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: 14-1300	Period: From 09/01/2016 To 08/31/2017	Worksheet S Parts I-III Date/Time Prepared: 1/29/2018 4:46 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 1/29/2018 Time: 4:46 pm
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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

PART II - CERTIFICATION

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

CERTIFICATION BY 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 THOMAS H BOYD CRITICAL ACC HOSPITAL (14-1300) for the cost reporting period beginning 09/01/2016 and ending 08/31/2017 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.

(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	-191,932	-78,306	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	-160,968	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
10.00	RURAL HEALTH CLINIC I	0		105,759		0	10.00
200.00	Total	0	-352,900	27,453	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: 14-1300 | Period: From 09/01/2016 To 08/31/2017 | Worksheet S-2 Part I | Date/Time Prepared: 1/29/2018 4:45 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 800 SCHOOL STREET	PO Box:			1.00
2.00	City: CARROLLTON	State: IL	Zip Code: 62016	County: GREENE	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	THOMAS H BOYD CRITICAL ACC HOSPITAL	141300	99914	1	07/12/1999	N	O	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	THOMAS H BOYD CRITICAL ACC SWING BED	14Z300	99914		07/12/1999	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	GREENE COUNTY RHC	143403	99914		06/22/1995	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: 1.00	To: 2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	09/01/2016	08/31/2017	20.00
21.00	Type of Control (see instructions)	2		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: 14-1300 | Period: From 09/01/2016 To 08/31/2017 | Worksheet S-2 Part I Date/Time Prepared: 1/29/2018 4:45 pm

		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)(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)(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 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
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N			60.00

		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)				0.00	0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00	0.00			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)		0.00	0.00			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)		0.00	0.00			61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).		0.00	0.00			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)		0.00	0.00			61.05

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1300 | Period: From 09/01/2016 To 08/31/2017 | Worksheet S-2 Part I | Date/Time Prepared: 1/29/2018 4:45 pm

		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
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)		0.00	0.00			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 and enter in column 4, 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 and enter in column 4, 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 64-67. (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	
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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1300 | Period: From 09/01/2016 To 08/31/2017 | Worksheet S-2 Part I Date/Time Prepared: 1/29/2018 4:45 pm

		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 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 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

		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 a "subclause (II)" LTCH classified under section 1886(d)(1)(B)(iv)(II)? 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

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		V	XIX	
		1.00	2.00	
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
	Rural Providers			
105.00	Does this hospital qualify as a critical access hospital (CAH)?	Y		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	Y		106.00
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II.	N		107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00

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

		1.00	
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (410A Demo)for the current cost reporting period? Enter "Y" for yes or "N" for no.	N	110.00

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

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	140,357	0	0	118.01

		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	N		121.00
122.00	Does the cost report contain state health or similar taxes? 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.	Y	5.00	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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1300 | Period: From 09/01/2016 To 08/31/2017 | Worksheet S-2 Part I Date/Time Prepared: 1/29/2018 4:45 pm

		1.00	2.00	
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	N		140.00

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

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

		1.00	2.00	
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.	N	N	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	Y	Y	N	N	155.00
156.00	Subprovider - IPF	N	N	N	N	156.00
157.00	Subprovider - IRF	N	N	N	N	157.00
158.00	SUBPROVIDER					158.00
159.00	SNF	N	N	N	N	159.00
160.00	HOME HEALTH AGENCY	N	N	N	N	160.00
161.00	CMHC		N	N	N	161.00

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

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

		1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act		
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.	Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)	1	168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)		168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	0.00	169.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 14-1300	Period: From 09/01/2016 To 08/31/2017	Worksheet S-2 Part I Date/Time Prepared: 1/29/2018 4:45 pm

		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	10/01/2015	09/30/2016	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: 14-1300 | Period: From 09/01/2016 To 08/31/2017 | Worksheet S-2 Part II | Date/Time Prepared: 1/29/2018 4:45 pm

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

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

		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A		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	12/28/2017	Y	12/28/2017	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: 14-1300 | Period: From 09/01/2016 To 08/31/2017 | Worksheet S-2 Part II Date/Time Prepared: 1/29/2018 4:45 pm

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

		1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)		
	Capital Related Cost		
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions	N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.	N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions	Y	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.	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.		33.00
	Provider-Based Physicians		
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.	Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.	N	35.00

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

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	KEVIN	WELLEN	41.00
42.00	Enter the employer/company name of the cost report preparer.	CLIFTONLARSONALLEN LLP		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	314-925-4446	KEVIN.WELLEN@CLACONNECT.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 14-1300	Period: From 09/01/2016 To 08/31/2017	Worksheet S-2 Part II Date/Time Prepared: 1/29/2018 4:45 pm

		3.00		
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	DIRECTOR		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: 14-1300 | Period: From 09/01/2016 To 08/31/2017 | Worksheet S-3 Part I Date/Time Prepared: 1/29/2018 4:45 pm

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	25	9,125	12,869.00	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	12,869.00	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	12,869.00	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	RHC (CONSOLIDATED)	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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 14-1300 | Period: From 09/01/2016 To 08/31/2017 | Worksheet S-3 Part I | Date/Time Prepared: 1/29/2018 4:45 pm

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	398	35	552			1.00
2.00	HMO and other (see instructions)	36	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	358	0	415			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	46			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	756	35	1,013			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)	756	35	1,013	0.00	102.21	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	RHC (CONSOLIDATED)	3,891	0	15,514	0.00	24.46	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	126.67	27.00
28.00	Observation Bed Days		0	122			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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 14-1300 | Period: From 09/01/2016 To 08/31/2017 | Worksheet S-3 Part I | Date/Time Prepared: 1/29/2018 4:45 pm

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	141	14	207	1.00
2.00	HMO and other (see instructions)			16	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	141	14	207	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	RHC (CONSOLIDATED)	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						33.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 14-1300 | Component CCN: 14-3403 | Period: From 09/01/2016 To 08/31/2017 | Worksheet S-8 | Date/Time Prepared: 1/29/2018 4:45 pm

		RHC I	Cost
		1.00	
	Clinic Address and Identification		
1.00	Street	800 SCHOOL STREET	1.00

		City	State	ZIP Code	
		1.00	2.00	3.00	
2.00	City, State, ZIP Code, County	CARROLLTON	IL	62016	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	07:00	19:00	07:00	19:00	07:00	11.00

		1.00	2.00	
12.00	Have you received an approval for an exception to the productivity standard?			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.	Y	4	13.00

		Provider name	CCN number	
		1.00	2.00	
14.00	RHC/FQHC name, CCN number	GREENE COUNTY RURAL HEALTHC CLINIC	143403	14.00
14.01		THOMAS H BOYD RURAL HEALTH CLINIC	143475	14.01
14.02		BOYD-FILLAGER CLINIC - GREENFIELD	143474	14.02
14.03		RURAL HEALTH CENTER OF ROODHOUSE	143476	14.03

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

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA	Provider CCN: 14-1300 Component CCN: 14-3403	Period: From 09/01/2016 To 08/31/2017	Worksheet S-8 Date/Time Prepared: 1/29/2018 4:45 pm
		RHC I	Cost

			County				
			4.00				
2.00	City, State, ZIP Code, County		GREENE COUNTY				2.00
		Tuesday	Wednesday		Thursday		
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)						
11.00	Clinic	19:00	07:00	19:00	07:00	19:00	11.00
		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	Clinic	07:00	19:00	07:00	19:00		11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 14-1300 | Period: From 09/01/2016 To 08/31/2017 | Worksheet S-10 | Date/Time Prepared: 1/29/2018 4:45 pm

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.551580	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	2,930,141	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	N	3.00
4.00	If line 3 is yes, does line 2 include all DSH or supplemental payments from Medicaid?	N	4.00
5.00	If line 4 is no, then enter DSH or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	3,896,154	6.00
7.00	Medicaid cost (line 1 times line 6)	2,149,041	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)	0	8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone CHIP	0	9.00
10.00	Stand-alone CHIP charges	0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	0	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)	19,764	46,359	66,123	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	10,901	46,359	57,260	21.00
22.00	Payments received from patients for amounts previously written off as charity care	365	80	445	22.00
23.00	Cost of charity care (line 21 minus line 22)	10,536	46,279	56,815	23.00

