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: 14-1305	Period: From 07/01/2016 To 06/30/2017	Worksheet S Parts I-III Date/Time Prepared: 11/28/2017 9:28 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 11/28/2017 Time: 9:28 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 MEMORIAL HOSPITAL ASSOCIATION (14-1305) 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	149,655	29,300	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	159,935	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
10.00	RURAL HEALTH CLINIC I	0		66,238		0	10.00
200.00	Total	0	309,590	95,538	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: 14-1305	Period: From 07/01/2016 To 06/30/2017	Worksheet S-2 Part I Date/Time Prepared: 11/27/2017 8:13 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: SOUTH ADAMS STREET	PO Box: 160			1.00
2.00	City: CARTHAGE	State: IL	Zip Code: 62321-	County: HANCOCK	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	MEMORIAL HOSPITAL ASSOCIATION	141305	99914	1	08/08/2000	N	O	P	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	MEMORIAL HOSPITAL	14Z305	99914		08/08/2000	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	BOWEN CLINIC	143456	99914		02/05/1999	N	O	N	15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	07/01/2016	06/30/2017	20.00
21.00	Type of Control (see instructions)	2		21.00
	Inpatient PPS Information			
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	N	N	22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	N	N	22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N	22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.	N	N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	2	N	23.00

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	0	0	0	0	0	0	24.00
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: 14-1305	Period: From 07/01/2016 To 06/30/2017	Worksheet S-2 Part I Date/Time Prepared: 11/27/2017 8:13 pm

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

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

		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)				0.00	0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00	0.00			61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)		0.00	0.00			61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)		0.00	0.00			61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).		0.00	0.00			61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)		0.00	0.00			61.05

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 14-1305	Period: From 07/01/2016 To 06/30/2017	Worksheet S-2 Part I Date/Time Prepared: 11/27/2017 8:13 pm

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 14-1305	Period: From 07/01/2016 To 06/30/2017	Worksheet S-2 Part I Date/Time Prepared: 11/27/2017 8:13 pm

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 14-1305	Period: From 07/01/2016 To 06/30/2017	Worksheet S-2 Part I Date/Time Prepared: 11/27/2017 8:13 pm

Line	Description	V 1.00	XIX 2.00	Line
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

Line	Description	Physical 1.00	Occupational 2.00	Speech 3.00	Respiratory 4.00	Line
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.	Y	Y	Y	N	109.00

Line	Description	1.00	Line
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

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

Line	Description	Premiums 1.00	Losses 2.00	Insurance 3.00	Line
118.01	List amounts of malpractice premiums and paid losses:	167,573	0	0	118.01

Line	Description	1.00	2.00	Line
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.	Y	5.01	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: 14-1305	Period: From 07/01/2016 To 06/30/2017	Worksheet S-2 Part I Date/Time Prepared: 11/27/2017 8:13 pm

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

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

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

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

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

		Part A	Part B	Title V	Title XIX	
		1.00	2.00	3.00	4.00	
	Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)					
155.00	Hospital	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)	1	168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)		168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	0.00	169.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 14-1305	Period: From 07/01/2016 To 06/30/2017	Worksheet S-2 Part I Date/Time Prepared: 11/27/2017 8:13 pm

		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	10/01/2015	09/30/2016	170.00
		1.00	2.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)	N	0	171.00

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

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

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

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

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

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	Y	11/19/2017	Y	11/19/2017	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 14-1305	Period: From 07/01/2016 To 06/30/2017	Worksheet S-2 Part II Date/Time Prepared: 11/27/2017 8:13 pm

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

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

		1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)		
	Capital Related Cost		
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions	N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.	N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions	Y	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.	Y	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.	Y	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.	N	31.00
	Purchased Services		
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.	Y	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.	N	33.00
	Provider-Based Physicians		
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.	Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.	Y	35.00

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

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	TERESA	SMITH	41.00
42.00	Enter the employer/company name of the cost report preparer.	MEMORIAL HOSPITAL ASSOCIATION		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	217-357-8564	TSMITH@MHTLC.ORG	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 14-1305	Period: From 07/01/2016 To 06/30/2017	Worksheet S-2 Part II Date/Time Prepared: 11/27/2017 8:13 pm

		3.00		
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	CHIEF FINANCIAL OFFICER		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: 14-1305 | Period: From 07/01/2016 To 06/30/2017 | Worksheet S-3 Part I Date/Time Prepared: 11/27/2017 8:13 pm

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	18	6,570	27,072.00	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)		18	6,570	27,072.00	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	43.00				0	13.00
14.00	Total (see instructions)		18	6,570	27,072.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE	46.00	0	0			21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RHC (CONSOLIDATED)	88.00				0	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		18				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: 14-1305 | Period: From 07/01/2016 To 06/30/2017 | Worksheet S-3 Part I | Date/Time Prepared: 11/27/2017 8:13 pm

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	530	275	1,128			1.00
2.00	HMO and other (see instructions)	100	0				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	686	0	723			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	61			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,216	275	1,912			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		140	254			13.00
14.00	Total (see instructions)	1,216	415	2,166	0.00	157.62	14.00
15.00	CAH visits	6,809	4,565	19,055			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE			0	0.00	0.00	21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	0	0	0			24.10
25.00	CMHC - CMHC						25.00
26.00	RHC (CONSOLIDATED)	3,430	0	23,824	0.00	29.38	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	187.00	27.00
28.00	Observation Bed Days		104	302			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	34	73			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: 14-1305 | Period: From 07/01/2016 To 06/30/2017 | Worksheet S-3 Part I | Date/Time Prepared: 11/27/2017 8:13 pm

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	192	113	464	1.00
2.00	HMO and other (see instructions)			40	0		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				0		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	192	113	464	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE	0.00				0	21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RHC (CONSOLIDATED)	0.00					26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-1305 | Period: From 07/01/2016 To 06/30/2017 | Worksheet S-8

Component CCN: 14-3456 | Date/Time Prepared: 11/27/2017 8:13 pm

RHC I | Cost

		1.00	
	Clinic Address and Identification		
1.00	Street		1.00

		City	State	ZIP Code	
		1.00	2.00	3.00	
2.00	City, State, ZIP Code, County		IL		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
9.01				9.01
9.02				9.02
9.03				9.03
9.04				9.04
9.05				9.05
9.06				9.06
9.07				9.07
9.08				9.08
9.09				9.09
9.10				9.10

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

		Sunday		Monday		Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
	Facility hours of operations (1)						
11.00	Clinic			08:00	17:00	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.	Y	6	13.00

		Provider name	CCN number	
		1.00	2.00	
14.00	RHC/FQHC name, CCN number	BOWEN CLINIC	143456	14.00
14.01		ADAMS STREET CLINIC	143405	14.01
14.02		LAHARPE CLINIC	148534	14.02
14.03		NAUVOO CLINIC	148547	14.03
14.04		CARTHAGE CLINIC	148571	14.04
14.05		COLCHESTER CLINIC	148572	14.05

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

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA	Provider CCN: 14-1305 Component CCN: 14-3456	Period: From 07/01/2016 To 06/30/2017	Worksheet S-8 Date/Time Prepared: 11/27/2017 8:13 pm
		RHC I	Cost

			County		
			4.00		
2.00	City, State, ZIP Code, County		HANCOCK		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	18:00	08:00	17:00	08:00	17:00	11.00

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

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 14-1305	Period: From 07/01/2016 To 06/30/2017	Worksheet S-10 Date/Time Prepared: 11/27/2017 8:13 pm

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.551879	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	2,496,119	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH or supplemental payments from Medicaid?	N	4.00
5.00	If line 4 is no, then enter DSH or supplemental payments from Medicaid	1,487,302	5.00
6.00	Medicaid charges	12,785,066	6.00
7.00	Medicaid cost (line 1 times line 6)	7,055,809	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)	3,072,388	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	40,990	18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	3,072,388	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)	195,699	175,913	371,612	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	108,002	175,913	283,915	21.00
22.00	Payments received from patients for amounts previously written off as charity care	882	3,957	4,839	22.00
23.00	Cost of charity care (line 21 minus line 22)	107,120	171,956	279,076	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)	1,075,494	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	125,958	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	193,782	27.01
28.00	Non-Medicare bad debt expense (line 26 minus line 27.01)	881,712	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	554,422	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	833,498	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	3,905,886	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-1305 | Period: From 07/01/2016 To 06/30/2017 | Worksheet A | Date/Time Prepared: 11/27/2017 8:13 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		1,503,706	1,503,706	-1,458,325	45,381	1.00
1.02	00102	NEW CAP REL COSTS-BLDG & FIXT (NEW B		0	0	3,002,478	3,002,478	1.02
1.03	00103	CAP REL COSTS-BLDG & FIXT MOB		0	0	430,770	430,770	1.03
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		674,758	674,758	-61,906	612,852	2.00
2.01	00201	CAP REL COSTS-MOB MVBLE EQUIP		0	0	84,932	84,932	2.01
3.00	00300	OTHER CAPITAL RELATED COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	134,039	2,544,740	2,678,779	-44,994	2,633,785	4.00
5.01	00550	ADMINISTRATION & GENERAL	1,781,021	1,917,605	3,698,626	9,652	3,708,278	5.01
7.00	00700	OPERATION OF PLANT	204,526	474,794	679,320	0	679,320	7.00
7.01	00701	OPERATION OF PLANT MOB	0	50,693	50,693	0	50,693	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	69,902	69,902	0	69,902	8.00
9.00	00900	HOUSEKEEPING	147,187	46,157	193,344	0	193,344	9.00
10.00	01000	DIETARY	177,825	112,756	290,581	-113,260	177,321	10.00
11.00	01100	CAFETERIA	0	0	0	113,260	113,260	11.00
13.00	01300	NURSING ADMINISTRATION	194,807	68,172	262,979	-44,049	218,930	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	103,300	79,977	183,277	0	183,277	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	44,049	44,049	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	467,081	25,710	492,791	0	492,791	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	890,493	433,708	1,324,201	184,727	1,508,928	30.00
43.00	04300	NURSERY	0	0	0	192,191	192,191	43.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	341,252	197,719	538,971	0	538,971	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	351,448	79,139	430,587	-376,918	53,669	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	481,366	430,917	912,283	0	912,283	54.00
56.00	05600	RADIOISOTOPE	0	81,211	81,211	0	81,211	56.00
60.00	06000	LABORATORY	639,913	433,613	1,073,526	0	1,073,526	60.00
60.02	06002	GEO PSYCH	116,192	88,871	205,063	0	205,063	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	37,969	37,969	0	37,969	62.00
65.00	06500	RESPIRATORY THERAPY	201,084	60,895	261,979	-29,910	232,069	65.00
66.00	06600	PHYSICAL THERAPY	0	124,051	124,051	0	124,051	66.00
69.00	06900	ELECTROCARDIOLOGY	0	7,487	7,487	29,910	37,397	69.00
69.01	06901	PULMONARY REHAB	57,677	63,963	121,640	0	121,640	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	35,894	751,449	787,343	-105,149	682,194	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	105,149	105,149	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	169,008	1,026,629	1,195,637	0	1,195,637	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	3,905,033	1,150,262	5,055,295	-1,864,875	3,190,420	88.00
90.00	09000	CLINIC	33,117	326,561	359,678	1,606,358	1,966,036	90.00
91.00	09100	EMERGENCY	418,478	1,808,998	2,227,476	0	2,227,476	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
93.01	04950	DIABETIC EDUCATION	85,578	3,647	89,225	0	89,225	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		2,025,021	2,025,021	-2,025,021	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	10,936,319	16,701,080	27,637,399	-320,931	27,316,468	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	98,000	24,452	122,452	320,931	443,383	192.00
194.00	07950	NAUVOO APARTMENTS	0	0	0	0	0	194.00
194.02	07951	BEAUTY SHOP	0	0	0	0	0	194.02
200.00		TOTAL (SUM OF LINES 118-199)	11,034,319	16,725,532	27,759,851	0	27,759,851	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-1305 | Period: From 07/01/2016 To 06/30/2017 | Worksheet A | Date/Time Prepared: 11/27/2017 8:13 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
		GENERAL SERVICE COST CENTERS			
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	0	45,381	1.00
1.02	00102	NEW CAP REL COSTS-BLDG & FIXT (NEW B	-29,181	2,973,297	1.02
1.03	00103	CAP REL COSTS-BLDG & FIXT MOB	-51,587	379,183	1.03
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	-54,294	558,558	2.00
2.01	00201	CAP REL COSTS-MOB MVBLE EQUIP	0	84,932	2.01
3.00	00300	OTHER CAPITAL RELATED COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-51,686	2,582,099	4.00
5.01	00550	ADMINISTRATION & GENERAL	-569,074	3,139,204	5.01
7.00	00700	OPERATION OF PLANT	0	679,320	7.00
7.01	00701	OPERATION OF PLANT MOB	0	50,693	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	69,902	8.00
9.00	00900	HOUSEKEEPING	0	193,344	9.00
10.00	01000	DIETARY	-1,583	175,738	10.00
11.00	01100	CAFETERIA	-31,401	81,859	11.00
13.00	01300	NURSING ADMINISTRATION	0	218,930	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-4,565	178,712	16.00
17.00	01700	SOCIAL SERVICE	0	44,049	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	492,791	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	0	1,508,928	30.00
43.00	04300	NURSERY	0	192,191	43.00
46.00	04600	OTHER LONG TERM CARE	0	0	46.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0	538,971	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	53,669	52.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	912,283	54.00
56.00	05600	RADIOISOTOPE	0	81,211	56.00
60.00	06000	LABORATORY	0	1,073,526	60.00
60.02	06002	GEO PSYCH	-16,817	188,246	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	37,969	62.00
65.00	06500	RESPIRATORY THERAPY	0	232,069	65.00
66.00	06600	PHYSICAL THERAPY	-11,671	112,380	66.00
69.00	06900	ELECTROCARDIOLOGY	0	37,397	69.00
69.01	06901	PULMONARY REHAB	0	121,640	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	682,194	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	105,149	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-412,469	783,168	73.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	-20,719	3,169,701	88.00
90.00	09000	CLINIC	-1,345,761	620,275	90.00
91.00	09100	EMERGENCY	-394,388	1,833,088	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	93.00
93.01	04950	DIABETIC EDUCATION	0	89,225	93.01
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0	0	95.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-2,995,196	24,321,272	118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	443,383	192.00
194.00	07950	NAUVOO APARTMENTS	0	0	194.00
194.02	07951	BEAUTY SHOP	0	0	194.02
200.00		TOTAL (SUM OF LINES 118-199)	-2,995,196	24,764,655	200.00

