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: 14-1301	Period: From 07/01/2016 To 06/30/2017	Worksheet S Parts I-III Date/Time Prepared: 11/20/2017 5:39 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 11/20/2017 Time: 5:39 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 KIRBY HOSPITAL (14-1301) for the cost reporting period beginning 07/01/2016 and ending 06/30/2017 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	-79	-958,735	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	-32,073	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
10.00	RURAL HEALTH CLINIC I	0		12,212		0	10.00
10.01	RURAL HEALTH CLINIC II	0		166,171		0	10.01
10.02	RURAL HEALTH CLINIC III	0		44,940		0	10.02
200.00	Total	0	-32,152	-735,412	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: 14-1301 | Period: From 07/01/2016 To 06/30/2017 | Worksheet S-2 Part I Date/Time Prepared: 11/20/2017 10:55 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 1000 MEDICAL CENTER DRIVE	PO Box:			1.00
2.00	City: MONTICELLO	State: IL	Zip Code: 61856	County: PIATT	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	KIRBY HOSPITAL	141301	16580	1	08/08/1999	N	O	N	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	KIRBY HOSPITAL - SWING BED	14Z301	16580		08/08/1999	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	ATWOOD RURAL HEALTH CLINIC	143438	16580		11/17/1997	N	O	N	15.00
15.01	Hospital-Based Health Clinic - RHC II	KIRBY MEDICAL GROUP RHC	143495	16580		11/20/2008	N	O	N	15.01
15.02	Hospital-Based Health Clinic - RHC III	CERRO GORDO RURAL HEALTH CLINIC	148566	16580		12/29/2016	N	O	N	15.02
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	07/01/2016	06/30/2017	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.	2	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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1301 | Period: From 07/01/2016 To 06/30/2017 | Worksheet S-2 Part I Date/Time Prepared: 11/20/2017 10:55 am

		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	
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0		25.00

		Urban/Rural S	Date of Geogr	
		1.00	2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	2		26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	2		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0		35.00
		Beginning:	Ending:	
		1.00	2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.			36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.	0		37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)	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.				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)	N			0.00	0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00	0.00			61.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 14-1301	Period: From 07/01/2016 To 06/30/2017	Worksheet S-2 Part I Date/Time Prepared: 11/20/2017 10:55 am

		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
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
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	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1301 | Period: From 07/01/2016 To 06/30/2017 | Worksheet S-2 Part I Date/Time Prepared: 11/20/2017 10:55 am

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

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

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

		1.00	2.00	3.00	
	Inpatient Psychiatric Facility PPS				
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	N			70.00
71.00	If line 70 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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 14-1301	Period: From 07/01/2016 To 06/30/2017	Worksheet S-2 Part I Date/Time Prepared: 11/20/2017 10:55 am

		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
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.	Y		108.00

		Physical	Occupational	Speech	Respiratory	
		1.00	2.00	3.00	4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	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:	79,170	0	0	118.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 14-1301	Period: From 07/01/2016 To 06/30/2017	Worksheet S-2 Part I Date/Time Prepared: 11/20/2017 10:55 am

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

	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	N	N	N	N	155.00
156.00	Subprovider - IPF	N	N	N	N	156.00
157.00	Subprovider - IRF	N	N	N	N	157.00
158.00	SUBPROVIDER					158.00
159.00	SNF	N	N	N	N	159.00
160.00	HOME HEALTH AGENCY	N	N	N	N	160.00
161.00	CMHC		N	N	N	161.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 14-1301	Period: From 07/01/2016 To 06/30/2017	Worksheet S-2 Part I Date/Time Prepared: 11/20/2017 10:55 am

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

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

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

		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	10/01/2015	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: 14-1301	Period: From 07/01/2016 To 06/30/2017	Worksheet S-2 Part II Date/Time Prepared: 11/20/2017 10:55 am

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

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

		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	10/30/2017	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00

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

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

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	N		N		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)	Y	09/28/2017	Y	09/28/2017	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: 14-1301	Period: From 07/01/2016 To 06/30/2017	Worksheet S-2 Part II Date/Time Prepared: 11/20/2017 10:55 am

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

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

		1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)		
	Capital Related Cost		
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions	N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.	N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions	N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.	N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.	N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.	N	27.00
	Interest Expense		
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.	N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions	Y	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.	N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.	N	31.00
	Purchased Services		
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.	Y	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.	Y	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.			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.			38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			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: 14-1301	Period: From 07/01/2016 To 06/30/2017	Worksheet S-2 Part II Date/Time Prepared: 11/20/2017 10:55 am

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 14-1301 | Period: From 07/01/2016 To 06/30/2017 | Worksheet S-3 Part I | Date/Time Prepared: 11/20/2017 10:55 am

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	16	5,840	8,952.00	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)		16	5,840	8,952.00	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)		16	5,840	8,952.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	88.00				0	26.00
26.01	RURAL HEALTH CLINIC II	88.01				0	26.01
26.02	RURAL HEALTH CLINIC III	88.02				0	26.02
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		16				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: 14-1301 | Period: From 07/01/2016 To 06/30/2017 | Worksheet S-3 Part I | Date/Time Prepared: 11/20/2017 10:55 am

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	196	27	373			1.00
2.00	HMO and other (see instructions)	110	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	714	0	1,154			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	339			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	910	27	1,866			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)	910	27	1,866	0.00	164.89	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	0	0	0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	419	0	3,252	0.00	5.01	26.00
26.01	RURAL HEALTH CLINIC II	2,972	0	16,312	0.00	28.01	26.01
26.02	RURAL HEALTH CLINIC III	140	0	1,129	0.00	3.83	26.02
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	201.74	27.00
28.00	Observation Bed Days		0	173			28.00
29.00	Ambulance Trips	627					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: 14-1301 | Period: From 07/01/2016 To 06/30/2017 | Worksheet S-3 Part I | Date/Time Prepared: 11/20/2017 10:55 am

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	64	8	109	1.00
2.00	HMO and other (see instructions)			29	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	64	8	109	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	0.00					26.00
26.01	RURAL HEALTH CLINIC II	0.00					26.01
26.02	RURAL HEALTH CLINIC III	0.00					26.02
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 14-1301 | Component CCN: 14-3438 | Period: From 07/01/2016 To 06/30/2017 | Worksheet S-8 | Date/Time Prepared: 11/20/2017 10:55 am

RHC I | Cost

		1.00	
	Clinic Address and Identification		
1.00	Street	108 SOUTH MAIN STREET	1.00

		City	State	ZIP Code	
		1.00	2.00	3.00	
2.00	City, State, ZIP Code, County	ATWOOD	IL	61913	2.00

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

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

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

		Sunday		Monday		Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
	Facility hours of operations (1)						
11.00	Clinic			08:00	16:30	08:00	11.00

		1.00	2.00	
12.00	Have you received an approval for an exception to the productivity standard?	N		12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.	N	0	13.00

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

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

		County	
		4.00	
2.00	City, State, ZIP Code, County	DOUGLAS	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	16:30	08:00	16:30	08:00	16:30	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA	Provider CCN: 14-1301 Component CCN: 14-3438	Period: From 07/01/2016 To 06/30/2017	Worksheet S-8 Date/Time Prepared: 11/20/2017 10:55 am
		RHC I	Cost

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

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-1301 | Component CCN: 14-3495 | Period: From 07/01/2016 To 06/30/2017 | Worksheet S-8 | Date/Time Prepared: 11/20/2017 10:55 am

RHC II | Cost

		1.00	
	Clinic Address and Identification		
1.00	Street	1000 MEDICAL CENTER DRIVE	1.00

		City	State	ZIP Code	
		1.00	2.00	3.00	
2.00	City, State, ZIP Code, County	MONTICELLO	IL	61856	2.00

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

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

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

		Sunday from	Sunday to	Monday from	Monday to	Tuesday from	
		1.00	2.00	3.00	4.00	5.00	
	Facility hours of operations (1)						
11.00	Clinic			07:00	18:00	07:00	11.00

		1.00	2.00	
12.00	Have you received an approval for an exception to the productivity standard?	N		12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.	N	0	13.00

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

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

		County	
		4.00	
2.00	City, State, ZIP Code, County	PIATT	2.00

		Tuesday to	Wednesday from	Wednesday to	Thursday from	Thursday to	
		6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)						
11.00	Clinic	18:00	07:00	18:00	07:00	18:00	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA	Provider CCN: 14-1301 Component CCN: 14-3495	Period: From 07/01/2016 To 06/30/2017	Worksheet S-8 Date/Time Prepared: 11/20/2017 10:55 am
		RHC II	Cost

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	Clinic	07:00	16:00	08:00	12:00		11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA	Provider CCN: 14-1301 Component CCN: 14-8566	Period: From 07/01/2016 To 06/30/2017	Worksheet S-8 Date/Time Prepared: 11/20/2017 10:55 am
		RHC III	Cost

		1.00	
	Clinic Address and Identification		
1.00	Street	407 S. JACKSON STREET, SUITE A	1.00

		City	State	ZIP Code	
		1.00	2.00	3.00	
2.00	City, State, ZIP Code, County	CERRO GORDO	IL	61818	2.00

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

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

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

		Sunday		Monday		Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
	Facility hours of operations (1)						
11.00	Clinic			08:00	16:30	08:00	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.	N	0	13.00

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

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

		County	
		4.00	
2.00	City, State, ZIP Code, County	PIATT	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	16:30	08:00	16:30	08:00	16:30	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-1301 | Component CCN: 14-8566 | Period: From 07/01/2016 To 06/30/2017 | Worksheet S-8 | Date/Time Prepared: 11/20/2017 10:55 am

RHC III | Cost

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

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 14-1301 | Period: From 07/01/2016 To 06/30/2017 | Worksheet S-10 | Date/Time Prepared: 11/20/2017 10:55 am

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.364613	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	3,110,420	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH or supplemental payments from Medicaid?	Y	4.00
5.00	If line 4 is no, then enter DSH or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	10,082,041	6.00
7.00	Medicaid cost (line 1 times line 6)	3,676,043	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)	565,623	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)	565,623	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)	254,225	905,087	1,159,312	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	92,694	905,087	997,781	21.00
22.00	Payments received from patients for amounts previously written off as charity care	30,524	98,971	129,495	22.00
23.00	Cost of charity care (line 21 minus line 22)	62,170	806,116	868,286	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)	2,023,256	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	176,686	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	271,825	27.01
28.00	Non-Medicare bad debt expense (line 26 minus line 27.01)	1,751,431	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	733,734	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	1,602,020	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	2,167,643	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-1301 | Period: From 07/01/2016 To 06/30/2017 | Worksheet A | Date/Time Prepared: 11/20/2017 10:55 am