		1.00	
24.00	Does the amount in 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)	874,734	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	114,429	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	176,045	27.01
28.00	Non-Medicare bad debt expense (line 26 minus line 27.01)	698,689	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	446,999	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	503,814	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	503,814	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-1300 | Period: From 09/01/2016 To 08/31/2017 | Worksheet A | Date/Time Prepared: 1/29/2018 4:45 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		377,322	377,322	-324,834	52,488	1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT NON HOSP.		0	0	7,761	7,761	1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		0	0	406,681	406,681	2.00
3.00	00300	OTHER CAPITAL RELATED COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	786,339	786,339	51,470	837,809	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	799,524	839,209	1,638,733	413,887	2,052,620	5.00
7.00	00700	OPERATION OF PLANT	56,853	133,984	190,837	21,596	212,433	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	25,344	4,692	30,036	0	30,036	8.00
9.00	00900	HOUSEKEEPING	64,900	30,599	95,499	3,674	99,173	9.00
10.00	01000	DIETARY	160,951	52,538	213,489	0	213,489	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	249,410	17,381	266,791	0	266,791	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	28,937	51,002	79,939	0	79,939	14.00
15.00	01500	PHARMACY	0	224,906	224,906	0	224,906	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	115,459	10,053	125,512	0	125,512	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	811,152	174,998	986,150	-50,953	935,197	30.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	366,939	255,050	621,989	-50,005	571,984	54.00
60.00	06000	LABORATORY	381,855	350,451	732,306	743	733,049	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	14,710	14,710	1,621	16,331	63.00
64.00	06400	INTRAVENOUS THERAPY	1,773	0	1,773	0	1,773	64.00
66.00	06600	PHYSICAL THERAPY	242,820	54,292	297,112	0	297,112	66.00
69.00	06900	ELECTROCARDIOLOGY	0	29,940	29,940	19,704	49,644	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	83,100	83,100	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,590,893	382,359	1,973,252	-313,015	1,660,237	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	1,054,421	625,462	1,679,883	-85,236	1,594,647	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	480,018	147,719	627,737	-161,910	465,827	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		31,013	31,013	-31,013	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	6,431,249	4,594,019	11,025,268	-6,729	11,018,539	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07951	WELLNESS	52,195	1,434	53,629	6,729	60,358	194.00
200.00		TOTAL (SUM OF LINES 118-199)	6,483,444	4,595,453	11,078,897	0	11,078,897	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-1300 | Period: From 09/01/2016 To 08/31/2017 | Worksheet A | Date/Time Prepared: 1/29/2018 4:45 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	-5,472	47,016		1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT NON HOSP.	0	7,761		1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	-250,230	156,451		2.00
3.00	00300	OTHER CAPITAL RELATED COSTS	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-4,384	833,425		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-226,819	1,825,801		5.00
7.00	00700	OPERATION OF PLANT	0	212,433		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	30,036		8.00
9.00	00900	HOUSEKEEPING	0	99,173		9.00
10.00	01000	DIETARY	-31,423	182,066		10.00
11.00	01100	CAFETERIA	0	0		11.00
13.00	01300	NURSING ADMINISTRATION	0	266,791		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	79,939		14.00
15.00	01500	PHARMACY	0	224,906		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-12,058	113,454		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	935,197		30.00
		ANCILLARY SERVICE COST CENTERS				
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	571,984		54.00
60.00	06000	LABORATORY	0	733,049		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	16,331		63.00
64.00	06400	INTRAVENOUS THERAPY	0	1,773		64.00
66.00	06600	PHYSICAL THERAPY	0	297,112		66.00
69.00	06900	ELECTROCARDIOLOGY	-29,940	19,704		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	83,100		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	1,660,237		88.00
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	-181,941	1,412,706		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	-353,346	112,481		95.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-1,095,613	9,922,926		118.00
		NONREIMBURSABLE COST CENTERS				
194.00	07951	WELLNESS	0	60,358		194.00
200.00		TOTAL (SUM OF LINES 118-199)	-1,095,613	9,983,284		200.00

RECLASSIFICATIONS | Provider CCN: 14-1300 | Period: From 09/01/2016 To 08/31/2017 | Worksheet A-6 | Date/Time Prepared: 1/29/2018 4:45 pm

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - DEPRECIATION EXPENSE				
1.00	CAP REL COSTS-BLDG & FIXT NON HOSP.	1.01	0	5,730	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	336,669	2.00
3.00	RURAL HEALTH CLINIC	88.00	0	2,000	3.00
	0		0	344,399	
	B - INTEREST EXPENSE				
1.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	3,127	1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	27,886	2.00
	0		0	31,013	
	C - EKG SALARIES				
1.00	ELECTROCARDIOLOGY	69.00	18,304	1,400	1.00
2.00		0.00	0	0	2.00
	0		18,304	1,400	
	E - RHC ADMIN COSTS				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	59,344	1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	17,412	2.00
3.00	OPERATION OF PLANT	7.00	0	11,504	3.00
	0		0	88,260	
	F - RHC BUSINESS OFFICE AND HOUSEKEEPING				
1.00	ADMINISTRATIVE & GENERAL	5.00	235,917	13,584	1.00
2.00	HOUSEKEEPING	9.00	3,439	235	2.00
	0		239,356	13,819	
	G - RHC LAB TIME				
1.00	LABORATORY	60.00	2,220	144	1.00
2.00	BLOOD STORING, PROCESSING & TRANS.	63.00	1,511	110	2.00
	0		3,731	254	
	H - ER ADMIN TIME				
1.00	ADMINISTRATIVE & GENERAL	5.00	6,150	5,949	1.00
	0		6,150	5,949	
	I - LEASE EXPENSE				
1.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	43,845	1.00
2.00		0.00	0	0	2.00
	0		0	43,845	
	K - ER PHYS. SAL TO RHC CARROLLTON				
1.00	RURAL HEALTH CLINIC	88.00	10,480	2,620	1.00
	0		10,480	2,620	
	L - PROPERTY TAXES				
1.00	CAP REL COSTS-BLDG & FIXT NON HOSP.	1.01	0	1,380	1.00
2.00	RURAL HEALTH CLINIC	88.00	0	4,634	2.00
3.00	WELLNESS	194.00	0	6,729	3.00
	0		0	12,743	
	M - CONTINUING EDUCATION COSTS IN ER				
1.00	RURAL HEALTH CLINIC	88.00	0	11,050	1.00
	0		0	11,050	
	N - PROPERTY INSURANCE				
1.00	OTHER CAPITAL RELATED COSTS	3.00	0	43,256	1.00
2.00		0.00	0	0	2.00
	TOTALS		0	43,256	
	O - AMBULANCE OVERHEAD				
1.00	OPERATION OF PLANT	7.00	0	10,092	1.00
2.00	AMBULANCE SERVICES	95.00	0	7,874	2.00
	TOTALS		0	17,966	
	P - MEDICAL SUPPLIES				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	83,100	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
	TOTALS		0	83,100	
	Q - BILLER SALARIES				
1.00	ADMINISTRATIVE & GENERAL	5.00	135,832	10,391	1.00
2.00		0.00	0	0	2.00
	TOTALS		135,832	10,391	
500.00	Grand Total: Increases		413,853	710,065	500.00

RECLASSIFICATIONS | Provider CCN: 14-1300 | Period: From 09/01/2016 To 08/31/2017 | Worksheet A-6 | Date/Time Prepared: 1/29/2018 4:45 pm

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - DEPRECIATION EXPENSE						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	344,399	9		1.00
2.00		0.00	0	0	9		2.00
3.00		0.00	0	0	0		3.00
	0		0	344,399			
	B - INTEREST EXPENSE						
1.00	INTEREST EXPENSE	113.00	0	31,013	11		1.00
2.00		0.00	0	0	0		2.00
	0		0	31,013			
	C - EKG SALARIES						
1.00	ADULTS & PEDIATRICS	30.00	8,922	683	0		1.00
2.00	RADIOLOGY-DIAGNOSTIC	54.00	9,382	717	0		2.00
	0		18,304	1,400			
	E - RHC ADMIN COSTS						
1.00	RURAL HEALTH CLINIC	88.00	0	88,260	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
	0		0	88,260			
	F - RHC BUSINESS OFFICE AND HOUSEKEEPING						
1.00	RURAL HEALTH CLINIC	88.00	239,356	13,819	0		1.00
2.00		0.00	0	0	0		2.00
	0		239,356	13,819			
	G - RHC LAB TIME						
1.00	LABORATORY	60.00	1,511	110	0		1.00
2.00	RURAL HEALTH CLINIC	88.00	2,220	144	0		2.00
	0		3,731	254			
	H - ER ADMIN TIME						
1.00	EMERGENCY	91.00	6,150	5,949	0		1.00
	0		6,150	5,949			
	I - LEASE EXPENSE						
1.00	ADULTS & PEDIATRICS	30.00	0	13,550	10		1.00
2.00	RADIOLOGY-DIAGNOSTIC	54.00	0	30,295	0		2.00
	0		0	43,845			
	K - ER PHYS. SAL TO RHC CARROLLTON						
1.00	EMERGENCY	91.00	10,480	2,620	0		1.00
	0		10,480	2,620			
	L - PROPERTY TAXES						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	12,743	13		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
	0		0	12,743			
	M - CONTINUING EDUCATION COSTS IN ER						
1.00	EMERGENCY	91.00	0	11,050	0		1.00
	0		0	11,050			
	N - PROPERTY INSURANCE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	26,491	0		1.00
2.00	AMBULANCE SERVICES	95.00	0	16,765	0		2.00
	TOTALS		0	43,256			
	O - AMBULANCE OVERHEAD						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	7,874	0		1.00
2.00	AMBULANCE SERVICES	95.00	0	10,092	0		2.00
	TOTALS		0	17,966			
	P - MEDICAL SUPPLIES						
1.00	ADULTS & PEDIATRICS	30.00	0	27,798	0		1.00
2.00	RADIOLOGY-DIAGNOSTIC	54.00	0	9,611	0		2.00
3.00	EMERGENCY	91.00	0	45,691	0		3.00
	TOTALS		0	83,100			
	Q - BILLER SALARIES						
1.00	EMERGENCY	91.00	3,062	234	0		1.00
2.00	AMBULANCE SERVICES	95.00	132,770	10,157	0		2.00
	TOTALS		135,832	10,391			
500.00	Grand Total: Decreases		413,853	710,065			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1300 | Period: From 09/01/2016 To 08/31/2017 | Worksheet A-7 Part I | Date/Time Prepared: 1/29/2018 4:45 pm

