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: 14-1304	Period: From 07/01/2016 To 06/30/2017	Worksheet S Parts I-III Date/Time Prepared: 11/27/2017 9:32 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 11/27/2017 Time: 9:32 am
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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

PART II - CERTIFICATION

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

CERTIFICATION BY 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 GENESIS MEDICAL CENTER - ALEDO (14-1304) 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	98,035	-14,312	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	68,310	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
10.00	RURAL HEALTH CLINIC I	0		16,554		0	10.00
200.00	Total	0	166,345	2,242	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: 14-1304 | Period: From 07/01/2016 To 06/30/2017 | Worksheet S-2 Part I | Date/Time Prepared: 11/27/2017 9:30 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 409 N.W. NINTH AVENUE	PO Box:			1.00
2.00	City: ALEDO	State: IL	Zip Code: 61231-	County: MERCER	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	GENESIS MEDICAL CENTER - ALEDO	141304	19340	1	05/01/2000	N	O	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	GENESIS MEDICAL CENTER - ALEDO, SWB	14Z304	19340		05/01/2000	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	GENESIS MEDICAL CENTER - ALEDO, RHC	143453	19340		02/29/2000	N	O	N	15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From: 1.00	To: 2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	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.	0		23.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1304 | Period: From 07/01/2016 To 06/30/2017 | Worksheet S-2 Part I Date/Time Prepared: 11/27/2017 9:30 am

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

		V	XVIII	XIX	
		1.00	2.00	3.00	
	Prospective Payment System (PPS)-Capital				
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y for yes or "N" for no.	N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00
	Teaching Hospitals				
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N			56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.				57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.	N			58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59.00
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N			60.00

		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	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
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)		0.00	0.00			61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)		0.00	0.00			61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).		0.00	0.00			61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)		0.00	0.00			61.05

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1304 | Period: From 07/01/2016 To 06/30/2017 | Worksheet S-2 Part I Date/Time Prepared: 11/27/2017 9:30 am

		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)		0.00	0.00			61.06

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1304 | Period: From 07/01/2016 To 06/30/2017 | Worksheet S-2 Part I Date/Time Prepared: 11/27/2017 9:30 am

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

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

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

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

		V	XIX	
		1.00	2.00	
	Title V and XIX Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00

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		V	XIX	
		1.00	2.00	
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
	Rural Providers			
105.00	Does this hospital qualify as a critical access hospital (CAH)?	Y		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	Y		106.00
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II.	N		107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	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	Y	N	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.	N			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	2			118.00

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	14,528	0	0	118.01

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1304 | Period: From 07/01/2016 To 06/30/2017 | Worksheet S-2 Part I Date/Time Prepared: 11/27/2017 9:30 am

		1.00	2.00	
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	H55790	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: GENESIS HEALTH SYSTEM	Contractor's Name: WISCONSIN PHYSICIAN SERVICE HEALTH	Contractor's Number: 05001	141.00
142.00	Street: 1227 E RUSHOLME STREET	PO Box:		142.00
143.00	City: DAVENPORT	State: IA	Zip Code: 52803	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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 14-1304	Period: From 07/01/2016 To 06/30/2017	Worksheet S-2 Part I Date/Time Prepared: 11/27/2017 9:30 am

		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: 14-1304 | Period: From 07/01/2016 To 06/30/2017 | Worksheet S-2 Part II | Date/Time Prepared: 11/27/2017 9:30 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)	Y			3.00

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

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

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

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	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	10/11/2017	Y	10/11/2017	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: 14-1304 | Period: From 07/01/2016 To 06/30/2017 | Worksheet S-2 Part II Date/Time Prepared: 11/27/2017 9:30 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.				N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				N	33.00
	Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				N	35.00
				Y/N	Date	
				1.00	2.00	
	Home Office Costs					
36.00	Were home office costs claimed on the cost report?			Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			Y		37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.			N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			N		40.00
		1.00		2.00		
	Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	KEVIN		WELLEN		41.00
42.00	Enter the employer/company name of the cost report preparer.	CLIFTONLARSONALLEN				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	3149254446		KEVIN.WELLEN@CLACONNECT.COM		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 14-1304	Period: From 07/01/2016 To 06/30/2017	Worksheet S-2 Part II Date/Time Prepared: 11/27/2017 9:30 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: 14-1304 | Period: From 07/01/2016 To 06/30/2017 | Worksheet S-3 Part I Date/Time Prepared: 11/27/2017 9:30 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	22	8,030	10,584.00	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)		22	8,030	10,584.00	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)		22	8,030	10,584.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	88.00				0	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		22				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: 14-1304 | Period: From 07/01/2016 To 06/30/2017 | Worksheet S-3 Part I | Date/Time Prepared: 11/27/2017 9:30 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)	266	5	441			1.00
2.00	HMO and other (see instructions)	73	24				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	398	0	540			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	73			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	664	5	1,054			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)	664	5	1,054	0.00	81.06	14.00
15.00	CAH visits	5,276	736	17,663			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	4,493	6,848	23,486	0.00	14.66	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	95.72	27.00
28.00	Observation Bed Days		5	286			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 14-1304 | Period: From 07/01/2016 To 06/30/2017 | Worksheet S-3 Part I Date/Time Prepared: 11/27/2017 9:30 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	78	2	146	1.00
2.00	HMO and other (see instructions)			23	8		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	78	2	146	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	0.00					26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 14-1304 | Component CCN: 14-3453 | Period: From 07/01/2016 To 06/30/2017 | Worksheet S-8 | Date/Time Prepared: 11/27/2017 9:30 am

			RHC I	Cost
			1.00	
	Clinic Address and Identification			
1.00	Street		1007 NW 3RD STREET	1.00
		City	State	ZIP Code
		1.00	2.00	3.00
2.00	City, State, ZIP Code, County	ALEDO	IL	61231 2.00
				1.00
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban			0 3.00
		Grant Award		Date
		1.00		2.00
	Source of Federal Funds			
4.00	Community Health Center (Section 330(d), PHS Act)			4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)			5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)			6.00
7.00	Appalachian Regional Commission			7.00
8.00	Look-Alikes			8.00
9.00	OTHER (SPECIFY)			9.00
			1.00	2.00
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)		N	0 10.00

		Sunday		Monday		Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
	Facility hours of operations (1)						
11.00	Clinic			07:00	19:00	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		MERCER				2.00
		Tuesday	Wednesday		Thursday		
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)						
11.00	Clinic	17:00	08:00	17:00	08:00	17:00	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-1304
Component CCN: 14-3453

Period:
From 07/01/2016
To 06/30/2017

Worksheet S-8

Date/Time Prepared:
11/27/2017 9:30 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	07:00	18:00				11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 14-1304 | Period: From 07/01/2016 To 06/30/2017 | Worksheet S-10 | Date/Time Prepared: 11/27/2017 9:30 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)	0.513209	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	928,016	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	N	3.00
4.00	If line 3 is yes, does line 2 include all DSH or supplemental payments from Medicaid?		4.00
5.00	If line 4 is no, then enter DSH or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	4,455,913	6.00
7.00	Medicaid cost (line 1 times line 6)	2,286,815	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)	1,358,799	8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone CHIP	0	9.00
10.00	Stand-alone CHIP charges	0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	1,358,799	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)	336,126	0	336,126	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	172,503	0	172,503	21.00
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	172,503	0	172,503	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)	650,055	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	82,883	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	127,512	27.01
28.00	Non-Medicare bad debt expense (line 26 minus line 27.01)	522,543	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	312,803	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	485,306	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	1,844,105	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-1304 | Period: From 07/01/2016 To 06/30/2017 | Worksheet A | Date/Time Prepared: 11/27/2017 9:30 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		740,465	740,465	35,236	775,701	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		299,828	299,828	258	300,086	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	26,763	665,773	692,536	0	692,536	4.00
5.01	00570	ADMITTING	132,021	13,103	145,124	0	145,124	5.01
5.02	00590	HOSPITAL ONLY A & G	0	175,180	175,180	0	175,180	5.02
5.03	00591	SHARED ADMN & GENERAL	298,272	2,366,028	2,664,300	188,937	2,853,237	5.03
6.00	00600	MAINTENANCE & REPAIRS	282	546,979	547,261	0	547,261	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	25,237	1,917	27,154	0	27,154	8.00
9.00	00900	HOUSEKEEPING	0	154,331	154,331	0	154,331	9.00
10.00	01000	DIETARY	0	103,720	103,720	0	103,720	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	15,796	15,796	0	15,796	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	56,174	5,653	61,827	0	61,827	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	249,951	249,951	-99,661	150,290	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	771,903	245,544	1,017,447	-10,310	1,007,137	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	137,329	110,484	247,813	-27,507	220,306	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	426,927	354,359	781,286	0	781,286	54.00
60.00	06000	LABORATORY	413,548	549,237	962,785	-15,698	947,087	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	0	0	15,698	15,698	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	202,213	54,808	257,021	-12,781	244,240	65.00
66.00	06600	PHYSICAL THERAPY	269,435	92,358	361,793	-86	361,707	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	46,392	46,392	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	10,046	10,046	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	239,120	369,116	608,236	-143,074	465,162	73.00
76.00	03950	SLEEP LAB	26,675	5,617	32,292	-837	31,455	76.00
76.01	03951	DIABETIC EDUCATION	5,021	290	5,311	0	5,311	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,901,120	524,426	2,425,546	-224,431	2,201,115	88.00
91.00	09100	EMERGENCY	705,313	1,322,892	2,028,205	-4,917	2,023,288	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		382,792	382,792	0	382,792	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	5,637,353	9,350,647	14,988,000	-242,735	14,745,265	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	440,989	197,468	638,457	99,661	738,118	192.00
194.00	07950	RETAIL PHARMACY	0	30,157	30,157	143,074	173,231	194.00
194.01	07951	NONPATIENT RELATED MEALS	0	0	0	0	0	194.01
194.02	07952	KIDNEY CENTER	0	0	0	0	0	194.02
200.00		TOTAL (SUM OF LINES 118-199)	6,078,342	9,578,272	15,656,614	0	15,656,614	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-1304 | Period: From 07/01/2016 To 06/30/2017 | Worksheet A | Date/Time Prepared: 11/27/2017 9:30 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	0	775,701		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-3,281	296,805		2.00
3.00	00300	OTHER CAP REL COSTS	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-152,580	539,956		4.00
5.01	00570	ADMITTING	0	145,124		5.01
5.02	00590	HOSPITAL ONLY A & G	-11,287	163,893		5.02
5.03	00591	SHARED ADMN & GENERAL	-416,367	2,436,870		5.03
6.00	00600	MAINTENANCE & REPAIRS	0	547,261		6.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	27,154		8.00
9.00	00900	HOUSEKEEPING	0	154,331		9.00
10.00	01000	DIETARY	0	103,720		10.00
11.00	01100	CAFETERIA	0	0		11.00
13.00	01300	NURSING ADMINISTRATION	143,422	143,422		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	12,569	28,365		14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	160,228	160,228		16.00
17.00	01700	SOCIAL SERVICE	0	61,827		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	150,290		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	1,007,137		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	220,306		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-516	780,770		54.00
60.00	06000	LABORATORY	0	947,087		60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	15,698		63.00
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	-15,671	228,569		65.00
66.00	06600	PHYSICAL THERAPY	-11,755	349,952		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	46,392		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	10,046		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-2,475	462,687		73.00
76.00	03950	SLEEP LAB	0	31,455		76.00
76.01	03951	DIABETIC EDUCATION	-70	5,241		76.01
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	-17,713	2,183,402		88.00
91.00	09100	EMERGENCY	-149,716	1,873,572		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	-382,792	0		113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-848,004	13,897,261		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	-2,714	735,404		192.00
194.00	07950	RETAIL PHARMACY	0	173,231		194.00
194.01	07951	NONPATIENT RELATED MEALS	0	0		194.01
194.02	07952	KIDNEY CENTER	0	0		194.02
200.00		TOTAL (SUM OF LINES 118-199)	-850,718	14,805,896		200.00