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		3,482,295	3,482,295	75,862	3,558,157	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		1,030,286	1,030,286	21,254	1,051,540	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	-11,069	-11,069	169,398	158,329	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,552,946	4,206,185	6,759,131	57,887	6,817,018	5.00
6.00	00600	MAINTENANCE & REPAIRS	243,200	316,378	559,578	0	559,578	6.00
7.00	00700	OPERATION OF PLANT	0	342,041	342,041	-27,803	314,238	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	49,899	49,899	8.00
9.00	00900	HOUSEKEEPING	274,679	126,119	400,798	0	400,798	9.00
10.00	01000	DIETARY	365,278	269,759	635,037	-558,397	76,640	10.00
11.00	01100	CAFETERIA	0	0	0	544,854	544,854	11.00
14.00	01400	CENTRAL SERVICES & SUPPLY	95,228	32,823	128,051	0	128,051	14.00
15.00	01500	PHARMACY	48,167	223,575	271,742	0	271,742	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	542,012	254,857	796,869	0	796,869	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	206,049	20,431	226,480	0	226,480	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,332,573	690,005	2,022,578	-18,338	2,004,240	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	408,737	1,191,887	1,600,624	-6,760	1,593,864	50.00
53.00	05300	ANESTHESIOLOGY	0	42,320	42,320	0	42,320	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	726,913	819,828	1,546,741	-5,186	1,541,555	54.00
56.00	03630	ULTRA SOUND	0	58,451	58,451	0	58,451	56.00
60.00	06000	LABORATORY	549,573	1,120,337	1,669,910	-2,568	1,667,342	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	523,114	195,956	719,070	-2,282	716,788	66.00
67.00	06700	OCCUPATIONAL THERAPY	125,165	23,675	148,840	0	148,840	67.00
68.00	06800	SPEECH PATHOLOGY	0	28,844	28,844	0	28,844	68.00
69.00	06900	ELECTROCARDIOLOGY	6,530	11,076	17,606	15,238	32,844	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	57,311	57,311	0	57,311	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	86,807	86,807	0	86,807	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	391,609	391,609	0	391,609	73.00
76.00	03950	SLEEP LAB	101,691	115,552	217,243	-1,634	215,609	76.00
76.01	03951	DIABETIC EDUCATION	0	0	0	11,857	11,857	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	329,780	157,028	486,808	-66,092	420,716	88.00
88.01	08801	RURAL HEALTH CLINIC II	2,078,646	964,965	3,043,611	-187,584	2,856,027	88.01
88.02	08802	RURAL HEALTH CLINIC III	164,655	127,019	291,674	-44,680	246,994	88.02
91.00	09100	EMERGENCY	952,461	2,206,541	3,159,002	-25,414	3,133,588	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	300,702	195,994	496,696	-446	496,250	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	11,928,099	18,778,885	30,706,984	-935	30,706,049	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	FOUNDATION	58,964	63,396	122,360	0	122,360	190.01
190.02	19002	CROSSFIT	105,274	79,687	184,961	-15,616	169,345	190.02
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	16,551	16,551	192.00
200.00		TOTAL (SUM OF LINES 118-199)	12,092,337	18,921,968	31,014,305	0	31,014,305	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-1301 | Period: From 07/01/2016 To 06/30/2017 | Worksheet A | Date/Time Prepared: 11/20/2017 10:55 am

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
		GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT	-64,711	3,493,446	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-199,743	851,797	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	158,329	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-1,126,695	5,690,323	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	559,578	6.00
7.00	00700	OPERATION OF PLANT	11,746	325,984	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	49,899	8.00
9.00	00900	HOUSEKEEPING	-33	400,765	9.00
10.00	01000	DIETARY	-42	76,598	10.00
11.00	01100	CAFETERIA	-162,272	382,582	11.00
14.00	01400	CENTRAL SERVICES & SUPPLY	-27	128,024	14.00
15.00	01500	PHARMACY	0	271,742	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-23	796,846	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	-79,109	147,371	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	-180,156	1,824,084	30.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	-153,040	1,440,824	50.00
53.00	05300	ANESTHESIOLOGY	-38,900	3,420	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-282,477	1,259,078	54.00
56.00	03630	ULTRA SOUND	0	58,451	56.00
60.00	06000	LABORATORY	0	1,667,342	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	64.00
66.00	06600	PHYSICAL THERAPY	-31,507	685,281	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	148,840	67.00
68.00	06800	SPEECH PATHOLOGY	0	28,844	68.00
69.00	06900	ELECTROCARDIOLOGY	-16,408	16,436	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	57,311	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	86,807	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	391,609	73.00
76.00	03950	SLEEP LAB	-67,871	147,738	76.00
76.01	03951	DIABETIC EDUCATION	0	11,857	76.01
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	-29	420,687	88.00
88.01	08801	RURAL HEALTH CLINIC II	-363	2,855,664	88.01
88.02	08802	RURAL HEALTH CLINIC III	-11,023	235,971	88.02
91.00	09100	EMERGENCY	-876,569	2,257,019	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	-58,485	437,765	95.00
		SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1-117)	-3,337,737	27,368,312	118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
190.01	19001	FOUNDATION	0	122,360	190.01
190.02	19002	CROSSFIT	0	169,345	190.02
192.00	19200	PHYSICIANS' PRIVATE OFFICES	11,746	28,297	192.00
200.00		TOTAL (SUM OF LINES 118-199)	-3,325,991	27,688,314	200.00

RECLASSIFICATIONS | Provider CCN: 14-1301 | Period: From 07/01/2016 To 06/30/2017 | Worksheet A-6 | Date/Time Prepared: 11/20/2017 10:55 am

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - PROPERTY INSURANCE				
1.00	OTHER CAP REL COSTS	3.00	0	97,058	1.00
	0		0	97,058	
	B - CAPITAL LEASE INTEREST EXPENSE				
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	58	1.00
	0		0	58	
	C - CAFETERIA				
1.00	CAFETERIA	11.00	310,673	234,181	1.00
2.00	DIABETIC EDUCATION	76.01	9,944	1,913	2.00
	0		320,617	236,094	
	D - EKG				
1.00	ELECTROCARDIOLOGY	69.00	11,971	3,267	1.00
2.00		0.00	0	0	2.00
	0		11,971	3,267	
	E - RHC ADMITTING				
1.00	ADMINISTRATIVE & GENERAL	5.00	239,774	49,553	1.00
2.00	PHYSICIANS' PRIVATE OFFICES	192.00	4,063	826	2.00
3.00		0.00	0	0	3.00
	0		243,837	50,379	
	F - LAUNDRY				
1.00	LAUNDRY & LINEN SERVICE	8.00	0	49,899	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
	0		0	49,899	
	G - CROSSFIT EMPLOYEE BENEFITS				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	8,550	6,420	1.00
	0		8,550	6,420	
	H - WORKERS' COMP INS				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	154,428	1.00
	TOTALS		0	154,428	
	J - TELEPHONE EXPENSE				
1.00	ADMINISTRATIVE & GENERAL	5.00	0	16,506	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
	TOTALS		0	16,506	
	K - DOCTORS BLDG COSTS				
1.00	ADMINISTRATIVE & GENERAL	5.00	0	3,598	1.00
2.00	OPERATION OF PLANT	7.00	0	6,543	2.00
3.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	11,662	3.00
	TOTALS		0	21,803	
500.00	Grand Total: Increases		584,975	635,912	500.00

RECLASSIFICATIONS | Provider CCN: 14-1301 | Period: From 07/01/2016 To 06/30/2017 | Worksheet A-6 | Date/Time Prepared: 11/20/2017 10:55 am

	Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
	A - PROPERTY INSURANCE					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	97,058	12	1.00
	0		0	97,058		
	B - CAPITAL LEASE INTEREST EXPENSE					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	58	11	1.00
	0		0	58		
	C - CAFETERIA					
1.00	DIETARY	10.00	320,617	236,094	0	1.00
2.00		0.00	0	0	0	2.00
	0		320,617	236,094		
	D - EKG					
1.00	LABORATORY	60.00	1,994	574	0	1.00
2.00	EMERGENCY	91.00	9,977	2,693	0	2.00
	0		11,971	3,267		
	E - RHC ADMITTING					
1.00	RURAL HEALTH CLINIC	88.00	52,493	10,474	0	1.00
2.00	RURAL HEALTH CLINIC II	88.01	155,732	31,675	0	2.00
3.00	RURAL HEALTH CLINIC III	88.02	35,612	8,230	0	3.00
	0		243,837	50,379		
	F - LAUNDRY					
1.00	DIETARY	10.00	0	1,686	0	1.00
2.00	ADULTS & PEDIATRICS	30.00	0	18,338	0	2.00
3.00	OPERATING ROOM	50.00	0	6,760	0	3.00
4.00	RADIOLOGY-DIAGNOSTIC	54.00	0	5,186	0	4.00
5.00	PHYSICAL THERAPY	66.00	0	2,282	0	5.00
6.00	SLEEP LAB	76.00	0	1,634	0	6.00
7.00	RURAL HEALTH CLINIC II	88.01	0	177	0	7.00
8.00	EMERGENCY	91.00	0	12,744	0	8.00
9.00	AMBULANCE SERVICES	95.00	0	446	0	9.00
10.00	CROSSFIT	190.02	0	646	0	10.00
	0		0	49,899		
	G - CROSSFIT EMPLOYEE BENEFITS					
1.00	CROSSFIT	190.02	8,550	6,420	0	1.00
	0		8,550	6,420		
	H - WORKERS' COMP INS					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	154,428	0	1.00
	TOTALS		0	154,428		
	J - TELEPHONE EXPENSE					
1.00	RURAL HEALTH CLINIC	88.00	0	3,125	0	1.00
2.00	RURAL HEALTH CLINIC III	88.02	0	838	0	2.00
3.00	OPERATION OF PLANT	7.00	0	12,543	0	3.00
	TOTALS		0	16,506		
	K - DOCTORS BLDG COSTS					
1.00	OPERATION OF PLANT	7.00	0	21,803	0	1.00
2.00		0.00	0	0	0	2.00
3.00		0.00	0	0	0	3.00
	TOTALS		0	21,803		
500.00	Grand Total: Decreases		584,975	635,912		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1301 | Period: From 07/01/2016 To 06/30/2017 | Worksheet A-7 Part I | Date/Time Prepared: 11/20/2017 10:55 am

		Beginning Balances	Acquisitions Purchases	Acquisitions Donation	Acquisitions Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	349,650	40,130	0	40,130	0	1.00
2.00	Land Improvements	6,444,285	384,982	0	384,982	892,785	2.00
3.00	Buildings and Fixtures	16,433,590	1,207,172	0	1,207,172	140,344	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	10,516,761	654,415	0	654,415	0	5.00
6.00	Movable Equipment	6,466,374	1,298,647	0	1,298,647	1,114,425	6.00
7.00	HIT designated Assets	3,070,784	17,373	0	17,373	0	7.00
8.00	Subtotal (sum of lines 1-7)	43,281,444	3,602,719	0	3,602,719	2,147,554	8.00
9.00	Reconciling Items	-141,561	-2,502,281	0	-2,502,281	-1,599,274	9.00
10.00	Total (line 8 minus line 9)	43,423,005	6,105,000	0	6,105,000	3,746,828	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	389,780	0	1.00
2.00	Land Improvements	5,936,482	0	2.00
3.00	Buildings and Fixtures	17,500,418	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	11,171,176	0	5.00
6.00	Movable Equipment	6,650,596	0	6.00
7.00	HIT designated Assets	3,088,157	0	7.00
8.00	Subtotal (sum of lines 1-7)	44,736,609	0	8.00
9.00	Reconciling Items	-1,044,568	0	9.00
10.00	Total (line 8 minus line 9)	45,781,177	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1301 | Period: From 07/01/2016 To 06/30/2017 | Worksheet A-7 Part II Date/Time Prepared: 11/20/2017 10:55 am

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	1,911,772	0	1,570,523	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	1,030,286	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	2,942,058	0	1,570,523	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL		
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
		14.00	15.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	3,482,295	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	1,030,286	2.00
3.00	Total (sum of lines 1-2)	0	4,512,581	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1301 | Period: From 07/01/2016 To 06/30/2017 | Worksheet A-7 Part III Date/Time Prepared: 11/20/2017 10:55 am

	Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	34,856,295	0	34,856,295	0.781618	75,862	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	9,738,753	0	9,738,753	0.218382	21,196	2.00
3.00	Total (sum of lines 1-2)	44,595,048	0	44,595,048	1.000000	97,058	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	75,862	1,911,772	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	21,196	830,545	0	2.00
3.00	Total (sum of lines 1-2)	0	0	97,058	2,742,317	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	1,505,812	75,862	0	0	3,493,446	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	56	21,196	0	0	851,797	2.00
3.00	Total (sum of lines 1-2)	1,505,868	97,058	0	0	4,345,243	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1301 | Period: From 07/01/2016 To 06/30/2017 | Worksheet A-8 | Date/Time Prepared: 11/20/2017 10:55 am

				Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-64,711	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)	B	-2	CAP REL COSTS-MVBLE EQUIP	2.00	11	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-1,477	ADMINISTRATIVE & GENERAL	5.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-1,617,454			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	-162,272	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts		0		0.00	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 - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	A	-199,741	CAP REL COSTS-MVBLE EQUIP	2.00	9	32.00
33.00	MISCELLANEOUS INCOME	B	-56,210	ADMINISTRATIVE & GENERAL	5.00	0	33.00
33.01	AMBULANCE INCOME	B	-58,485	AMBULANCE SERVICES	95.00	0	33.01

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-1301 | Period: From 07/01/2016 To 06/30/2017 | Worksheet A-8 | Date/Time Prepared: 11/20/2017 10:55 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
				Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.02	CANCER CLINIC INCOME	B	-19,214	ADMINISTRATIVE & GENERAL	5.00	0	33.02
33.03	PHASE III CARDIAC REHAB INCOME	B	-29,365	PHYSICAL THERAPY	66.00	0	33.03
33.04	ADVERTISING EXPENSE	A	-138,346	ADMINISTRATIVE & GENERAL	5.00	0	33.04
33.05	LOBBYING EXPENSE	A	-8,412	ADMINISTRATIVE & GENERAL	5.00	0	33.05
33.06	PROPERTY TAX	A	-18,981	ADMINISTRATIVE & GENERAL	5.00	0	33.06
33.07	MEDICAID ASSESSMENT TAX	A	-290,203	ADMINISTRATIVE & GENERAL	5.00	0	33.07
33.08	KEY EMPLOYEE LIFE INSURANCE	A	-17,449	ADMINISTRATIVE & GENERAL	5.00	0	33.08
33.09	TRUST DEPR HOSPITAL ADMINISTRATION	A	6,459	ADMINISTRATIVE & GENERAL	5.00	0	33.09
33.10	TRUST DEPR OPERATION OF PLANT	A	11,746	OPERATION OF PLANT	7.00	0	33.10
33.11	TRUST DEPR PHYSICIAN PRIVATE OFFICES	A	11,746	PHYSICIANS' PRIVATE OFFICES	192.00	0	33.11
33.12	TIF EXPENSE NON-HOSPITAL	A	-390,291	ADMINISTRATIVE & GENERAL	5.00	0	33.12
33.13	NON-ALLOWABLE CRNA COSTS	A	-79,109	NONPHYSICIAN ANESTHETISTS	19.00	0	33.13
33.14	DONATION EXPENSE	A	-192,566	ADMINISTRATIVE & GENERAL	5.00	0	33.14
33.15	CERRO GORDO RENT INCOME	B	-11,023	RURAL HEALTH CLINIC III	88.02	0	33.15
34.00	MISC EXPENSE - A&G	A	-5	ADMINISTRATIVE & GENERAL	5.00	0	34.00
34.01	MISC EXPENSE - HOUSEKEEPING	A	-33	HOUSEKEEPING	9.00	0	34.01
34.02	MISC EXPENSE - DIETARY	A	-42	DIETARY	10.00	0	34.02
34.03	MISC EXPENSE - CENTRAL SERVICES	A	-27	CENTRAL SERVICES & SUPPLY	14.00	0	34.03
34.04	MISC EXPENSE - MED RECORDS	A	-23	MEDICAL RECORDS & LIBRARY	16.00	0	34.04
34.05	MISC EXPENSE - OR	A	-10	OPERATING ROOM	50.00	0	34.05
34.06	MISC EXPENSE - RADIOLOGY	A	-48	RADIOLOGY-DIAGNOSTIC	54.00	0	34.06
34.07	MISC EXPENSE - PT	A	-51	PHYSICAL THERAPY	66.00	0	34.07
34.08	MISC EXPENSE - RHC I	A	-29	RURAL HEALTH CLINIC	88.00	0	34.08
34.09	MISC EXPENSE - RHC II	A	-363	RURAL HEALTH CLINIC II	88.01	0	34.09
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-3,325,991				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: 14-1301 | Period: From 07/01/2016 To 06/30/2017 | Worksheet A-8-2 | Date/Time Prepared: 11/20/2017 10:55 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	ADULTS & PEDIATRICS	180,156	180,156	0	0	0	1.00
2.00	50.00	OPERATING ROOM	153,030	153,030	0	0	0	2.00
3.00	53.00	ANESTHESIOLOGY	38,900	38,900	0	0	0	3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	282,429	282,429	0	0	0	4.00
5.00	66.00	PHYSICAL THERAPY	2,091	2,091	0	0	0	5.00
6.00	69.00	ELECTROCARDIOLOGY	16,408	16,408	0	0	0	6.00
7.00	76.00	SLEEP LAB	67,871	67,871	0	0	0	7.00
8.00	91.00	EMERGENCY	1,813,591	876,569	937,022	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			2,554,476	1,617,454	937,022		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	50.00	OPERATING ROOM	0	0	0	0	0	2.00
3.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	4.00
5.00	66.00	PHYSICAL THERAPY	0	0	0	0	0	5.00
6.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	6.00
7.00	76.00	SLEEP LAB	0	0	0	0	0	7.00
8.00	91.00	EMERGENCY	0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	180,156		1.00
2.00	50.00	OPERATING ROOM	0	0	0	153,030		2.00
3.00	53.00	ANESTHESIOLOGY	0	0	0	38,900		3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	282,429		4.00
5.00	66.00	PHYSICAL THERAPY	0	0	0	2,091		5.00
6.00	69.00	ELECTROCARDIOLOGY	0	0	0	16,408		6.00
7.00	76.00	SLEEP LAB	0	0	0	67,871		7.00
8.00	91.00	EMERGENCY	0	0	0	876,569		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	1,617,454		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 14-1301 | Period: From 07/01/2016 To 06/30/2017 | Worksheet A-8-3 Parts I-VI Date/Time Prepared: 11/20/2017 10:55 am

Speech Pathology | 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)	116	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	5.38	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	443.75	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	73.61	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)	36.81	36.81	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)	32,664	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)	32,664	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)	32,664	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)	73.61	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)	55,208	22.00
23.00	Total salary equivalency (see instructions)	55,208	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)	4,270	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)	4,270	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)	624	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)	4,894	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)	4,894	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: 14-1301	Period: From 07/01/2016 To 06/30/2017	Worksheet A-8-3 Parts I-VI Date/Time Prepared: 11/20/2017 10:55 am
		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)	73.61	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)	55,208	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	4,894	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)	60,102	63.00
64.00	Total cost of outside supplier services (from your records)	28,844	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	4,270	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	624	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	4,894	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	624	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	624	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: 14-1301 | Period: From 07/01/2016 To 06/30/2017 | Worksheet B Part I Date/Time Prepared: 11/20/2017 10:55 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	3,493,446	3,493,446				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	851,797		851,797			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	158,329	0	0	158,329		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5,690,323	220,918	85,790	36,853	6,033,884	5.00
6.00	00600	MAINTENANCE & REPAIRS	559,578	12,104	15,393	3,209	590,284	6.00
7.00	00700	OPERATION OF PLANT	325,984	644,152	51,219	0	1,021,355	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	49,899	14,166	0	0	64,065	8.00
9.00	00900	HOUSEKEEPING	400,765	53,302	652	3,625	458,344	9.00
10.00	01000	DIETARY	76,598	113,956	30,731	589	221,874	10.00
11.00	01100	CAFETERIA	382,582	52,719	0	4,100	439,401	11.00
14.00	01400	CENTRAL SERVICES & SUPPLY	128,024	56,664	1,895	1,257	187,840	14.00
15.00	01500	PHARMACY	271,742	36,625	2,787	636	311,790	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	796,846	67,692	14,506	7,152	886,196	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	147,371	0	0	1,675	149,046	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,824,084	432,915	53,485	17,585	2,328,069	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,440,824	316,135	80,501	5,394	1,842,854	50.00
53.00	05300	ANESTHESIOLOGY	3,420	0	0	0	3,420	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,259,078	167,213	261,420	9,592	1,697,303	54.00
56.00	03630	ULTRA SOUND	58,451	5,648	57,633	0	121,732	56.00
60.00	06000	LABORATORY	1,667,342	62,088	52,430	7,226	1,789,086	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	685,281	193,438	14,560	6,903	900,182	66.00
67.00	06700	OCCUPATIONAL THERAPY	148,840	0	0	1,652	150,492	67.00
68.00	06800	SPEECH PATHOLOGY	28,844	0	0	0	28,844	68.00
69.00	06900	ELECTROCARDIOLOGY	16,436	0	0	158	16,594	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	57,311	0	0	0	57,311	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	86,807	0	0	0	86,807	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	391,609	0	0	0	391,609	73.00
76.00	03950	SLEEP LAB	147,738	45,367	9,316	1,342	203,763	76.00
76.01	03951	DIABETIC EDUCATION	11,857	0	0	131	11,988	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	420,687	27,749	2,729	3,659	454,824	88.00
88.01	08801	RURAL HEALTH CLINIC II	2,855,664	343,795	12,772	25,375	3,237,606	88.01
88.02	08802	RURAL HEALTH CLINIC III	235,971	131,170	8,943	1,703	377,787	88.02
91.00	09100	EMERGENCY	2,257,019	282,199	13,220	12,437	2,564,875	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	437,765	38,822	77,492	3,968	558,047	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	27,368,312	3,318,837	847,474	156,221	27,187,272	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	14,121	0	0	14,121	190.00
190.01	19001	FOUNDATION	122,360	4,483	0	778	127,621	190.01
190.02	19002	CROSSFIT	169,345	156,005	4,323	1,276	330,949	190.02
192.00	19200	PHYSICIANS' PRIVATE OFFICES	28,297	0	0	54	28,351	192.00
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	27,688,314	3,493,446	851,797	158,329	27,688,314	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1301 | Period: From 07/01/2016 To 06/30/2017 | Worksheet B Part I Date/Time Prepared: 11/20/2017 10:55 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	6,033,884					5.00
6.00	00600	MAINTENANCE & REPAIRS	164,479	754,763				6.00
7.00	00700	OPERATION OF PLANT	284,594	149,115	1,455,064			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	17,851	3,279	8,957	94,152		8.00
9.00	00900	HOUSEKEEPING	127,715	12,339	33,701	0	632,099	9.00
10.00	01000	DIETARY	61,824	26,380	72,050	3,181	28,541	10.00
11.00	01100	CAFETERIA	122,436	12,204	33,332	0	13,204	11.00
14.00	01400	CENTRAL SERVICES & SUPPLY	52,340	13,117	35,827	0	14,192	14.00
15.00	01500	PHARMACY	86,878	8,479	23,157	0	9,173	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	246,933	15,670	42,799	0	16,954	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	41,531	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	648,702	100,217	273,719	34,613	108,426	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	513,500	73,183	199,881	12,746	79,178	50.00
53.00	05300	ANESTHESIOLOGY	953	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	472,943	38,708	105,723	9,785	41,879	54.00
56.00	03630	ULTRA SOUND	33,920	1,308	3,571	0	1,415	56.00
60.00	06000	LABORATORY	498,518	14,373	39,256	0	15,550	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	250,830	44,779	122,304	4,304	48,448	66.00
67.00	06700	OCCUPATIONAL THERAPY	41,934	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	8,037	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	4,624	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	15,969	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	24,188	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	109,119	0	0	0	0	73.00
76.00	03950	SLEEP LAB	56,777	10,502	28,684	3,081	11,362	76.00
76.01	03951	DIABETIC EDUCATION	3,340	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	126,734	6,424	0	0	6,950	88.00
88.01	08801	RURAL HEALTH CLINIC II	902,151	79,586	217,370	334	86,105	88.01
88.02	08802	RURAL HEALTH CLINIC III	105,268	30,365	0	0	26,587	88.02
91.00	09100	EMERGENCY	714,687	65,327	178,425	24,050	70,679	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	155,496	8,987	24,546	841	9,723	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	5,894,271	714,342	1,443,302	92,935	588,366	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	3,935	3,269	8,928	0	3,537	190.00
190.01	19001	FOUNDATION	35,561	1,038	2,834	0	1,123	190.01
190.02	19002	CROSSFIT	92,217	36,114	0	1,217	39,073	190.02
192.00	19200	PHYSICIANS' PRIVATE OFFICES	7,900	0	0	0	0	192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	6,033,884	754,763	1,455,064	94,152	632,099	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1301 | Period: From 07/01/2016 To 06/30/2017 | Worksheet B Part I | Date/Time Prepared: 11/20/2017 10:55 am