		Beginning Balances	Acquisitions: Purchases	Acquisitions: Donation	Acquisitions: Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	70,513	1	0	1	0	1.00
2.00	Land Improvements	36,143	0	0	0	0	2.00
3.00	Buildings and Fixtures	1,389,236	0	0	0	0	3.00
4.00	Building Improvements	1,188,414	0	0	0	0	4.00
5.00	Fixed Equipment	84,027	1	0	1	0	5.00
6.00	Movable Equipment	3,096,408	58,619	0	58,619	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	5,864,741	58,621	0	58,621	0	8.00
9.00	Reconciling Items	0	-13,426	0	-13,426	0	9.00
10.00	Total (line 8 minus line 9)	5,864,741	72,047	0	72,047	0	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	70,514	0	1.00
2.00	Land Improvements	36,143	0	2.00
3.00	Buildings and Fixtures	1,389,236	0	3.00
4.00	Building Improvements	1,188,414	0	4.00
5.00	Fixed Equipment	84,028	0	5.00
6.00	Movable Equipment	3,155,027	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	5,923,362	0	8.00
9.00	Reconciling Items	-13,426	0	9.00
10.00	Total (line 8 minus line 9)	5,936,788	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1300 | Period: From 09/01/2016 To 08/31/2017 | Worksheet A-7 Part II | Date/Time Prepared: 1/29/2018 4:45 pm

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	NEW CAP REL COSTS-BLDG & FIXT	377,322	0	0	0	0	1.00
1.01	CAP REL COSTS-BLDG & FIXT NON HOSP.	0	0	0	0	0	1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	377,322	0	0	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL			
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)		
		14.00	15.00		
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2				
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	377,322		1.00
1.01	CAP REL COSTS-BLDG & FIXT NON HOSP.	0	0		1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0		2.00
3.00	Total (sum of lines 1-2)	0	377,322		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1300 | Period: From 09/01/2016 To 08/31/2017 | Worksheet A-7 Part III Date/Time Prepared: 1/29/2018 4:45 pm

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	2,679,239	0	2,679,239	0.452317	19,565	1.00
1.01	CAP REL COSTS-BLDG & FIXT NON HOSP.	89,096	0	89,096	0.015041	651	1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	3,155,027	0	3,155,027	0.532642	23,040	2.00
3.00	Total (sum of lines 1-2)	5,923,362	0	5,923,362	1.000000	43,256	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	19,565	27,451	0	1.00
1.01	CAP REL COSTS-BLDG & FIXT NON HOSP.	0	0	651	5,730	0	1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	23,040	87,722	43,845	2.00
3.00	Total (sum of lines 1-2)	0	0	43,256	120,903	43,845	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	19,565	0	0	47,016	1.00
1.01	CAP REL COSTS-BLDG & FIXT NON HOSP.	0	651	1,380	0	7,761	1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	1,844	23,040	0	0	156,451	2.00
3.00	Total (sum of lines 1-2)	1,844	43,256	1,380	0	211,228	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-1300 | Period: From 09/01/2016 To 08/31/2017 | Worksheet A-8 | Date/Time Prepared: 1/29/2018 4:45 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
1.01	Investment income - CAP REL COSTS-BLDG & FIXT NON HOSP. (chapter 2)		0	CAP REL COSTS-BLDG & FIXT NON HOSP.	1.01	0	1.01
2.00	Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)	B	-1,283	NEW CAP REL COSTS-MVBLE EQUIP	2.00	11	2.00
3.00	Investment income - other (chapter 2)	B	-7,839	ADMINISTRATIVE & GENERAL	5.00	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)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)	A	-2,001	ADMINISTRATIVE & GENERAL	5.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-211,881			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	0			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-31,423	DIETARY	10.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-5,822	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing school (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	*** Cost Center Deleted ***	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - NEW CAP REL COSTS-BLDG & FIXT		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
26.01	Depreciation - CAP REL COSTS-BLDG & FIXT NON HOSP.		0	CAP REL COSTS-BLDG & FIXT NON HOSP.	1.01	0	26.01
27.00	Depreciation - NEW CAP REL COSTS-MVBLE EQUIP		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-1300 | Period: From 09/01/2016 To 08/31/2017 | Worksheet A-8 | Date/Time Prepared: 1/29/2018 4:45 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	A	-248,947	NEW CAP REL COSTS-MVBLE EQUIP	2.00	9	32.00
33.00	INTEREST EXPENSE - MEDICARE	A	-8,774	ADMINISTRATIVE & GENERAL	5.00	0	33.00
33.01	HEALTHLINK ADMIN FEES	A	14,117	ADMINISTRATIVE & GENERAL	5.00	0	33.01
33.02	PHYSICIAN BENEFITS	A	-4,384	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.02
33.03	MISC INC - ADMIN	B	-220	ADMINISTRATIVE & GENERAL	5.00	0	33.03
33.04	MISC INC - CPR	B	-150	AMBULANCE SERVICES	95.00	0	33.04
33.05	MISC INC - CHART REVIEW	B	-6,236	MEDICAL RECORDS & LIBRARY	16.00	0	33.05
33.06	HEALTH FAIR	B	-9,240	ADMINISTRATIVE & GENERAL	5.00	0	33.06
33.07	IHA LOBBYING DUES	A	-2,141	ADMINISTRATIVE & GENERAL	5.00	0	33.07
33.08	AMBULANCE SUBSIDY - OPERATIONS	B	-353,196	AMBULANCE SERVICES	95.00	0	33.08
33.09	MEDICAID ASSESSMENT TAX	A	-111,651	ADMINISTRATIVE & GENERAL	5.00	0	33.09
33.10	NON-ALLOWABLE EHR LEASE EXPENSE	A	-37,320	ADMINISTRATIVE & GENERAL	5.00	0	33.10
33.11	NON-ALLOWABLE IRS PENALTY EXPENSE	A	-61,750	ADMINISTRATIVE & GENERAL	5.00	0	33.11
33.12	GOODWILL AMORTIZATION	A	-5,472	NEW CAP REL COSTS-BLDG & FIXT	1.00	9	33.12
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-1,095,613				50.00

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 14-1300 | Period: From 09/01/2016 To 08/31/2017 | Worksheet A-8-2 | Date/Time Prepared: 1/29/2018 4:45 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	91.00	EMERGENCY	1,043,197	181,941	861,256	0	0	1.00
2.00	60.00	LABORATORY	6,000	0	6,000	0	0	2.00
3.00	69.00	ELECTROCARDIOLOGY	29,940	29,940	0	0	0	3.00
4.00	5.00	ADMINISTRATIVE & GENERAL	11,818	0	11,818	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			1,090,955	211,881	879,074		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	91.00	EMERGENCY	0	0	0	0	0	1.00
2.00	60.00	LABORATORY	0	0	0	0	0	2.00
3.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	3.00
4.00	5.00	ADMINISTRATIVE & GENERAL	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	91.00	EMERGENCY	0	0	0	181,941		1.00
2.00	60.00	LABORATORY	0	0	0	0		2.00
3.00	69.00	ELECTROCARDIOLOGY	0	0	0	29,940		3.00
4.00	5.00	ADMINISTRATIVE & GENERAL	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	211,881		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 14-1300 | Period: From 09/01/2016 To 08/31/2017 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 1/29/2018 4:45 pm

		Occupational Therapy	Cost
		1.00	
	PART I - GENERAL INFORMATION		
1.00	Total number of weeks worked (excluding aides) (see instructions)	50	1.00
2.00	Line 1 multiplied by 15 hours per week	750	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)	125	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)	0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)	0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)	0	6.00
7.00	Standard travel expense rate	5.37	7.00
8.00	Optional travel expense rate per mile	0.00	8.00

		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	274.75	15.11	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	76.94	57.71	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	38.47	38.47	28.86			11.00
12.00	Number of travel hours (provider site)	0	143	9			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01