RECLASSIFICATIONS | Provider CCN: 14-1305 | Period: From 07/01/2016 To 06/30/2017 | Worksheet A-6 | Date/Time Prepared: 11/27/2017 8:13 pm

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - TO RECLASS DEPRECIATION EXPENSE				
1.00	NEW CAP REL COSTS-BLDG & FIXT (NEW B	1.02	0	1,138,324	1.00
2.00	CAP REL COSTS-BLDG & FIXT MOB	1.03	0	313,683	2.00
3.00	RURAL HEALTH CLINIC	88.00	0	3,120	3.00
	TOTALS		0	1,455,127	
	B - TO RECLASS CAFETERIA				
1.00	CAFETERIA	11.00	69,311	43,949	1.00
	TOTALS		69,311	43,949	
	C - TO RECLASS RHC DEPR EXPENSE				
1.00	RURAL HEALTH CLINIC	88.00	0	14,300	1.00
2.00		0.00	0	0	2.00
	TOTALS		0	14,300	
	D - TO RECLASS SOCIAL SERVICES SALARY				
1.00	SOCIAL SERVICE	17.00	44,049	0	1.00
	TOTALS		44,049	0	
	E - TO RECLASS INTEREST				
1.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	34,128	1.00
2.00	ADMINISTRATION & GENERAL	5.01	0	9,652	2.00
3.00	NEW CAP REL COSTS-BLDG & FIXT (NEW B	1.02	0	1,864,154	3.00
4.00	CAP REL COSTS-BLDG & FIXT MOB	1.03	0	117,087	4.00
	TOTALS		0	2,025,021	
	F - TO RECLASS ACUTE AND NURSERY COSTS				
1.00	ADULTS & PEDIATRICS	30.00	150,775	33,952	1.00
2.00	NURSERY	43.00	156,868	35,323	2.00
	TOTALS		307,643	69,275	
	G - MOB EQUIPMENT DEPRECIATION				
1.00	CAP REL COSTS-MOB MVBLE EQUIP	2.01	0	84,932	1.00
	TOTALS		0	84,932	
	H - TO RECLASS EKG TIME				
1.00	ELECTROCARDIOLOGY	69.00	28,704	1,206	1.00
	TOTALS		28,704	1,206	
	I - TO RECLASS NON RHC TIME				
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	154,265	0	1.00
	TOTALS		154,265	0	
	J - TO RECLASS NON RHC TIME				
1.00	CLINIC	90.00	1,064,883	225,795	1.00
2.00	PHYSICIANS' PRIVATE OFFICES	192.00	88,333	78,333	2.00
3.00	CLINIC	90.00	270,686	0	3.00
	TOTALS		1,423,902	304,128	
	K - RECLASS ALLOWABLE PHYSICIAN FICA				
1.00	CLINIC	90.00	0	44,994	1.00
	TOTALS		0	44,994	
	M - IMPLANTABLE SUPPLIES RECLASS				
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	105,149	1.00
	TOTALS		0	105,149	
500.00	Grand Total: Increases		2,027,874	4,148,081	500.00

RECLASSIFICATIONS | Provider CCN: 14-1305 | Period: From 07/01/2016 To 06/30/2017 | Worksheet A-6 | Date/Time Prepared: 11/27/2017 8:13 pm

	Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
	A - TO RECLASS DEPRECIATION EXPENSE					
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1,455,127	9	1.00
2.00		0.00	0	0	9	2.00
3.00		0.00	0	0	9	3.00
	TOTALS		0	1,455,127		
	B - TO RECLASS CAFETERIA					
1.00	DIETARY	10.00	69,311	43,949	0	1.00
	TOTALS		69,311	43,949		
	C - TO RECLASS RHC DEPR EXPENSE					
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	3,198	9	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	11,102	11	2.00
	TOTALS		0	14,300		
	D - TO RECLASS SOCIAL SERVICES SALARY					
1.00	NURSING ADMINISTRATION	13.00	44,049	0	0	1.00
	TOTALS		44,049	0		
	E - TO RECLASS INTEREST					
1.00	INTEREST EXPENSE	113.00	0	2,025,021	11	1.00
2.00		0.00	0	0	0	2.00
3.00		0.00	0	0	11	3.00
4.00		0.00	0	0	11	4.00
	TOTALS		0	2,025,021		
	F - TO RECLASS ACUTE AND NURSERY COSTS					
1.00	DELIVERY ROOM & LABOR ROOM	52.00	150,775	33,952	0	1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	156,868	35,323	0	2.00
	TOTALS		307,643	69,275		
	G - MOB EQUIPMENT DEPRECIATION					
1.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	84,932	9	1.00
	TOTALS		0	84,932		
	H - TO RECLASS EKG TIME					
1.00	RESPIRATORY THERAPY	65.00	28,704	1,206	0	1.00
	TOTALS		28,704	1,206		
	I - TO RECLASS NON RHC TIME					
1.00	RURAL HEALTH CLINIC	88.00	154,265	0	0	1.00
	TOTALS		154,265	0		
	J - TO RECLASS NON RHC TIME					
1.00	RURAL HEALTH CLINIC	88.00	1,064,883	225,795	0	1.00
2.00	RURAL HEALTH CLINIC	88.00	88,333	78,333	0	2.00
3.00	RURAL HEALTH CLINIC	88.00	270,686	0	0	3.00
	TOTALS		1,423,902	304,128		
	K - RECLASS ALLOWABLE PHYSICIAN FICA					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	44,994	0	1.00
	TOTALS		0	44,994		
	M - IMPLANTABLE SUPPLIES RECLASS					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	105,149	0	1.00
	TOTALS		0	105,149		
500.00	Grand Total: Decreases		2,027,874	4,148,081		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1305 | Period: From 07/01/2016 To 06/30/2017 | Worksheet A-7 Part I Date/Time Prepared: 11/27/2017 8:13 pm

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	587,457	2,500	0	2,500	90,000	1.00
2.00	Land Improvements	1,279,933	46,247	0	46,247	0	2.00
3.00	Buildings and Fixtures	24,806,444	90,177	0	90,177	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	6,261,233	610,524	0	610,524	361,072	6.00
7.00	HIT designated Assets	1,968,769	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	34,903,836	749,448	0	749,448	451,072	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	34,903,836	749,448	0	749,448	451,072	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	499,957	0	1.00
2.00	Land Improvements	1,326,180	0	2.00
3.00	Buildings and Fixtures	24,896,621	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	6,510,685	0	6.00
7.00	HIT designated Assets	1,968,769	0	7.00
8.00	Subtotal (sum of lines 1-7)	35,202,212	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	35,202,212	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1305 | Period: From 07/01/2016 To 06/30/2017 | Worksheet A-7 Part II Date/Time Prepared: 11/27/2017 8:13 pm

	Cost Center Description	SUMMARY OF CAPITAL Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1,503,706	0	0	0	0	1.00
1.02	NEW CAP REL COSTS-BLDG & FIXT (NEW B	0	0	0	0	0	1.02
1.03	CAP REL COSTS-BLDG & FIXT MOB	0	0	0	0	0	1.03
2.00	NEW CAP REL COSTS-MVBLE EQUIP	674,758	0	0	0	0	2.00
2.01	CAP REL COSTS-MOB MVBLE EQUIP	0	0	0	0	0	2.01
3.00	Total (sum of lines 1-2)	2,178,464	0	0	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
		14.00	15.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2			
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	1,503,706	1.00
1.02	NEW CAP REL COSTS-BLDG & FIXT (NEW B	0	0	1.02
1.03	CAP REL COSTS-BLDG & FIXT MOB	0	0	1.03
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	674,758	2.00
2.01	CAP REL COSTS-MOB MVBLE EQUIP	0	0	2.01
3.00	Total (sum of lines 1-2)	0	2,178,464	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1305 | Period: From 07/01/2016 To 06/30/2017 | Worksheet A-7 Part III Date/Time Prepared: 11/27/2017 8:13 pm