		Cost Center Description	DIETARY	CAFETERIA	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			10.00	11.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
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	413,850					10.00
11.00	01100	CAFETERIA	0	620,577				11.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	14,156	317,472			14.00
15.00	01500	PHARMACY	0	4,982	238	444,697		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	61,949	1,211	0	1,271,712	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	413,850	104,909	10,057	0	153,750	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	35,118	38,421	0	85,713	50.00
53.00	05300	ANESTHESIOLOGY	0	2,910	53	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	59,878	4,657	0	48,452	54.00
56.00	03630	ULTRA SOUND	0	0	2,058	0	9,792	56.00
60.00	06000	LABORATORY	0	53,071	89,208	0	210,087	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0	34,082	1,636	0	60,915	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	6,708	1	0	4,833	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	4,069	68.00
69.00	06900	ELECTROCARDIOLOGY	0	691	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	10,951	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	16,587	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	74,827	444,697	0	73.00
76.00	03950	SLEEP LAB	0	7,694	1,180	0	13,607	76.00
76.01	03951	DIABETIC EDUCATION	0	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	7,693	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	127,794	41,715	0	27,723	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	5,068	0	0	88.02
91.00	09100	EMERGENCY	0	49,224	8,644	0	627,973	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	48,533	1,942	0	24,798	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	413,850	611,699	316,147	444,697	1,271,712	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	FOUNDATION	0	2,515	5	0	0	190.01
190.02	19002	CROSSFIT	0	6,116	1,320	0	0	190.02
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	247	0	0	0	192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	413,850	620,577	317,472	444,697	1,271,712	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1301 | Period: From 07/01/2016 To 06/30/2017 | Worksheet B Part I | Date/Time Prepared: 11/20/2017 10:55 am

		Cost Center Description	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			19.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
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
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	190,577					19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	4,176,312	-110,017	4,066,295		30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	2,880,594	0	2,880,594		50.00
53.00	05300	ANESTHESIOLOGY	190,577	197,913	0	197,913		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,479,328	0	2,479,328		54.00
56.00	03630	ULTRA SOUND	0	173,796	0	173,796		56.00
60.00	06000	LABORATORY	0	2,709,149	0	2,709,149		60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	110,017	110,017		64.00
66.00	06600	PHYSICAL THERAPY	0	1,467,480	0	1,467,480		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	203,968	0	203,968		67.00
68.00	06800	SPEECH PATHOLOGY	0	40,950	0	40,950		68.00
69.00	06900	ELECTROCARDIOLOGY	0	21,909	0	21,909		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	84,231	0	84,231		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	127,582	0	127,582		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,020,252	0	1,020,252		73.00
76.00	03950	SLEEP LAB	0	336,650	0	336,650		76.00
76.01	03951	DIABETIC EDUCATION	0	15,328	0	15,328		76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	602,625	0	602,625		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	4,720,384	0	4,720,384		88.01
88.02	08802	RURAL HEALTH CLINIC III	0	545,075	0	545,075		88.02
91.00	09100	EMERGENCY	0	4,303,884	0	4,303,884		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0			92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	832,913	0	832,913		95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	190,577	26,940,323	0	26,940,323		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	33,790	0	33,790		190.00
190.01	19001	FOUNDATION	0	170,697	0	170,697		190.01
190.02	19002	CROSSFIT	0	507,006	0	507,006		190.02
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	36,498	0	36,498		192.00
200.00		Cross Foot Adjustments	0	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118-201)	190,577	27,688,314	0	27,688,314		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1301 | Period: From 07/01/2016 To 06/30/2017 | Worksheet B Part II | Date/Time Prepared: 11/20/2017 10:55 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	10,740	220,918	85,790	317,448	0	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	12,104	15,393	27,497	0	6.00
7.00	00700	OPERATION OF PLANT	11,746	644,152	51,219	707,117	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	14,166	0	14,166	0	8.00
9.00	00900	HOUSEKEEPING	0	53,302	652	53,954	0	9.00
10.00	01000	DIETARY	0	113,956	30,731	144,687	0	10.00
11.00	01100	CAFETERIA	0	52,719	0	52,719	0	11.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	56,664	1,895	58,559	0	14.00
15.00	01500	PHARMACY	18,306	36,625	2,787	57,718	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	67,692	14,506	82,198	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	15,264	432,915	53,485	501,664	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	139,288	316,135	80,501	535,924	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	141,641	167,213	261,420	570,274	0	54.00
56.00	03630	ULTRA SOUND	0	5,648	57,633	63,281	0	56.00
60.00	06000	LABORATORY	0	62,088	52,430	114,518	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0	193,438	14,560	207,998	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950	SLEEP LAB	132	45,367	9,316	54,815	0	76.00
76.01	03951	DIABETIC EDUCATION	0	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	27,749	2,729	30,478	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	343,795	12,772	356,567	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	131,170	8,943	140,113	0	88.02
91.00	09100	EMERGENCY	3,453	282,199	13,220	298,872	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	38,822	77,492	116,314	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	340,570	3,318,837	847,474	4,506,881	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	14,121	0	14,121	0	190.00
190.01	19001	FOUNDATION	0	4,483	0	4,483	0	190.01
190.02	19002	CROSSFIT	0	156,005	4,323	160,328	0	190.02
192.00	19200	PHYSICIANS' PRIVATE OFFICES	11,746	0	0	11,746	0	192.00
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	352,316	3,493,446	851,797	4,697,559	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1301 | Period: From 07/01/2016 To 06/30/2017 | Worksheet B Part II | Date/Time Prepared: 11/20/2017 10:55 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	317,448					5.00
6.00	00600	MAINTENANCE & REPAIRS	8,654	36,151				6.00
7.00	00700	OPERATION OF PLANT	14,973	7,141	729,231			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	939	157	4,489	19,751		8.00
9.00	00900	HOUSEKEEPING	6,719	591	16,890	0	78,154	9.00
10.00	01000	DIETARY	3,253	1,264	36,109	667	3,529	10.00
11.00	01100	CAFETERIA	6,442	585	16,705	0	1,633	11.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,754	628	17,955	0	1,755	14.00
15.00	01500	PHARMACY	4,571	406	11,606	0	1,134	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	12,992	751	21,450	0	2,096	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	2,185	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	34,129	4,800	137,175	7,262	13,406	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	27,016	3,505	100,174	2,674	9,790	50.00
53.00	05300	ANESTHESIOLOGY	50	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	24,882	1,854	52,985	2,053	5,178	54.00
56.00	03630	ULTRA SOUND	1,785	63	1,790	0	175	56.00
60.00	06000	LABORATORY	26,228	688	19,674	0	1,923	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	13,197	2,145	61,295	903	5,990	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,206	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	423	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	243	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	840	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,273	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,741	0	0	0	0	73.00
76.00	03950	SLEEP LAB	2,987	503	14,376	646	1,405	76.00
76.01	03951	DIABETIC EDUCATION	176	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	6,668	308	0	0	859	88.00
88.01	08801	RURAL HEALTH CLINIC II	47,456	3,812	108,939	70	10,646	88.01
88.02	08802	RURAL HEALTH CLINIC III	5,538	1,454	0	0	3,287	88.02
91.00	09100	EMERGENCY	37,601	3,129	89,421	5,045	8,739	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	8,181	430	12,302	176	1,202	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	310,102	34,214	723,335	19,496	72,747	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	207	157	4,475	0	437	190.00
190.01	19001	FOUNDATION	1,871	50	1,421	0	139	190.01
190.02	19002	CROSSFIT	4,852	1,730	0	255	4,831	190.02
192.00	19200	PHYSICIANS' PRIVATE OFFICES	416	0	0	0	0	192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	317,448	36,151	729,231	19,751	78,154	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1301 | Period: From 07/01/2016 To 06/30/2017 | Worksheet B Part II | Date/Time Prepared: 11/20/2017 10:55 am

		Cost Center Description	DIETARY	CAFETERIA	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			10.00	11.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
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	189,509					10.00
11.00	01100	CAFETERIA	0	78,084				11.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,781	83,432			14.00
15.00	01500	PHARMACY	0	627	63	76,125		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	7,795	318	0	127,600	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	189,509	13,200	2,643	0	15,427	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	4,419	10,097	0	8,600	50.00
53.00	05300	ANESTHESIOLOGY	0	366	14	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	7,534	1,224	0	4,862	54.00
56.00	03630	ULTRA SOUND	0	0	541	0	983	56.00
60.00	06000	LABORATORY	0	6,678	23,443	0	21,080	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0	4,288	430	0	6,112	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	844	0	0	485	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	408	68.00
69.00	06900	ELECTROCARDIOLOGY	0	87	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	2,878	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	4,359	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	19,665	76,125	0	73.00
76.00	03950	SLEEP LAB	0	968	310	0	1,365	76.00
76.01	03951	DIABETIC EDUCATION	0	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	2,022	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	16,078	10,963	0	2,782	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	1,332	0	0	88.02
91.00	09100	EMERGENCY	0	6,194	2,272	0	63,008	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	6,107	510	0	2,488	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	189,509	76,966	83,084	76,125	127,600	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	FOUNDATION	0	317	1	0	0	190.01
190.02	19002	CROSSFIT	0	770	347	0	0	190.02
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	31	0	0	0	192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	189,509	78,084	83,432	76,125	127,600	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1301 | Period: From 07/01/2016 To 06/30/2017 | Worksheet B Part II | Date/Time Prepared: 11/20/2017 10:55 am