		1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION		
14.00	Supervisors (column 1, line 9 times column 1, line 10)	0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)	21,139	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)	872	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)	22,011	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)	0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)	0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)	22,011	20.00
	If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.		
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)	75.94	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)	56,955	22.00
23.00	Total salary equivalency (see instructions)	56,955	23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE		
	Standard Travel Allowance		
24.00	Therapists (line 3 times column 2, line 11)	4,809	24.00
25.00	Assistants (line 4 times column 3, line 11)	0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)	4,809	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)	671	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)	5,480	28.00
	Optional Travel Allowance and Optional Travel Expense		
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)	11,002	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)	519	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)	11,521	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)	0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)	5,480	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)	0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)	0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE		
	Standard Travel Expense		
36.00	Therapists (line 5 times column 2, line 11)	0	36.00
37.00	Assistants (line 6 times column 3, line 11)	0	37.00
38.00	Subtotal (sum of lines 36 and 37)	0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)	0	39.00
	Optional Travel Allowance and Optional Travel Expense		
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)	0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)	0	41.00
42.00	Subtotal (sum of lines 40 and 41)	0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)	0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.		
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)	0	44.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS	Provider CCN: 14-1300	Period: From 09/01/2016 To 08/31/2017	Worksheet A-8-3 Parts I-VI Date/Time Prepared: 1/29/2018 4:45 pm

		Occupational Therapy	Cost	
		1.00		
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)	0		45.00
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)	0		46.00

		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	76.94	57.71	0.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00

		1.00	
	Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT		
57.00	Salary equivalency amount (from line 23)	56,955	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	5,480	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)	0	59.00
60.00	Overtime allowance (from column 5, line 56)	0	60.00
61.00	Equipment cost (see instructions)	0	61.00
62.00	Supplies (see instructions)	0	62.00
63.00	Total allowance (sum of lines 57-62)	62,435	63.00
64.00	Total cost of outside supplier services (from your records)	16,485	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)	0	65.00
	LINE 33 CALCULATION		
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others	4,809	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	671	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	5,480	100.02
	LINE 34 CALCULATION		
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	671	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	11,521	101.01
101.02	Line 34 = sum of lines 27 and 31	12,192	101.02
	LINE 35 CALCULATION		
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	11,521	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others	0	102.01
102.02	Line 35 = sum of lines 31 and 32	11,521	102.02

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 14-1300 | Period: From 09/01/2016 To 08/31/2017 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 1/29/2018 4:45 pm

Speech Pathology | Cost

						1.00	
	PART I - GENERAL INFORMATION						
1.00	Total number of weeks worked (excluding aides) (see instructions)					10	1.00
2.00	Line 1 multiplied by 15 hours per week					150	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					18	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00
7.00	Standard travel expense rate					5.37	7.00
8.00	Optional travel expense rate per mile					0.00	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	78.25	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	73.94	0.00	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	36.97	36.97	0.00			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01
						1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION						
14.00	Supervisors (column 1, line 9 times column 1, line 10)					0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					5,786	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)					0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					5,786	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)					0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)					0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)					5,786	20.00
	If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.						
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)					73.94	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					11,091	22.00
23.00	Total salary equivalency (see instructions)					11,091	23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE						
	Standard Travel Allowance						
24.00	Therapists (line 3 times column 2, line 11)					665	24.00
25.00	Assistants (line 4 times column 3, line 11)					0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					665	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					97	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					762	28.00
	Optional Travel Allowance and Optional Travel Expense						
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)					0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)					0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)					0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)					762	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE						
	Standard Travel Expense						
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00
	Optional Travel Allowance and Optional Travel Expense						
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.						
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 14-1300 | Period: From 09/01/2016 To 08/31/2017 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 1/29/2018 4:45 pm

Speech Pathology | Cost

						1.00	
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00
		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	73.94	0.00	0.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00

		1.00		
	Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT			
57.00	Salary equivalency amount (from line 23)	11,091		57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	762		58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)	0		59.00
60.00	Overtime allowance (from column 5, line 56)	0		60.00
61.00	Equipment cost (see instructions)	0		61.00
62.00	Supplies (see instructions)	0		62.00
63.00	Total allowance (sum of lines 57-62)	11,853		63.00
64.00	Total cost of outside supplier services (from your records)	1,170		64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)	0		65.00
	LINE 33 CALCULATION			
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others	665		100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	97		100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	762		100.02
	LINE 34 CALCULATION			
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	97		101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0		101.01
101.02	Line 34 = sum of lines 27 and 31	97		101.02
	LINE 35 CALCULATION			
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0		102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others	0		102.01
102.02	Line 35 = sum of lines 31 and 32	0		102.02

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1300 | Period: From 09/01/2016 To 08/31/2017 | Worksheet B Part I | Date/Time Prepared: 1/29/2018 4:45 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS				
				NEW BLDG & FIXT	BLDG & FIXT NON HOSP.	NEW MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	1.01	2.00	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	47,016	47,016				1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT NON HOSP.	7,761	0	7,761			1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	156,451			156,451		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	833,425	0	0	0	833,425	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,825,801	6,229	948	76,084	153,597	5.00
7.00	00700	OPERATION OF PLANT	212,433	1,724	0	0	7,417	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	30,036	1,655	0	0	3,306	8.00
9.00	00900	HOUSEKEEPING	99,173	345	0	0	8,915	9.00
10.00	01000	DIETARY	182,066	4,882	0	0	20,996	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	266,791	0	0	0	32,536	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	79,939	928	0	0	3,775	14.00
15.00	01500	PHARMACY	224,906	637	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	113,454	1,214	0	332	15,062	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	935,197	14,708	0	15,890	104,653	30.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	571,984	2,485	0	35,556	46,644	54.00
60.00	06000	LABORATORY	733,049	1,525	0	2,072	49,906	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	16,331	0	0	0	197	63.00
64.00	06400	INTRAVENOUS THERAPY	1,773	0	0	0	231	64.00
66.00	06600	PHYSICAL THERAPY	297,112	2,827	0	17,230	31,676	66.00
69.00	06900	ELECTROCARDIOLOGY	19,704	0	0	0	2,388	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	83,100	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,660,237	2,479	0	8,521	177,387	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	1,412,706	4,376	0	766	122,631	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	112,481	706	0	0	45,299	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	9,922,926	46,720	948	156,451	826,616	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07951	WELLNESS	60,358	296	6,813	0	6,809	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	9,983,284	47,016	7,761	156,451	833,425	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1300 | Period: From 09/01/2016 To 08/31/2017 | Worksheet B Part I Date/Time Prepared: 1/29/2018 4:45 pm

		Cost Center Description	Subtotal	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			4A	5.00	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT NON HOSP.						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,062,659	2,062,659				5.00
7.00	00700	OPERATION OF PLANT	221,574	57,701	279,275			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	34,997	9,114	11,834	55,945		8.00
9.00	00900	HOUSEKEEPING	108,433	28,238	2,470	5,537	144,678	9.00
10.00	01000	DIETARY	207,944	54,152	34,904	551	7,496	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	299,327	77,950	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	84,642	22,042	6,632	0	0	14.00
15.00	01500	PHARMACY	225,543	58,735	4,551	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	130,062	33,870	8,676	0	86	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,070,448	278,762	105,153	24,409	97,129	30.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	656,669	171,007	17,769	3,685	7,438	54.00
60.00	06000	LABORATORY	786,552	204,831	10,902	0	7,295	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	16,528	4,304	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	2,004	522	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	348,845	90,845	20,211	2,407	801	66.00
69.00	06900	ELECTROCARDIOLOGY	22,092	5,753	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	83,100	21,641	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,848,624	481,412	17,723	106	8,955	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	1,540,479	401,165	31,285	10,977	12,760	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0					92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	158,486	41,272	5,048	8,227	887	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	9,909,008	2,043,316	277,158	55,899	142,847	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07951	WELLNESS	74,276	19,343	2,117	46	1,831	194.00
200.00		Cross Foot Adjustments	0					200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	9,983,284	2,062,659	279,275	55,945	144,678	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1300 | Period: From 09/01/2016 To 08/31/2017 | Worksheet B Part I Date/Time Prepared: 1/29/2018 4:45 pm

		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT NON HOSP.						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	305,047					10.00
11.00	01100	CAFETERIA	235,415	235,415				11.00
13.00	01300	NURSING ADMINISTRATION	0	11,810	389,087			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	3,374	0	116,690		14.00
15.00	01500	PHARMACY	0	0	0	0	288,829	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	9,561	0	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	69,632	55,480	241,398	0	0	30.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	21,570	0	0	0	54.00
60.00	06000	LABORATORY	0	25,871	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	99	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	132	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0	12,505	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	1,092	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	116,690	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	288,829	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	14,722	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	47,705	147,689	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	28,087	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	305,047	232,008	389,087	116,690	288,829	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07951	WELLNESS	0	3,407	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	305,047	235,415	389,087	116,690	288,829	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1300 | Period: From 09/01/2016 To 08/31/2017 | Worksheet B Part I Date/Time Prepared: 1/29/2018 4:45 pm