RECLASSIFICATIONS | Provider CCN: 14-1304 | Period: From 07/01/2016 To 06/30/2017 | Worksheet A-6 | Date/Time Prepared: 11/27/2017 9:30 am

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - RHC SALARY					
1.00	SHARED ADMN & GENERAL	5.03	210,169	14,262		1.00
	0		210,169	14,262		
	B - BLOOD					
1.00	BLOOD STORING, PROCESSING, & TRANS.	63.00	2,911	12,787		1.00
	0		2,911	12,787		
	D - COST OF IMPLANTS & SUPPLIES					
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	10,046		1.00
2.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	56,438		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
	0		0	66,484		
	E - RETAIL PHARMACY					
1.00	RETAIL PHARMACY	194.00	58,681	84,393		1.00
	TOTALS		58,681	84,393		
	F - CRNA CLINIC SERVICES					
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	99,661		1.00
	0		0	99,661		
	G - PROPERTY INSURANCE					
1.00	OTHER CAP REL COSTS	3.00	0	35,494		1.00
	TOTALS		0	35,494		
500.00	Grand Total: Increases		271,761	313,081		500.00

RECLASSIFICATIONS | Provider CCN: 14-1304 | Period: From 07/01/2016 To 06/30/2017 | Worksheet A-6 | Date/Time Prepared: 11/27/2017 9:30 am

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - RHC SALARY						
1.00	RURAL HEALTH CLINIC	88.00	210,169	14,262	0		1.00
	0		210,169	14,262			
	B - BLOOD						
1.00	LABORATORY	60.00	2,911	12,787	0		1.00
	0		2,911	12,787			
	D - COST OF IMPLANTS & SUPPLIES						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	10,046	0		1.00
2.00	ADULTS & PEDIATRICS	30.00	0	10,310	0		2.00
3.00	OPERATING ROOM	50.00	0	27,507	0		3.00
4.00	RESPIRATORY THERAPY	65.00	0	12,781	0		4.00
5.00	SLEEP LAB	76.00	0	837	0		5.00
6.00	PHYSICAL THERAPY	66.00	0	86	0		6.00
7.00	EMERGENCY	91.00	0	4,917	0		7.00
	0		0	66,484			
	E - RETAIL PHARMACY						
1.00	DRUGS CHARGED TO PATIENTS	73.00	58,681	84,393	0		1.00
	TOTALS		58,681	84,393			
	F - CRNA CLINIC SERVICES						
1.00	NONPHYSICIAN ANESTHETISTS	19.00	0	99,661	0		1.00
	0		0	99,661			
	G - PROPERTY INSURANCE						
1.00	SHARED ADMN & GENERAL	5.03	0	35,494	11		1.00
	TOTALS		0	35,494			
500.00	Grand Total: Decreases		271,761	313,081			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1304 | Period: From 07/01/2016 To 06/30/2017 | Worksheet A-7 Part I | Date/Time Prepared: 11/27/2017 9:30 am

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	65,000	0	0	0	0	1.00
2.00	Land Improvements	148,361	177,657	0	177,657	0	2.00
3.00	Buildings and Fixtures	12,061,638	364,435	0	364,435	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	1,859,377	309,660	0	309,660	0	5.00
6.00	Movable Equipment	109,793	0	0	0	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	14,244,169	851,752	0	851,752	0	8.00
9.00	Reconciling Items	-616,306	-159,135	0	-159,135	0	9.00
10.00	Total (line 8 minus line 9)	14,860,475	1,010,887	0	1,010,887	0	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	65,000	0	1.00
2.00	Land Improvements	326,018	0	2.00
3.00	Buildings and Fixtures	12,426,073	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	2,169,037	0	5.00
6.00	Movable Equipment	109,793	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	15,095,921	0	8.00
9.00	Reconciling Items	-775,441	0	9.00
10.00	Total (line 8 minus line 9)	15,871,362	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1304 | Period: From 07/01/2016 To 06/30/2017 | Worksheet A-7 Part II | Date/Time Prepared: 11/27/2017 9:30 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	740,465	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	299,828	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	1,040,293	0	0	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL		
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
		14.00	15.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	740,465	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	299,828	2.00
3.00	Total (sum of lines 1-2)	0	1,040,293	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1304 | Period: From 07/01/2016 To 06/30/2017 | Worksheet A-7 Part III Date/Time Prepared: 11/27/2017 9:30 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	14,986,128	0	14,986,128	0.992727	35,236	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	109,793	0	109,793	0.007273	258	2.00
3.00	Total (sum of lines 1-2)	15,095,921	0	15,095,921	1.000000	35,494	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	35,236	740,465	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	258	296,547	0	2.00
3.00	Total (sum of lines 1-2)	0	0	35,494	1,037,012	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	0	35,236	0	0	775,701	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	258	0	0	296,805	2.00
3.00	Total (sum of lines 1-2)	0	35,494	0	0	1,072,506	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-1304 | Period: From 07/01/2016 To 06/30/2017 | Worksheet A-8 | Date/Time Prepared: 11/27/2017 9:30 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)	B	-507	SHARED ADMN & GENERAL	5.03	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)	A	-3,219	CAP REL COSTS-MVBLE EQUIP	2.00	9	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-165,757			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	-329,063			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests		0		0.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients	B	-2,475	DRUGS CHARGED TO PATIENTS	73.00	0	17.00
18.00	Sale of medical records and abstracts		0		0.00	0	18.00
19.00	Nursing 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	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		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	*** Cost Center Deleted ***	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	A	-87,832	SHARED ADMN & GENERAL	5.03	0	32.00
33.00			0		0.00	0	33.00
33.01	RENTAL INCOME	B	-2,250	SHARED ADMN & GENERAL	5.03	0	33.01

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-1304 | Period: From 07/01/2016 To 06/30/2017 | Worksheet A-8 | Date/Time Prepared: 11/27/2017 9:30 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	
33.04	MISC INCOME - DIABETES CTR	B	-70	DIABETIC EDUCATION	76.01	0	33.04
33.05	MISC INCOME - PT	B	-5,428	PHYSICAL THERAPY	66.00	0	33.05
33.06	MISC INCOME - RHC	B	-13,746	RURAL HEALTH CLINIC	88.00	0	33.06
34.00	PATIENT PHONES - DEPRECIATION	A	-62	CAP REL COSTS-MVBLE EQUIP	2.00	9	34.00
34.02	PATIENT PHONES - SALARY	A	-842	RURAL HEALTH CLINIC	88.00	0	34.02
34.03	PATIENT PHONES - BENEFITS	A	-96	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	34.03
35.00	ADVERTISING	A	-7,699	SHARED ADMN & GENERAL	5.03	0	35.00
35.01	ADVERTISING	A	-516	RADIOLOGY-DIAGNOSTIC	54.00	0	35.01
35.02	ADVERTISING	A	-6,327	PHYSICAL THERAPY	66.00	0	35.02
35.03	ADVERTISING	A	-3,125	RURAL HEALTH CLINIC	88.00	0	35.03
35.04	ADVERTISING	A	-488	EMERGENCY	91.00	0	35.04
35.05	ADVERTISING	A	-2,714	PHYSICIANS' PRIVATE OFFICES	192.00	0	35.05
36.00	PROVIDER TAX ASSESSMENT	A	-152,029	SHARED ADMN & GENERAL	5.03	0	36.00
37.00	LOBBYING PORTION OF DUES	A	-7,416	SHARED ADMN & GENERAL	5.03	0	37.00
38.00	EMPLOYEE HEALTH INSURANCE	A	-152,484	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	38.00
40.00	LEGAL FEES (CHOW) - AMORTIZED	A	93,427	SHARED ADMN & GENERAL	5.03	0	40.00
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-850,718				50.00

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 14-1304 | Period: From 07/01/2016 To 06/30/2017 | Worksheet A-8-1 | Date/Time Prepared: 11/27/2017 9:30 am