	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	NEW CAP REL COSTS-BLDG & FIXT	1,561,143	0	1,561,143	0.044348	0	1.00
1.02	NEW CAP REL COSTS-BLDG & FIXT (NEW B	20,100,921	0	20,100,921	0.571013	0	1.02
1.03	CAP REL COSTS-BLDG & FIXT MOB	5,060,694	0	5,060,694	0.143761	0	1.03
2.00	NEW CAP REL COSTS-MVBLE EQUIP	7,984,512	0	7,984,512	0.226818	0	2.00
2.01	CAP REL COSTS-MOB MVBLE EQUIP	494,942	0	494,942	0.014060	0	2.01
3.00	Total (sum of lines 1-2)	35,202,212	0	35,202,212	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	45,381	0	1.00
1.02	NEW CAP REL COSTS-BLDG & FIXT (NEW B	0	0	0	1,133,426	0	1.02
1.03	CAP REL COSTS-BLDG & FIXT MOB	0	0	0	313,683	0	1.03
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	535,532	0	2.00
2.01	CAP REL COSTS-MOB MVBLE EQUIP	0	0	0	84,932	0	2.01
3.00	Total (sum of lines 1-2)	0	0	0	2,112,954	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	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	0	45,381	1.00
1.02	NEW CAP REL COSTS-BLDG & FIXT (NEW B	1,839,871	0	0	0	2,973,297	1.02
1.03	CAP REL COSTS-BLDG & FIXT MOB	65,500	0	0	0	379,183	1.03
2.00	NEW CAP REL COSTS-MVBLE EQUIP	23,026	0	0	0	558,558	2.00
2.01	CAP REL COSTS-MOB MVBLE EQUIP	0	0	0	0	84,932	2.01
3.00	Total (sum of lines 1-2)	1,928,397	0	0	0	4,041,351	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-1305 | Period: From 07/01/2016 To 06/30/2017 | Worksheet A-8 | Date/Time Prepared: 11/27/2017 8:13 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
				Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
1.02	Investment income - NEW CAP REL COSTS-BLDG & FIXT (NEW B (chapter 2)		0	NEW CAP REL COSTS-BLDG & FIXT (NEW B	1.02	0	1.02
1.03	Investment income - CAP REL COSTS-BLDG & FIXT MOB (chapter 2)		0	CAP REL COSTS-BLDG & FIXT MOB	1.03	0	1.03
2.00	Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
2.01	Investment income - CAP REL COSTS-MOB MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MOB MVBLE EQUIP	2.01	0	2.01
3.00	Investment income - other (chapter 2)	B	-4,898	NEW CAP REL COSTS-BLDG & FIXT (NEW B	1.02	9	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-1,246	ADMINISTRATION & GENERAL	5.01	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-1,680,787			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	0			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-31,401	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-4,565	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines	B	-1,583	DIETARY	10.00	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	-11,671	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - NEW CAP REL COSTS-BLDG & FIXT		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
26.02	Depreciation - NEW CAP REL COSTS-BLDG & FIXT (NEW B		0	NEW CAP REL COSTS-BLDG & FIXT (NEW B	1.02	0	26.02
26.03	Depreciation - CAP REL COSTS-BLDG & FIXT MOB		0	CAP REL COSTS-BLDG & FIXT MOB	1.03	0	26.03

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-1305 | Period: From 07/01/2016 To 06/30/2017 | Worksheet A-8 | Date/Time Prepared: 11/27/2017 8:13 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
				Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
27.00	Depreciation - NEW CAP REL COSTS-MVBLE EQUIP		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
27.01	Depreciation - CAP REL COSTS-MOB MVBLE EQUIP		0	CAP REL COSTS-MOB MVBLE EQUIP	2.01	0	27.01
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	-54,294	NEW CAP REL COSTS-MVBLE EQUIP	2.00	9	32.00
33.00	RENT INCOME	B	-34,924	CLINIC	90.00	0	33.00
34.00			0		0.00	0	34.00
35.00			0		0.00	0	35.00
36.00	LOBBYING	A	-9,339	ADMINISTRATION & GENERAL	5.01	0	36.00
37.00			0		0.00	0	37.00
38.00	ADVERTISING - LAHARPE	A	-1,735	RURAL HEALTH CLINIC	88.00	0	38.00
39.00	ADVERTISING - HOSPITAL	A	-87,742	ADMINISTRATION & GENERAL	5.01	0	39.00
40.00	ADVERTSING- BOWEN	A	-2,236	RURAL HEALTH CLINIC	88.00	0	40.00
41.00	ADVERTISING - CLINIC	A	-1,608	CLINIC	90.00	0	41.00
42.00	ADVERTISING - WOMENS	A	-8,623	RURAL HEALTH CLINIC	88.00	0	42.00
43.00	PROFESSIONL LIABILITY	A	-52,233	CLINIC	90.00	0	43.00
44.00	UNNECESSARY BORROWING -HOSPITAL	A	-24,283	NEW CAP REL COSTS-BLDG & FIXT (NEW B	1.02	11	44.00
45.00	CLINIC SALARY REIMBURSEMENT	B	-37,614	CLINIC	90.00	0	45.00
45.01	ADVERTISING - AUGUSTA	A	-3,864	RURAL HEALTH CLINIC	88.00	0	45.01
45.02	RENTAL INCOME - MIDWEST	B	-1,486	CLINIC	90.00	0	45.02
45.03	PROVIDER TAX	A	-379,386	ADMINISTRATION & GENERAL	5.01	0	45.03
45.04	MISC INCOME	B	-840	ADMINISTRATION & GENERAL	5.01	0	45.04
45.05	UNNECESSARY BORROWING - MOB	A	-51,587	CAP REL COSTS-BLDG & FIXT MOB	1.03	11	45.05
45.06			0		0.00	0	45.06
45.07	ADVERTISING - NAUVOO	A	-2,334	RURAL HEALTH CLINIC	88.00	0	45.07
45.08	PURCHASE DISCOUNTS	B	-2,666	ADMINISTRATION & GENERAL	5.01	0	45.08
45.09			0		0.00	0	45.09
45.10	MARKETING SALARIES	A	-65,996	ADMINISTRATION & GENERAL	5.01	0	45.10
45.11	MARKETING FRINGES	A	-15,978	ADMINISTRATION & GENERAL	5.01	0	45.11
45.12	CITY OF CARTHAGE INTEREST	A	-5,881	ADMINISTRATION & GENERAL	5.01	0	45.12
45.13	ADVERTISING - COLCHSTR	A	-1,927	RURAL HEALTH CLINIC	88.00	0	45.13
45.14	340B PHARMACY	A	-412,469	DRUGS CHARGED TO PATIENTS	73.00	0	45.14
45.15			0		0.00	0	45.15
45.16			0		0.00	0	45.16
45.17			0		0.00	0	45.17
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-2,995,196				50.00

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 14-1305 | Period: From 07/01/2016 To 06/30/2017 | Worksheet A-8-2 | Date/Time Prepared: 11/27/2017 8:13 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	60.00	LABORATORY	74,531	0	74,531	0	0	1.00
2.00	0.00		0	0	0	0	0	2.00
3.00	60.02	GEO PSYCH	16,817	16,817	0	0	0	3.00
4.00	69.01	PULMONARY REHAB	9,085	0	9,085	0	0	4.00
5.00	90.00	CLINIC	1,217,896	1,217,896	0	0	0	5.00
6.00	91.00	EMERGENCY	1,770,145	394,388	1,375,757	0	0	6.00
7.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	51,686	51,686	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			3,140,160	1,680,787	1,459,373		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	60.00	LABORATORY	0	0	0	0	0	1.00
2.00	0.00		0	0	0	0	0	2.00
3.00	60.02	GEO PSYCH	0	0	0	0	0	3.00
4.00	69.01	PULMONARY REHAB	0	0	0	0	0	4.00
5.00	90.00	CLINIC	0	0	0	0	0	5.00
6.00	91.00	EMERGENCY	0	0	0	0	0	6.00
7.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	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	60.00	LABORATORY	0	0	0	0	1.00
2.00	0.00		0	0	0	0	2.00
3.00	60.02	GEO PSYCH	0	0	0	16,817	3.00
4.00	69.01	PULMONARY REHAB	0	0	0	0	4.00
5.00	90.00	CLINIC	0	0	0	1,217,896	5.00
6.00	91.00	EMERGENCY	0	0	0	394,388	6.00
7.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	51,686	7.00
8.00	0.00		0	0	0	0	8.00
9.00	0.00		0	0	0	0	9.00
10.00	0.00		0	0	0	0	10.00
200.00			0	0	0	1,680,787	200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS	Provider CCN: 14-1305	Period: From 07/01/2016 To 06/30/2017	Worksheet A-8-3 Parts I-VI Date/Time Prepared: 11/27/2017 8:13 pm
		Physical Therapy	Cost

		1.00	
	PART I - GENERAL INFORMATION		
1.00	Total number of weeks worked (excluding aides) (see instructions)	52	1.00
2.00	Line 1 multiplied by 15 hours per week	780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)	0	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	5.38	8.00

		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	410.00	619.75	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	80.83	60.62	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)	40.42	40.42	30.31			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)	33,140	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)	37,569	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)	70,709	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)	70,709	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)	70,709	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)	0	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)	0	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)	0	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)	0	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)	0	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)	0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)	0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE		
	Standard Travel Expense		
36.00	Therapists (line 5 times column 2, line 11)	0	36.00
37.00	Assistants (line 6 times column 3, line 11)	0	37.00
38.00	Subtotal (sum of lines 36 and 37)	0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)	0	39.00
	Optional Travel Allowance and Optional Travel Expense		
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)	0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)	0	41.00
42.00	Subtotal (sum of lines 40 and 41)	0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)	0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.		
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)	0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)	0	45.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 14-1305 | Period: From 07/01/2016 To 06/30/2017 | Worksheet A-8-3 Parts I-VI Date/Time Prepared: 11/27/2017 8:13 pm

Physical Therapy | Cost

		1.00	
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)	0	46.00

		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	80.83	60.62	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)	70,709	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	0	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)	70,709	63.00
64.00	Total cost of outside supplier services (from your records)	82,380	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)	11,671	65.00
	LINE 33 CALCULATION		
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others	0	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	0	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	0	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	0	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	0	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

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS

Provider CCN: 14-1305 | Period: From 07/01/2016 To 06/30/2017 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 11/27/2017 8:13 pm

Occupational Therapy | Cost

		1.00	
	PART I - GENERAL INFORMATION		
1.00	Total number of weeks worked (excluding aides) (see instructions)	52	1.00
2.00	Line 1 multiplied by 15 hours per week	780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)	0	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	162.75	291.95	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	76.61	57.45	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	28.73			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)	12,468	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)	16,773	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)	29,241	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)	29,241	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)	64.31	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)	50,162	22.00
23.00	Total salary equivalency (see instructions)	50,162	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)	0	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)	0	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)	0	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)	0	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)	0	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: 14-1305	Period: From 07/01/2016 To 06/30/2017	Worksheet A-8-3 Parts I-VI Date/Time Prepared: 11/27/2017 8:13 pm
		Occupational Therapy	Cost

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

		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	76.61	57.45	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)	50,162	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	0	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)	50,162	63.00
64.00	Total cost of outside supplier services (from your records)	36,376	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	0	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	0	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	0	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	0	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	0	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

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 14-1305 | Period: From 07/01/2016 To 06/30/2017 | Worksheet A-8-3 Parts I-VI Date/Time Prepared: 11/27/2017 8:13 pm

Speech Pathology | Cost

		1.00	
	PART I - GENERAL INFORMATION		
1.00	Total number of weeks worked (excluding aides) (see instructions)	52	1.00
2.00	Line 1 multiplied by 15 hours per week	780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)	0	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	58.00	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	73.61	0.00	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	36.81	36.81	0.00			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	1,890	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)	4,269	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)	4,269	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)	4,269	20.00
	If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.		
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)	73.60	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)	57,408	22.00
23.00	Total salary equivalency (see instructions)	57,408	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)	0	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)	0	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)	0	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)	0	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)	0	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)	0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)	0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE		
	Standard Travel Expense		
36.00	Therapists (line 5 times column 2, line 11)	0	36.00
37.00	Assistants (line 6 times column 3, line 11)	0	37.00
38.00	Subtotal (sum of lines 36 and 37)	0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)	0	39.00
	Optional Travel Allowance and Optional Travel Expense		
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)	0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)	0	41.00
42.00	Subtotal (sum of lines 40 and 41)	0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)	0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.		
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)	0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)	0	45.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS	Provider CCN: 14-1305	Period: From 07/01/2016 To 06/30/2017	Worksheet A-8-3 Parts I-VI Date/Time Prepared: 11/27/2017 8:13 pm
		Speech Pathology	Cost