		Cost Center Description	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			16.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT NON HOSP.						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	182,255					16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	41,561	1,983,972	-129,891	1,854,081		30.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	21,305	899,443	0	899,443		54.00
60.00	06000	LABORATORY	35,567	1,071,018	0	1,071,018		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	20,931	0	20,931		63.00
64.00	06400	INTRAVENOUS THERAPY	0	2,658	711,077	713,735		64.00
66.00	06600	PHYSICAL THERAPY	6,693	482,307	0	482,307		66.00
69.00	06900	ELECTROCARDIOLOGY	0	28,937	0	28,937		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	221,431	0	221,431		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	288,829	0	288,829		73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	34,342	2,405,884	0	2,405,884		88.00
90.00	09000	CLINIC	0	0	0	0		90.00
91.00	09100	EMERGENCY	41,956	2,234,016	-581,186	1,652,830		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0			92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	831	242,838	0	242,838		95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	182,255	9,882,264	0	9,882,264		118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07951	WELLNESS	0	101,020	0	101,020		194.00
200.00		Cross Foot Adjustments		0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118-201)	182,255	9,983,284	0	9,983,284		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1300 | Period: From 09/01/2016 To 08/31/2017 | Worksheet B Part II | Date/Time Prepared: 1/29/2018 4:45 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS				
				NEW BLDG & FIXT	BLDG & FIXT NON HOSP.	NEW MVBLE EQUIP	Subtotal	
			0	1.00	1.01	2.00	2A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT NON HOSP.						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	6,229	948	76,084	83,261	5.00
7.00	00700	OPERATION OF PLANT	0	1,724	0	0	1,724	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	1,655	0	0	1,655	8.00
9.00	00900	HOUSEKEEPING	0	345	0	0	345	9.00
10.00	01000	DIETARY	0	4,882	0	0	4,882	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	928	0	0	928	14.00
15.00	01500	PHARMACY	0	637	0	0	637	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,214	0	332	1,546	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	14,708	0	15,890	30,598	30.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,485	0	35,556	38,041	54.00
60.00	06000	LABORATORY	0	1,525	0	2,072	3,597	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0	2,827	0	17,230	20,057	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	21,334	2,479	0	8,521	32,334	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	4,376	0	766	5,142	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	706	0	0	706	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	21,334	46,720	948	156,451	225,453	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07951	WELLNESS	6,729	296	6,813	0	13,838	194.00
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	28,063	47,016	7,761	156,451	239,291	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1300 | Period: From 09/01/2016 To 08/31/2017 | Worksheet B Part II Date/Time Prepared: 1/29/2018 4:45 pm

		Cost Center Description	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			4.00	5.00	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT NON HOSP.						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	83,261				5.00
7.00	00700	OPERATION OF PLANT	0	2,329	4,053			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	368	172	2,195		8.00
9.00	00900	HOUSEKEEPING	0	1,140	36	217	1,738	9.00
10.00	01000	DIETARY	0	2,186	507	22	90	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	3,147	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	890	96	0	0	14.00
15.00	01500	PHARMACY	0	2,371	66	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,367	126	0	1	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	11,253	1,526	957	1,166	30.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	6,903	258	145	89	54.00
60.00	06000	LABORATORY	0	8,268	158	0	88	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	174	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	21	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0	3,667	293	94	10	66.00
69.00	06900	ELECTROCARDIOLOGY	0	232	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	874	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	19,430	257	4	108	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	16,194	454	431	153	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	1,666	73	323	11	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	82,480	4,022	2,193	1,716	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07951	WELLNESS	0	781	31	2	22	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	0	83,261	4,053	2,195	1,738	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1300 | Period: From 09/01/2016 To 08/31/2017 | Worksheet B Part II Date/Time Prepared: 1/29/2018 4:45 pm

		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT NON HOSP.						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	7,687					10.00
11.00	01100	CAFETERIA	5,932	5,932				11.00
13.00	01300	NURSING ADMINISTRATION	0	298	3,445			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	85	0	1,999		14.00
15.00	01500	PHARMACY	0	0	0	0	3,074	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	241	0	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,755	1,396	2,137	0	0	30.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	544	0	0	0	54.00
60.00	06000	LABORATORY	0	652	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	3	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	3	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0	315	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	28	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	1,999	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	3,074	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	371	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	1,202	1,308	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	708	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	7,687	5,846	3,445	1,999	3,074	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07951	WELLNESS	0	86	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	7,687	5,932	3,445	1,999	3,074	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1300 | Period: From 09/01/2016 To 08/31/2017 | Worksheet B Part II | Date/Time Prepared: 1/29/2018 4:45 pm

		Cost Center Description	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			16.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT NON HOSP.						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,281					16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	748	51,536	0	51,536		30.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	384	46,364	0	46,364		54.00
60.00	06000	LABORATORY	640	13,403	0	13,403		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	177	0	177		63.00
64.00	06400	INTRAVENOUS THERAPY	0	24	0	24		64.00
66.00	06600	PHYSICAL THERAPY	120	24,556	0	24,556		66.00
69.00	06900	ELECTROCARDIOLOGY	0	260	0	260		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2,873	0	2,873		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,074	0	3,074		73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	618	53,122	0	53,122		88.00
90.00	09000	CLINIC	0	0	0	0		90.00
91.00	09100	EMERGENCY	756	25,640	0	25,640		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0			92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	15	3,502	0	3,502		95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	3,281	224,531	0	224,531		118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07951	WELLNESS	0	14,760	0	14,760		194.00
200.00		Cross Foot Adjustments		0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118-201)	3,281	239,291	0	239,291		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1300 | Period: From 09/01/2016 To 08/31/2017 | Worksheet B-1 | Date/Time Prepared: 1/29/2018 4:45 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			NEW BLDG & FIXT (SQUARE FEET)	BLDG & FIXT NON HOSP. (SQUARE FEET)	NEW MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	
			1.00	1.01	2.00	4.00	5A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	37,153					1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT NON HOSP.	0	7,074				1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP			133,411			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	6,388,766		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	4,922	864	64,879	1,177,424	-2,062,659	5.00
7.00	00700	OPERATION OF PLANT	1,362	0	0	56,853	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,308	0	0	25,344	0	8.00
9.00	00900	HOUSEKEEPING	273	0	0	68,339	0	9.00
10.00	01000	DIETARY	3,858	0	0	160,951	0	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	249,410	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	733	0	0	28,937	0	14.00
15.00	01500	PHARMACY	503	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	959	0	283	115,459	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	11,623	0	13,550	802,230	0	30.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,964	0	30,320	357,557	0	54.00
60.00	06000	LABORATORY	1,205	0	1,767	382,564	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	1,511	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	1,773	0	64.00
66.00	06600	PHYSICAL THERAPY	2,234	0	14,693	242,820	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	18,304	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,959	0	7,266	1,359,797	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	3,458	0	653	940,050	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	558	0	0	347,248	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	36,919	864	133,411	6,336,571	-2,062,659	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07951	WELLNESS	234	6,210	0	52,195	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	47,016	7,761	156,451	833,425		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	1.265470	1.097116	1.172699	0.130452		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)				0		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)				0.000000		205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1300 | Period: From 09/01/2016 To 08/31/2017 | Worksheet B-1 | Date/Time Prepared: 1/29/2018 4:45 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT NON HOSP.						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	7,920,625					5.00
7.00	00700	OPERATION OF PLANT	221,574	30,869				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	34,997	1,308	40,273			8.00
9.00	00900	HOUSEKEEPING	108,433	273	3,986	75,855		9.00
10.00	01000	DIETARY	207,944	3,858	397	3,930	16,161	10.00
11.00	01100	CAFETERIA	0	0	0	0	12,472	11.00
13.00	01300	NURSING ADMINISTRATION	299,327	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	84,642	733	0	0	0	14.00
15.00	01500	PHARMACY	225,543	503	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	130,062	959	0	45	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,070,448	11,623	17,571	50,925	3,689	30.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	656,669	1,964	2,653	3,900	0	54.00
60.00	06000	LABORATORY	786,552	1,205	0	3,825	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	16,528	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	2,004	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	348,845	2,234	1,733	420	0	66.00
69.00	06900	ELECTROCARDIOLOGY	22,092	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	83,100	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,848,624	1,959	76	4,695	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	1,540,479	3,458	7,902	6,690	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	158,486	558	5,922	465	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	7,846,349	30,635	40,240	74,895	16,161	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07951	WELLNESS	74,276	234	33	960	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	2,062,659	279,275	55,945	144,678	305,047	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.260416	9.047102	1.389144	1.907297	18.875503	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	83,261	4,053	2,195	1,738	7,687	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.010512	0.131297	0.054503	0.022912	0.475651	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1300 | Period: From 09/01/2016 To 08/31/2017 | Worksheet B-1 | Date/Time Prepared: 1/29/2018 4:45 pm