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	5.03	SHARED ADMN & GENERAL	HOME OFFICE - ADMIN	1,767	0	1.00
2.00	5.03	SHARED ADMN & GENERAL	HOME OFFICE - IT	162,015	650,149	2.00
3.00	5.02	HOSPITAL ONLY A & G	HOME OFFICE - SBS PATIENT AC	163,515	174,802	3.00
4.00	5.03	SHARED ADMN & GENERAL	HOME OFFICE - SBS PATIENT AC	127,542	0	4.00
4.01	16.00	MEDICAL RECORDS & LIBRARY	HOME OFFICE - TRANSCRIPTION	160,228	0	4.01
4.02	14.00	CENTRAL SERVICES & SUPPLY	HOME OFFICE - CENTRAL SUPPLY	12,569	0	4.02
4.03	5.03	SHARED ADMN & GENERAL	HOME OFFICE - MEDICAL AFFAIR	23,231	0	4.03
4.04	5.03	SHARED ADMN & GENERAL	HOME OFFICE - PAYOR CONTRACT	7,678	0	4.04
4.05	13.00	NURSING ADMINISTRATION	HOME OFFICE - CARE COORDINAT	143,422	0	4.05
4.06	5.03	SHARED ADMN & GENERAL	HOME OFFICE - PHYSICIAN RECR	10,531	0	4.06
4.10	5.03	SHARED ADMN & GENERAL	HOME OFFICE - LIBRARY	5,950	0	4.10
4.11	5.03	SHARED ADMN & GENERAL	HOME OFFICE - AFFILIATE FACI	196,495	0	4.11
4.12	5.03	SHARED ADMN & GENERAL	HOME OFFICE - POOLED CAPITAL	283,061	0	4.12
4.13	5.03	SHARED ADMN & GENERAL	HOME OFFICE - POOLED NON-CAP	877,421	1,296,745	4.13
4.14	5.03	SHARED ADMN & GENERAL	VARIOUS SERVICES - RELATED	200	200	4.14
4.15	6.00	MAINTENANCE & REPAIRS	VARIOUS SERVICES - RELATED	3,370	3,370	4.15
4.16	17.00	SOCIAL SERVICE	VARIOUS SERVICES - RELATED	40	40	4.16
4.17	194.00	RETAIL PHARMACY	VARIOUS SERVICES - RELATED	5,380	5,380	4.17
4.18	30.00	ADULTS & PEDIATRICS	VARIOUS SERVICES - RELATED	13,737	13,737	4.18
4.19	50.00	OPERATING ROOM	VARIOUS SERVICES - RELATED	2,143	2,143	4.19
4.20	54.00	RADIOLOGY-DIAGNOSTIC	VARIOUS SERVICES - RELATED	2,892	2,892	4.20
4.21	60.00	LABORATORY	VARIOUS SERVICES - RELATED	64,529	64,529	4.21
4.22	65.00	RESPIRATORY THERAPY	VARIOUS SERVICES - RELATED	5,250	5,250	4.22
4.24	66.00	PHYSICAL THERAPY	VARIOUS SERVICES - RELATED	158	158	4.24
4.25	73.00	DRUGS CHARGED TO PATIENTS	VARIOUS SERVICES - RELATED	25,616	25,616	4.25
4.26	88.00	RURAL HEALTH CLINIC	VARIOUS SERVICES - RELATED	327	327	4.26
4.27	91.00	EMERGENCY	VARIOUS SERVICES - RELATED	9,192	9,192	4.27
4.28	192.00	PHYSICIANS' PRIVATE OFFICES	VARIOUS SERVICES - RELATED	7,135	7,135	4.28
4.29	113.00	INTEREST EXPENSE	INTEREST EXPENSE - RELATED	0	382,792	4.29
4.30	88.00	RURAL HEALTH CLINIC	GHG - MGMT FEE	109,646	109,646	4.30
4.31	192.00	PHYSICIANS' PRIVATE OFFICES	GHG - MGMT FEE	24,991	24,991	4.31
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			2,450,031	2,779,094	5.00

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

				Related Organization(s) and/or Home Office		
	Symbol (1)	Name	Percentage of Ownership	Name	Percentage of Ownership	
	1.00	2.00	3.00	4.00	5.00	
	B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:					
6.00	B	GMC ALEDO	100.00	GENESIS HLTH SY	100.00	6.00
7.00			0.00		0.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	Provider CCN: 14-1304	Period: From 07/01/2016 To 06/30/2017	Worksheet A-8-1 Date/Time Prepared: 11/27/2017 9:30 am

				Related Organization(s) and/or Home Office		
	Symbol (1)	Name	Percentage of Ownership	Name	Percentage of Ownership	
	1.00	2.00	3.00	4.00	5.00	

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	Provider CCN: 14-1304	Period: From 07/01/2016 To 06/30/2017	Worksheet A-8-1 Date/Time Prepared: 11/27/2017 9:30 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	1,767	9		1.00
2.00	-488,134	0		2.00
3.00	-11,287	0		3.00
4.00	127,542	0		4.00
4.01	160,228	0		4.01
4.02	12,569	0		4.02
4.03	23,231	0		4.03
4.04	7,678	0		4.04
4.05	143,422	0		4.05
4.06	10,531	0		4.06
4.10	5,950	0		4.10
4.11	196,495	0		4.11
4.12	283,061	0		4.12
4.13	-419,324	0		4.13
4.14	0	0		4.14
4.15	0	0		4.15
4.16	0	0		4.16
4.17	0	0		4.17
4.18	0	0		4.18
4.19	0	0		4.19
4.20	0	0		4.20
4.21	0	0		4.21
4.22	0	0		4.22
4.24	0	0		4.24
4.25	0	0		4.25
4.26	0	0		4.26
4.27	0	0		4.27
4.28	0	0		4.28
4.29	-382,792	0		4.29
4.30	0	0		4.30
4.31	0	0		4.31
5.00	-329,063			5.00

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

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

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

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

6.00	NOT-FOR PROFIT		6.00
7.00			7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 14-1304 | Period: From 07/01/2016 To 06/30/2017 | Worksheet A-8-2 | Date/Time Prepared: 11/27/2017 9:30 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	65.00	RESPIRATORY THERAPY	15,671	15,671	0	0	0	1.00
2.00	91.00	EMERGENCY	1,160,954	149,228	1,011,726	0	0	2.00
3.00	5.03	SHARED ADMN & GENERAL	858	858	0	0	0	3.00
4.00	76.00	SLEEP LAB	237	0	237	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			1,177,720	165,757	1,011,963		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	65.00	RESPIRATORY THERAPY	0	0	0	0	0	1.00
2.00	91.00	EMERGENCY	0	0	0	0	0	2.00
3.00	5.03	SHARED ADMN & GENERAL	0	0	0	0	0	3.00
4.00	76.00	SLEEP LAB	0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	65.00	RESPIRATORY THERAPY	0	0	0	15,671		1.00
2.00	91.00	EMERGENCY	0	0	0	149,228		2.00
3.00	5.03	SHARED ADMN & GENERAL	0	0	0	858		3.00
4.00	76.00	SLEEP LAB	0	0	0	0		4.00
5.00	0.00		0	0	0	0		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	165,757		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS	Provider CCN: 14-1304	Period: From 07/01/2016 To 06/30/2017	Worksheet A-8-3 Parts I-VI Date/Time Prepared: 11/27/2017 9:30 am

		Occupational Therapy	Cost	
			1.00	
	PART I - GENERAL INFORMATION			
1.00	Total number of weeks worked (excluding aides) (see instructions)		45	1.00
2.00	Line 1 multiplied by 15 hours per week		675	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)		207	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	975.00	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	76.61	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)	38.31	38.31	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)	74,695	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)	74,695	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)	74,695	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)	0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)	0	22.00
23.00	Total salary equivalency (see instructions)	74,695	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)	7,930	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)	7,930	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)	1,114	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)	9,044	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)	9,044	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)	0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)	0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE		
	Standard Travel Expense		
36.00	Therapists (line 5 times column 2, line 11)	0	36.00
37.00	Assistants (line 6 times column 3, line 11)	0	37.00
38.00	Subtotal (sum of lines 36 and 37)	0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)	0	39.00
	Optional Travel Allowance and Optional Travel Expense		
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)	0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)	0	41.00
42.00	Subtotal (sum of lines 40 and 41)	0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)	0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.		
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)	0	44.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS	Provider CCN: 14-1304	Period: From 07/01/2016 To 06/30/2017	Worksheet A-8-3 Parts I-VI Date/Time Prepared: 11/27/2017 9:30 am

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

		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	76.61	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)		74,695	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))		9,044	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)		83,739	63.00
64.00	Total cost of outside supplier services (from your records)		48,330	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		7,930	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others		1,114	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27		9,044	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		1,114	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		1,114	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: 14-1304 | Period: From 07/01/2016 To 06/30/2017 | Worksheet B Part I Date/Time Prepared: 11/27/2017 9:30 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	ADMITTING	
			0	1.00	2.00	4.00	5.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	775,701	775,701				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	296,805		296,805			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	539,956	0	0	539,956		4.00
5.01	00570	ADMITTING	145,124	0	1,844	11,781	158,749	5.01
5.02	00590	HOSPITAL ONLY A & G	163,893	910	0	0	0	5.02
5.03	00591	SHARED ADMN & GENERAL	2,436,870	156,274	10,411	45,372	0	5.03
6.00	00600	MAINTENANCE & REPAIRS	547,261	71,277	13,626	25	0	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	27,154	2,114	0	2,252	0	8.00
9.00	00900	HOUSEKEEPING	154,331	10,210	0	0	0	9.00
10.00	01000	DIETARY	103,720	32,322	5,564	0	0	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	143,422	1,642	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	28,365	27,233	4,937	0	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	160,228	3,544	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	61,827	2,439	0	5,013	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	150,290	910	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,007,137	150,747	19,269	68,883	12,538	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	220,306	82,300	53,068	12,255	9,981	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	780,770	70,805	153,262	38,098	44,138	54.00
60.00	06000	LABORATORY	947,087	27,542	2,098	36,644	37,125	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	15,698	0	0	260	263	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	228,569	5,170	4,055	18,045	4,853	65.00
66.00	06600	PHYSICAL THERAPY	349,952	38,614	13,764	24,044	9,742	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	46,392	0	0	0	2,386	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	10,046	0	0	0	273	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	462,687	9,625	159	16,102	10,170	73.00
76.00	03950	SLEEP LAB	31,455	13,738	1,617	2,380	2,849	76.00
76.01	03951	DIABETIC EDUCATION	5,241	0	0	448	78	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	2,183,402	0	602	150,823	0	88.00
91.00	09100	EMERGENCY	1,873,572	38,565	8,617	62,941	24,353	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	13,897,261	745,981	292,893	495,366	158,749	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	4,178	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	735,404	0	2,307	39,353	0	192.00
194.00	07950	RETAIL PHARMACY	173,231	0	1,605	5,237	0	194.00
194.01	07951	NONPATIENT RELATED MEALS	0	0	0	0	0	194.01
194.02	07952	KIDNEY CENTER	0	25,542	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	14,805,896	775,701	296,805	539,956	158,749	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1304 | Period: From 07/01/2016 To 06/30/2017 | Worksheet B Part I | Date/Time Prepared: 11/27/2017 9:30 am

