,871	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.190409	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		8,224,059	841,094	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)		8,224,059		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 14-1348 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D-3

Component CCN: 14-Z348 | Date/Time Prepared: 11/29/2018 9:06 am

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	0.113121	48,476	5,484	50.00
53.00	05300	ANESTHESIOLOGY	0.238646	940	224	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.054830	286,560	15,712	54.00
60.00	06000	LABORATORY	0.050936	1,602,313	81,615	60.00
65.00	06500	RESPIRATORY THERAPY	0.130948	589,534	77,198	65.00
66.00	06600	PHYSICAL THERAPY	0.136087	2,384,718	324,529	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.119307	1,496,917	178,593	67.00
68.00	06800	SPEECH PATHOLOGY	0.206159	147,286	30,364	68.00
69.00	06900	ELECTROCARDIOLOGY	0.040829	49,516	2,022	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.097382	764,604	74,459	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.196818	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.242361	1,084,029	262,726	73.00
76.00	03610	BLANK	0.000000	0	0	76.00
76.01	03550	SLEEP LAB	0.000000	0	0	76.01
76.02	03020	PSYCH SERVICES	0.000000	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
91.00	09100	EMERGENCY	0.299629	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.190409	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		8,454,893	1,052,926	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)		8,454,893		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-1348	Period: From 07/01/2017 To 06/30/2018	Worksheet E Part B Date/Time Prepared: 11/29/2018 9:06 am
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	3,109,146	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)	3,109,146	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)	3,140,237	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	0	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	25,653	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	4,718,841	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)	-1,604,257	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)	-1,604,257	30.00
31.00	Primary payer payments	439	31.00
32.00	Subtotal (line 30 minus line 31)	-1,604,696	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)	687,591	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	446,934	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	631,714	36.00
37.00	Subtotal (see instructions)	-1,157,762	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)	-1,157,762	40.00
40.01	Sequestration adjustment (see instructions)	0	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
41.00	Interim payments	1,709,663	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	-2,867,425	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: 14-1348 | Period: From 07/01/2017 To 06/30/2018 | Worksheet E-1 Part I | Date/Time Prepared: 11/29/2018 9:06 am

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		1,502,449		1,709,663	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,502,449		1,709,663	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		185,111		2,867,425	6.02
7.00	Total Medicare program liability (see instructions)		1,317,338		-1,157,762	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: 14-1348 | Component CCN: 14-Z348 | Period: From 07/01/2017 To 06/30/2018 | Worksheet E-1 Part I | Date/Time Prepared: 11/29/2018 9:06 am

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		2,920,567		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)		2,920,567		0	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		353,638		0	6.02
7.00	Total Medicare program liability (see instructions)		2,566,929		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: 14-1348	Period: From 07/01/2017 To 06/30/2018	Worksheet E-1 Part II Date/Time Prepared: 11/29/2018 9:06 am
	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: 14-1348 | Component CCN: 14-Z348 | Period: From 07/01/2017 To 06/30/2018 | Worksheet E-2 | Date/Time Prepared: 11/29/2018 9:06 am

Title XVIII | Swing Beds - SNF | Cost

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	1,702,930	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)	1,063,455	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	2,893	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)	2,766,385	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	2,766,385	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)	2,766,385	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	147,070	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)	2,619,315	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)	2,619,315	0	19.00
19.01	Sequestration adjustment (see instructions)	52,386	0	19.01
19.02	Demonstration payment adjustment amount after sequestration)	0	0	19.02
20.00	Interim payments	2,920,567	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)	-353,638	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: 14-1348	Period: From 07/01/2017 To 06/30/2018	Worksheet E-3 Part V Date/Time Prepared: 11/29/2018 9:06 am
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	1,750,278	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)	1,750,278	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	1,767,781	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)	1,767,781	19.00
20.00	Deductibles (exclude professional component)	457,072	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	1,310,709	22.00
23.00	Coinsurance	0	23.00
24.00	Subtotal (line 22 minus line 23)	1,310,709	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	51,558	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	33,513	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	45,076	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	1,344,222	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)	1,344,222	30.00
30.01	Sequestration adjustment (see instructions)	26,884	30.01
30.02	Demonstration payment adjustment amount after sequestration	0	30.02
31.00	Interim payments	1,502,449	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)	-185,111	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: 14-1348 | Period: From 07/01/2017 To 06/30/2018 | Worksheet G | Date/Time Prepared: 11/29/2018 9:06 am