		Cost Center Description	CAFETERIA (FTE'S)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT NON HOSP.						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	7,116					11.00
13.00	01300	NURSING ADMINISTRATION	357	2,703				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	102	0	100			14.00
15.00	01500	PHARMACY	0	0	0	100		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	289	0	0	0	104,150	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,677	1,677	0	0	23,750	30.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	652	0	0	0	12,175	54.00
60.00	06000	LABORATORY	782	0	0	0	20,325	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	3	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	4	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	378	0	0	0	3,825	66.00
69.00	06900	ELECTROCARDIOLOGY	33	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	100	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	100	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	445	0	0	0	19,625	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	1,442	1,026	0	0	23,975	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	849	0	0	0	475	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	7,013	2,703	100	100	104,150	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07951	WELLNESS	103	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	235,415	389,087	116,690	288,829	182,255	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	33.082490	143.946356	1,166.900000	2,888.290000	1.749928	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	5,932	3,445	1,999	3,074	3,281	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.833614	1.274510	19.990000	30.740000	0.031503	205.00

POST STEPDOWN ADJUSTMENTS | Provider CCN: 14-1300 | Period: From 09/01/2016 To 08/31/2017 | Worksheet B-2 | Date/Time Prepared: 1/29/2018 4:45 pm

		Description	Worksheet Part	Worksheet Line No.	Amount	
		1.00	2.00	3.00	4.00	
1.00		ADJ FOR EPO COSTS IN RENAL DIALYSIS	1	74.00	0	1.00
2.00		ADJ FOR EPO COSTS IN HOME PROGRAM	1	94.00	0	2.00
3.00		ADJ FOR ARANESP COSTS IN RENAL DIALYSIS	1	74.00	0	3.00
4.00		ADJ FOR ARANESP COSTS IN HOME PROGRAM	1	94.00	0	4.00
5.00		ADJ FOR ESA COSTS IN RENAL DIALYSIS	1	74.00	0	5.00
6.00		ADJ FOR ESA COSTS IN HOME PROGRAM	1	94.00	0	6.00
7.00		IV THERAPY	1	30.00	-129,891	7.00
8.00		IV THERAPY	1	64.00	711,077	8.00
9.00		IV THERAPY	1	91.00	-581,186	9.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1300 | Period: From 09/01/2016 To 08/31/2017 | Worksheet C Part I Date/Time Prepared: 1/29/2018 4:45 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,854,081		1,854,081	0	0	30.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	899,443		899,443	0	0	54.00
60.00	06000	LABORATORY	1,071,018		1,071,018	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	20,931		20,931	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	713,735		713,735	0	0	64.00
66.00	06600	PHYSICAL THERAPY	482,307	0	482,307	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	28,937		28,937	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	221,431		221,431	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	288,829		288,829	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	2,405,884		2,405,884	0	0	88.00
90.00	09000	CLINIC	0		0	0	0	90.00
91.00	09100	EMERGENCY	1,652,830		1,652,830	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	206,911		206,911		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	242,838		242,838	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	10,089,175	0	10,089,175	0	0	200.00
201.00		Less Observation Beds	206,911		206,911		0	201.00
202.00		Total (see instructions)	9,882,264	0	9,882,264	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1300 | Period: From 09/01/2016 To 08/31/2017 | Worksheet C Part I Date/Time Prepared: 1/29/2018 4:45 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Charges					
			Inpatient	Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	838,287		838,287			30.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	136,963	3,978,977	4,115,940	0.218527	0.000000	54.00
60.00	06000	LABORATORY	195,028	3,913,922	4,108,950	0.260655	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	9,070	73,087	82,157	0.254768	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY	2,922	726,874	729,796	0.977992	0.000000	64.00
66.00	06600	PHYSICAL THERAPY	139,767	874,330	1,014,097	0.475602	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	12,852	355,762	368,614	0.078502	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	214,962	249,348	464,310	0.476903	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	301,367	366,230	667,597	0.432640	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	2,485,122	2,485,122			88.00
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
91.00	09100	EMERGENCY	2,146	1,302,395	1,304,541	1.266982	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	149,989	149,989	1.379508	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	1,586,879	1,586,879	0.153029	0.000000	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	1,853,364	16,062,915	17,916,279			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	1,853,364	16,062,915	17,916,279			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1300 | Period: From 09/01/2016 To 08/31/2017 | Worksheet C Part I Date/Time Prepared: 1/29/2018 4:45 pm

Title XVIII | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
		ANCILLARY SERVICE COST CENTERS			
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	06000	LABORATORY	0.000000		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000		63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000		64.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC			88.00
90.00	09000	CLINIC	0.000000		90.00
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0.000000		95.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1300 | Period: From 09/01/2016 To 08/31/2017 | Worksheet C Part I Date/Time Prepared: 1/29/2018 4:45 pm

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,854,081		1,854,081	0	1,854,081	30.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	899,443		899,443	0	899,443	54.00
60.00	06000	LABORATORY	1,071,018		1,071,018	0	1,071,018	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	20,931		20,931	0	20,931	63.00
64.00	06400	INTRAVENOUS THERAPY	713,735		713,735	0	713,735	64.00
66.00	06600	PHYSICAL THERAPY	482,307	0	482,307	0	482,307	66.00
69.00	06900	ELECTROCARDIOLOGY	28,937		28,937	0	28,937	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	221,431		221,431	0	221,431	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	288,829		288,829	0	288,829	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	2,405,884		2,405,884	0	2,405,884	88.00
90.00	09000	CLINIC	0		0	0	0	90.00
91.00	09100	EMERGENCY	1,652,830		1,652,830	0	1,652,830	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	206,911		206,911		206,911	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	242,838		242,838	0	242,838	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	10,089,175	0	10,089,175	0	10,089,175	200.00
201.00		Less Observation Beds	206,911		206,911		206,911	201.00
202.00		Total (see instructions)	9,882,264	0	9,882,264	0	9,882,264	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1300 | Period: From 09/01/2016 To 08/31/2017 | Worksheet C Part I Date/Time Prepared: 1/29/2018 4:45 pm

Title XIX | Hospital | Cost

		Cost Center Description	Charges					
			Inpatient	Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	838,287		838,287			30.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	136,963	3,978,977	4,115,940	0.218527	0.000000	54.00
60.00	06000	LABORATORY	195,028	3,913,922	4,108,950	0.260655	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	9,070	73,087	82,157	0.254768	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY	2,922	726,874	729,796	0.977992	0.000000	64.00
66.00	06600	PHYSICAL THERAPY	139,767	874,330	1,014,097	0.475602	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	12,852	355,762	368,614	0.078502	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	214,962	249,348	464,310	0.476903	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	301,367	366,230	667,597	0.432640	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	2,485,122	2,485,122	0.968115	0.000000	88.00
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
91.00	09100	EMERGENCY	2,146	1,302,395	1,304,541	1.266982	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	149,989	149,989	1.379508	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	1,586,879	1,586,879	0.153029	0.000000	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	1,853,364	16,062,915	17,916,279			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	1,853,364	16,062,915	17,916,279			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1300 | Period: From 09/01/2016 To 08/31/2017 | Worksheet C Part I Date/Time Prepared: 1/29/2018 4:45 pm

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
		ANCILLARY SERVICE COST CENTERS			
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	06000	LABORATORY	0.000000		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000		63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000		64.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	0.000000		88.00
90.00	09000	CLINIC	0.000000		90.00
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0.000000		95.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 14-1300 | Period: From 09/01/2016 To 08/31/2017 | Worksheet D Part II Date/Time Prepared: 1/29/2018 4:45 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	46,364	4,115,940	0.011264	87,813	989	54.00
60.00	06000	LABORATORY	13,403	4,108,950	0.003262	112,647	367	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	177	82,157	0.002154	5,442	12	63.00
64.00	06400	INTRAVENOUS THERAPY	24	729,796	0.000033	732	0	64.00
66.00	06600	PHYSICAL THERAPY	24,556	1,014,097	0.024215	34,857	844	66.00
69.00	06900	ELECTROCARDIOLOGY	260	368,614	0.000705	5,531	4	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,873	464,310	0.006188	117,875	729	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,074	667,597	0.004605	154,010	709	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	53,122	2,485,122	0.021376	0	0	88.00
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
91.00	09100	EMERGENCY	25,640	1,304,541	0.019654	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	5,751	149,989	0.038343	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	175,244	15,491,113		518,907	3,654	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1300 | Period: From 09/01/2016 To 08/31/2017 | Worksheet D Part IV | Date/Time Prepared: 1/29/2018 4:45 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1300 | Period: From 09/01/2016 To 08/31/2017 | Worksheet D Part IV Date/Time Prepared: 1/29/2018 4:45 pm