		Cost Center Description	Subtotal	HOSPITAL ONLY A & G	Subtotal	SHARED ADMN & GENERAL	MAINTENANCE & REPAIRS	
			5A.01	5.02	5A.02	5.03	6.00	
		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
5.01	00570	ADMITTING						5.01
5.02	00590	HOSPITAL ONLY A & G	164,803	164,803				5.02
5.03	00591	SHARED ADMN & GENERAL	2,648,927	38,570	2,687,497	2,687,497		5.03
6.00	00600	MAINTENANCE & REPAIRS	632,189	9,204	641,393	142,542	783,935	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	31,520	459	31,979	7,107	2,611	8.00
9.00	00900	HOUSEKEEPING	164,541	2,396	166,937	37,100	12,612	9.00
10.00	01000	DIETARY	141,606	2,062	143,668	31,928	39,925	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	145,064	2,112	147,176	32,708	2,028	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	60,535	881	61,416	13,649	33,639	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	163,772	2,384	166,156	36,926	4,378	16.00
17.00	01700	SOCIAL SERVICE	69,279	1,009	70,288	15,621	3,012	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	151,200	2,201	153,401	34,092	1,125	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,258,574	18,324	1,276,898	283,775	186,208	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	377,910	5,502	383,412	85,209	101,660	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,087,073	15,827	1,102,900	245,106	87,461	54.00
60.00	06000	LABORATORY	1,050,496	15,294	1,065,790	236,859	34,020	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	16,221	236	16,457	3,657	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	260,692	3,795	264,487	58,779	6,386	65.00
66.00	06600	PHYSICAL THERAPY	436,116	6,349	442,465	98,333	47,697	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	48,778	710	49,488	10,998	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	10,319	150	10,469	2,327	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	498,743	7,261	506,004	112,453	11,889	73.00
76.00	03950	SLEEP LAB	52,039	758	52,797	11,733	16,970	76.00
76.01	03951	DIABETIC EDUCATION	5,767	84	5,851	1,300	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	2,334,827	0	2,334,827	518,892	107,966	88.00
91.00	09100	EMERGENCY	2,008,048	29,235	2,037,283	452,762	47,637	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0			92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	13,819,039	164,803	13,819,039	2,473,856	747,224	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	4,178	0	4,178	929	5,161	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	777,064	0	777,064	172,693	0	192.00
194.00	07950	RETAIL PHARMACY	180,073	0	180,073	40,019	0	194.00
194.01	07951	NONPATIENT RELATED MEALS	0	0	0	0	0	194.01
194.02	07952	KIDNEY CENTER	25,542	0	25,542	0	31,550	194.02
200.00		Cross Foot Adjustments	0		0			200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	14,805,896	164,803	14,805,896	2,687,497	783,935	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1304 | Period: From 07/01/2016 To 06/30/2017 | Worksheet B Part I | Date/Time Prepared: 11/27/2017 9:30 am

		Cost Center Description	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
			8.00	9.00	10.00	11.00	13.00	
		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
5.01	00570	ADMITTING						5.01
5.02	00590	HOSPITAL ONLY A & G						5.02
5.03	00591	SHARED ADMN & GENERAL						5.03
6.00	00600	MAINTENANCE & REPAIRS						6.00
8.00	00800	LAUNDRY & LINEN SERVICE	41,697					8.00
9.00	00900	HOUSEKEEPING	0	216,649				9.00
10.00	01000	DIETARY	0	11,252	226,773			10.00
11.00	01100	CAFETERIA	0	0	167,178	167,178		11.00
13.00	01300	NURSING ADMINISTRATION	0	572	0	0	182,484	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	9,481	0	0	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,234	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	849	0	2,204	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	317	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	20,542	52,478	59,595	30,188	99,764	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,345	28,651	0	4,853	13,504	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,500	24,649	0	14,235	35	54.00
60.00	06000	LABORATORY	0	9,588	0	18,562	0	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	0	0	202	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	1,800	0	6,855	260	65.00
66.00	06600	PHYSICAL THERAPY	221	13,443	0	9,463	663	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,351	0	5,298	0	73.00
76.00	03950	SLEEP LAB	0	4,783	0	930	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	154	30,428	0	42,926	0	88.00
91.00	09100	EMERGENCY	12,935	13,426	0	21,170	68,258	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	41,697	206,302	226,773	156,886	182,484	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	1,455	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	10,292	0	192.00
194.00	07950	RETAIL PHARMACY	0	0	0	0	0	194.00
194.01	07951	NONPATIENT RELATED MEALS	0	0	0	0	0	194.01
194.02	07952	KIDNEY CENTER	0	8,892	0	0	0	194.02
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)	41,697	216,649	226,773	167,178	182,484	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1304 | Period: From 07/01/2016 To 06/30/2017 | Worksheet B Part I | Date/Time Prepared: 11/27/2017 9:30 am

		Cost Center Description	CENTRAL SERVICES & SUPPLY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	Subtotal	
			14.00	16.00	17.00	19.00	24.00	
		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
5.01	00570	ADMITTING						5.01
5.02	00590	HOSPITAL ONLY A & G						5.02
5.03	00591	SHARED ADMN & GENERAL						5.03
6.00	00600	MAINTENANCE & REPAIRS						6.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	118,185					14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	208,694				16.00
17.00	01700	SOCIAL SERVICE	0	0	91,974			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	188,935		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	17,202	16,483	91,974	0	2,135,107	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	13,056	13,121	0	188,935	835,746	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	18,895	58,024	0	0	1,555,805	54.00
60.00	06000	LABORATORY	0	48,805	0	0	1,413,624	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	346	0	0	20,662	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	1,274	6,380	0	0	346,221	65.00
66.00	06600	PHYSICAL THERAPY	3,120	12,807	0	0	628,212	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	26,344	3,136	0	0	89,966	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	5,707	359	0	0	18,862	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	715	13,370	0	0	653,080	73.00
76.00	03950	SLEEP LAB	1,131	3,745	0	0	92,089	76.00
76.01	03951	DIABETIC EDUCATION	0	103	0	0	7,254	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	9,338	0	0	0	3,044,531	88.00
91.00	09100	EMERGENCY	16,196	32,015	0	0	2,701,682	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	112,978	208,694	91,974	188,935	13,542,841	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	11,723	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	5,207	0	0	0	965,256	192.00
194.00	07950	RETAIL PHARMACY	0	0	0	0	220,092	194.00
194.01	07951	NONPATIENT RELATED MEALS	0	0	0	0	0	194.01
194.02	07952	KIDNEY CENTER	0	0	0	0	65,984	194.02
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	118,185	208,694	91,974	188,935	14,805,896	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1304 | Period: From 07/01/2016 To 06/30/2017 | Worksheet B Part I | Date/Time Prepared: 11/27/2017 9:30 am

		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			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
5.01	00570	ADMITTING				5.01
5.02	00590	HOSPITAL ONLY A & G				5.02
5.03	00591	SHARED ADMN & GENERAL				5.03
6.00	00600	MAINTENANCE & REPAIRS				6.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
17.00	01700	SOCIAL SERVICE				17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS				19.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-237,510	1,897,597		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	25,780	861,526		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,555,805		54.00
60.00	06000	LABORATORY	0	1,413,624		60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	20,662		63.00
64.00	06400	INTRAVENOUS THERAPY	211,729	211,729		64.00
65.00	06500	RESPIRATORY THERAPY	0	346,221		65.00
66.00	06600	PHYSICAL THERAPY	0	628,212		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	89,966		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	18,862		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	653,080		73.00
76.00	03950	SLEEP LAB	0	92,089		76.00
76.01	03951	DIABETIC EDUCATION	0	7,254		76.01
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	3,044,531		88.00
91.00	09100	EMERGENCY	0	2,701,682		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0			92.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE				113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	13,542,840		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	11,723		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	965,256		192.00
194.00	07950	RETAIL PHARMACY	0	220,092		194.00
194.01	07951	NONPATIENT RELATED MEALS	0	0		194.01
194.02	07952	KIDNEY CENTER	0	65,984		194.02
200.00		Cross Foot Adjustments	0	0		200.00
201.00		Negative Cost Centers	0	0		201.00
202.00		TOTAL (sum lines 118-201)	0	14,805,895		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1304 | Period: From 07/01/2016 To 06/30/2017 | Worksheet B Part II Date/Time Prepared: 11/27/2017 9:30 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	4.00
5.01	00570	ADMITTING	0	0	1,844	1,844	0	5.01
5.02	00590	HOSPITAL ONLY A & G	0	910	0	910	0	5.02
5.03	00591	SHARED ADMN & GENERAL	216,862	156,274	10,411	383,547	0	5.03
6.00	00600	MAINTENANCE & REPAIRS	704	71,277	13,626	85,607	0	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	2,114	0	2,114	0	8.00
9.00	00900	HOUSEKEEPING	0	10,210	0	10,210	0	9.00
10.00	01000	DIETARY	2,551	32,322	5,564	40,437	0	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	1,642	0	1,642	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	27,233	4,937	32,170	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	3,544	0	3,544	0	16.00
17.00	01700	SOCIAL SERVICE	0	2,439	0	2,439	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	910	0	910	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	93	150,747	19,269	170,109	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	82,300	53,068	135,368	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	70,805	153,262	224,067	0	54.00
60.00	06000	LABORATORY	0	27,542	2,098	29,640	0	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	53	5,170	4,055	9,278	0	65.00
66.00	06600	PHYSICAL THERAPY	71	38,614	13,764	52,449	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	9,625	159	9,784	0	73.00
76.00	03950	SLEEP LAB	0	13,738	1,617	15,355	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	67,508	0	602	68,110	0	88.00
91.00	09100	EMERGENCY	0	38,565	8,617	47,182	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	287,842	745,981	292,893	1,326,716	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	4,178	0	4,178	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	26,728	0	2,307	29,035	0	192.00
194.00	07950	RETAIL PHARMACY	0	0	1,605	1,605	0	194.00
194.01	07951	NONPATIENT RELATED MEALS	0	0	0	0	0	194.01
194.02	07952	KIDNEY CENTER	0	25,542	0	25,542	0	194.02
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)	314,570	775,701	296,805	1,387,076	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1304 | Period: From 07/01/2016 To 06/30/2017 | Worksheet B Part II | Date/Time Prepared: 11/27/2017 9:30 am