		Cost Center Description	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			19.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
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
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	2,185					19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS		919,215	0	919,215		30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM		702,199	0	702,199		50.00
53.00	05300	ANESTHESIOLOGY		430	0	430		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		670,846	0	670,846		54.00
56.00	03630	ULTRA SOUND		68,618	0	68,618		56.00
60.00	06000	LABORATORY		214,232	0	214,232		60.00
64.00	06400	INTRAVENOUS THERAPY		0	0	0		64.00
66.00	06600	PHYSICAL THERAPY		302,358	0	302,358		66.00
67.00	06700	OCCUPATIONAL THERAPY		3,535	0	3,535		67.00
68.00	06800	SPEECH PATHOLOGY		831	0	831		68.00
69.00	06900	ELECTROCARDIOLOGY		330	0	330		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS		3,718	0	3,718		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		5,632	0	5,632		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		101,531	0	101,531		73.00
76.00	03950	SLEEP LAB		77,375	0	77,375		76.00
76.01	03951	DIABETIC EDUCATION		176	0	176		76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC		40,335	0	40,335		88.00
88.01	08801	RURAL HEALTH CLINIC II		557,313	0	557,313		88.01
88.02	08802	RURAL HEALTH CLINIC III		151,724	0	151,724		88.02
91.00	09100	EMERGENCY		514,281	0	514,281		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0			92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES		147,710	0	147,710		95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	4,482,389	0	4,482,389		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN		19,397	0	19,397		190.00
190.01	19001	FOUNDATION		8,282	0	8,282		190.01
190.02	19002	CROSSFIT		173,113	0	173,113		190.02
192.00	19200	PHYSICIANS' PRIVATE OFFICES		12,193	0	12,193		192.00
200.00		Cross Foot Adjustments	2,185	2,185	0	2,185		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118-201)	2,185	4,697,559	0	4,697,559		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1301 | Period: From 07/01/2016 To 06/30/2017 | Worksheet B-1 | Date/Time Prepared: 11/20/2017 10:55 am

		Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	77,928					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		830,586				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	11,998,147			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	4,928	83,654	2,792,720	-6,033,884	21,654,430	5.00
6.00	00600	MAINTENANCE & REPAIRS	270	15,010	243,200	0	590,284	6.00
7.00	00700	OPERATION OF PLANT	14,369	49,944	0	0	1,021,355	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	316	0	0	0	64,065	8.00
9.00	00900	HOUSEKEEPING	1,189	636	274,679	0	458,344	9.00
10.00	01000	DIETARY	2,542	29,966	44,661	0	221,874	10.00
11.00	01100	CAFETERIA	1,176	0	310,673	0	439,401	11.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,264	1,848	95,228	0	187,840	14.00
15.00	01500	PHARMACY	817	2,718	48,167	0	311,790	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,510	14,145	542,012	0	886,196	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	126,940	0	149,046	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	9,657	52,153	1,332,573	0	2,328,069	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	7,052	78,496	408,737	0	1,842,854	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	3,420	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,730	254,910	726,913	0	1,697,303	54.00
56.00	03630	ULTRA SOUND	126	56,198	0	0	121,732	56.00
60.00	06000	LABORATORY	1,385	51,124	547,579	0	1,789,086	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	4,315	14,197	523,114	0	900,182	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	125,165	0	150,492	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	28,844	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	11,971	0	16,594	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	57,311	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	86,807	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	391,609	73.00
76.00	03950	SLEEP LAB	1,012	9,084	101,691	0	203,763	76.00
76.01	03951	DIABETIC EDUCATION	0	0	9,944	0	11,988	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	619	2,661	277,287	0	454,824	88.00
88.01	08801	RURAL HEALTH CLINIC II	7,669	12,454	1,922,913	0	3,237,606	88.01
88.02	08802	RURAL HEALTH CLINIC III	2,926	8,720	129,043	0	377,787	88.02
91.00	09100	EMERGENCY	6,295	12,891	942,484	0	2,564,875	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	866	75,562	300,702	0	558,047	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	74,033	826,371	11,838,396	-6,033,884	21,153,388	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	315	0	0	0	14,121	190.00
190.01	19001	FOUNDATION	100	0	58,964	0	127,621	190.01
190.02	19002	CROSSFIT	3,480	4,215	96,724	0	330,949	190.02
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	4,063	0	28,351	192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	3,493,446	851,797	158,329		6,033,884	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	44.829150	1.025537	0.013196		0.278644	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			0		317,448	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000000		0.014660	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1301 | Period: From 07/01/2016 To 06/30/2017 | Worksheet B-1 | Date/Time Prepared: 11/20/2017 10:55 am

		Cost Center Description	MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	
			6.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS	72,730					6.00
7.00	00700	OPERATION OF PLANT	14,369	51,336				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	316	316	82,140			8.00
9.00	00900	HOUSEKEEPING	1,189	1,189	0	56,298		9.00
10.00	01000	DIETARY	2,542	2,542	2,775	2,542	7,900	10.00
11.00	01100	CAFETERIA	1,176	1,176	0	1,176	0	11.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,264	1,264	0	1,264	0	14.00
15.00	01500	PHARMACY	817	817	0	817	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,510	1,510	0	1,510	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	9,657	9,657	30,196	9,657	7,900	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	7,052	7,052	11,120	7,052	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,730	3,730	8,537	3,730	0	54.00
56.00	03630	ULTRA SOUND	126	126	0	126	0	56.00
60.00	06000	LABORATORY	1,385	1,385	0	1,385	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	4,315	4,315	3,755	4,315	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950	SLEEP LAB	1,012	1,012	2,688	1,012	0	76.00
76.01	03951	DIABETIC EDUCATION	0	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	619	0	0	619	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	7,669	7,669	291	7,669	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	2,926	0	0	2,368	0	88.02
91.00	09100	EMERGENCY	6,295	6,295	20,982	6,295	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	866	866	734	866	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	68,835	50,921	81,078	52,403	7,900	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	315	315	0	315	0	190.00
190.01	19001	FOUNDATION	100	100	0	100	0	190.01
190.02	19002	CROSSFIT	3,480	0	1,062	3,480	0	190.02
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	754,763	1,455,064	94,152	632,099	413,850	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	10.377602	28.343930	1.146238	11.227735	52.386076	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	36,151	729,231	19,751	78,154	189,509	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.497058	14.205061	0.240455	1.388220	23.988481	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1301 | Period: From 07/01/2016 To 06/30/2017 | Worksheet B-1 | Date/Time Prepared: 11/20/2017 10:55 am

		Cost Center Description	CAFETERIA (FTES)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	
			11.00	14.00	15.00	16.00	19.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
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	12,582					11.00
14.00	01400	CENTRAL SERVICES & SUPPLY	287	1,661,490				14.00
15.00	01500	PHARMACY	101	1,245	100			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,256	6,336	0	10,000		16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	100	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,127	52,633	0	1,209	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	712	201,074	0	674	0	50.00
53.00	05300	ANESTHESIOLOGY	59	275	0	0	100	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,214	24,370	0	381	0	54.00
56.00	03630	ULTRA SOUND	0	10,772	0	77	0	56.00
60.00	06000	LABORATORY	1,076	466,876	0	1,652	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	691	8,560	0	479	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	136	4	0	38	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	32	0	68.00
69.00	06900	ELECTROCARDIOLOGY	14	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	57,311	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	86,807	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	391,609	100	0	0	73.00
76.00	03950	SLEEP LAB	156	6,177	0	107	0	76.00
76.01	03951	DIABETIC EDUCATION	0	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	40,260	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	2,591	218,317	0	218	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	26,524	0	0	0	88.02
91.00	09100	EMERGENCY	998	45,239	0	4,938	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	984	10,165	0	195	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	12,402	1,654,554	100	10,000	100	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	FOUNDATION	51	26	0	0	0	190.01
190.02	19002	CROSSFIT	124	6,910	0	0	0	190.02
192.00	19200	PHYSICIANS' PRIVATE OFFICES	5	0	0	0	0	192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	620,577	317,472	444,697	1,271,712	190,577	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	49.322604	0.191077	4,446.970000	127.171200	1,905.770000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	78,084	83,432	76,125	127,600	2,185	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	6.206009	0.050215	761.250000	12.760000	21.850000	205.00

POST STEPDOWN ADJUSTMENTS | Provider CCN: 14-1301 | Period: From 07/01/2016 To 06/30/2017 | Worksheet B-2 | Date/Time Prepared: 11/20/2017 10:55 am

	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	INTRAVENOUS THERAPY	1	30.00	-110,017	7.00
8.00	INTRAVENOUS THERAPY	1	64.00	110,017	8.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1301 | Period: From 07/01/2016 To 06/30/2017 | Worksheet C Part I Date/Time Prepared: 11/20/2017 10:55 am

Title XVIII | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs: Total Costs	Costs: RCE Disallowance	Costs: Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,066,295		4,066,295	0	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,880,594		2,880,594	0	0	50.00
53.00	05300	ANESTHESIOLOGY	197,913		197,913	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,479,328		2,479,328	0	0	54.00
56.00	03630	ULTRA SOUND	173,796		173,796	0	0	56.00
60.00	06000	LABORATORY	2,709,149		2,709,149	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	110,017		110,017	0	0	64.00
66.00	06600	PHYSICAL THERAPY	1,467,480	0	1,467,480	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	203,968	0	203,968	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	40,950	0	40,950	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	21,909		21,909	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	84,231		84,231	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	127,582		127,582	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,020,252		1,020,252	0	0	73.00
76.00	03950	SLEEP LAB	336,650		336,650	0	0	76.00
76.01	03951	DIABETIC EDUCATION	15,328		15,328	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	602,625		602,625	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	4,720,384		4,720,384	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	545,075		545,075	0	0	88.02
91.00	09100	EMERGENCY	4,303,884		4,303,884	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	408,716		408,716		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	832,913		832,913	0	0	95.00
200.00		Subtotal (see instructions)	27,349,039	0	27,349,039	0	0	200.00
201.00		Less Observation Beds	408,716		408,716		0	201.00
202.00		Total (see instructions)	26,940,323	0	26,940,323	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1301 | Period: From 07/01/2016 To 06/30/2017 | Worksheet C Part I | Date/Time Prepared: 11/20/2017 10:55 am

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	6,863,195		6,863,195			30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	8,506	9,527,485	9,535,991	0.302076	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	3,184	1,551,833	1,555,017	0.127274	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	124,835	10,477,781	10,602,616	0.233841	0.000000	54.00
56.00	03630	ULTRA SOUND	98,880	1,239,366	1,338,246	0.129868	0.000000	56.00
60.00	06000	LABORATORY	598,257	13,499,136	14,097,393	0.192174	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	0	341,140	341,140	0.322498	0.000000	64.00
66.00	06600	PHYSICAL THERAPY	380,340	3,748,874	4,129,214	0.355390	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	271,587	159,437	431,024	0.473217	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	26,347	116,316	142,663	0.287040	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	15,189	621,482	636,671	0.034412	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	130,290	91,348	221,638	0.380039	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	127,858	127,858	0.997841	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,077,629	3,601,687	4,679,316	0.218034	0.000000	73.00
76.00	03950	SLEEP LAB	0	1,368,192	1,368,192	0.246055	0.000000	76.00
76.01	03951	DIABETIC EDUCATION	0	56,657	56,657	0.270540	0.000000	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	625,335	625,335			88.00
88.01	08801	RURAL HEALTH CLINIC II	0	3,140,131	3,140,131			88.01
88.02	08802	RURAL HEALTH CLINIC III	0	217,061	217,061			88.02
91.00	09100	EMERGENCY	0	11,015,118	11,015,118	0.390725	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	338,488	338,488	1.207476	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	2,424,516	2,424,516	0.343538	0.000000	95.00
200.00		Subtotal (see instructions)	9,598,239	64,289,241	73,887,480			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	9,598,239	64,289,241	73,887,480			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1301 | Period: From 07/01/2016 To 06/30/2017 | Worksheet C Part I | Date/Time Prepared: 11/20/2017 10:55 am