Title XVIII | Hospital | Cost

		Cost Center Description	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)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	4,115,940	0.000000	0.000000	87,813	54.00
60.00	06000	LABORATORY	0	4,108,950	0.000000	0.000000	112,647	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	82,157	0.000000	0.000000	5,442	63.00
64.00	06400	INTRAVENOUS THERAPY	0	729,796	0.000000	0.000000	732	64.00
66.00	06600	PHYSICAL THERAPY	0	1,014,097	0.000000	0.000000	34,857	66.00
69.00	06900	ELECTROCARDIOLOGY	0	368,614	0.000000	0.000000	5,531	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	464,310	0.000000	0.000000	117,875	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	667,597	0.000000	0.000000	154,010	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	2,485,122	0.000000	0.000000	0	88.00
90.00	09000	CLINIC	0	0	0.000000	0.000000	0	90.00
91.00	09100	EMERGENCY	0	1,304,541	0.000000	0.000000	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	149,989	0.000000	0.000000	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	15,491,113			518,907	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1300 | Period: From 09/01/2016 To 08/31/2017 | Worksheet D Part IV | Date/Time Prepared: 1/29/2018 4:45 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
60.00	06000	LABORATORY	0	0	0		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0		63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0		64.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	0		88.00
90.00	09000	CLINIC	0	0	0		90.00
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES					95.00
200.00		Total (lines 50-199)	0	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-1300 | Period: From 09/01/2016 To 08/31/2017 | Worksheet D Part V Date/Time Prepared: 1/29/2018 4:45 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.218527	0	1,514,540	0	0	54.00
60.00	06000	LABORATORY	0.260655	0	1,807,035	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.254768	0	29,180	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0.977992	0	338,405	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0.475602	0	314,564	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.078502	0	175,337	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.476903	0	114,007	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.432640	0	176,652	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	1.266982	0	439,148	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.379508	0	80,489	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.153029		0			95.00
200.00		Subtotal (see instructions)		0	4,989,357	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	4,989,357	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-1300 | Period: From 09/01/2016 To 08/31/2017 | Worksheet D Part V Date/Time Prepared: 1/29/2018 4:45 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
54.00	05400	RADIOLOGY-DIAGNOSTIC	330,968	0		54.00
60.00	06000	LABORATORY	471,013	0		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	7,434	0		63.00
64.00	06400	INTRAVENOUS THERAPY	330,957	0		64.00
66.00	06600	PHYSICAL THERAPY	149,607	0		66.00
69.00	06900	ELECTROCARDIOLOGY	13,764	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	54,370	0		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	76,427	0		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	556,393	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	111,035	0		92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	2,101,968	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	2,101,968	0		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1300 | Component CCN: 14-Z300 | Period: From 09/01/2016 To 08/31/2017 | Worksheet D Part V Date/Time Prepared: 1/29/2018 4:45 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.218527	0	0	0	0	54.00
60.00	06000	LABORATORY	0.260655	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.254768	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0.977992	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0.475602	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.078502	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.476903	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.432640	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	1.266982	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.379508	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.153029		0			95.00
200.00		Subtotal (see instructions)		0	0	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		0	0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1300 | Component CCN: 14-Z300 | Period: From 09/01/2016 To 08/31/2017 | Worksheet D Part V | Date/Time Prepared: 1/29/2018 4:45 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
60.00	06000	LABORATORY	0	0		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0		63.00
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	0	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	0	0		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1300 | Period: From 09/01/2016 To 08/31/2017 | Worksheet D-1 | Date/Time Prepared: 1/29/2018 4:45 pm

Title XVIII | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	1,135	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	674	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)	552	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	160	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)	255	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	31	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)	15	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	398	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)	119	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)	239	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	155.41	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	155.41	20.00
21.00	Total general inpatient routine service cost (see instructions)	1,854,081	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)	4,818	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)	2,331	25.00
26.00	Total swing-bed cost (see instructions)	710,985	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	1,143,096	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)	1,143,096	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,695.99	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	675,004	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)	675,004	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1300 | Period: From 09/01/2016 To 08/31/2017 | Worksheet D-1 | Date/Time Prepared: 1/29/2018 4:45 pm

Title XVIII | Hospital | Cost

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	190,512	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	865,516	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)	201,823	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	405,342	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	607,165	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)	122	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,695.99	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	206,911	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1300 | Period: From 09/01/2016 To 08/31/2017 | Worksheet D-1 | Date/Time Prepared: 1/29/2018 4:45 pm

Title XVIII | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	51,536	1,854,081	0.027796	206,911	5,751	90.00
91.00	Nursing School cost	0	1,854,081	0.000000	206,911	0	91.00
92.00	Allied health cost	0	1,854,081	0.000000	206,911	0	92.00
93.00	All other Medical Education	0	1,854,081	0.000000	206,911	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 14-1300 | Period: From 09/01/2016 To 08/31/2017 | Worksheet D-3 | Date/Time Prepared: 1/29/2018 4:45 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		458,245		30.00
		ANCILLARY SERVICE COST CENTERS				
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.218527	87,813	19,190	54.00
60.00	06000	LABORATORY	0.260655	112,647	29,362	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.254768	5,442	1,386	63.00
64.00	06400	INTRAVENOUS THERAPY	0.977992	732	716	64.00
66.00	06600	PHYSICAL THERAPY	0.475602	34,857	16,578	66.00
69.00	06900	ELECTROCARDIOLOGY	0.078502	5,531	434	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.476903	117,875	56,215	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.432640	154,010	66,631	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000	CLINIC	0.000000	0	0	90.00
91.00	09100	EMERGENCY	1.266982	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.379508	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		518,907	190,512	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)		518,907		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 14-1300 | Component CCN: 14-Z300 | Period: From 09/01/2016 To 08/31/2017 | Worksheet D-3 | Date/Time Prepared: 1/29/2018 4:45 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
		ANCILLARY SERVICE COST CENTERS				
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.218527	14,672	3,206	54.00
60.00	06000	LABORATORY	0.260655	34,843	9,082	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.254768	3,628	924	63.00
64.00	06400	INTRAVENOUS THERAPY	0.977992	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0.475602	85,112	40,479	66.00
69.00	06900	ELECTROCARDIOLOGY	0.078502	1,428	112	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.476903	68,712	32,769	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.432640	84,600	36,601	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000	CLINIC	0.000000	0	0	90.00
91.00	09100	EMERGENCY	1.266982	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.379508	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		292,995	123,173	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)		292,995		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-1300	Period: From 09/01/2016 To 08/31/2017	Worksheet E Part B Date/Time Prepared: 1/29/2018 4:45 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	2,101,968	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	PPS payments	0	3.00
4.00	Outlier payment (see instructions)	0	4.00
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 line 3 plus line 4 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)	2,101,968	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 (line 11 minus line 20) (for CAH see instructions)	2,122,988	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, 8 and 9)	0	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	19,928	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	628,605	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)	1,474,455	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)	1,474,455	30.00
31.00	Primary payer payments	880	31.00
32.00	Subtotal (line 30 minus line 31)	1,473,575	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)	101,570	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	66,021	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	62,654	36.00
37.00	Subtotal (see instructions)	1,539,596	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)	0	39.50
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)	1,539,596	40.00
40.01	Sequestration adjustment (see instructions)	30,792	40.01
41.00	Interim payments	1,587,110	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	-78,306	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: 14-1300 | Period: From 09/01/2016 To 08/31/2017 | Worksheet E-1 Part I Date/Time Prepared: 1/29/2018 4:45 pm

Title XVIII | Hospital | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		857,021		1,666,468	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		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	03/14/2017	85,921		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	03/14/2017	79,358	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		85,921		-79,358	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)		942,942		1,587,110	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		191,932		78,306	6.02
7.00	Total Medicare program liability (see instructions)		751,010		1,508,804	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: 14-1300 | Component CCN: 14-Z300 | Period: From 09/01/2016 To 08/31/2017 | Worksheet E-1 Part I | Date/Time Prepared: 1/29/2018 4:45 pm

Title XVIII | Swing Beds - SNF | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		814,791		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	03/14/2017	60,642		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)		60,642		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)		875,433		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		160,968		0	6.02
7.00	Total Medicare program liability (see instructions)		714,465		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: 14-1300	Period: From 09/01/2016 To 08/31/2017	Worksheet E-1 Part II Date/Time Prepared: 1/29/2018 4:45 pm
	Title XVIII	Hospital	Cost

		1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS		
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION		
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14	207	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12	398	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2	36	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12	552	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200	17,916,279	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20	66,123	6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168	1	7.00
8.00	Calculation of the HIT incentive payment (see instructions)	1	8.00
9.00	Sequestration adjustment amount (see instructions)	0	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)	1	10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH		
30.00	Initial/interim HIT payment adjustment (see instructions)	1	30.00
31.00	Other Adjustment (specify)	0	31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)	0	32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS	Provider CCN: 14-1300 Component CCN: 14-Z300	Period: From 09/01/2016 To 08/31/2017	Worksheet E-2 Date/Time Prepared: 1/29/2018 4:45 pm
	Title XVIII	Swing Beds - SNF	Cost

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	613,237	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)	124,405	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	358	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)	737,642	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	737,642	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)	737,642	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	8,596	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)	729,046	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	0	16.50
16.55	410A RURAL DEMONSTRATION PROJECT	0		16.55
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)	729,046	0	19.00
19.01	Sequestration adjustment (see instructions)	14,581	0	19.01
20.00	Interim payments	875,433	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)	-160,968	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