						1.00	
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00
		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	73.61	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)	57,408	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	0	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)	57,408	63.00
64.00	Total cost of outside supplier services (from your records)	5,295	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	0	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	0	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	0	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	0	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	0	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: 14-1305 | Period: From 07/01/2016 To 06/30/2017 | Worksheet B Part I | Date/Time Prepared: 11/27/2017 8:13 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS				
				NEW BLDG & FIXT	NEW BLDG & FIXT (NEW B	BLDG & FIXT MOB	NEW MVBLE EQUIP	
			0	1.00	1.02	1.03	2.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	45,381	45,381				1.00
1.02	00102	NEW CAP REL COSTS-BLDG & FIXT (NEW B	2,973,297	0	2,973,297			1.02
1.03	00103	CAP REL COSTS-BLDG & FIXT MOB	379,183	0	0	379,183		1.03
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	558,558				558,558	2.00
2.01	00201	CAP REL COSTS-MOB MVBLE EQUIP	84,932				0	2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,582,099	0	0	0	0	4.00
5.01	00550	ADMINISTRATION & GENERAL	3,139,204	15,972	714,160	150,989	144,401	5.01
7.00	00700	OPERATION OF PLANT	679,320	1,985	147,361	0	27,150	7.00
7.01	00701	OPERATION OF PLANT MOB	50,693	0	0	7,751	0	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	69,902	0	12,759	0	2,004	8.00
9.00	00900	HOUSEKEEPING	193,344	0	31,968	3,049	5,020	9.00
10.00	01000	DIETARY	175,738	0	60,431	0	9,490	10.00
11.00	01100	CAFETERIA	81,859	0	34,422	0	5,406	11.00
13.00	01300	NURSING ADMINISTRATION	218,930	0	18,578	0	2,918	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	178,712	4,891	55,173	0	18,540	16.00
17.00	01700	SOCIAL SERVICE	44,049	0	12,268	0	1,927	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	492,791	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,508,928	0	685,768	0	107,695	30.00
43.00	04300	NURSERY	192,191	0	15,774	0	2,477	43.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	538,971	0	280,911	0	44,115	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	53,669	0	62,113	0	9,754	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	912,283	0	310,495	0	48,761	54.00
56.00	05600	RADIOISOTOPE	81,211	0	21,733	0	3,413	56.00
60.00	06000	LABORATORY	1,073,526	0	118,337	0	18,584	60.00
60.02	06002	GEO PSYCH	188,246	0	0	14,743	0	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	37,969	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	232,069	0	48,443	0	7,608	65.00
66.00	06600	PHYSICAL THERAPY	112,380	0	18,157	0	2,851	66.00
69.00	06900	ELECTROCARDIOLOGY	37,397	0	78,868	0	12,386	69.00
69.01	06901	PULMONARY REHAB	121,640	0	0	14,576	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	682,194	0	22,854	0	3,589	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	105,149	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	783,168	0	87,701	0	13,773	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	3,169,701	22,533	0	31,851	45,491	88.00
90.00	09000	CLINIC	620,275	0	0	85,013	0	90.00
91.00	09100	EMERGENCY	1,833,088	0	129,835	0	20,390	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
93.01	04950	DIABETIC EDUCATION	89,225	0	0	9,950	0	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	24,321,272	45,381	2,968,109	317,922	557,743	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	5,188	0	815	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	443,383	0	0	61,261	0	192.00
194.00	07950	NAUVOO APARTMENTS	0	0	0	0	0	194.00
194.02	07951	BEAUTY SHOP	0	0	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)	24,764,655	45,381	2,973,297	379,183	558,558	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1305 | Period: From 07/01/2016 To 06/30/2017 | Worksheet B Part I Date/Time Prepared: 11/27/2017 8:13 pm

		Cost Center Description	CAPITAL RELATED COSTS MOB MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATION & GENERAL	OPERATION OF PLANT	
			2.01	4.00	4A	5.01	7.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.02	00102	NEW CAP REL COSTS-BLDG & FIXT (NEW B						1.02
1.03	00103	CAP REL COSTS-BLDG & FIXT MOB						1.03
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	CAP REL COSTS-MOB MVBLE EQUIP	84,932					2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	2,582,099				4.00
5.01	00550	ADMINISTRATION & GENERAL	33,819	459,890	4,658,435	4,658,435		5.01
7.00	00700	OPERATION OF PLANT	0	52,812	908,628	210,521	1,119,149	7.00
7.01	00701	OPERATION OF PLANT MOB	1,736	0	60,180	13,943	0	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	84,665	19,616	6,762	8.00
9.00	00900	HOUSEKEEPING	683	38,006	272,070	63,036	16,942	9.00
10.00	01000	DIETARY	0	28,020	273,679	63,409	32,026	10.00
11.00	01100	CAFETERIA	0	17,897	139,584	32,340	18,242	11.00
13.00	01300	NURSING ADMINISTRATION	0	38,928	279,354	64,724	9,845	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	26,674	283,990	65,798	29,239	16.00
17.00	01700	SOCIAL SERVICE	0	11,374	69,618	16,130	6,502	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	120,608	613,399	142,119	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	268,873	2,571,264	595,739	363,426	30.00
43.00	04300	NURSERY	0	40,506	250,948	58,142	8,359	43.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	88,117	952,114	220,596	148,871	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	11,311	136,847	31,706	32,917	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	124,297	1,395,836	323,403	164,549	54.00
56.00	05600	RADIOISOTOPE	0	0	106,357	24,642	11,517	56.00
60.00	06000	LABORATORY	0	165,236	1,375,683	318,733	62,714	60.00
60.02	06002	GEO PSYCH	3,302	30,003	236,294	54,747	0	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	37,969	8,797	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	44,511	332,631	77,068	25,672	65.00
66.00	06600	PHYSICAL THERAPY	0	0	133,388	30,905	9,623	66.00
69.00	06900	ELECTROCARDIOLOGY	0	7,412	136,063	31,525	41,797	69.00
69.01	06901	PULMONARY REHAB	3,265	14,893	154,374	35,767	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	9,268	717,905	166,332	12,112	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	105,149	24,362	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	43,641	928,283	215,075	46,478	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	7,134	600,841	3,877,551	898,399	0	88.00
90.00	09000	CLINIC	19,042	120,877	845,207	195,827	0	90.00
91.00	09100	EMERGENCY	0	108,058	2,091,371	484,552	68,807	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0			92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
93.01	04950	DIABETIC EDUCATION	2,229	22,098	123,502	28,614	0	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	71,210	2,494,151	24,152,338	4,516,567	1,116,400	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	6,003	1,391	2,749	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	13,722	87,948	606,314	140,477	0	192.00
194.00	07950	NAUVOO APARTMENTS	0	0	0	0	0	194.00
194.02	07951	BEAUTY SHOP	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments			0			200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	84,932	2,582,099	24,764,655	4,658,435	1,119,149	202.00

		Cost Center Description	OPERATION OF PLANT MOB	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
			7.01	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.02	00102	NEW CAP REL COSTS-BLDG & FIXT (NEW B						1.02
1.03	00103	CAP REL COSTS-BLDG & FIXT MOB						1.03
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	CAP REL COSTS-MOB MVBLE EQUIP						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	ADMINISTRATION & GENERAL						5.01
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT MOB	74,123					7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	111,043				8.00
9.00	00900	HOUSEKEEPING	1,025	0	353,073			9.00
10.00	01000	DIETARY	0	0	6,231	375,345		10.00
11.00	01100	CAFETERIA	0	0	3,549	0	193,715	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	1,915	0	5,252	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	12,172	0	6,482	16.00
17.00	01700	SOCIAL SERVICE	0	0	1,265	0	1,208	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	2,050	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	34,042	70,706	375,345	34,274	30.00
43.00	04300	NURSERY	0	0	1,626	0	5,643	43.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	42,975	28,963	0	12,386	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	6,404	0	1,582	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	15,097	32,013	0	16,658	54.00
56.00	05600	RADIOISOTOPE	0	0	2,241	0	0	56.00
60.00	06000	LABORATORY	0	0	12,201	0	24,901	60.00
60.02	06002	GEO PSYCH	4,957	0	7,026	0	6,202	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	4,995	0	6,685	65.00
66.00	06600	PHYSICAL THERAPY	0	0	1,872	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	8,132	0	1,113	69.00
69.01	06901	PULMONARY REHAB	4,901	0	6,946	0	3,086	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	2,356	0	1,639	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	9,042	0	4,485	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	10,710	2,395	45,046	0	14,807	88.00
90.00	09000	CLINIC	28,585	2,279	40,514	0	29,619	90.00
91.00	09100	EMERGENCY	0	14,229	13,387	0	12,610	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
93.01	04950	DIABETIC EDUCATION	3,346	0	4,742	0	3,033	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	53,524	111,017	323,344	375,345	193,715	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	535	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	20,599	26	29,194	0	0	192.00
194.00	07950	NAUVOO APARTMENTS	0	0	0	0	0	194.00
194.02	07951	BEAUTY SHOP	0	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)	74,123	111,043	353,073	375,345	193,715	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1305 | Period: From 07/01/2016 To 06/30/2017 | Worksheet B Part I Date/Time Prepared: 11/27/2017 8:13 pm

		Cost Center Description	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	Subtotal	
			13.00	16.00	17.00	19.00	24.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.02	00102	NEW CAP REL COSTS-BLDG & FIXT (NEW B						1.02
1.03	00103	CAP REL COSTS-BLDG & FIXT MOB						1.03
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	CAP REL COSTS-MOB MVBLE EQUIP						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	ADMINISTRATION & GENERAL						5.01
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT MOB						7.01
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	361,090					13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	397,681				16.00
17.00	01700	SOCIAL SERVICE	0	0	94,723			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	8,827	0	0	766,395		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	147,573	27,221	92,829	0	4,312,419	30.00
43.00	04300	NURSERY	24,297	1,455	0	0	350,470	43.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	53,331	21,697	0	0	1,480,933	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	6,810	1,318	0	0	217,584	52.00
53.00	05300	ANESTHESIOLOGY	0	15,412	0	766,395	781,807	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	92,967	0	0	2,040,523	54.00
56.00	05600	RADIOISOTOPE	0	5,665	0	0	150,422	56.00
60.00	06000	LABORATORY	0	98,384	0	0	1,892,616	60.00
60.02	06002	GEO PSYCH	0	5,539	0	0	314,765	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	584	0	0	47,350	62.00
65.00	06500	RESPIRATORY THERAPY	28,786	7,053	0	0	482,890	65.00
66.00	06600	PHYSICAL THERAPY	0	2,600	0	0	178,388	66.00
69.00	06900	ELECTROCARDIOLOGY	4,794	5,917	0	0	229,341	69.00
69.01	06901	PULMONARY REHAB	0	1,559	0	0	206,633	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	9,126	0	0	909,470	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,868	0	0	131,379	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	19,311	17,271	0	0	1,239,945	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	55,337	0	0	4,904,245	88.00
90.00	09000	CLINIC	0	3,654	0	0	1,145,685	90.00
91.00	09100	EMERGENCY	54,300	22,807	1,894	0	2,763,957	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
93.01	04950	DIABETIC EDUCATION	13,061	247	0	0	176,545	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	361,090	397,681	94,723	766,395	23,957,367	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	10,678	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	796,610	192.00
194.00	07950	NAUVOO APARTMENTS	0	0	0	0	0	194.00
194.02	07951	BEAUTY SHOP	0	0	0	0	0	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)	361,090	397,681	94,723	766,395	24,764,655	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1305 | Period: From 07/01/2016 To 06/30/2017 | Worksheet B Part I | Date/Time Prepared: 11/27/2017 8:13 pm