		Cost Center Description	ADMITTING	HOSPITAL ONLY A & G	SHARED ADMN & GENERAL	MAINTENANCE & REPAIRS	LAUNDRY & LINEN SERVICE	
			5.01	5.02	5.03	6.00	8.00	
		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
5.01	00570	ADMITTING	1,844					5.01
5.02	00590	HOSPITAL ONLY A & G	0	910				5.02
5.03	00591	SHARED ADMN & GENERAL	0	215	383,762			5.03
6.00	00600	MAINTENANCE & REPAIRS	0	51	20,355	106,013		6.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	3	1,015	353	3,485	8.00
9.00	00900	HOUSEKEEPING	0	13	5,298	1,706	0	9.00
10.00	01000	DIETARY	0	11	4,559	5,399	0	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	12	4,671	274	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	5	1,949	4,549	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	13	5,273	592	0	16.00
17.00	01700	SOCIAL SERVICE	0	6	2,231	407	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	12	4,868	152	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	146	101	40,522	25,180	1,717	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	116	30	12,168	13,748	280	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	510	87	35,001	11,828	376	54.00
60.00	06000	LABORATORY	432	84	33,823	4,601	0	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	3	1	522	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	57	21	8,393	864	0	65.00
66.00	06600	PHYSICAL THERAPY	113	35	14,042	6,450	18	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	28	4	1,571	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3	1	332	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	118	40	16,058	1,608	0	73.00
76.00	03950	SLEEP LAB	33	4	1,676	2,295	0	76.00
76.01	03951	DIABETIC EDUCATION	1	0	186	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	74,088	14,600	13	88.00
91.00	09100	EMERGENCY	284	161	64,653	6,442	1,081	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,844	910	353,254	101,048	3,485	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	133	698	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	24,660	0	0	192.00
194.00	07950	RETAIL PHARMACY	0	0	5,715	0	0	194.00
194.01	07951	NONPATIENT RELATED MEALS	0	0	0	0	0	194.01
194.02	07952	KIDNEY CENTER	0	0	0	4,267	0	194.02
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)	1,844	910	383,762	106,013	3,485	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1304 | Period: From 07/01/2016 To 06/30/2017 | Worksheet B Part II | Date/Time Prepared: 11/27/2017 9:30 am

		Cost Center Description	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			9.00	10.00	11.00	13.00	14.00	
		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
5.01	00570	ADMITTING						5.01
5.02	00590	HOSPITAL ONLY A & G						5.02
5.03	00591	SHARED ADMN & GENERAL						5.03
6.00	00600	MAINTENANCE & REPAIRS						6.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING	17,227					9.00
10.00	01000	DIETARY	895	51,301				10.00
11.00	01100	CAFETERIA	0	37,819	37,819			11.00
13.00	01300	NURSING ADMINISTRATION	45	0	0	6,644		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	754	0	0	0	39,427	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	98	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	68	0	499	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	25	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,173	13,482	6,829	3,633	5,739	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,278	0	1,098	492	4,356	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,960	0	3,220	1	6,303	54.00
60.00	06000	LABORATORY	762	0	4,199	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	0	46	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	143	0	1,551	9	425	65.00
66.00	06600	PHYSICAL THERAPY	1,069	0	2,141	24	1,041	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	8,788	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	1,904	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	266	0	1,198	0	239	73.00
76.00	03950	SLEEP LAB	380	0	210	0	377	76.00
76.01	03951	DIABETIC EDUCATION	0	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	2,420	0	9,711	0	3,115	88.00
91.00	09100	EMERGENCY	1,068	0	4,789	2,485	5,403	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	16,404	51,301	35,491	6,644	37,690	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	116	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	2,328	0	1,737	192.00
194.00	07950	RETAIL PHARMACY	0	0	0	0	0	194.00
194.01	07951	NONPATIENT RELATED MEALS	0	0	0	0	0	194.01
194.02	07952	KIDNEY CENTER	707	0	0	0	0	194.02
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)	17,227	51,301	37,819	6,644	39,427	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1304 | Period: From 07/01/2016 To 06/30/2017 | Worksheet B Part II Date/Time Prepared: 11/27/2017 9:30 am

		Cost Center Description	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			16.00	17.00	19.00	24.00	25.00	
		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
5.01	00570	ADMITTING						5.01
5.02	00590	HOSPITAL ONLY A & G						5.02
5.03	00591	SHARED ADMN & GENERAL						5.03
6.00	00600	MAINTENANCE & REPAIRS						6.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	9,520					16.00
17.00	01700	SOCIAL SERVICE	0	5,650				17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	5,967			19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	752	5,650		278,033	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	599	0		170,533	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,645	0		285,998	0	54.00
60.00	06000	LABORATORY	2,227	0		75,768	0	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	16	0		588	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0		0	0	64.00
65.00	06500	RESPIRATORY THERAPY	291	0		21,032	0	65.00
66.00	06600	PHYSICAL THERAPY	584	0		77,966	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	143	0		10,534	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	16	0		2,256	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	610	0		29,921	0	73.00
76.00	03950	SLEEP LAB	171	0		20,501	0	76.00
76.01	03951	DIABETIC EDUCATION	5	0		192	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0		172,057	0	88.00
91.00	09100	EMERGENCY	1,461	0		135,009	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	9,520	5,650	0	1,280,388	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0		5,125	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0		57,760	0	192.00
194.00	07950	RETAIL PHARMACY	0	0		7,320	0	194.00
194.01	07951	NONPATIENT RELATED MEALS	0	0		0	0	194.01
194.02	07952	KIDNEY CENTER	0	0		30,516	0	194.02
200.00		Cross Foot Adjustments			5,967	5,967	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	9,520	5,650	5,967	1,387,076	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1304 | Period: From 07/01/2016 To 06/30/2017 | Worksheet B Part II | Date/Time Prepared: 11/27/2017 9:30 am

		Cost Center Description	Total		
			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
5.01	00570	ADMITTING			5.01
5.02	00590	HOSPITAL ONLY A & G			5.02
5.03	00591	SHARED ADMN & GENERAL			5.03
6.00	00600	MAINTENANCE & REPAIRS			6.00
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
13.00	01300	NURSING ADMINISTRATION			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY			14.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
17.00	01700	SOCIAL SERVICE			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS			19.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	278,033		30.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	170,533		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	285,998		54.00
60.00	06000	LABORATORY	75,768		60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	588		63.00
64.00	06400	INTRAVENOUS THERAPY	0		64.00
65.00	06500	RESPIRATORY THERAPY	21,032		65.00
66.00	06600	PHYSICAL THERAPY	77,966		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	10,534		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,256		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	29,921		73.00
76.00	03950	SLEEP LAB	20,501		76.00
76.01	03951	DIABETIC EDUCATION	192		76.01
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	172,057		88.00
91.00	09100	EMERGENCY	135,009		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,280,388		118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	5,125		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	57,760		192.00
194.00	07950	RETAIL PHARMACY	7,320		194.00
194.01	07951	NONPATIENT RELATED MEALS	0		194.01
194.02	07952	KIDNEY CENTER	30,516		194.02
200.00		Cross Foot Adjustments	5,967		200.00
201.00		Negative Cost Centers	0		201.00
202.00		TOTAL (sum lines 118-201)	1,387,076		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1304 | Period: From 07/01/2016 To 06/30/2017 | Worksheet B-1 | Date/Time Prepared: 11/27/2017 9:30 am

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	ADMITTING (GROSS CHARGES)	Reconciliation	
			1.00	2.00	4.00	5.01	5A.02	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	47,711					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		296,547				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	6,050,737			4.00
5.01	00570	ADMITTING	0	1,842	132,021	21,251,064		5.01
5.02	00590	HOSPITAL ONLY A & G	56	0	0	0	-164,803	5.02
5.03	00591	SHARED ADMN & GENERAL	9,612	10,402	508,441	0	0	5.03
6.00	00600	MAINTENANCE & REPAIRS	4,384	13,614	282	0	0	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	130	0	25,237	0	0	8.00
9.00	00900	HOUSEKEEPING	628	0	0	0	0	9.00
10.00	01000	DIETARY	1,988	5,559	0	0	0	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	101	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,675	4,933	0	0	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	218	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	150	0	56,174	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	56	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	9,272	19,252	771,903	1,678,508	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,062	53,022	137,329	1,336,139	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,355	153,129	426,927	5,907,923	0	54.00
60.00	06000	LABORATORY	1,694	2,096	410,637	4,969,927	0	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	0	2,911	35,237	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	318	4,051	202,213	649,714	0	65.00
66.00	06600	PHYSICAL THERAPY	2,375	13,752	269,435	1,304,133	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	319,393	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	36,567	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	592	159	180,439	1,361,487	0	73.00
76.00	03950	SLEEP LAB	845	1,616	26,675	381,393	0	76.00
76.01	03951	DIABETIC EDUCATION	0	0	5,021	10,482	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	601	1,690,109	0	-2,334,827	88.00
91.00	09100	EMERGENCY	2,372	8,610	705,313	3,260,161	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	45,883	292,638	5,551,067	21,251,064	-2,499,630	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	257	0	0	0	-4,178	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	2,305	440,989	0	-777,064	192.00
194.00	07950	RETAIL PHARMACY	0	1,604	58,681	0	-180,073	194.00
194.01	07951	NONPATIENT RELATED MEALS	0	0	0	0	0	194.01
194.02	07952	KIDNEY CENTER	1,571	0	0	0	-25,542	194.02
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)	775,701	296,805	539,956	158,749		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	16.258326	1.000870	0.089238	0.007470		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			0	1,844		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000000	0.000087		205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1304 | Period: From 07/01/2016 To 06/30/2017 | Worksheet B-1 | Date/Time Prepared: 11/27/2017 9:30 am