Title XVIII | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	54.00
56.00	03630	ULTRA SOUND	0.000000	56.00
60.00	06000	LABORATORY	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	64.00
66.00	06600	PHYSICAL THERAPY	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	73.00
76.00	03950	SLEEP LAB	0.000000	76.00
76.01	03951	DIABETIC EDUCATION	0.000000	76.01
		OUTPATIENT SERVICE COST CENTERS		
88.00	08800	RURAL HEALTH CLINIC		88.00
88.01	08801	RURAL HEALTH CLINIC II		88.01
88.02	08802	RURAL HEALTH CLINIC III		88.02
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
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: 14-1301 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D Part II Date/Time Prepared: 11/20/2017 10:55 am

Title XVIII | Hospital | Cost

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	702,199	9,535,991	0.073637	0	0	50.00
53.00	05300	ANESTHESIOLOGY	430	1,555,017	0.000277	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	670,846	10,602,616	0.063272	42,168	2,668	54.00
56.00	03630	ULTRA SOUND	68,618	1,338,246	0.051275	26,228	1,345	56.00
60.00	06000	LABORATORY	214,232	14,097,393	0.015197	136,424	2,073	60.00
64.00	06400	INTRAVENOUS THERAPY	0	341,140	0.000000	0	0	64.00
66.00	06600	PHYSICAL THERAPY	302,358	4,129,214	0.073224	21,370	1,565	66.00
67.00	06700	OCCUPATIONAL THERAPY	3,535	431,024	0.008201	7,331	60	67.00
68.00	06800	SPEECH PATHOLOGY	831	142,663	0.005825	4,581	27	68.00
69.00	06900	ELECTROCARDIOLOGY	330	636,671	0.000518	3,740	2	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,718	221,638	0.016775	29,949	502	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	5,632	127,858	0.044049	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	101,531	4,679,316	0.021698	197,127	4,277	73.00
76.00	03950	SLEEP LAB	77,375	1,368,192	0.056553	0	0	76.00
76.01	03951	DIABETIC EDUCATION	176	56,657	0.003106	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	40,335	625,335	0.064501	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	557,313	3,140,131	0.177481	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	151,724	217,061	0.698992	0	0	88.02
91.00	09100	EMERGENCY	514,281	11,015,118	0.046689	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	92,393	338,488	0.272958	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	3,507,857	64,599,769		468,918	12,519	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 14-1301 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D Part IV Date/Time Prepared: 11/20/2017 10:55 am

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						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	190,577	0	0	0	190,577	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
56.00	03630	ULTRA SOUND	0	0	0	0	0	56.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950	SLEEP LAB	0	0	0	0	0	76.00
76.01	03951	DIABETIC EDUCATION	0	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	0	88.02
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)	190,577	0	0	0	190,577	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1301 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D Part IV | Date/Time Prepared: 11/20/2017 10:55 am

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						
50.00	05000	OPERATING ROOM	0	9,535,991	0.000000	0.000000	0	50.00
53.00	05300	ANESTHESIOLOGY	0	1,555,017	0.122556	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	10,602,616	0.000000	0.000000	42,168	54.00
56.00	03630	ULTRA SOUND	0	1,338,246	0.000000	0.000000	26,228	56.00
60.00	06000	LABORATORY	0	14,097,393	0.000000	0.000000	136,424	60.00
64.00	06400	INTRAVENOUS THERAPY	0	341,140	0.000000	0.000000	0	64.00
66.00	06600	PHYSICAL THERAPY	0	4,129,214	0.000000	0.000000	21,370	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	431,024	0.000000	0.000000	7,331	67.00
68.00	06800	SPEECH PATHOLOGY	0	142,663	0.000000	0.000000	4,581	68.00
69.00	06900	ELECTROCARDIOLOGY	0	636,671	0.000000	0.000000	3,740	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	221,638	0.000000	0.000000	29,949	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	127,858	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	4,679,316	0.000000	0.000000	197,127	73.00
76.00	03950	SLEEP LAB	0	1,368,192	0.000000	0.000000	0	76.00
76.01	03951	DIABETIC EDUCATION	0	56,657	0.000000	0.000000	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	625,335	0.000000	0.000000	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	3,140,131	0.000000	0.000000	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	217,061	0.000000	0.000000	0	88.02
91.00	09100	EMERGENCY	0	11,015,118	0.000000	0.000000	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	338,488	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	64,599,769			468,918	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-1301	Period: From 07/01/2016 To 06/30/2017	Worksheet D Part IV Date/Time Prepared: 11/20/2017 10:55 am
	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				
50.00	05000	OPERATING ROOM	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	54.00
56.00	03630	ULTRA SOUND	0	0	0	56.00
60.00	06000	LABORATORY	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	73.00
76.00	03950	SLEEP LAB	0	0	0	76.00
76.01	03951	DIABETIC EDUCATION	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	88.02
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: 14-1301 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D Part V Date/Time Prepared: 11/20/2017 10:55 am

Title XVIII | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.302076	0	2,007,692	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.127274	0	341,421	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.233841	0	2,697,614	0	0	54.00
56.00	03630	ULTRA SOUND	0.129868	0	318,700	0	0	56.00
60.00	06000	LABORATORY	0.192174	0	3,457,428	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.322498	0	179,995	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0.355390	0	923,744	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.473217	0	24,505	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.287040	0	39,621	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.034412	0	213,643	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.380039	0	25,128	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.997841	0	38,063	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.218034	0	2,255,385	0	0	73.00
76.00	03950	SLEEP LAB	0.246055	0	195,095	0	0	76.00
76.01	03951	DIABETIC EDUCATION	0.270540	0	1,704	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000				0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000				0	88.02
91.00	09100	EMERGENCY	0.390725	0	2,775,582	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.207476	0	198,822	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.343538		0			95.00
200.00		Subtotal (see instructions)		0	15,694,142	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	15,694,142	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-1301 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D Part V Date/Time Prepared: 11/20/2017 10:55 am

Title XVIII | Hospital | Cost

		Cost Center Description	Costs		
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
			6.00	7.00	
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	606,476	0	50.00
53.00	05300	ANESTHESIOLOGY	43,454	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	630,813	0	54.00
56.00	03630	ULTRA SOUND	41,389	0	56.00
60.00	06000	LABORATORY	664,428	0	60.00
64.00	06400	INTRAVENOUS THERAPY	58,048	0	64.00
66.00	06600	PHYSICAL THERAPY	328,289	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	11,596	0	67.00
68.00	06800	SPEECH PATHOLOGY	11,373	0	68.00
69.00	06900	ELECTROCARDIOLOGY	7,352	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	9,550	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	37,981	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	491,751	0	73.00
76.00	03950	SLEEP LAB	48,004	0	76.00
76.01	03951	DIABETIC EDUCATION	461	0	76.01
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	88.02
91.00	09100	EMERGENCY	1,084,489	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	240,073	0	92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0		95.00
200.00		Subtotal (see instructions)	4,315,527	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 +/- line 201)	4,315,527	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-1301 | Component CCN: 14-Z301 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D Part V | Date/Time Prepared: 11/20/2017 10:55 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0.302076	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.127274	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.233841	0	0	0	0	54.00
56.00	03630	ULTRA SOUND	0.129868	0	0	0	0	56.00
60.00	06000	LABORATORY	0.192174	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.322498	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0.355390	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.473217	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.287040	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.034412	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.380039	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.997841	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.218034	0	0	0	0	73.00
76.00	03950	SLEEP LAB	0.246055	0	0	0	0	76.00
76.01	03951	DIABETIC EDUCATION	0.270540	0	0	0	0	76.01
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000				0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000				0	88.02
91.00	09100	EMERGENCY	0.390725	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.207476	0	0	0	0	92.00
	OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0.343538		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: 14-1301 | Component CCN: 14-Z301 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D Part V | Date/Time Prepared: 11/20/2017 10:55 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Costs		
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
			6.00	7.00	
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
56.00	03630	ULTRA SOUND	0	0	56.00
60.00	06000	LABORATORY	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
76.00	03950	SLEEP LAB	0	0	76.00
76.01	03951	DIABETIC EDUCATION	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	88.02
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: 14-1301	Period: From 07/01/2016 To 06/30/2017	Worksheet D-1 Date/Time Prepared: 11/20/2017 10:55 am
	Title XVIII	Hospital	Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	2,039	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	546	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)	373	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	373	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)	781	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	339	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	196	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)	357	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)	357	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	147.52	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	147.52	20.00
21.00	Total general inpatient routine service cost (see instructions)	4,066,295	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)	50,009	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	2,776,357	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	1,289,938	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)	1,289,938	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)	2,362.52	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	463,054	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)	463,054	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1301 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D-1 | Date/Time Prepared: 11/20/2017 10:55 am

Title XVIII | Hospital | Cost

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	106,354	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	569,408	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)	843,420	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	843,420	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	1,686,840	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)	173	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	2,362.52	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	408,716	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1301 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D-1 Date/Time Prepared: 11/20/2017 10:55 am

Title XVIII | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	919,215	4,066,295	0.226057	408,716	92,393	90.00
91.00	Nursing School cost	0	4,066,295	0.000000	408,716	0	91.00
92.00	Allied health cost	0	4,066,295	0.000000	408,716	0	92.00
93.00	All other Medical Education	0	4,066,295	0.000000	408,716	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 14-1301 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D-3 | Date/Time Prepared: 11/20/2017 10:55 am

Title XVIII | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		860,393		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.302076	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.127274	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.233841	42,168	9,861	54.00
56.00	03630	ULTRA SOUND	0.129868	26,228	3,406	56.00
60.00	06000	LABORATORY	0.192174	136,424	26,217	60.00
64.00	06400	INTRAVENOUS THERAPY	0.322498	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0.355390	21,370	7,595	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.473217	7,331	3,469	67.00
68.00	06800	SPEECH PATHOLOGY	0.287040	4,581	1,315	68.00
69.00	06900	ELECTROCARDIOLOGY	0.034412	3,740	129	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.380039	29,949	11,382	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.997841	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.218034	197,127	42,980	73.00
76.00	03950	SLEEP LAB	0.246055	0	0	76.00
76.01	03951	DIABETIC EDUCATION	0.270540	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000		0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000		0	88.02
91.00	09100	EMERGENCY	0.390725	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.207476	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)		468,918	106,354	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)		468,918		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 14-1301 | Component CCN: 14-Z301 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D-3 | Date/Time Prepared: 11/20/2017 10:55 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.302076	8,347	2,521	50.00
53.00	05300	ANESTHESIOLOGY	0.127274	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.233841	32,630	7,630	54.00
56.00	03630	ULTRA SOUND	0.129868	7,283	946	56.00
60.00	06000	LABORATORY	0.192174	212,846	40,903	60.00
64.00	06400	INTRAVENOUS THERAPY	0.322498	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0.355390	189,200	67,240	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.473217	143,340	67,831	67.00
68.00	06800	SPEECH PATHOLOGY	0.287040	8,552	2,455	68.00
69.00	06900	ELECTROCARDIOLOGY	0.034412	4,760	164	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.380039	46,367	17,621	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.997841	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.218034	432,510	94,302	73.00
76.00	03950	SLEEP LAB	0.246055	0	0	76.00
76.01	03951	DIABETIC EDUCATION	0.270540	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000		0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000		0	88.02
91.00	09100	EMERGENCY	0.390725	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.207476	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)		1,085,835	301,613	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)		1,085,835		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-1301	Period: From 07/01/2016 To 06/30/2017	Worksheet E Part B Date/Time Prepared: 11/20/2017 10:55 am
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	4,315,527	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)	4,315,527	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)	4,358,682	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)	23,689	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	2,441,189	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)	1,893,804	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)	1,893,804	30.00
31.00	Primary payer payments	1,384	31.00
32.00	Subtotal (line 30 minus line 31)	1,892,420	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)	254,589	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	165,483	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	130,133	36.00
37.00	Subtotal (see instructions)	2,057,903	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)	2,057,903	40.00
40.01	Sequestration adjustment (see instructions)	41,158	40.01
41.00	Interim payments	2,975,480	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	-958,735	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: 14-1301 | Period: From 07/01/2016 To 06/30/2017 | Worksheet E-1 Part I Date/Time Prepared: 11/20/2017 10:55 am