		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			25.00	26.00	
		GENERAL SERVICE COST CENTERS			
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT			1.00
1.02	00102	NEW CAP REL COSTS-BLDG & FIXT (NEW B			1.02
1.03	00103	CAP REL COSTS-BLDG & FIXT MOB			1.03
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP			2.00
2.01	00201	CAP REL COSTS-MOB MVBLE EQUIP			2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.01	00550	ADMINISTRATION & GENERAL			5.01
7.00	00700	OPERATION OF PLANT			7.00
7.01	00701	OPERATION OF PLANT MOB			7.01
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
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	0	4,312,419	30.00
43.00	04300	NURSERY	0	350,470	43.00
46.00	04600	OTHER LONG TERM CARE	0	0	46.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0	1,480,933	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	217,584	52.00
53.00	05300	ANESTHESIOLOGY	0	781,807	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,040,523	54.00
56.00	05600	RADIOISOTOPE	0	150,422	56.00
60.00	06000	LABORATORY	0	1,892,616	60.00
60.02	06002	GEO PSYCH	0	314,765	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	47,350	62.00
65.00	06500	RESPIRATORY THERAPY	0	482,890	65.00
66.00	06600	PHYSICAL THERAPY	0	178,388	66.00
69.00	06900	ELECTROCARDIOLOGY	0	229,341	69.00
69.01	06901	PULMONARY REHAB	0	206,633	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	909,470	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	131,379	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,239,945	73.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	0	4,904,245	88.00
90.00	09000	CLINIC	0	1,145,685	90.00
91.00	09100	EMERGENCY	0	2,763,957	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	93.00
93.01	04950	DIABETIC EDUCATION	0	176,545	93.01
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0	0	95.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	23,957,367	118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	10,678	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	796,610	192.00
194.00	07950	NAUVOO APARTMENTS	0	0	194.00
194.02	07951	BEAUTY SHOP	0	0	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	24,764,655	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1305 | Period: From 07/01/2016 To 06/30/2017 | Worksheet B Part II Date/Time Prepared: 11/27/2017 8:13 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS				
				NEW BLDG & FIXT	NEW BLDG & FIXT (NEW B	BLDG & FIXT MOB	NEW MVBLE EQUIP	
			0	1.00	1.02	1.03	2.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.02	00102	NEW CAP REL COSTS-BLDG & FIXT (NEW B						1.02
1.03	00103	CAP REL COSTS-BLDG & FIXT MOB						1.03
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	CAP REL COSTS-MOB MVBLE EQUIP						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	4.00
5.01	00550	ADMINISTRATION & GENERAL	0	15,972	714,160	150,989	144,401	5.01
7.00	00700	OPERATION OF PLANT	0	1,985	147,361	0	27,150	7.00
7.01	00701	OPERATION OF PLANT MOB	0	0	0	7,751	0	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	12,759	0	2,004	8.00
9.00	00900	HOUSEKEEPING	0	0	31,968	3,049	5,020	9.00
10.00	01000	DIETARY	0	0	60,431	0	9,490	10.00
11.00	01100	CAFETERIA	0	0	34,422	0	5,406	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	18,578	0	2,918	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	4,891	55,173	0	18,540	16.00
17.00	01700	SOCIAL SERVICE	0	0	12,268	0	1,927	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	685,768	0	107,695	30.00
43.00	04300	NURSERY	0	0	15,774	0	2,477	43.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	280,911	0	44,115	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	62,113	0	9,754	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	310,495	0	48,761	54.00
56.00	05600	RADIOISOTOPE	0	0	21,733	0	3,413	56.00
60.00	06000	LABORATORY	0	0	118,337	0	18,584	60.00
60.02	06002	GEO PSYCH	0	0	0	14,743	0	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	48,443	0	7,608	65.00
66.00	06600	PHYSICAL THERAPY	0	0	18,157	0	2,851	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	78,868	0	12,386	69.00
69.01	06901	PULMONARY REHAB	0	0	0	14,576	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	22,854	0	3,589	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	87,701	0	13,773	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	22,533	0	31,851	45,491	88.00
90.00	09000	CLINIC	0	0	0	85,013	0	90.00
91.00	09100	EMERGENCY	0	0	129,835	0	20,390	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
93.01	04950	DIABETIC EDUCATION	0	0	0	9,950	0	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	45,381	2,968,109	317,922	557,743	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	5,188	0	815	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	61,261	0	192.00
194.00	07950	NAUVOO APARTMENTS	0	0	0	0	0	194.00
194.02	07951	BEAUTY SHOP	0	0	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)	0	45,381	2,973,297	379,183	558,558	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1305 | Period: From 07/01/2016 To 06/30/2017 | Worksheet B Part II Date/Time Prepared: 11/27/2017 8:13 pm

		Cost Center Description	CAPITAL RELATED COSTS MOB MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATION & GENERAL	OPERATION OF PLANT	
			2.01	2A	4.00	5.01	7.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.02	00102	NEW CAP REL COSTS-BLDG & FIXT (NEW B						1.02
1.03	00103	CAP REL COSTS-BLDG & FIXT MOB						1.03
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	CAP REL COSTS-MOB MVBLE EQUIP						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0			4.00
5.01	00550	ADMINISTRATION & GENERAL	33,819	1,059,341	0	1,059,341		5.01
7.00	00700	OPERATION OF PLANT	0	176,496	0	47,873	224,369	7.00
7.01	00701	OPERATION OF PLANT MOB	1,736	9,487	0	3,171	0	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	14,763	0	4,461	1,356	8.00
9.00	00900	HOUSEKEEPING	683	40,720	0	14,335	3,396	9.00
10.00	01000	DIETARY	0	69,921	0	14,419	6,421	10.00
11.00	01100	CAFETERIA	0	39,828	0	7,354	3,657	11.00
13.00	01300	NURSING ADMINISTRATION	0	21,496	0	14,718	1,974	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	78,604	0	14,963	5,862	16.00
17.00	01700	SOCIAL SERVICE	0	14,195	0	3,668	1,303	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	32,318	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	793,463	0	135,472	72,862	30.00
43.00	04300	NURSERY	0	18,251	0	13,222	1,676	43.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	325,026	0	50,164	29,846	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	71,867	0	7,210	6,599	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	359,256	0	73,542	32,989	54.00
56.00	05600	RADIOISOTOPE	0	25,146	0	5,604	2,309	56.00
60.00	06000	LABORATORY	0	136,921	0	72,481	12,573	60.00
60.02	06002	GEO PSYCH	3,302	18,045	0	12,450	0	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	2,000	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	56,051	0	17,525	5,147	65.00
66.00	06600	PHYSICAL THERAPY	0	21,008	0	7,028	1,929	66.00
69.00	06900	ELECTROCARDIOLOGY	0	91,254	0	7,169	8,379	69.00
69.01	06901	PULMONARY REHAB	3,265	17,841	0	8,134	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	26,443	0	37,824	2,428	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	5,540	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	101,474	0	48,908	9,318	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	7,134	107,009	0	204,301	0	88.00
90.00	09000	CLINIC	19,042	104,055	0	44,531	0	90.00
91.00	09100	EMERGENCY	0	150,225	0	110,188	13,794	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0				92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
93.01	04950	DIABETIC EDUCATION	2,229	12,179	0	6,507	0	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	71,210	3,960,365	0	1,027,080	223,818	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	6,003	0	316	551	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	13,722	74,983	0	31,945	0	192.00
194.00	07950	NAUVOO APARTMENTS	0	0	0	0	0	194.00
194.02	07951	BEAUTY SHOP	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments		0				200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	84,932	4,041,351	0	1,059,341	224,369	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1305 | Period: From 07/01/2016 To 06/30/2017 | Worksheet B Part II | Date/Time Prepared: 11/27/2017 8:13 pm

		Cost Center Description	OPERATION OF PLANT MOB	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
			7.01	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.02	00102	NEW CAP REL COSTS-BLDG & FIXT (NEW B						1.02
1.03	00103	CAP REL COSTS-BLDG & FIXT MOB						1.03
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	CAP REL COSTS-MOB MVBLE EQUIP						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	ADMINISTRATION & GENERAL						5.01
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT MOB	12,658					7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	20,580				8.00
9.00	00900	HOUSEKEEPING	175	0	58,626			9.00
10.00	01000	DIETARY	0	0	1,035	91,796		10.00
11.00	01100	CAFETERIA	0	0	589	0	51,428	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	318	0	1,394	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	2,021	0	1,721	16.00
17.00	01700	SOCIAL SERVICE	0	0	210	0	321	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	544	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	6,309	11,741	91,796	9,098	30.00
43.00	04300	NURSERY	0	0	270	0	1,498	43.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	7,965	4,809	0	3,288	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	1,063	0	420	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,798	5,316	0	4,423	54.00
56.00	05600	RADIOISOTOPE	0	0	372	0	0	56.00
60.00	06000	LABORATORY	0	0	2,026	0	6,611	60.00
60.02	06002	GEO PSYCH	847	0	1,167	0	1,647	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	829	0	1,775	65.00
66.00	06600	PHYSICAL THERAPY	0	0	311	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	1,350	0	296	69.00
69.01	06901	PULMONARY REHAB	837	0	1,153	0	819	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	391	0	435	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	1,501	0	1,191	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,829	444	7,480	0	3,931	88.00
90.00	09000	CLINIC	4,881	422	6,727	0	7,863	90.00
91.00	09100	EMERGENCY	0	2,637	2,223	0	3,348	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
93.01	04950	DIABETIC EDUCATION	571	0	787	0	805	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	9,140	20,575	53,689	91,796	51,428	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	89	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	3,518	5	4,848	0	0	192.00
194.00	07950	NAUVOO APARTMENTS	0	0	0	0	0	194.00
194.02	07951	BEAUTY SHOP	0	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)	12,658	20,580	58,626	91,796	51,428	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1305 | Period: From 07/01/2016 To 06/30/2017 | Worksheet B Part II Date/Time Prepared: 11/27/2017 8:13 pm

		Cost Center Description	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	Subtotal	
			13.00	16.00	17.00	19.00	24.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.02	00102	NEW CAP REL COSTS-BLDG & FIXT (NEW B						1.02
1.03	00103	CAP REL COSTS-BLDG & FIXT MOB						1.03
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	CAP REL COSTS-MOB MVBLE EQUIP						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	ADMINISTRATION & GENERAL						5.01
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT MOB						7.01
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	39,900					13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	103,171				16.00
17.00	01700	SOCIAL SERVICE	0	0	19,697			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	975	0	0	33,837		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	16,306	7,063	19,303		1,163,413	30.00
43.00	04300	NURSERY	2,685	378	0		37,980	43.00
46.00	04600	OTHER LONG TERM CARE	0	0	0		0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,893	5,630	0		432,621	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	753	342	0		88,254	52.00
53.00	05300	ANESTHESIOLOGY	0	3,999	0		3,999	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	24,122	0		502,446	54.00
56.00	05600	RADIOISOTOPE	0	1,470	0		34,901	56.00
60.00	06000	LABORATORY	0	25,511	0		256,123	60.00
60.02	06002	GEO PSYCH	0	1,437	0		35,593	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	152	0		2,152	62.00
65.00	06500	RESPIRATORY THERAPY	3,181	1,830	0		86,338	65.00
66.00	06600	PHYSICAL THERAPY	0	675	0		30,951	66.00
69.00	06900	ELECTROCARDIOLOGY	530	1,535	0		110,513	69.00
69.01	06901	PULMONARY REHAB	0	405	0		29,189	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2,368	0		69,889	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	485	0		6,025	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,134	4,481	0		169,007	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	14,358	0		339,352	88.00
90.00	09000	CLINIC	0	948	0		169,427	90.00
91.00	09100	EMERGENCY	6,000	5,918	394		294,727	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0		0	93.00
93.01	04950	DIABETIC EDUCATION	1,443	64	0		22,356	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0		0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	39,900	103,171	19,697	0	3,885,256	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0		6,959	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0		115,299	192.00
194.00	07950	NAUVOO APARTMENTS	0	0	0		0	194.00
194.02	07951	BEAUTY SHOP	0	0	0		0	194.02
200.00		Cross Foot Adjustments				33,837	33,837	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	39,900	103,171	19,697	33,837	4,041,351	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1305 | Period: From 07/01/2016 To 06/30/2017 | Worksheet B Part II Date/Time Prepared: 11/27/2017 8:13 pm