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-1300	Period: From 09/01/2016 To 08/31/2017	Worksheet E-3 Part V Date/Time Prepared: 1/29/2018 4:45 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	865,516	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)	865,516	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	874,171	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)	874,171	19.00
20.00	Deductibles (exclude professional component)	127,736	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	746,435	22.00
23.00	Coinsurance	0	23.00
24.00	Subtotal (line 22 minus line 23)	746,435	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	30,619	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	19,902	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	27,312	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	766,337	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	Recovery of Accelerated Depreciation	0	29.99
30.00	Subtotal (see instructions)	766,337	30.00
30.01	Sequestration adjustment (see instructions)	15,327	30.01
31.00	Interim payments	942,942	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, 31, and 32)	-191,932	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: 14-1300 | Period: From 09/01/2016 To 08/31/2017 | Worksheet G | Date/Time Prepared: 1/29/2018 4:45 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	-1,074,299	0	0	0	1.00
2.00	Temporary investments	47,764	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	5,678,824	0	0	0	4.00
5.00	Other receivable	-51,532	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-3,805,013	0	0	0	6.00
7.00	Inventory	33,093	0	0	0	7.00
8.00	Prepaid expenses	22,787	0	0	0	8.00
9.00	Other current assets	38,302	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)	889,926	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	70,514	0	0	0	12.00
13.00	Land improvements	36,143	0	0	0	13.00
14.00	Accumulated depreciation	-36,143	0	0	0	14.00
15.00	Buildings	2,577,650	0	0	0	15.00
16.00	Accumulated depreciation	-2,399,432	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	84,028	0	0	0	19.00
20.00	Accumulated depreciation	-82,660	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	3,155,027	0	0	0	23.00
24.00	Accumulated depreciation	-3,058,202	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	13,426	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	360,351	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	0	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	0	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	1,250,277	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	1,402,328	0	0	0	37.00
38.00	Salaries, wages, and fees payable	749,141	0	0	0	38.00
39.00	Payroll taxes payable	379,045	0	0	0	39.00
40.00	Notes and loans payable (short term)	192,440	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	0	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	2,722,954	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	167,097	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	20,136	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	187,233	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	2,910,187	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	-1,659,910				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)	-1,659,910	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	1,250,277	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 14-1300 | Period: From 09/01/2016 To 08/31/2017 | Worksheet G-1 | Date/Time Prepared: 1/29/2018 4:45 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		-1,516,033		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-143,877				2.00
3.00	Total (sum of line 1 and line 2)		-1,659,910		0		3.00
4.00		0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		-1,659,910		0		11.00
12.00		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)		-1,659,910		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			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			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: 14-1300 | Period: From 09/01/2016 To 08/31/2017 | Worksheet G-2 Parts I & II Date/Time Prepared: 1/29/2018 4:45 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	456,796		456,796	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	381,491		381,491	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)	838,287		838,287	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)	838,287		838,287	17.00
18.00	Ancillary services	1,012,931	10,538,530	11,551,461	18.00
19.00	Outpatient services	2,146	1,452,384	1,454,530	19.00
20.00	RURAL HEALTH CLINIC	0	2,485,122	2,485,122	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES	0	1,586,879	1,586,879	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PRO FEES	232,762	864,433	1,097,195	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	2,086,126	16,927,348	19,013,474	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		11,078,897		29.00
30.00	BAD DEBTS	1,331,596			30.00
31.00	INTEREST EXPENSE	31,013			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)		1,362,609		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)		12,441,506		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 14-1300 | Period: From 09/01/2016 To 08/31/2017 | Worksheet G-3 | Date/Time Prepared: 1/29/2018 4:45 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	19,013,474	1.00
2.00	Less contractual allowances and discounts on patients' accounts	7,405,468	2.00
3.00	Net patient revenues (line 1 minus line 2)	11,608,006	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	12,441,506	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-833,500	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	11,971	6.00
7.00	Income from investments	12,720	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	31,423	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	5,822	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	-1,242	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	11,600	22.00
23.00	Governmental appropriations	63,562	23.00
24.00	AMBULANCE	353,196	24.00
24.01	WELLNESS CENTER	12,296	24.01
24.02	HEALTH FAIR	9,240	24.02
24.03	UNREALIZED GAIN ON INVESTMENTS	3,852	24.03
24.04	OTHER MISC INCOME	175,183	24.04
25.00	Total other income (sum of lines 6-24)	689,623	25.00
26.00	Total (line 5 plus line 25)	-143,877	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-143,877	29.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1300 | Component CCN: 14-3403 | Period: From 09/01/2016 To 08/31/2017 | Worksheet M-1 | Date/Time Prepared: 1/29/2018 4:45 pm

RHC I | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	588,556	35,992	624,548	10,480	635,028	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	456,178	26,709	482,887	0	482,887	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	237,494	14,888	252,382	0	252,382	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	17,821	17,821	0	17,821	9.00
10.00	Subtotal (sum of lines 1 through 9)	1,282,228	95,410	1,377,638	10,480	1,388,118	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	14,534	14,534	0	14,534	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	14,534	14,534	0	14,534	14.00
15.00	Medical Supplies	0	52,760	52,760	0	52,760	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	113,129	113,129	-59,344	53,785	18.00
19.00	Other Health Care Costs	0	0	0	11,050	11,050	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	165,889	165,889	-48,294	117,595	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	1,282,228	275,833	1,558,061	-37,814	1,520,247	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	54,791	54,791	-4,870	49,921	29.00
30.00	Administrative Costs	308,665	51,735	360,400	-270,331	90,069	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	308,665	106,526	415,191	-275,201	139,990	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	1,590,893	382,359	1,973,252	-313,015	1,660,237	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1300 | Component CCN: 14-3403 | Period: From 09/01/2016 To 08/31/2017 | Worksheet M-1 | Date/Time Prepared: 1/29/2018 4:45 pm

RHC I | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	635,028		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	482,887		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	252,382		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	17,821		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	1,388,118		10.00
11.00	Physician Services Under Agreement	0	0		11.00
12.00	Physician Supervision Under Agreement	0	14,534		12.00
13.00	Other Costs Under Agreement	0	0		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	14,534		14.00
15.00	Medical Supplies	0	52,760		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	53,785		18.00
19.00	Other Health Care Costs	0	11,050		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	117,595		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	1,520,247		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	49,921		29.00
30.00	Administrative Costs	0	90,069		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	139,990		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	1,660,237		32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1300 | Component CCN: 14-3403 | Period: From 09/01/2016 To 08/31/2017 | Worksheet M-2 | Date/Time Prepared: 1/29/2018 4:45 pm

RHC I | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	1.94	6,548	4,200	8,148		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	4.06	8,966	2,100	8,526		3.00
4.00	Subtotal (sum of lines 1 through 3)	6.00	15,514		16,674	16,674	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)	6.00	15,514			16,674	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)					1,520,247	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)					1,520,247	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)					139,990	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					745,647	15.00
16.00	Total overhead (sum of lines 14 and 15)					885,637	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					885,637	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					885,637	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					2,405,884	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 14-1300 Component CCN: 14-3403	Period: From 09/01/2016 To 08/31/2017	Worksheet M-3 Date/Time Prepared: 1/29/2018 4:45 pm
	Title XVIII	RHC I	Cost

				1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES				
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			2,405,884	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			44,167	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			2,361,717	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			16,674	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)			16,674	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			141.64	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)	81.32	82.30		8.00
9.00	Rate for Program covered visits (see instructions)	141.64	141.64		9.00
	CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	0	3,891		10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	551,121		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	551,121		16.00
16.01	Total program charges (see instructions)(from contractor's records)		641,481		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		24,955		16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		21,440		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.)		361,827		16.04
16.05	Total program cost (see instructions)	0	383,267		16.05
17.00	Primary payer amounts		0		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		77,397		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		107,826		19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		383,267		20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		26,975		21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		410,242		22.00
23.00	Allowable bad debts (see instructions)		43,856		23.00
23.01	Adjusted reimbursable bad debts (see instructions)		28,506		23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		36,348		24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0		25.50
26.00	Net reimbursable amount (see instructions)		438,748		26.00
26.01	Sequestration adjustment (see instructions)		8,775		26.01
27.00	Interim payments		324,214		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, 27, and 28)		105,759		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: 14-1300 | Component CCN: 14-3403 | Period: From 09/01/2016 To 08/31/2017 | Worksheet M-4 | Date/Time Prepared: 1/29/2018 4:45 pm

Title XVIII | RHC I | Cost

		Pneumococcal	Influenza	
		1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	1,388,118	1,388,118	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.001595	0.007171	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	2,214	9,954	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	8,443	7,298	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	10,657	17,252	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	1,520,247	1,520,247	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	885,637	885,637	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.007010	0.011348	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	6,208	10,050	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	16,865	27,302	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	99	445	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	170.35	61.35	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	82	212	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	13,969	13,006	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)		44,167	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)		26,975	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 14-1300 Component CCN: 14-3403	Period: From 09/01/2016 To 08/31/2017	Worksheet M-5 Date/Time Prepared: 1/29/2018 4:45 pm
		RHC I	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		317,536	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		03/14/2017	6,678	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)		6,678	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		324,214	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		105,759	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		429,973	7.00

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