Title XVIII | Hospital | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		450,510		2,975,480	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	01/25/2017	46,800		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)		46,800		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)		497,310		2,975,480	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		79		958,735	6.02
7.00	Total Medicare program liability (see instructions)		497,231		2,016,745	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: 14-1301 Component CCN: 14-Z301	Period: From 07/01/2016 To 06/30/2017	Worksheet E-1 Part I Date/Time Prepared: 11/20/2017 10:55 am
	Title XVIII	Swing Beds - SNF	Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,796,689		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	01/25/2017	191,000		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)		191,000		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,987,689		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		32,073		0	6.02
7.00	Total Medicare program liability (see instructions)		1,955,616		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: 14-1301	Period: From 07/01/2016 To 06/30/2017	Worksheet E-1 Part II Date/Time Prepared: 11/20/2017 10:55 am
	Title XVIII	Hospital	Cost

		1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS		
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION		
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14	109	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12	196	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2	110	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12	373	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200	73,887,480	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20	1,159,312	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: 14-1301 Component CCN: 14-Z301	Period: From 07/01/2016 To 06/30/2017	Worksheet E-2 Date/Time Prepared: 11/20/2017 10:55 am
	Title XVIII	Swing Beds - SNF	Cost

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	1,703,708	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)	304,629	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	714	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)		0	6.00
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	2,008,337	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	2,008,337	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0	0	11.00
12.00	Subtotal (line 10 minus line 11)	2,008,337	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	12,810	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)	1,995,527	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)	1,995,527	0	19.00
19.01	Sequestration adjustment (see instructions)	39,911	0	19.01
20.00	Interim payments	1,987,689	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)	-32,073	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: 14-1301	Period: From 07/01/2016 To 06/30/2017	Worksheet E-3 Part V Date/Time Prepared: 11/20/2017 10:55 am
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	569,408	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)	569,408	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	575,102	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)	575,102	19.00
20.00	Deductibles (exclude professional component)	67,732	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	507,370	22.00
23.00	Coinsurance	0	23.00
24.00	Subtotal (line 22 minus line 23)	507,370	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	14	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	9	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	14	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	507,379	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)	507,379	30.00
30.01	Sequestration adjustment (see instructions)	10,148	30.01
31.00	Interim payments	497,310	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)	-79	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: 14-1301 | Period: From 07/01/2016 To 06/30/2017 | Worksheet G | Date/Time Prepared: 11/20/2017 10:55 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	4,385,230	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	5,553,739	0	0	0	4.00
5.00	Other receivable	320,240	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	256,290	0	0	0	7.00
8.00	Prepaid expenses	787,653	0	0	0	8.00
9.00	Other current assets	0	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)	11,303,152	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	389,780	0	0	0	12.00
13.00	Land improvements	6,012,653	0	0	0	13.00
14.00	Accumulated depreciation	-1,709,984	0	0	0	14.00
15.00	Buildings	17,424,247	0	0	0	15.00
16.00	Accumulated depreciation	-5,293,698	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	11,171,176	0	0	0	19.00
20.00	Accumulated depreciation	-3,766,043	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	6,650,596	0	0	0	23.00
24.00	Accumulated depreciation	-3,485,815	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	3,088,157	0	0	0	27.00
28.00	Accumulated depreciation	-2,911,017	0	0	0	28.00
29.00	Minor equipment-nondepreciable	1,044,568	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	28,614,620	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	45,673,997	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	397,665	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	46,071,662	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	85,989,434	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	829,265	0	0	0	37.00
38.00	Salaries, wages, and fees payable	2,099,821	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	743,670	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	1,390,464	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	5,063,220	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	26,044,409	0	0	0	46.00
47.00	Notes payable	60,985	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	12,000	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	26,117,394	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	31,180,614	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	54,808,820				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)	54,808,820	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	85,989,434	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 14-1301 | Period: From 07/01/2016 To 06/30/2017 | Worksheet G-1 | Date/Time Prepared: 11/20/2017 10:55 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		47,959,391		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		6,849,429				2.00
3.00	Total (sum of line 1 and line 2)		54,808,820		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		54,808,820		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		54,808,820		0		19.00

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

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 14-1301 | Period: From 07/01/2016 To 06/30/2017 | Worksheet G-2 Parts I & II | Date/Time Prepared: 11/20/2017 10:55 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	1,837,815		1,837,815	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	3,884,319		3,884,319	5.00
6.00	Swing bed - NF	1,141,061		1,141,061	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)	6,863,195		6,863,195	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)	6,863,195		6,863,195	17.00
18.00	Ancillary services	2,735,044	46,528,592	49,263,636	18.00
19.00	Outpatient services	0	11,353,606	11,353,606	19.00
20.00	RURAL HEALTH CLINIC	0	625,335	625,335	20.00
20.01	RURAL HEALTH CLINIC II	0	3,140,131	3,140,131	20.01
20.02	RURAL HEALTH CLINIC III	0	217,061	217,061	20.02
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES	0	2,424,516	2,424,516	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PROFESSIONAL FEES	144,529	7,469,236	7,613,765	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	9,742,768	71,758,477	81,501,245	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		31,014,305		29.00
30.00	GAIN/LOSS ON SALE OF ASSETS	24,460			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		24,460		36.00
37.00		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)		31,038,765		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 14-1301	Period: From 07/01/2016 To 06/30/2017	Worksheet G-3 Date/Time Prepared: 11/20/2017 10:55 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	81,501,245	1.00
2.00	Less contractual allowances and discounts on patients' accounts	46,971,827	2.00
3.00	Net patient revenues (line 1 minus line 2)	34,529,418	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	31,038,765	4.00
5.00	Net income from service to patients (line 3 minus line 4)	3,490,653	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	323,236	6.00
7.00	Income from investments	1,388,843	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	88,213	23.00
24.00	TRUST HOSPITAL INCOME	881,681	24.00
24.01	EHR INCENTIVE REIMBURSEMENT	119,298	24.01
24.02	OTHER DOCTOR BUILDING INCOME	37,563	24.02
24.03	340B NET REVENUES	260,389	24.03
24.04	PHYSICAL THERAPY	29,365	24.04
24.05	DIETARY INCOME	218,929	24.05
24.06	CROSSFIT INCOME	102,667	24.06
24.07	TIF INCOME	169,947	24.07
24.08	MISCELLANEOUS INCOME	30,460	24.08
25.00	Total other income (sum of lines 6-24)	3,650,591	25.00
26.00	Total (line 5 plus line 25)	7,141,244	26.00
27.00	AGENCY FARMLAND LOSS	291,815	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	291,815	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	6,849,429	29.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1301 | Period: From 07/01/2016 To 06/30/2017 | Worksheet M-1

Component CCN: 14-3438 | Date/Time Prepared: 11/20/2017 10:55 am

RHC I | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	58,280	0	58,280	0	58,280	1.00
2.00	Physician Assistant	81,641	0	81,641	0	81,641	2.00
3.00	Nurse Practitioner	23,165	0	23,165	0	23,165	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	114,201	0	114,201	0	114,201	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	7,038	7,038	0	7,038	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	277,287	7,038	284,325	0	284,325	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	52,913	52,913	0	52,913	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	52,913	52,913	0	52,913	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	277,287	59,951	337,238	0	337,238	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	9,530	9,530	0	9,530	29.00
30.00	Administrative Costs	52,493	84,422	136,915	-62,967	73,948	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	52,493	93,952	146,445	-62,967	83,478	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	329,780	153,903	483,683	-62,967	420,716	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1301 | Component CCN: 14-3438 | Period: From 07/01/2016 To 06/30/2017 | Worksheet M-1 | Date/Time Prepared: 11/20/2017 10:55 am

RHC I | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
		6.00	7.00	
	FACILITY HEALTH CARE STAFF COSTS			
1.00	Physician	0	58,280	1.00
2.00	Physician Assistant	0	81,641	2.00
3.00	Nurse Practitioner	0	23,165	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	114,201	5.00
6.00	Clinical Psychologist	0	0	6.00
7.00	Clinical Social Worker	0	7,038	7.00
8.00	Laboratory Technician	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	0	284,325	10.00
11.00	Physician Services Under Agreement	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	12.00
13.00	Other Costs Under Agreement	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	14.00
15.00	Medical Supplies	0	52,913	15.00
16.00	Transportation (Health Care Staff)	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	17.00
18.00	Professional Liability Insurance	0	0	18.00
19.00	Other Health Care Costs	0	0	19.00
20.00	Allowable GME Costs			20.00
21.00	Subtotal (sum of lines 15 through 20)	0	52,913	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	337,238	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	9,530	29.00
30.00	Administrative Costs	-29	73,919	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-29	83,449	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-29	420,687	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1301 | Period: From 07/01/2016 To 06/30/2017 | Worksheet M-1

Component CCN: 14-3495 | Date/Time Prepared: 11/20/2017 10:55 am

RHC II | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	761,732	0	761,732	0	761,732	1.00
2.00	Physician Assistant	234,003	0	234,003	0	234,003	2.00
3.00	Nurse Practitioner	151,381	0	151,381	0	151,381	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	531,683	0	531,683	0	531,683	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	21,930	31,535	53,465	0	53,465	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	1,700,729	31,535	1,732,264	0	1,732,264	10.00
11.00	Physician Services Under Agreement	0	78,175	78,175	0	78,175	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	78,175	78,175	0	78,175	14.00
15.00	Medical Supplies	0	296,515	296,515	0	296,515	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	296,515	296,515	0	296,515	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	1,700,729	406,225	2,106,954	0	2,106,954	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	12,951	12,951	0	12,951	29.00
30.00	Administrative Costs	377,918	545,789	923,707	-187,585	736,122	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	377,918	558,740	936,658	-187,585	749,073	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	2,078,647	964,965	3,043,612	-187,585	2,856,027	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS	Provider CCN: 14-1301 Component CCN: 14-3495	Period: From 07/01/2016 To 06/30/2017	Worksheet M-1 Date/Time Prepared: 11/20/2017 10:55 am
		RHC II	Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
		6.00	7.00	
	FACILITY HEALTH CARE STAFF COSTS			
1.00	Physician	0	761,732	1.00
2.00	Physician Assistant	0	234,003	2.00
3.00	Nurse Practitioner	0	151,381	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	531,683	5.00
6.00	Clinical Psychologist	0	0	6.00
7.00	Clinical Social Worker	0	53,465	7.00
8.00	Laboratory Technician	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	0	1,732,264	10.00
11.00	Physician Services Under Agreement	0	78,175	11.00
12.00	Physician Supervision Under Agreement	0	0	12.00
13.00	Other Costs Under Agreement	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	78,175	14.00
15.00	Medical Supplies	0	296,515	15.00
16.00	Transportation (Health Care Staff)	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	17.00
18.00	Professional Liability Insurance	0	0	18.00
19.00	Other Health Care Costs	0	0	19.00
20.00	Allowable GME Costs			20.00
21.00	Subtotal (sum of lines 15 through 20)	0	296,515	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	2,106,954	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	-363	12,588	29.00
30.00	Administrative Costs	0	736,122	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-363	748,710	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-363	2,855,664	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1301 | Component CCN: 14-8566 | Period: From 07/01/2016 To 06/30/2017 | Worksheet M-1 | Date/Time Prepared: 11/20/2017 10:55 am