		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			25.00	26.00	
		GENERAL SERVICE COST CENTERS			
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT			1.00
1.02	00102	NEW CAP REL COSTS-BLDG & FIXT (NEW B			1.02
1.03	00103	CAP REL COSTS-BLDG & FIXT MOB			1.03
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP			2.00
2.01	00201	CAP REL COSTS-MOB MVBLE EQUIP			2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.01	00550	ADMINISTRATION & GENERAL			5.01
7.00	00700	OPERATION OF PLANT			7.00
7.01	00701	OPERATION OF PLANT MOB			7.01
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
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	0	1,163,413	30.00
43.00	04300	NURSERY	0	37,980	43.00
46.00	04600	OTHER LONG TERM CARE	0	0	46.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0	432,621	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	88,254	52.00
53.00	05300	ANESTHESIOLOGY	0	3,999	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	502,446	54.00
56.00	05600	RADIOISOTOPE	0	34,901	56.00
60.00	06000	LABORATORY	0	256,123	60.00
60.02	06002	GEO PSYCH	0	35,593	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	2,152	62.00
65.00	06500	RESPIRATORY THERAPY	0	86,338	65.00
66.00	06600	PHYSICAL THERAPY	0	30,951	66.00
69.00	06900	ELECTROCARDIOLOGY	0	110,513	69.00
69.01	06901	PULMONARY REHAB	0	29,189	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	69,889	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	6,025	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	169,007	73.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	0	339,352	88.00
90.00	09000	CLINIC	0	169,427	90.00
91.00	09100	EMERGENCY	0	294,727	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	93.00
93.01	04950	DIABETIC EDUCATION	0	22,356	93.01
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0	0	95.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	3,885,256	118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	6,959	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	115,299	192.00
194.00	07950	NAUVOO APARTMENTS	0	0	194.00
194.02	07951	BEAUTY SHOP	0	0	194.02
200.00		Cross Foot Adjustments	0	33,837	200.00
201.00		Negative Cost Centers	0	0	201.00
202.00		TOTAL (sum lines 118-201)	0	4,041,351	202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1305 | Period: From 07/01/2016 To 06/30/2017 | Worksheet B-1 | Date/Time Prepared: 11/27/2017 8:13 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			NEW BLDG & FIXT (WFMG/ADMIN SQUARE FEET)	NEW BLDG & FIXT (NEW B (NEW HOSP SQUARE FE)	BLDG & FIXT MOB (MOB SQUARE FEET)	NEW MVBLE EQUIP (HOSP/WFMG/ADM IN SQUARE FEET)	MOB MVBLE EQUIP (MOB SQUARE FEET)	
			1.00	1.02	1.03	2.00	2.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	8,322					1.00
1.02	00102	NEW CAP REL COSTS-BLDG & FIXT (NEW B	0	42,412				1.02
1.03	00103	CAP REL COSTS-BLDG & FIXT MOB	0	0	25,000			1.03
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP				50,734		2.00
2.01	00201	CAP REL COSTS-MOB MVBLE EQUIP				0	25,000	2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	4.00
5.01	00550	ADMINISTRATION & GENERAL	2,929	10,187	9,955	13,116	9,955	5.01
7.00	00700	OPERATION OF PLANT	364	2,102	0	2,466	0	7.00
7.01	00701	OPERATION OF PLANT MOB	0	0	511	0	511	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	182	0	182	0	8.00
9.00	00900	HOUSEKEEPING	0	456	201	456	201	9.00
10.00	01000	DIETARY	0	862	0	862	0	10.00
11.00	01100	CAFETERIA	0	491	0	491	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	265	0	265	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	897	787	0	1,684	0	16.00
17.00	01700	SOCIAL SERVICE	0	175	0	175	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	9,782	0	9,782	0	30.00
43.00	04300	NURSERY	0	225	0	225	0	43.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	4,007	0	4,007	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	886	0	886	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	4,429	0	4,429	0	54.00
56.00	05600	RADIOISOTOPE	0	310	0	310	0	56.00
60.00	06000	LABORATORY	0	1,688	0	1,688	0	60.00
60.02	06002	GEO PSYCH	0	0	972	0	972	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	691	0	691	0	65.00
66.00	06600	PHYSICAL THERAPY	0	259	0	259	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	1,125	0	1,125	0	69.00
69.01	06901	PULMONARY REHAB	0	0	961	0	961	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	326	0	326	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	1,251	0	1,251	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	4,132	0	2,100	4,132	2,100	88.00
90.00	09000	CLINIC	0	0	5,605	0	5,605	90.00
91.00	09100	EMERGENCY	0	1,852	0	1,852	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
93.01	04950	DIABETIC EDUCATION	0	0	656	0	656	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	8,322	42,338	20,961	50,660	20,961	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	74	0	74	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	4,039	0	4,039	192.00
194.00	07950	NAUVOO APARTMENTS	0	0	0	0	0	194.00
194.02	07951	BEAUTY SHOP	0	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)	45,381	2,973,297	379,183	558,558	84,932	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	5.453136	70.105088	15.167320	11.009540	3.397280	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)						204.00
205.00		Unit cost multiplier (Wkst. B, Part II)						205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1305 | Period: From 07/01/2016 To 06/30/2017 | Worksheet B-1 | Date/Time Prepared: 11/27/2017 8:13 pm

		Cost Center Description	EMPLOYEE BENEFITS DEPARTMENT (SALARIES)	Reconciliation	ADMINISTRATION & GENERAL (ACCUM. COST)	OPERATION OF PLANT (HOSP ONLY SQUARE FT)	OPERATION OF PLANT MOB (MOB SQUARE FEET)	
			4.00	5A.01	5.01	7.00	7.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.02	00102	NEW CAP REL COSTS-BLDG & FIXT (NEW B						1.02
1.03	00103	CAP REL COSTS-BLDG & FIXT MOB						1.03
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	CAP REL COSTS-MOB MVBLE EQUIP						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	9,999,714					4.00
5.01	00550	ADMINISTRATION & GENERAL	1,781,021	-4,658,435	20,106,220			5.01
7.00	00700	OPERATION OF PLANT	204,526	0	908,628	30,123		7.00
7.01	00701	OPERATION OF PLANT MOB	0	0	60,180	0	14,534	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	84,665	182	0	8.00
9.00	00900	HOUSEKEEPING	147,187	0	272,070	456	201	9.00
10.00	01000	DIETARY	108,514	0	273,679	862	0	10.00
11.00	01100	CAFETERIA	69,311	0	139,584	491	0	11.00
13.00	01300	NURSING ADMINISTRATION	150,758	0	279,354	265	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	103,300	0	283,990	787	0	16.00
17.00	01700	SOCIAL SERVICE	44,049	0	69,618	175	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	467,081	0	613,399	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,041,268	0	2,571,264	9,782	0	30.00
43.00	04300	NURSERY	156,868	0	250,948	225	0	43.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	341,252	0	952,114	4,007	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	43,805	0	136,847	886	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	481,366	0	1,395,836	4,429	0	54.00
56.00	05600	RADIOISOTOPE	0	0	106,357	310	0	56.00
60.00	06000	LABORATORY	639,913	0	1,375,683	1,688	0	60.00
60.02	06002	GEO PSYCH	116,192	0	236,294	0	972	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	37,969	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	172,380	0	332,631	691	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	133,388	259	0	66.00
69.00	06900	ELECTROCARDIOLOGY	28,704	0	136,063	1,125	0	69.00
69.01	06901	PULMONARY REHAB	57,677	0	154,374	0	961	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	35,894	0	717,905	326	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	105,149	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	169,008	0	928,283	1,251	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	2,326,866	0	3,877,551	0	2,100	88.00
90.00	09000	CLINIC	468,120	0	845,207	0	5,605	90.00
91.00	09100	EMERGENCY	418,478	0	2,091,371	1,852	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
93.01	04950	DIABETIC EDUCATION	85,578	0	123,502	0	656	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	9,659,116	-4,658,435	19,493,903	30,049	10,495	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	6,003	74	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	340,598	0	606,314	0	4,039	192.00
194.00	07950	NAUVOO APARTMENTS	0	0	0	0	0	194.00
194.02	07951	BEAUTY SHOP	0	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)	2,582,099		4,658,435	1,119,149	74,123	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.258217		0.231691	37.152641	5.099972	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	0		1,059,341	224,369	12,658	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000		0.052687	7.448428	0.870923	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1305 | Period: From 07/01/2016 To 06/30/2017 | Worksheet B-1 | Date/Time Prepared: 11/27/2017 8:13 pm

		Cost Center Description	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (NEW HOSP, WFMG/ADMIN, MOB SQFT)	DIETARY (HOSP PATIENT DAYS)	CAFETERIA (HOURS OF SERVICE)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	
			8.00	9.00	10.00	11.00	13.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.02	00102	NEW CAP REL COSTS-BLDG & FIXT (NEW B						1.02
1.03	00103	CAP REL COSTS-BLDG & FIXT MOB						1.03
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	CAP REL COSTS-MOB MVBLE EQUIP						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	ADMINISTRATION & GENERAL						5.01
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT MOB						7.01
8.00	00800	LAUNDRY & LINEN SERVICE	50,391					8.00
9.00	00900	HOUSEKEEPING	0	48,847				9.00
10.00	01000	DIETARY	0	862	1,912			10.00
11.00	01100	CAFETERIA	0	491	0	208,455		11.00
13.00	01300	NURSING ADMINISTRATION	0	265	0	5,652	90,240	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,684	0	6,975	0	16.00
17.00	01700	SOCIAL SERVICE	0	175	0	1,300	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	2,206	2,206	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	15,448	9,782	1,912	36,880	36,880	30.00
43.00	04300	NURSERY	0	225	0	6,072	6,072	43.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	19,502	4,007	0	13,328	13,328	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	886	0	1,702	1,702	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,851	4,429	0	17,926	0	54.00
56.00	05600	RADIOISOTOPE	0	310	0	0	0	56.00
60.00	06000	LABORATORY	0	1,688	0	26,796	0	60.00
60.02	06002	GEO PSYCH	0	972	0	6,674	0	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	691	0	7,194	7,194	65.00
66.00	06600	PHYSICAL THERAPY	0	259	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	1,125	0	1,198	1,198	69.00
69.01	06901	PULMONARY REHAB	0	961	0	3,321	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	326	0	1,764	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	1,251	0	4,826	4,826	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,087	6,232	0	15,934	0	88.00
90.00	09000	CLINIC	1,034	5,605	0	31,873	0	90.00
91.00	09100	EMERGENCY	6,457	1,852	0	13,570	13,570	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
93.01	04950	DIABETIC EDUCATION	0	656	0	3,264	3,264	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	50,379	44,734	1,912	208,455	90,240	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	74	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	12	4,039	0	0	0	192.00
194.00	07950	NAUVOO APARTMENTS	0	0	0	0	0	194.00
194.02	07951	BEAUTY SHOP	0	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)	111,043	353,073	375,345	193,715	361,090	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	2.203628	7.228141	196.310146	0.929289	4.001441	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	20,580	58,626	91,796	51,428	39,900	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.408406	1.200197	48.010460	0.246710	0.442154	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1305 | Period: From 07/01/2016 To 06/30/2017 | Worksheet B-1 | Date/Time Prepared: 11/27/2017 8:13 pm