		Cost Center Description	HOSPITAL ONLY A & G (ACCUM. COST)	Reconciliation	SHARED ADMN & GENERAL (ACCUM. COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	
			5.02	5A.03	5.03	6.00	8.00	
		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
5.01	00570	ADMITTING						5.01
5.02	00590	HOSPITAL ONLY A & G	11,319,409					5.02
5.03	00591	SHARED ADMN & GENERAL	2,648,927	-2,687,497	12,092,857			5.03
6.00	00600	MAINTENANCE & REPAIRS	632,189	0	641,393	39,035		6.00
8.00	00800	LAUNDRY & LINEN SERVICE	31,520	0	31,979	130	41,373	8.00
9.00	00900	HOUSEKEEPING	164,541	0	166,937	628	0	9.00
10.00	01000	DIETARY	141,606	0	143,668	1,988	0	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	145,064	0	147,176	101	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	60,535	0	61,416	1,675	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	163,772	0	166,156	218	0	16.00
17.00	01700	SOCIAL SERVICE	69,279	0	70,288	150	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	151,200	0	153,401	56	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,258,574	0	1,276,898	9,272	20,383	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	377,910	0	383,412	5,062	3,319	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,087,073	0	1,102,900	4,355	4,465	54.00
60.00	06000	LABORATORY	1,050,496	0	1,065,790	1,694	0	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	16,221	0	16,457	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	260,692	0	264,487	318	0	65.00
66.00	06600	PHYSICAL THERAPY	436,116	0	442,465	2,375	219	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	48,778	0	49,488	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	10,319	0	10,469	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	498,743	0	506,004	592	0	73.00
76.00	03950	SLEEP LAB	52,039	0	52,797	845	0	76.00
76.01	03951	DIABETIC EDUCATION	5,767	0	5,851	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	2,334,827	5,376	153	88.00
91.00	09100	EMERGENCY	2,008,048	0	2,037,283	2,372	12,834	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	11,319,409	-2,687,497	11,131,542	37,207	41,373	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	4,178	257	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	777,064	0	0	192.00
194.00	07950	RETAIL PHARMACY	0	0	180,073	0	0	194.00
194.01	07951	NONPATIENT RELATED MEALS	0	0	0	0	0	194.01
194.02	07952	KIDNEY CENTER	0	-25,542	0	1,571	0	194.02
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)	164,803		2,687,497	783,935	41,697	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.014559		0.222238	20.082874	1.007831	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	910		383,762	106,013	3,485	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000080		0.031735	2.715845	0.084234	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1304 | Period: From 07/01/2016 To 06/30/2017 | Worksheet B-1 | Date/Time Prepared: 11/27/2017 9:30 am

		Cost Center Description	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	NURSING ADMINISTRATION (DIRECT NRSING)	CENTRAL SERVICES & SUPPLY (REQUIS.)	
			9.00	10.00	11.00	13.00	14.00	
		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
5.01	00570	ADMITTING						5.01
5.02	00590	HOSPITAL ONLY A & G						5.02
5.03	00591	SHARED ADMN & GENERAL						5.03
6.00	00600	MAINTENANCE & REPAIRS						6.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING	38,277					9.00
10.00	01000	DIETARY	1,988	20,107				10.00
11.00	01100	CAFETERIA	0	14,823	8,268			11.00
13.00	01300	NURSING ADMINISTRATION	101	0	0	52,552		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,675	0	0	0	208,034	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	218	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	150	0	109	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	56	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	9,272	5,284	1,493	28,730	30,279	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,062	0	240	3,889	22,982	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,355	0	704	10	33,259	54.00
60.00	06000	LABORATORY	1,694	0	918	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	0	10	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	318	0	339	75	2,243	65.00
66.00	06600	PHYSICAL THERAPY	2,375	0	468	191	5,492	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	46,372	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	10,046	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	592	0	262	0	1,259	73.00
76.00	03950	SLEEP LAB	845	0	46	0	1,991	76.00
76.01	03951	DIABETIC EDUCATION	0	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	5,376	0	2,123	0	16,437	88.00
91.00	09100	EMERGENCY	2,372	0	1,047	19,657	28,508	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	36,449	20,107	7,759	52,552	198,868	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	257	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	509	0	9,166	192.00
194.00	07950	RETAIL PHARMACY	0	0	0	0	0	194.00
194.01	07951	NONPATIENT RELATED MEALS	0	0	0	0	0	194.01
194.02	07952	KIDNEY CENTER	1,571	0	0	0	0	194.02
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)	216,649	226,773	167,178	182,484	118,185	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	5.660031	11.278311	20.219884	3.472446	0.568104	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	17,227	51,301	37,819	6,644	39,427	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.450061	2.551400	4.574141	0.126427	0.189522	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1304 | Period: From 07/01/2016 To 06/30/2017 | Worksheet B-1 | Date/Time Prepared: 11/27/2017 9:30 am

		Cost Center Description	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TIME SPENT)	NONPHYSICIAN ANESTHETISTS (TIME SPENT)		
			16.00	17.00	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
5.01	00570	ADMITTING					5.01
5.02	00590	HOSPITAL ONLY A & G					5.02
5.03	00591	SHARED ADMN & GENERAL					5.03
6.00	00600	MAINTENANCE & REPAIRS					6.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	21,251,064				16.00
17.00	01700	SOCIAL SERVICE	0	2,269			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	100		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	1,678,508	2,269	0		30.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	1,336,139	0	100		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,907,923	0	0		54.00
60.00	06000	LABORATORY	4,969,927	0	0		60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	35,237	0	0		63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	649,714	0	0		65.00
66.00	06600	PHYSICAL THERAPY	1,304,133	0	0		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	319,393	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	36,567	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,361,487	0	0		73.00
76.00	03950	SLEEP LAB	381,393	0	0		76.00
76.01	03951	DIABETIC EDUCATION	10,482	0	0		76.01
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	0		88.00
91.00	09100	EMERGENCY	3,260,161	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	21,251,064	2,269	100		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0		192.00
194.00	07950	RETAIL PHARMACY	0	0	0		194.00
194.01	07951	NONPATIENT RELATED MEALS	0	0	0		194.01
194.02	07952	KIDNEY CENTER	0	0	0		194.02
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)	208,694	91,974	188,935		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.009820	40.535037	1,889.350000		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	9,520	5,650	5,967		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000448	2.490084	59.670000		205.00

POST STEPDOWN ADJUSTMENTS | Provider CCN: 14-1304 | Period: From 07/01/2016 To 06/30/2017 | Worksheet B-2 | Date/Time Prepared: 11/27/2017 9:30 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		IV THERAPY/RECOVERY ROOM	1	30.00	-237,510	7.00
8.00		RECOVERY ROOM	1	50.00	25,780	8.00
9.00		IV THERAPY	1	64.00	211,729	9.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1304 | Period: From 07/01/2016 To 06/30/2017 | Worksheet C Part I Date/Time Prepared: 11/27/2017 9:30 am

Title XVIII | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,897,597		1,897,597	0	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	861,526		861,526	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,555,805		1,555,805	0	0	54.00
60.00	06000	LABORATORY	1,413,624		1,413,624	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	20,662		20,662	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	211,729		211,729	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	346,221	0	346,221	0	0	65.00
66.00	06600	PHYSICAL THERAPY	628,212	0	628,212	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	89,966		89,966	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	18,862		18,862	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	653,080		653,080	0	0	73.00
76.00	03950	SLEEP LAB	92,089		92,089	0	0	76.00
76.01	03951	DIABETIC EDUCATION	7,254		7,254	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	3,044,531		3,044,531	0	0	88.00
91.00	09100	EMERGENCY	2,701,682		2,701,682	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	425,914		425,914		0	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	13,968,754	0	13,968,754	0	0	200.00
201.00		Less Observation Beds	425,914		425,914		0	201.00
202.00		Total (see instructions)	13,542,840	0	13,542,840	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1304 | Period: From 07/01/2016 To 06/30/2017 | Worksheet C Part I Date/Time Prepared: 11/27/2017 9:30 am

Title XVIII | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	929,208		929,208			30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	9,778	1,415,915	1,425,693	0.604286	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	214,718	5,693,205	5,907,923	0.263342	0.000000	54.00
60.00	06000	LABORATORY	368,600	4,601,327	4,969,927	0.284436	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	12,051	23,186	35,237	0.586372	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY	20,880	391,211	412,091	0.513792	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	170,100	479,614	649,714	0.532882	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	226,064	1,078,069	1,304,133	0.481709	0.000000	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	135,182	184,211	319,393	0.281678	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	24,796	11,771	36,567	0.515820	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	364,795	996,692	1,361,487	0.479681	0.000000	73.00
76.00	03950	SLEEP LAB	0	381,393	381,393	0.241454	0.000000	76.00
76.01	03951	DIABETIC EDUCATION	0	10,482	10,482	0.692044	0.000000	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	5,137,467	5,137,467			88.00
91.00	09100	EMERGENCY	41,239	3,218,922	3,260,161	0.828696	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,860	245,795	247,655	1.719788	0.000000	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	2,519,271	23,869,260	26,388,531			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	2,519,271	23,869,260	26,388,531			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1304 | Period: From 07/01/2016 To 06/30/2017 | Worksheet C Part I Date/Time Prepared: 11/27/2017 9:30 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
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	54.00
60.00	06000	LABORATORY	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	73.00
76.00	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
91.00	09100	EMERGENCY	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	92.00
		SPECIAL PURPOSE COST CENTERS		
113.00	11300	INTEREST EXPENSE		113.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1304 | Period: From 07/01/2016 To 06/30/2017 | Worksheet C Part I Date/Time Prepared: 11/27/2017 9:30 am

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,897,597		1,897,597	0	1,897,597	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	861,526		861,526	0	861,526	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,555,805		1,555,805	0	1,555,805	54.00
60.00	06000	LABORATORY	1,413,624		1,413,624	0	1,413,624	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	20,662		20,662	0	20,662	63.00
64.00	06400	INTRAVENOUS THERAPY	211,729		211,729	0	211,729	64.00
65.00	06500	RESPIRATORY THERAPY	346,221	0	346,221	0	346,221	65.00
66.00	06600	PHYSICAL THERAPY	628,212	0	628,212	0	628,212	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	89,966		89,966	0	89,966	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	18,862		18,862	0	18,862	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	653,080		653,080	0	653,080	73.00
76.00	03950	SLEEP LAB	92,089		92,089	0	92,089	76.00
76.01	03951	DIABETIC EDUCATION	7,254		7,254	0	7,254	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	3,044,531		3,044,531	0	3,044,531	88.00
91.00	09100	EMERGENCY	2,701,682		2,701,682	0	2,701,682	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	425,914		425,914		425,914	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	13,968,754	0	13,968,754	0	13,968,754	200.00
201.00		Less Observation Beds	425,914		425,914		425,914	201.00
202.00		Total (see instructions)	13,542,840	0	13,542,840	0	13,542,840	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1304 | Period: From 07/01/2016 To 06/30/2017 | Worksheet C Part I Date/Time Prepared: 11/27/2017 9:30 am