RHC III | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	11,134	0	11,134	0	11,134	1.00
2.00	Physician Assistant	28,422	0	28,422	0	28,422	2.00
3.00	Nurse Practitioner	43,009	0	43,009	0	43,009	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	45,698	0	45,698	0	45,698	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	781	0	781	0	781	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	129,044	0	129,044	0	129,044	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	67,163	67,163	0	67,163	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	67,163	67,163	0	67,163	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	129,044	67,163	196,207	0	196,207	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	13,012	13,012	-11,023	1,989	29.00
30.00	Administrative Costs	35,612	46,006	81,618	-43,843	37,775	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	35,612	59,018	94,630	-54,866	39,764	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	164,656	126,181	290,837	-54,866	235,971	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1301 | Component CCN: 14-8566 | Period: From 07/01/2016 To 06/30/2017 | Worksheet M-1 | Date/Time Prepared: 11/20/2017 10:55 am

RHC III | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
		6.00	7.00	
	FACILITY HEALTH CARE STAFF COSTS			
1.00	Physician	0	11,134	1.00
2.00	Physician Assistant	0	28,422	2.00
3.00	Nurse Practitioner	0	43,009	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	45,698	5.00
6.00	Clinical Psychologist	0	0	6.00
7.00	Clinical Social Worker	0	781	7.00
8.00	Laboratory Technician	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	0	129,044	10.00
11.00	Physician Services Under Agreement	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	12.00
13.00	Other Costs Under Agreement	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	14.00
15.00	Medical Supplies	0	67,163	15.00
16.00	Transportation (Health Care Staff)	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	17.00
18.00	Professional Liability Insurance	0	0	18.00
19.00	Other Health Care Costs	0	0	19.00
20.00	Allowable GME Costs			20.00
21.00	Subtotal (sum of lines 15 through 20)	0	67,163	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	196,207	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	1,989	29.00
30.00	Administrative Costs	0	37,775	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	39,764	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	235,971	32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES | Provider CCN: 14-1301 | Period: From 07/01/2016 To 06/30/2017 | Worksheet M-2

Component CCN: 14-3438 | Date/Time Prepared: 11/20/2017 10:55 am

RHC I | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	0.22	582	4,200	924		1.00
2.00	Physician Assistant	0.83	1,953	2,100	1,743		2.00
3.00	Nurse Practitioner	0.28	624	2,100	588		3.00
4.00	Subtotal (sum of lines 1 through 3)	1.33	3,159		3,255	3,255	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	93			93	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)	1.33	3,252			3,348	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)	337,238	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)	337,238	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)	83,449	14.00
15.00	Parent provider overhead allocated to facility (see instructions)	181,938	15.00
16.00	Total overhead (sum of lines 14 and 15)	265,387	16.00
17.00	Allowable GME overhead (see instructions)	0	17.00
18.00	Enter the amount from line 16	265,387	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)	265,387	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)	602,625	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 14-1301 Component CCN: 14-3495	Period: From 07/01/2016 To 06/30/2017	Worksheet M-2 Date/Time Prepared: 11/20/2017 10:55 am
		RHC II	Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	2.24	8,196	4,200	9,408		1.00
2.00	Physician Assistant	1.53	4,751	2,100	3,213		2.00
3.00	Nurse Practitioner	1.16	2,643	2,100	2,436		3.00
4.00	Subtotal (sum of lines 1 through 3)	4.93	15,590		15,057	15,590	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	0.39	722			722	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)	5.32	16,312			16,312	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)	2,106,954	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)	2,106,954	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)	748,710	14.00
15.00	Parent provider overhead allocated to facility (see instructions)	1,864,720	15.00
16.00	Total overhead (sum of lines 14 and 15)	2,613,430	16.00
17.00	Allowable GME overhead (see instructions)	0	17.00
18.00	Enter the amount from line 16	2,613,430	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)	2,613,430	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)	4,720,384	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 14-1301 Component CCN: 14-8566	Period: From 07/01/2016 To 06/30/2017	Worksheet M-2 Date/Time Prepared: 11/20/2017 10:55 am
		RHC III	Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	0.07	295	4,200	294		1.00
2.00	Physician Assistant	0.15	291	2,100	315		2.00
3.00	Nurse Practitioner	0.30	537	2,100	630		3.00
4.00	Subtotal (sum of lines 1 through 3)	0.52	1,123		1,239	1,239	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	0.01	6			6	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	0.53	1,129			1,245	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)	196,207	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)	196,207	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)	39,764	14.00
15.00	Parent provider overhead allocated to facility (see instructions)	309,104	15.00
16.00	Total overhead (sum of lines 14 and 15)	348,868	16.00
17.00	Allowable GME overhead (see instructions)	0	17.00
18.00	Enter the amount from line 16	348,868	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)	348,868	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)	545,075	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 14-1301 Component CCN: 14-3438	Period: From 07/01/2016 To 06/30/2017	Worksheet M-3 Date/Time Prepared: 11/20/2017 10:55 am
	Title XVIII	RHC I	Cost

		1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES		
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)	602,625	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)	15,482	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)	587,143	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)	3,348	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)	0	5.00
6.00	Total adjusted visits (line 4 plus line 5)	3,348	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)	175.37	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)	175.37	175.37	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	419	0	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	73,480	0	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	73,480	16.00
16.01	Total program charges (see instructions)(from contractor's records)		73,988	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		985	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		978	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.)		50,688	16.04
16.05	Total program cost (see instructions)	0	51,666	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		9,142	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		12,772	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		51,666	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		3,321	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		54,987	22.00
23.00	Allowable bad debts (see instructions)		2,526	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		1,642	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		2,526	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)		56,629	26.00
26.01	Sequestration adjustment (see instructions)		1,133	26.01
27.00	Interim payments		43,284	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)		12,212	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0	30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 14-1301 Component CCN: 14-3495	Period: From 07/01/2016 To 06/30/2017	Worksheet M-3 Date/Time Prepared: 11/20/2017 10:55 am
	Title XVIII	RHC II	Cost

			1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES			
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)		4,720,384	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)		137,419	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		4,582,965	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		16,312	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)		16,312	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		280.96	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)	280.96	280.96	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	2,967	0	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	833,608	0	11.00
12.00	Program covered visits for mental health services (from contractor records)	5	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	1,405	0	13.00
14.00	Limit adjustment for mental health services (see instructions)	1,405	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	835,013	16.00
16.01	Total program charges (see instructions)(from contractor's records)		521,955	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		15,882	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		25,408	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.)		600,870	16.04
16.05	Total program cost (see instructions)	0	626,278	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		58,517	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		89,512	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		626,278	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		46,405	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		672,683	22.00
23.00	Allowable bad debts (see instructions)		14,696	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		9,552	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		14,696	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)		682,235	26.00
26.01	Sequestration adjustment (see instructions)		13,645	26.01
27.00	Interim payments		502,419	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)		166,171	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0	30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 14-1301 Component CCN: 14-8566	Period: From 07/01/2016 To 06/30/2017	Worksheet M-3 Date/Time Prepared: 11/20/2017 10:55 am
	Title XVIII	RHC III	Cost

			1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES			
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)		545,075	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)		8,712	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		536,363	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		1,245	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)		1,245	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		430.81	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)	430.81	430.81	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	140	0	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	60,313	0	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	60,313	16.00
16.01	Total program charges (see instructions)(from contractor's records)		24,679	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		448	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		1,095	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.)		45,191	16.04
16.05	Total program cost (see instructions)	0	46,286	16.05
17.00	Primary payer amounts		79	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		2,729	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		4,300	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		46,207	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		2,661	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		48,868	22.00
23.00	Allowable bad debts (see instructions)		0	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		0	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	25.50
26.00	Net reimbursable amount (see instructions)		48,868	26.00
26.01	Sequestration adjustment (see instructions)		977	26.01
27.00	Interim payments		2,951	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)		44,940	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: 14-1301 Component CCN: 14-3438	Period: From 07/01/2016 To 06/30/2017	Worksheet M-4 Date/Time Prepared: 11/20/2017 10:55 am
	Title XVIII	RHC I	Cost

		Pneumococcal	Influenza	
		1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	284,325	284,325	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000786	0.002418	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	223	687	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	5,560	2,194	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	5,783	2,881	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	337,238	337,238	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	265,387	265,387	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.017148	0.008543	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	4,551	2,267	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	10,334	5,148	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	39	120	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	264.97	42.90	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	8	28	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	2,120	1,201	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)		15,482	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)		3,321	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA VACCINE COST	Provider CCN: 14-1301 Component CCN: 14-3495	Period: From 07/01/2016 To 06/30/2017	Worksheet M-4 Date/Time Prepared: 11/20/2017 10:55 am
	Title XVIII	RHC II	Cost

		Pneumococcal	Influenza	
		1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	1,732,264	1,732,264	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.001367	0.002690	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	2,368	4,660	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	42,689	11,620	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	45,057	16,280	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	2,106,954	2,106,954	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	2,613,430	2,613,430	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.021385	0.007727	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	55,888	20,194	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	100,945	36,474	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	282	555	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	357.96	65.72	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	92	205	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	32,932	13,473	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)		137,419	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)		46,405	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA VACCINE COST	Provider CCN: 14-1301 Component CCN: 14-8566	Period: From 07/01/2016 To 06/30/2017	Worksheet M-4 Date/Time Prepared: 11/20/2017 10:55 am
	Title XVIII	RHC III	Cost

		Pneumococcal	Influenza	
		1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	129,044	129,044	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000953	0.000048	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	123	6	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	2,989	18	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	3,112	24	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	196,207	196,207	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	348,868	348,868	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.015861	0.000122	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	5,533	43	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	8,645	67	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	20	1	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	432.25	67.00	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	6	1	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	2,594	67	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)		8,712	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)		2,661	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 14-1301 Component CCN: 14-3438	Period: From 07/01/2016 To 06/30/2017	Worksheet M-5 Date/Time Prepared: 11/20/2017 10:55 am
		RHC I	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		43,284	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00
	Program to Provider			
3.01			0	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
	Provider to Program			
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		43,284	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		12,212	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		55,496	7.00

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

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 14-1301 Component CCN: 14-3495	Period: From 07/01/2016 To 06/30/2017	Worksheet M-5 Date/Time Prepared: 11/20/2017 10:55 am
		RHC II	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		502,419	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00
	Program to Provider			
3.01			0	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
	Provider to Program			
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		502,419	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		166,171	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		668,590	7.00

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

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 14-1301 Component CCN: 14-8566	Period: From 07/01/2016 To 06/30/2017	Worksheet M-5 Date/Time Prepared: 11/20/2017 10:55 am
		RHC III	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		2,951	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00
	Program to Provider			
3.01			0	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
	Provider to Program			
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		2,951	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		44,940	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		47,891	7.00

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