		Cost Center Description	MEDICAL RECORDS & LIBRARY (GROSS REVENUES)	SOCIAL SERVICE (TIME SPENT)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)		
			16.00	17.00	19.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
1.02	00102	NEW CAP REL COSTS-BLDG & FIXT (NEW B					1.02
1.03	00103	CAP REL COSTS-BLDG & FIXT MOB					1.03
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
2.01	00201	CAP REL COSTS-MOB MVBLE EQUIP					2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00550	ADMINISTRATION & GENERAL					5.01
7.00	00700	OPERATION OF PLANT					7.00
7.01	00701	OPERATION OF PLANT MOB					7.01
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
16.00	01600	MEDICAL RECORDS & LIBRARY	43,410,527				16.00
17.00	01700	SOCIAL SERVICE	0	100			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	2,080		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	2,971,429	98	0		30.00
43.00	04300	NURSERY	158,860	0	0		43.00
46.00	04600	OTHER LONG TERM CARE	0	0	0		46.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	2,368,355	0	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	143,911	0	0		52.00
53.00	05300	ANESTHESIOLOGY	1,682,327	0	2,080		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	10,148,121	0	0		54.00
56.00	05600	RADIOISOTOPE	618,413	0	0		56.00
60.00	06000	LABORATORY	10,739,602	0	0		60.00
60.02	06002	GEO PSYCH	604,597	0	0		60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	63,753	0	0		62.00
65.00	06500	RESPIRATORY THERAPY	769,868	0	0		65.00
66.00	06600	PHYSICAL THERAPY	283,808	0	0		66.00
69.00	06900	ELECTROCARDIOLOGY	645,923	0	0		69.00
69.01	06901	PULMONARY REHAB	170,178	0	0		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	996,221	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	203,909	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,885,275	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	6,040,520	0	0		88.00
90.00	09000	CLINIC	398,882	0	0		90.00
91.00	09100	EMERGENCY	2,489,624	2	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0		93.00
93.01	04950	DIABETIC EDUCATION	26,951	0	0		93.01
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0	0	0		95.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	43,410,527	100	2,080		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	NAUVOO APARTMENTS	0	0	0		194.00
194.02	07951	BEAUTY SHOP	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)	397,681	94,723	766,395		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.009161	947.230000	368.459135		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	103,171	19,697	33,837		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.002377	196.970000	16.267788		205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1305 | Period: From 07/01/2016 To 06/30/2017 | Worksheet C Part I Date/Time Prepared: 11/27/2017 8:13 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,312,419		4,312,419	0	0	30.00
43.00	04300	NURSERY	350,470		350,470	0	0	43.00
46.00	04600	OTHER LONG TERM CARE	0		0	0	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,480,933		1,480,933	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	217,584		217,584	0	0	52.00
53.00	05300	ANESTHESIOLOGY	781,807		781,807	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,040,523		2,040,523	0	0	54.00
56.00	05600	RADIOISOTOPE	150,422		150,422	0	0	56.00
60.00	06000	LABORATORY	1,892,616		1,892,616	0	0	60.00
60.02	06002	GEO PSYCH	314,765		314,765	0	0	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	47,350		47,350	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	482,890	0	482,890	0	0	65.00
66.00	06600	PHYSICAL THERAPY	178,388	0	178,388	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	229,341		229,341	0	0	69.00
69.01	06901	PULMONARY REHAB	206,633		206,633	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	909,470		909,470	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	131,379		131,379	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,239,945		1,239,945	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	4,904,245		4,904,245	0	0	88.00
90.00	09000	CLINIC	1,145,685		1,145,685	0	0	90.00
91.00	09100	EMERGENCY	2,763,957		2,763,957	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	603,662		603,662		0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0		0	0	0	93.00
93.01	04950	DIABETIC EDUCATION	176,545		176,545	0	0	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0		0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	24,561,029	0	24,561,029	0	0	200.00
201.00		Less Observation Beds	603,662		603,662		0	201.00
202.00		Total (see instructions)	23,957,367	0	23,957,367	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1305 | Period: From 07/01/2016 To 06/30/2017 | Worksheet C Part I | Date/Time Prepared: 11/27/2017 8:13 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Charges					
			Inpatient	Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,235,686		2,235,686			30.00
43.00	04300	NURSERY	158,860		158,860			43.00
46.00	04600	OTHER LONG TERM CARE	0		0			46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	624,952	1,743,403	2,368,355	0.625300	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	143,911	0	143,911	1.511934	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	459,614	1,222,713	1,682,327	0.464718	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	546,158	9,601,963	10,148,121	0.201074	0.000000	54.00
56.00	05600	RADIOISOTOPE	11,628	606,785	618,413	0.243239	0.000000	56.00
60.00	06000	LABORATORY	947,169	9,792,433	10,739,602	0.176228	0.000000	60.00
60.02	06002	GEO PSYCH	0	604,597	604,597	0.520620	0.000000	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	26,597	37,156	63,753	0.742710	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	237,686	532,182	769,868	0.627237	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	277,548	6,260	283,808	0.628552	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	49,324	596,599	645,923	0.355059	0.000000	69.00
69.01	06901	PULMONARY REHAB	0	170,178	170,178	1.214217	0.000000	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	738,913	257,308	996,221	0.912920	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	55,000	148,909	203,909	0.644302	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	546,211	1,339,064	1,885,275	0.657700	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	6,040,520	6,040,520			88.00
90.00	09000	CLINIC	0	398,882	398,882	2.872240	0.000000	90.00
91.00	09100	EMERGENCY	17,022	2,472,602	2,489,624	1.110191	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	18,216	717,527	735,743	0.820479	0.000000	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0.000000	0.000000	93.00
93.01	04950	DIABETIC EDUCATION	0	26,951	26,951	6.550592	0.000000	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	7,094,495	36,316,032	43,410,527			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	7,094,495	36,316,032	43,410,527			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES	Provider CCN: 14-1305	Period: From 07/01/2016 To 06/30/2017	Worksheet C Part I Date/Time Prepared: 11/27/2017 8:13 pm
	Title XVIII	Hospital	Cost

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
43.00	04300	NURSERY		43.00
46.00	04600	OTHER LONG TERM CARE		46.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	54.00
56.00	05600	RADIOISOTOPE	0.000000	56.00
60.00	06000	LABORATORY	0.000000	60.00
60.02	06002	GEO PSYCH	0.000000	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	69.00
69.01	06901	PULMONARY REHAB	0.000000	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS		
88.00	08800	RURAL HEALTH CLINIC		88.00
90.00	09000	CLINIC	0.000000	90.00
91.00	09100	EMERGENCY	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	93.00
93.01	04950	DIABETIC EDUCATION	0.000000	93.01
		OTHER REIMBURSABLE COST CENTERS		
95.00	09500	AMBULANCE SERVICES	0.000000	95.00
		SPECIAL PURPOSE COST CENTERS		
113.00	11300	INTEREST EXPENSE		113.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1305 | Period: From 07/01/2016 To 06/30/2017 | Worksheet C Part I Date/Time Prepared: 11/27/2017 8:13 pm

Title XIX | Hospital | PPS

		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	4,312,419		4,312,419	0	4,312,419	30.00
43.00	04300	NURSERY	350,470		350,470	0	350,470	43.00
46.00	04600	OTHER LONG TERM CARE	0		0	0	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,480,933		1,480,933	0	1,480,933	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	217,584		217,584	0	217,584	52.00
53.00	05300	ANESTHESIOLOGY	781,807		781,807	0	781,807	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,040,523		2,040,523	0	2,040,523	54.00
56.00	05600	RADIOISOTOPE	150,422		150,422	0	150,422	56.00
60.00	06000	LABORATORY	1,892,616		1,892,616	0	1,892,616	60.00
60.02	06002	GEO PSYCH	314,765		314,765	0	314,765	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	47,350		47,350	0	47,350	62.00
65.00	06500	RESPIRATORY THERAPY	482,890	0	482,890	0	482,890	65.00
66.00	06600	PHYSICAL THERAPY	178,388	11,671	190,059	0	190,059	66.00
69.00	06900	ELECTROCARDIOLOGY	229,341		229,341	0	229,341	69.00
69.01	06901	PULMONARY REHAB	206,633		206,633	0	206,633	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	909,470		909,470	0	909,470	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	131,379		131,379	0	131,379	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,239,945		1,239,945	0	1,239,945	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	4,904,245		4,904,245	0	4,904,245	88.00
90.00	09000	CLINIC	1,145,685		1,145,685	0	1,145,685	90.00
91.00	09100	EMERGENCY	2,763,957		2,763,957	0	2,763,957	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	603,662		603,662		603,662	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0		0	0	0	93.00
93.01	04950	DIABETIC EDUCATION	176,545		176,545	0	176,545	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0		0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	24,561,029	0	24,572,700	0	24,572,700	200.00
201.00		Less Observation Beds	603,662		603,662		603,662	201.00
202.00		Total (see instructions)	23,957,367	0	23,969,038	0	23,969,038	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1305 | Period: From 07/01/2016 To 06/30/2017 | Worksheet C Part I Date/Time Prepared: 11/27/2017 8:13 pm

Title XIX | Hospital | PPS

		Cost Center Description	Charges Inpatient	Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,235,686		2,235,686			30.00
43.00	04300	NURSERY	158,860		158,860			43.00
46.00	04600	OTHER LONG TERM CARE	0		0			46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	624,952	1,743,403	2,368,355	0.625300	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	143,911	0	143,911	1.511934	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	459,614	1,222,713	1,682,327	0.464718	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	546,158	9,601,963	10,148,121	0.201074	0.000000	54.00
56.00	05600	RADIOISOTOPE	11,628	606,785	618,413	0.243239	0.000000	56.00
60.00	06000	LABORATORY	947,169	9,792,433	10,739,602	0.176228	0.000000	60.00
60.02	06002	GEO PSYCH	0	604,597	604,597	0.520620	0.000000	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	26,597	37,156	63,753	0.742710	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	237,686	532,182	769,868	0.627237	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	277,548	6,260	283,808	0.628552	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	49,324	596,599	645,923	0.355059	0.000000	69.00
69.01	06901	PULMONARY REHAB	0	170,178	170,178	1.214217	0.000000	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	738,913	257,308	996,221	0.912920	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	55,000	148,909	203,909	0.644302	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	546,211	1,339,064	1,885,275	0.657700	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	6,040,520	6,040,520	0.811891	0.000000	88.00
90.00	09000	CLINIC	0	398,882	398,882	2.872240	0.000000	90.00
91.00	09100	EMERGENCY	17,022	2,472,602	2,489,624	1.110191	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	18,216	717,527	735,743	0.820479	0.000000	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0.000000	0.000000	93.00
93.01	04950	DIABETIC EDUCATION	0	26,951	26,951	6.550592	0.000000	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	7,094,495	36,316,032	43,410,527			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	7,094,495	36,316,032	43,410,527			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES	Provider CCN: 14-1305	Period: From 07/01/2016 To 06/30/2017	Worksheet C Part I Date/Time Prepared: 11/27/2017 8:13 pm
	Title XIX	Hospital	PPS

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
43.00	04300	NURSERY		43.00
46.00	04600	OTHER LONG TERM CARE		46.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.625300	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.511934	52.00
53.00	05300	ANESTHESIOLOGY	0.464718	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.201074	54.00
56.00	05600	RADIOISOTOPE	0.243239	56.00
60.00	06000	LABORATORY	0.176228	60.00
60.02	06002	GEO PSYCH	0.520620	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.742710	62.00
65.00	06500	RESPIRATORY THERAPY	0.627237	65.00
66.00	06600	PHYSICAL THERAPY	0.669675	66.00
69.00	06900	ELECTROCARDIOLOGY	0.355059	69.00
69.01	06901	PULMONARY REHAB	1.214217	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.912920	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.644302	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.657700	73.00
		OUTPATIENT SERVICE COST CENTERS		
88.00	08800	RURAL HEALTH CLINIC	0.811891	88.00
90.00	09000	CLINIC	2.872240	90.00
91.00	09100	EMERGENCY	1.110191	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.820479	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	93.00
93.01	04950	DIABETIC EDUCATION	6.550592	93.01
		OTHER REIMBURSABLE COST CENTERS		
95.00	09500	AMBULANCE SERVICES	0.000000	95.00
		SPECIAL PURPOSE COST CENTERS		
113.00	11300	INTEREST EXPENSE		113.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

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

Provider CCN: 14-1305 | Period: From 07/01/2016 To 06/30/2017 | Worksheet C Part II | Date/Time Prepared: 11/27/2017 8:13 pm

Title XIX | Hospital | PPS

		Cost Center Description	Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,480,933	432,621	1,048,312	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	217,584	88,254	129,330	0	0	52.00
53.00	05300	ANESTHESIOLOGY	781,807	3,999	777,808	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,040,523	502,446	1,538,077	0	0	54.00
56.00	05600	RADIOISOTOPE	150,422	34,901	115,521	0	0	56.00
60.00	06000	LABORATORY	1,892,616	256,123	1,636,493	0	0	60.00
60.02	06002	GEO PSYCH	314,765	35,593	279,172	0	0	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	47,350	2,152	45,198	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	482,890	86,338	396,552	0	0	65.00
66.00	06600	PHYSICAL THERAPY	178,388	30,951	147,437	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	229,341	110,513	118,828	0	0	69.00
69.01	06901	PULMONARY REHAB	206,633	29,189	177,444	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	909,470	69,889	839,581	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	131,379	6,025	125,354	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,239,945	169,007	1,070,938	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	4,904,245	339,352	4,564,893	0	0	88.00
90.00	09000	CLINIC	1,145,685	169,427	976,258	0	0	90.00
91.00	09100	EMERGENCY	2,763,957	294,727	2,469,230	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	603,662	162,857	440,805	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
93.01	04950	DIABETIC EDUCATION	176,545	22,356	154,189	0	0	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (sum of lines 50 thru 199)	19,898,140	2,846,720	17,051,420	0	0	200.00
201.00		Less Observation Beds	603,662	162,857	440,805	0	0	201.00
202.00		Total (line 200 minus line 201)	19,294,478	2,683,863	16,610,615	0	0	202.00