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	929,208		929,208			30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	9,778	1,415,915	1,425,693	0.604286	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	214,718	5,693,205	5,907,923	0.263342	0.000000	54.00
60.00	06000	LABORATORY	368,600	4,601,327	4,969,927	0.284436	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	12,051	23,186	35,237	0.586372	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY	20,880	391,211	412,091	0.513792	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	170,100	479,614	649,714	0.532882	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	226,064	1,078,069	1,304,133	0.481709	0.000000	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	135,182	184,211	319,393	0.281678	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	24,796	11,771	36,567	0.515820	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	364,795	996,692	1,361,487	0.479681	0.000000	73.00
76.00	03950	SLEEP LAB	0	381,393	381,393	0.241454	0.000000	76.00
76.01	03951	DIABETIC EDUCATION	0	10,482	10,482	0.692044	0.000000	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	5,137,467	5,137,467	0.592613	0.000000	88.00
91.00	09100	EMERGENCY	41,239	3,218,922	3,260,161	0.828696	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,860	245,795	247,655	1.719788	0.000000	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	2,519,271	23,869,260	26,388,531			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	2,519,271	23,869,260	26,388,531			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1304 | Period: From 07/01/2016 To 06/30/2017 | Worksheet C Part I Date/Time Prepared: 11/27/2017 9:30 am

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	06000	LABORATORY	0.000000		60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0.000000		63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000		64.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
76.00	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	0.000000		88.00
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 14-1304 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D Part II Date/Time Prepared: 11/27/2017 9:30 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	170,533	1,425,693	0.119614	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	285,998	5,907,923	0.048409	88,689	4,293	54.00
60.00	06000	LABORATORY	75,768	4,969,927	0.015245	161,869	2,468	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	588	35,237	0.016687	3,426	57	63.00
64.00	06400	INTRAVENOUS THERAPY	0	412,091	0.000000	7,194	0	64.00
65.00	06500	RESPIRATORY THERAPY	21,032	649,714	0.032371	64,449	2,086	65.00
66.00	06600	PHYSICAL THERAPY	77,966	1,304,133	0.059784	15,047	900	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	10,534	319,393	0.032981	51,490	1,698	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,256	36,567	0.061695	24,796	1,530	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	29,921	1,361,487	0.021977	117,861	2,590	73.00
76.00	03950	SLEEP LAB	20,501	381,393	0.053753	0	0	76.00
76.01	03951	DIABETIC EDUCATION	192	10,482	0.018317	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	172,057	5,137,467	0.033491	0	0	88.00
91.00	09100	EMERGENCY	135,009	3,260,161	0.041412	9,252	383	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	62,404	247,655	0.251980	1,860	469	92.00
200.00		Total (lines 50-199)	1,064,759	25,459,323		545,933	16,474	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1304 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D Part IV | Date/Time Prepared: 11/27/2017 9:30 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	188,935	0	0	0	188,935	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	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
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
200.00		Total (lines 50-199)	188,935	0	0	0	188,935	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1304 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D Part IV | Date/Time Prepared: 11/27/2017 9:30 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	1,425,693	0.132522	0.000000	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	5,907,923	0.000000	0.000000	88,689	54.00
60.00	06000	LABORATORY	0	4,969,927	0.000000	0.000000	161,869	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	35,237	0.000000	0.000000	3,426	63.00
64.00	06400	INTRAVENOUS THERAPY	0	412,091	0.000000	0.000000	7,194	64.00
65.00	06500	RESPIRATORY THERAPY	0	649,714	0.000000	0.000000	64,449	65.00
66.00	06600	PHYSICAL THERAPY	0	1,304,133	0.000000	0.000000	15,047	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	319,393	0.000000	0.000000	51,490	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	36,567	0.000000	0.000000	24,796	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,361,487	0.000000	0.000000	117,861	73.00
76.00	03950	SLEEP LAB	0	381,393	0.000000	0.000000	0	76.00
76.01	03951	DIABETIC EDUCATION	0	10,482	0.000000	0.000000	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	5,137,467	0.000000	0.000000	0	88.00
91.00	09100	EMERGENCY	0	3,260,161	0.000000	0.000000	9,252	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	247,655	0.000000	0.000000	1,860	92.00
200.00		Total (lines 50-199)	0	25,459,323			545,933	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1304 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D Part IV | Date/Time Prepared: 11/27/2017 9:30 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
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
60.00	06000	LABORATORY	0	0	0		60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	0	0		63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	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
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0		92.00
200.00		Total (lines 50-199)	0	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-1304 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D Part V Date/Time Prepared: 11/27/2017 9:30 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	0.604286	0	388,747	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.263342	0	1,644,835	0	0	54.00
60.00	06000	LABORATORY	0.284436	0	1,374,584	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0.586372	0	14,682	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0.513792	0	187,028	810	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.532882	0	163,877	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.481709	0	360,007	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.281678	0	64,638	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.515820	0	4,422	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.479681	0	401,684	663	0	73.00
76.00	03950	SLEEP LAB	0.241454	0	133,056	0	0	76.00
76.01	03951	DIABETIC EDUCATION	0.692044	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
91.00	09100	EMERGENCY	0.828696	0	768,090	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.719788	0	116,323	0	0	92.00
200.00		Subtotal (see instructions)		0	5,621,973	1,473	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	5,621,973	1,473	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-1304 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D Part V Date/Time Prepared: 11/27/2017 9:30 am