		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	245,306	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	3,522,871	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-865,880	0	0	0	6.00
7.00	Inventory	434,415	0	0	0	7.00
8.00	Prepaid expenses	285,714	0	0	0	8.00
9.00	Other current assets	434,930	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)	4,057,356	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	39,727	0	0	0	12.00
13.00	Land improvements	356,121	0	0	0	13.00
14.00	Accumulated depreciation	-151,999	0	0	0	14.00
15.00	Buildings	1,861,623	0	0	0	15.00
16.00	Accumulated depreciation	-1,306,997	0	0	0	16.00
17.00	Leasehold improvements	4,535,199	0	0	0	17.00
18.00	Accumulated depreciation	-1,717,707	0	0	0	18.00
19.00	Fixed equipment	2,609,867	0	0	0	19.00
20.00	Accumulated depreciation	-1,571,660	0	0	0	20.00
21.00	Automobiles and trucks	34,042	0	0	0	21.00
22.00	Accumulated depreciation	-29,787	0	0	0	22.00
23.00	Major movable equipment	4,181,054	0	0	0	23.00
24.00	Accumulated depreciation	-3,511,434	0	0	0	24.00
25.00	Minor equipment depreciable	2,984,072	0	0	0	25.00
26.00	Accumulated depreciation	-2,587,194	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)	5,724,927	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	1,464,997	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	1,464,997	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	11,247,280	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	1,665,701	0	0	0	37.00
38.00	Salaries, wages, and fees payable	799,197	0	0	0	38.00
39.00	Payroll taxes payable	109,993	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	-6,954,768	0	0	0	43.00
44.00	Other current liabilities	257,457	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	-4,122,420	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)	-4,122,420	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	15,369,700				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)	15,369,700	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	11,247,280	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 14-1348 | Period: From 07/01/2017 To 06/30/2018 | Worksheet G-1 | Date/Time Prepared: 11/29/2018 9:06 am

		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		12,179,593		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		3,190,106				2.00
3.00	Total (sum of line 1 and line 2)		15,369,699		0		3.00
4.00	Additions (credit adjustments) (specify)	1		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)		1		0		10.00
11.00	Subtotal (line 3 plus line 10)		15,369,700		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		15,369,700		0		19.00

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

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 14-1348 | Period: From 07/01/2017 To 06/30/2018 | Worksheet G-2 Parts I & II | Date/Time Prepared: 11/29/2018 9:06 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	12,885,453		12,885,453	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	12,885,453		12,885,453	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)	12,885,453		12,885,453	17.00
18.00	Ancillary services	25,260,260	76,133,969	101,394,229	18.00
19.00	Outpatient services	604,131	12,605,289	13,209,420	19.00
20.00	RURAL HEALTH CLINIC	0	3,231,910	3,231,910	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	PHYSICIAN CLINIC CHARGES	0	6,222,028	6,222,028	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	38,749,844	98,193,196	136,943,040	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		23,757,875		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)		23,757,875		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 14-1348 | Period: From 07/01/2017 To 06/30/2018 | Worksheet G-3 | Date/Time Prepared: 11/29/2018 9:06 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	136,943,040	1.00
2.00	Less contractual allowances and discounts on patients' accounts	110,134,614	2.00
3.00	Net patient revenues (line 1 minus line 2)	26,808,426	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	23,757,875	4.00
5.00	Net income from service to patients (line 3 minus line 4)	3,050,551	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 INCOME	138,935	24.00
25.00	Total other income (sum of lines 6-24)	138,935	25.00
26.00	Total (line 5 plus line 25)	3,189,486	26.00
27.00	EXPENSE DIFF BETWEEN WS A AND TB	-620	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	-620	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	3,190,106	29.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 14-1348	Period: From 07/01/2017 To 06/30/2018	Worksheet L Parts I-III Date/Time Prepared: 11/29/2018 9:06 am
	Title XVIII	Hospital	Cost

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	0	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	0	2.00
2.01	Model 4 BPCI Capital DRG outlier payments	0	2.01
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)	0.00	3.00
4.00	Number of interns & residents (see instructions)	0.00	4.00
5.00	Indirect medical education percentage (see instructions)	0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)	0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)	0.00	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)	0.00	8.00
9.00	Sum of lines 7 and 8	0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)	0.00	10.00
11.00	Disproportionate share adjustment (see instructions)	0	11.00
12.00	Total prospective capital payments (see instructions)	0	12.00
		1.00	
	PART II - PAYMENT UNDER REASONABLE COST		
1.00	Program inpatient routine capital cost (see instructions)	0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)	0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)	0	3.00
4.00	Capital cost payment factor (see instructions)	0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)	0	5.00
		1.00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS		
1.00	Program inpatient capital costs (see instructions)	0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)	0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)	0	3.00
4.00	Applicable exception percentage (see instructions)	0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)	0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)	0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)	0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)	0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)	0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)	0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)	0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)	0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)	0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)	0	14.00
15.00	Current year allowable operating and capital payment (see instructions)	0	15.00
16.00	Current year operating and capital costs (see instructions)	0	16.00
17.00	Current year exception offset amount (see instructions)	0	17.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1348 | Component CCN: 14-8514 | Period: From 07/01/2017 To 06/30/2018 | Worksheet M-1 | Date/Time Prepared: 11/29/2018 9:06 am

RHC I | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	1,434,552	0	1,434,552	0	1,434,552	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	406,190	0	406,190	0	406,190	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	27,374	0	27,374	0	27,374	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	197,406	63,108	260,514	0	260,514	9.00
10.00	Subtotal (sum of lines 1 through 9)	2,065,522	63,108	2,128,630	0	2,128,630	10.00
11.00	Physician Services Under Agreement	0	12,974	12,974	0	12,974	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	12,974	12,974	0	12,974	14.00
15.00	Medical Supplies	0	52,067	52,067	0	52,067	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	46,817	46,817	-46,817	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	98,884	98,884	-46,817	52,067	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	2,065,522	174,966	2,240,488	-46,817	2,193,671	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	40,533	40,533	-40,533	0	29.00
30.00	Administrative Costs	238,035	243,288	481,323	88,069	569,392	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	238,035	283,821	521,856	47,536	569,392	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	2,303,557	458,787	2,762,344	719	2,763,063	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1348 | Component CCN: 14-8514 | Period: From 07/01/2017 To 06/30/2018 | Worksheet M-1 | Date/Time Prepared: 11/29/2018 9:06 am

RHC I | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	-612,071	822,481		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	-112,052	294,138		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	27,374		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	-116,139	144,375		9.00
10.00	Subtotal (sum of lines 1 through 9)	-840,262	1,288,368		10.00
11.00	Physician Services Under Agreement	0	12,974		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	0		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	12,974		14.00
15.00	Medical Supplies	0	52,067		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	52,067		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-840,262	1,353,409		22.00
	COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
25.01	Telehealth	0	0		25.01
25.02	Chronic Care Management	0	0		25.02
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs				27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	0		29.00
30.00	Administrative Costs	0	569,392		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	569,392		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-840,262	1,922,801		32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1348 | Component CCN: 14-8514 | Period: From 07/01/2017 To 06/30/2018 | Worksheet M-2 | Date/Time Prepared: 11/29/2018 9:06 am

		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	2.28	7,844	4,200	9,576		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	2.30	4,486	2,100	4,830		3.00
4.00	Subtotal (sum of lines 1 through 3)	4.58	12,330		14,406	14,406	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	4.58	12,330			14,406	8.00
9.00	Physician Services Under Agreements		0			0	9.00
						1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)					1,353,409	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					1,353,409	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)					569,392	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					1,358,858	15.00
16.00	Total overhead (sum of lines 14 and 15)					1,928,250	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					1,928,250	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					1,928,250	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					3,281,659	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 14-1348 Component CCN: 14-8514	Period: From 07/01/2017 To 06/30/2018	Worksheet M-3 Date/Time Prepared: 11/29/2018 9:06 am
	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)			3,281,659	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			23,885	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			3,257,774	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			14,406	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)			14,406	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			226.14	7.00
		Calculation of Limit (1)			
		Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)		
		1.00	2.00		
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	82.30	83.45		8.00
9.00	Rate for Program covered visits (see instructions)	226.14	226.14		9.00
	CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	3,165	3,165		10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	715,733	715,733		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	1,431,466		16.00
16.01	Total program charges (see instructions)(from contractor's records)		1,246,908		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		77,431		16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		88,891		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.)		993,539		16.04
16.05	Total program cost (see instructions)	0	1,082,430		16.05
17.00	Primary payer amounts		0		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		100,651		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		213,765		19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		1,082,430		20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		16,862		21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		1,099,292		22.00
23.00	Allowable bad debts (see instructions)		0		23.00
23.01	Adjusted reimbursable bad debts (see instructions)		0		23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0		24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0		25.50
25.99	Demonstration payment adjustment amount before sequestration		0		25.99
26.00	Net reimbursable amount (see instructions)		1,099,292		26.00
26.01	Sequestration adjustment (see instructions)		21,986		26.01
26.02	Demonstration payment adjustment amount after sequestration		0		26.02
27.00	Interim payments		1,250,363		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)		-173,057		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: 14-1348 Component CCN: 14-8514	Period: From 07/01/2017 To 06/30/2018	Worksheet M-4 Date/Time Prepared: 11/29/2018 9:06 am
	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)	1,288,368	1,288,368	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.001664	0.001051	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	2,144	1,354	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	4,760	1,593	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	6,904	2,947	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	1,353,409	1,353,409	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	1,928,250	1,928,250	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.005101	0.002177	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	9,836	4,198	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	16,740	7,145	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	95	260	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	176.21	27.48	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	67	184	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	11,806	5,056	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)		23,885	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)		16,862	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 14-1348 Component CCN: 14-8514	Period: From 07/01/2017 To 06/30/2018	Worksheet M-5 Date/Time Prepared: 11/29/2018 9:06 am
		RHC I	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		1,198,063	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		01/31/2018	52,300	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)		52,300	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		1,250,363	4.00
	TO BE COMPLETED BY CONTRACTOR			
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			5.00
	Program to Provider			
5.01			0	5.01
5.02			0	5.02
5.03			0	5.03
	Provider to Program			
5.50			0	5.50
5.51			0	5.51
5.52			0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00
6.01	SETTLEMENT TO PROVIDER		0	6.01
6.02	SETTLEMENT TO PROGRAM		173,057	6.02
7.00	Total Medicare program liability (see instructions)		1,077,306	7.00

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