Title XVIII | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	234,914	0		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	433,154	0		54.00
60.00	06000	LABORATORY	390,981	0		60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	8,609	0		63.00
64.00	06400	INTRAVENOUS THERAPY	96,093	416		64.00
65.00	06500	RESPIRATORY THERAPY	87,327	0		65.00
66.00	06600	PHYSICAL THERAPY	173,419	0		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	18,207	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,281	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	192,680	318		73.00
76.00	03950	SLEEP LAB	32,127	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
91.00	09100	EMERGENCY	636,513	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	200,051	0		92.00
200.00		Subtotal (see instructions)	2,506,356	734		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	2,506,356	734		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1304 | Component CCN: 14-Z304 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D Part V Date/Time Prepared: 11/27/2017 9:30 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	0.604286	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.263342	0	0	0	0	54.00
60.00	06000	LABORATORY	0.284436	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0.586372	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0.513792	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.532882	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.481709	0	0	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.281678	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.515820	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.479681	0	0	0	0	73.00
76.00	03950	SLEEP LAB	0.241454	0	0	0	0	76.00
76.01	03951	DIABETIC EDUCATION	0.692044	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
91.00	09100	EMERGENCY	0.828696	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.719788	0	0	0	0	92.00
200.00		Subtotal (see instructions)		0	0	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		0	0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1304 | Component CCN: 14-Z304 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D Part V | Date/Time Prepared: 11/27/2017 9:30 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
60.00	06000	LABORATORY	0	0		60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	0		63.00
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
76.00	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
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
200.00		Subtotal (see instructions)	0	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	0	0		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1304 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D-1 | Date/Time Prepared: 11/27/2017 9:30 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)	1,340	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	727	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)	441	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	270	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)	270	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	36	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)	37	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	266	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	198	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)	200	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)	1,897,597	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)	5,311	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)	5,458	25.00
26.00	Total swing-bed cost (see instructions)	814,942	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	1,082,655	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)	1,082,655	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,489.21	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	396,130	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)	396,130	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1304 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D-1 | Date/Time Prepared: 11/27/2017 9:30 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)	211,390	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	607,520	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)	294,864	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	297,842	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	592,706	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)	286	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,489.21	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	425,914	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1304 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D-1 | Date/Time Prepared: 11/27/2017 9:30 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	278,033	1,897,597	0.146518	425,914	62,404	90.00
91.00	Nursing School cost	0	1,897,597	0.000000	425,914	0	91.00
92.00	Allied health cost	0	1,897,597	0.000000	425,914	0	92.00
93.00	All other Medical Education	0	1,897,597	0.000000	425,914	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 14-1304 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D-3 | Date/Time Prepared: 11/27/2017 9:30 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		247,809		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.604286	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.263342	88,689	23,356	54.00
60.00	06000	LABORATORY	0.284436	161,869	46,041	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0.586372	3,426	2,009	63.00
64.00	06400	INTRAVENOUS THERAPY	0.513792	7,194	3,696	64.00
65.00	06500	RESPIRATORY THERAPY	0.532882	64,449	34,344	65.00
66.00	06600	PHYSICAL THERAPY	0.481709	15,047	7,248	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.281678	51,490	14,504	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.515820	24,796	12,790	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.479681	117,861	56,536	73.00
76.00	03950	SLEEP LAB	0.241454	0	0	76.00
76.01	03951	DIABETIC EDUCATION	0.692044	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
91.00	09100	EMERGENCY	0.828696	9,252	7,667	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.719788	1,860	3,199	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		545,933	211,390	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)		545,933		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 14-1304 | Component CCN: 14-Z304 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D-3 | Date/Time Prepared: 11/27/2017 9:30 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	0.604286	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.263342	29,350	7,729	54.00
60.00	06000	LABORATORY	0.284436	67,505	19,201	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0.586372	3,426	2,009	63.00
64.00	06400	INTRAVENOUS THERAPY	0.513792	7,329	3,766	64.00
65.00	06500	RESPIRATORY THERAPY	0.532882	20,534	10,942	65.00
66.00	06600	PHYSICAL THERAPY	0.481709	138,358	66,648	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.281678	23,029	6,487	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.515820	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.479681	88,867	42,628	73.00
76.00	03950	SLEEP LAB	0.241454	0	0	76.00
76.01	03951	DIABETIC EDUCATION	0.692044	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
91.00	09100	EMERGENCY	0.828696	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.719788	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		378,398	159,410	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)		378,398		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-1304	Period: From 07/01/2016 To 06/30/2017	Worksheet E Part B Date/Time Prepared: 11/27/2017 9:30 am
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	2,507,090	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	PPS payments	0	3.00
4.00	Outlier payment (see instructions)	0	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	2,507,090	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	0	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)	2,532,161	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)	0	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	19,730	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	840,827	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)	1,671,604	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)	1,671,604	30.00
31.00	Primary payer payments	2,772	31.00
32.00	Subtotal (line 30 minus line 31)	1,668,832	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)	110,740	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	71,981	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	102,203	36.00
37.00	Subtotal (see instructions)	1,740,813	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	39.50
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	1,740,813	40.00
40.01	Sequestration adjustment (see instructions)	34,816	40.01
41.00	Interim payments	1,720,309	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	-14,312	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: 14-1304 | Period: From 07/01/2016 To 06/30/2017 | Worksheet E-1 Part I Date/Time Prepared: 11/27/2017 9:30 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		450,170		1,820,073	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM	02/02/2017	9,821	02/02/2017	99,764	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)		-9,821		-99,764	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)		440,349		1,720,309	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		98,035		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		14,312	6.02
7.00	Total Medicare program liability (see instructions)		538,384		1,705,997	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: 14-1304 | Component CCN: 14-Z304 | Period: From 07/01/2016 To 06/30/2017 | Worksheet E-1 Part I | Date/Time Prepared: 11/27/2017 9:30 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		689,867		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM	02/02/2017	22,524		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)		-22,524		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)		667,343		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		68,310		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		735,653		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: 14-1304	Period: From 07/01/2016 To 06/30/2017	Worksheet E-1 Part II Date/Time Prepared: 11/27/2017 9:30 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	146	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12	266	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2	73	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12	441	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200	26,388,531	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20	336,126	6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168	0	7.00
8.00	Calculation of the HIT incentive payment (see instructions)	0	8.00
9.00	Sequestration adjustment amount (see instructions)	0	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)	0	10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH		
30.00	Initial/interim HIT payment adjustment (see instructions)	0	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: 14-1304 Component CCN: 14-Z304	Period: From 07/01/2016 To 06/30/2017	Worksheet E-2 Date/Time Prepared: 11/27/2017 9:30 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)	598,633	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)	161,004	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	398	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)	759,637	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	759,637	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)	759,637	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	8,971	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)	750,666	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)	750,666	0	19.00
19.01	Sequestration adjustment (see instructions)	15,013	0	19.01
20.00	Interim payments	667,343	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)	68,310	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: 14-1304	Period: From 07/01/2016 To 06/30/2017	Worksheet E-3 Part V Date/Time Prepared: 11/27/2017 9:30 am
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	607,520	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)	607,520	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	613,595	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)	613,595	19.00
20.00	Deductibles (exclude professional component)	75,126	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	538,469	22.00
23.00	Coinsurance	0	23.00
24.00	Subtotal (line 22 minus line 23)	538,469	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	16,772	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	10,902	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	16,772	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	549,371	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)	549,371	30.00
30.01	Sequestration adjustment (see instructions)	10,987	30.01
31.00	Interim payments	440,349	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)	98,035	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: 14-1304 | Period: From 07/01/2016 To 06/30/2017 | Worksheet G | Date/Time Prepared: 11/27/2017 9:30 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	239,304	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	5,428,004	0	0	0	4.00
5.00	Other receivable	5,292	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-2,784,465	0	0	0	6.00
7.00	Inventory	159,361	0	0	0	7.00
8.00	Prepaid expenses	107,420	0	0	0	8.00
9.00	Other current assets	775,933	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)	3,930,849	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	65,000	0	0	0	12.00
13.00	Land improvements	326,018	0	0	0	13.00
14.00	Accumulated depreciation	-42,323	0	0	0	14.00
15.00	Buildings	12,426,073	0	0	0	15.00
16.00	Accumulated depreciation	-1,860,712	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	2,169,037	0	0	0	19.00
20.00	Accumulated depreciation	-685,894	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	109,793	0	0	0	23.00
24.00	Accumulated depreciation	-98,814	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	12,408,178	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	1,443,563	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	756,205	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	2,199,768	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	18,538,795	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	295,979	0	0	0	37.00
38.00	Salaries, wages, and fees payable	568,371	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	5,310,542	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	377,234	0	0	0	43.00
44.00	Other current liabilities	124,745	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	6,676,871	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	6,956,679	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	6,956,679	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	13,633,550	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	4,905,245				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)	4,905,245	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	18,538,795	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 14-1304 | Period: From 07/01/2016 To 06/30/2017 | Worksheet G-1 | Date/Time Prepared: 11/27/2017 9:30 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		5,485,717		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-580,472				2.00
3.00	Total (sum of line 1 and line 2)		4,905,245		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)		4,905,245		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)		4,905,245		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: 14-1304 | Period: From 07/01/2016 To 06/30/2017 | Worksheet G-2 Parts I & II Date/Time Prepared: 11/27/2017 9:30 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	504,130		504,130	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	374,457		374,457	5.00
6.00	Swing bed - NF	50,621		50,621	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)	929,208		929,208	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)	929,208		929,208	17.00
18.00	Ancillary services	1,545,754	15,289,195	16,834,949	18.00
19.00	Outpatient services	43,099	3,523,506	3,566,605	19.00
20.00	RURAL HEALTH CLINIC	0	5,137,467	5,137,467	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PROFESSIONAL CHARGES	21,120	1,714,642	1,735,762	27.00
27.01	PHYSICIANS' PRIVATE OFFICES	0	1,446,180	1,446,180	27.01
27.02	RETAIL PHARMACY	0	186,719	186,719	27.02
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	2,539,181	27,297,709	29,836,890	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		15,656,614		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		15,656,614		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 14-1304	Period: From 07/01/2016 To 06/30/2017	Worksheet G-3 Date/Time Prepared: 11/27/2017 9:30 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	29,836,890	1.00
2.00	Less contractual allowances and discounts on patients' accounts	15,543,138	2.00
3.00	Net patient revenues (line 1 minus line 2)	14,293,752	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	15,656,614	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-1,362,862	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	3,968	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	507	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	222,897	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	22,137	22.00
23.00	Governmental appropriations	13,333	23.00
24.00	INTERCOMPANY REVENUE	373,257	24.00
24.01	MISC INCOME	146,291	24.01
25.00	Total other income (sum of lines 6-24)	782,390	25.00
26.00	Total (line 5 plus line 25)	-580,472	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-580,472	29.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1304 | Component CCN: 14-3453 | Period: From 07/01/2016 To 06/30/2017 | Worksheet M-1 | Date/Time Prepared: 11/27/2017 9:30 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	770,450	58,610	829,060	0	829,060	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	318,884	24,258	343,142	0	343,142	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	273,925	20,838	294,763	0	294,763	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	60,236	4,582	64,818	0	64,818	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	189,359	14,405	203,764	0	203,764	9.00
10.00	Subtotal (sum of lines 1 through 9)	1,612,854	122,693	1,735,547	0	1,735,547	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	59,274	59,274	0	59,274	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	59,274	59,274	0	59,274	14.00
15.00	Medical Supplies	0	16,437	16,437	0	16,437	15.00
16.00	Transportation (Health Care Staff)	0	2,302	2,302	0	2,302	16.00
17.00	Depreciation-Medical Equipment	0	9,728	9,728	0	9,728	17.00
18.00	Professional Liability Insurance	0	34,283	34,283	0	34,283	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	62,750	62,750	0	62,750	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	1,612,854	244,717	1,857,571	0	1,857,571	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	17,931	17,931	0	17,931	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	17,931	17,931	0	17,931	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	95,295	95,295	0	95,295	29.00
30.00	Administrative Costs	288,266	166,483	454,749	-224,431	230,318	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	288,266	261,778	550,044	-224,431	325,613	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	1,901,120	524,426	2,425,546	-224,431	2,201,115	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1304 | Component CCN: 14-3453 | Period: From 07/01/2016 To 06/30/2017 | Worksheet M-1 | Date/Time Prepared: 11/27/2017 9:30 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	829,060		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	343,142		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	294,763		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	64,818		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	203,764		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	1,735,547		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	59,274		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	59,274		14.00
15.00	Medical Supplies	0	16,437		15.00
16.00	Transportation (Health Care Staff)	0	2,302		16.00
17.00	Depreciation-Medical Equipment	0	9,728		17.00
18.00	Professional Liability Insurance	0	34,283		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	62,750		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	1,857,571		22.00
	COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	17,931		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	17,931		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	95,295		29.00
30.00	Administrative Costs	-17,713	212,605		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-17,713	307,900		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-17,713	2,183,402		32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1304 | Component CCN: 14-3453 | Period: From 07/01/2016 To 06/30/2017 | Worksheet M-2 | Date/Time Prepared: 11/27/2017 9:30 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	3.24	14,890	4,200	13,608		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	2.34	6,869	2,100	4,914		3.00
4.00	Subtotal (sum of lines 1 through 3)	5.58	21,759		18,522	21,759	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	0.94	1,727			1,727	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	6.52	23,486			23,486	8.00
9.00	Physician Services Under Agreements		0			0	9.00
						1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)					1,857,571	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					17,931	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					1,875,502	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					0.990439	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					307,900	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					861,129	15.00
16.00	Total overhead (sum of lines 14 and 15)					1,169,029	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					1,169,029	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					1,157,852	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					3,015,423	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 14-1304 Component CCN: 14-3453	Period: From 07/01/2016 To 06/30/2017	Worksheet M-3 Date/Time Prepared: 11/27/2017 9:30 am
	Title XVIII	RHC I	Cost

				1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES				
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			3,015,423	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			28,866	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			2,986,557	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			23,486	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)			23,486	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			127.16	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)	127.16	127.16		9.00
	CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	0	4,493		10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	571,330		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	571,330		16.00
16.01	Total program charges (see instructions)(from contractor's records)		916,899		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		7,937		16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		4,945		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.)		389,970		16.04
16.05	Total program cost (see instructions)	0	394,915		16.05
17.00	Primary payer amounts		169		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		78,923		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		166,008		19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		394,746		20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		5,077		21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		399,823		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)		399,823		26.00
26.01	Sequestration adjustment (see instructions)		7,996		26.01
27.00	Interim payments		375,273		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)		16,554		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: 14-1304 | Component CCN: 14-3453 | Period: From 07/01/2016 To 06/30/2017 | Worksheet M-4 | Date/Time Prepared: 11/27/2017 9:30 am

Title XVIII | RHC I | Cost

		Pneumococcal	Influenza	
		1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	1,735,547	1,735,547	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000000	0.004393	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	0	7,624	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	0	10,158	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	0	17,782	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	1,857,571	1,857,571	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	1,157,852	1,157,852	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.000000	0.009573	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	0	11,084	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	0	28,866	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	0	398	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	0.00	72.53	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	0	70	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	0	5,077	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)		28,866	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)		5,077	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 14-1304 Component CCN: 14-3453	Period: From 07/01/2016 To 06/30/2017	Worksheet M-5 Date/Time Prepared: 11/27/2017 9:30 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		382,157	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		02/02/2017	6,884	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		-6,884	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		375,273	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		16,554	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		391,827	7.00

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