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY	Provider CCN: 14-1305	Period: From 07/01/2016 To 06/30/2017	Worksheet C Part II Date/Time Prepared: 11/27/2017 8:13 pm
	Title XIX	Hospital	PPS

		Cost Center Description	Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)	
			6.00	7.00	8.00	
	ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	1,480,933	2,368,355	0.625300	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	217,584	143,911	1.511934	52.00
53.00	05300	ANESTHESIOLOGY	781,807	1,682,327	0.464718	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,040,523	10,148,121	0.201074	54.00
56.00	05600	RADIOISOTOPE	150,422	618,413	0.243239	56.00
60.00	06000	LABORATORY	1,892,616	10,739,602	0.176228	60.00
60.02	06002	GEO PSYCH	314,765	604,597	0.520620	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	47,350	63,753	0.742710	62.00
65.00	06500	RESPIRATORY THERAPY	482,890	769,868	0.627237	65.00
66.00	06600	PHYSICAL THERAPY	178,388	283,808	0.628552	66.00
69.00	06900	ELECTROCARDIOLOGY	229,341	645,923	0.355059	69.00
69.01	06901	PULMONARY REHAB	206,633	170,178	1.214217	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	909,470	996,221	0.912920	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	131,379	203,909	0.644302	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,239,945	1,885,275	0.657700	73.00
	OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	4,904,245	6,040,520	0.811891	88.00
90.00	09000	CLINIC	1,145,685	398,882	2.872240	90.00
91.00	09100	EMERGENCY	2,763,957	2,489,624	1.110191	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	603,662	735,743	0.820479	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0.000000	93.00
93.01	04950	DIABETIC EDUCATION	176,545	26,951	6.550592	93.01
	OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0	0	0.000000	95.00
	SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE				113.00
200.00		Subtotal (sum of lines 50 thru 199)	19,898,140	41,015,981		200.00
201.00		Less Observation Beds	603,662	0		201.00
202.00		Total (line 200 minus line 201)	19,294,478	41,015,981		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 14-1305 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D Part II Date/Time Prepared: 11/27/2017 8:13 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	432,621	2,368,355	0.182667	79,190	14,465	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	88,254	143,911	0.613254	0	0	52.00
53.00	05300	ANESTHESIOLOGY	3,999	1,682,327	0.002377	41,283	98	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	502,446	10,148,121	0.049511	262,919	13,017	54.00
56.00	05600	RADIOISOTOPE	34,901	618,413	0.056436	5,162	291	56.00
60.00	06000	LABORATORY	256,123	10,739,602	0.023848	250,988	5,986	60.00
60.02	06002	GEO PSYCH	35,593	604,597	0.058871	0	0	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	2,152	63,753	0.033755	10,791	364	62.00
65.00	06500	RESPIRATORY THERAPY	86,338	769,868	0.112146	95,540	10,714	65.00
66.00	06600	PHYSICAL THERAPY	30,951	283,808	0.109056	11,331	1,236	66.00
69.00	06900	ELECTROCARDIOLOGY	110,513	645,923	0.171093	14,586	2,496	69.00
69.01	06901	PULMONARY REHAB	29,189	170,178	0.171520	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	69,889	996,221	0.070154	167,152	11,726	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	6,025	203,909	0.029547	54,318	1,605	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	169,007	1,885,275	0.089646	166,767	14,950	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	339,352	6,040,520	0.056179	0	0	88.00
90.00	09000	CLINIC	169,427	398,882	0.424755	0	0	90.00
91.00	09100	EMERGENCY	294,727	2,489,624	0.118382	647	77	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	162,857	735,743	0.221350	1,698	376	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0.000000	0	0	93.00
93.01	04950	DIABETIC EDUCATION	22,356	26,951	0.829505	0	0	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	2,846,720	41,015,981		1,162,372	77,401	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1305 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D Part IV | Date/Time Prepared: 11/27/2017 8:13 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	766,395	0	0	0	766,395	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
60.02	06002	GEO PSYCH	0	0	0	0	0	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901	PULMONARY REHAB	0	0	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
93.01	04950	DIABETIC EDUCATION	0	0	0	0	0	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	766,395	0	0	0	766,395	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 14-1305 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D Part IV Date/Time Prepared: 11/27/2017 8:13 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	2,368,355	0.000000	0.000000	79,190	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	143,911	0.000000	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0	1,682,327	0.455557	0.000000	41,283	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	10,148,121	0.000000	0.000000	262,919	54.00
56.00	05600	RADIOISOTOPE	0	618,413	0.000000	0.000000	5,162	56.00
60.00	06000	LABORATORY	0	10,739,602	0.000000	0.000000	250,988	60.00
60.02	06002	GEO PSYCH	0	604,597	0.000000	0.000000	0	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	63,753	0.000000	0.000000	10,791	62.00
65.00	06500	RESPIRATORY THERAPY	0	769,868	0.000000	0.000000	95,540	65.00
66.00	06600	PHYSICAL THERAPY	0	283,808	0.000000	0.000000	11,331	66.00
69.00	06900	ELECTROCARDIOLOGY	0	645,923	0.000000	0.000000	14,586	69.00
69.01	06901	PULMONARY REHAB	0	170,178	0.000000	0.000000	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	996,221	0.000000	0.000000	167,152	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	203,909	0.000000	0.000000	54,318	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,885,275	0.000000	0.000000	166,767	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	6,040,520	0.000000	0.000000	0	88.00
90.00	09000	CLINIC	0	398,882	0.000000	0.000000	0	90.00
91.00	09100	EMERGENCY	0	2,489,624	0.000000	0.000000	647	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	735,743	0.000000	0.000000	1,698	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0.000000	0.000000	0	93.00
93.01	04950	DIABETIC EDUCATION	0	26,951	0.000000	0.000000	0	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	41,015,981			1,162,372	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1305 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D Part IV | Date/Time Prepared: 11/27/2017 8:13 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	18,807	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	56.00
60.00	06000	LABORATORY	0	0	0	60.00
60.02	06002	GEO PSYCH	0	0	0	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	69.00
69.01	06901	PULMONARY REHAB	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	93.00
93.01	04950	DIABETIC EDUCATION	0	0	0	93.01
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (lines 50-199)	18,807	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-1305 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D Part V Date/Time Prepared: 11/27/2017 8:13 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs	
				PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0.625300	0	534,455	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.511934	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.464718	0	383,244	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.201074	0	3,165,638	0	0	54.00
56.00	05600	RADIOISOTOPE	0.243239	0	264,547	0	0	56.00
60.00	06000	LABORATORY	0.176228	0	3,337,115	0	0	60.00
60.02	06002	GEO PSYCH	0.520620	0	528,758	0	0	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.742710	0	26,472	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.627237	0	173,051	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.628552	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.355059	0	270,164	0	0	69.00
69.01	06901	PULMONARY REHAB	1.214217	0	152,440	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.912920	0	114,975	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.644302	0	21,905	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.657700	0	484,644	46,217	0	73.00
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
90.00	09000	CLINIC	2.872240	0	159,138	0	0	90.00
91.00	09100	EMERGENCY	1.110191	0	752,601	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.820479	0	195,436	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	0	0	93.00
93.01	04950	DIABETIC EDUCATION	6.550592	0	8,531	0	0	93.01
	OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0.000000		0			95.00
200.00		Subtotal (see instructions)		0	10,573,114	46,217	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	10,573,114	46,217	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-1305 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D Part V Date/Time Prepared: 11/27/2017 8:13 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Costs		
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
			6.00	7.00	
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	334,195	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300	ANESTHESIOLOGY	178,100	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	636,527	0	54.00
56.00	05600	RADIOISOTOPE	64,348	0	56.00
60.00	06000	LABORATORY	588,093	0	60.00
60.02	06002	GEO PSYCH	275,282	0	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	19,661	0	62.00
65.00	06500	RESPIRATORY THERAPY	108,544	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	95,924	0	69.00
69.01	06901	PULMONARY REHAB	185,095	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	104,963	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	14,113	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	318,750	30,397	73.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	0	0	88.00
90.00	09000	CLINIC	457,083	0	90.00
91.00	09100	EMERGENCY	835,531	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	160,351	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	93.00
93.01	04950	DIABETIC EDUCATION	55,883	0	93.01
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0		95.00
200.00		Subtotal (see instructions)	4,432,443	30,397	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 +/- line 201)	4,432,443	30,397	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1305 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D Part V | Date/Time Prepared: 11/27/2017 8:13 pm

Component CCN: 14-Z305

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	0.625300	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.511934	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.464718	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.201074	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0.243239	0	0	0	0	56.00
60.00	06000	LABORATORY	0.176228	0	0	0	0	60.00
60.02	06002	GEO PSYCH	0.520620	0	0	0	0	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.742710	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.627237	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.628552	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.355059	0	0	0	0	69.00
69.01	06901	PULMONARY REHAB	1.214217	0	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.912920	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.644302	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.657700	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
90.00	09000	CLINIC	2.872240	0	0	0	0	90.00
91.00	09100	EMERGENCY	1.110191	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.820479	0	0	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	0	0	93.00
93.01	04950	DIABETIC EDUCATION	6.550592	0	0	0	0	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.000000		0			95.00
200.00		Subtotal (see instructions)		0	0	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		0	0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1305
Component CCN: 14-Z305

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

Worksheet D Part V
Date/Time Prepared: 11/27/2017 8:13 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
			6.00	7.00	
	ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	56.00
60.00	06000	LABORATORY	0	0	60.00
60.02	06002	GEO PSYCH	0	0	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
69.01	06901	PULMONARY REHAB	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
	OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0	88.00
90.00	09000	CLINIC	0	0	90.00
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	93.00
93.01	04950	DIABETIC EDUCATION	0	0	93.01
	OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0		95.00
200.00		Subtotal (see instructions)	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 +/- line 201)	0	0	202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS	Provider CCN: 14-1305	Period: From 07/01/2016 To 06/30/2017	Worksheet D Part I Date/Time Prepared: 11/27/2017 8:13 pm
	Title XIX	Hospital	PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	1,163,413	390,686	772,727	1,430	540.37	30.00
43.00	NURSERY	37,980		37,980	254	149.53	43.00
200.00	Total (lines 30-199)	1,201,393		810,707	1,684		200.00

	Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)	
		6.00	7.00	
	INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	ADULTS & PEDIATRICS	275	148,602	30.00
43.00	NURSERY	140	20,934	43.00
200.00	Total (lines 30-199)	415	169,536	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 14-1305 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D Part II Date/Time Prepared: 11/27/2017 8:13 pm

Title XIX | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	432,621	2,368,355	0.182667	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	88,254	143,911	0.613254	0	0	52.00
53.00	05300	ANESTHESIOLOGY	3,999	1,682,327	0.002377	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	502,446	10,148,121	0.049511	0	0	54.00
56.00	05600	RADIOISOTOPE	34,901	618,413	0.056436	0	0	56.00
60.00	06000	LABORATORY	256,123	10,739,602	0.023848	0	0	60.00
60.02	06002	GEO PSYCH	35,593	604,597	0.058871	0	0	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	2,152	63,753	0.033755	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	86,338	769,868	0.112146	0	0	65.00
66.00	06600	PHYSICAL THERAPY	30,951	283,808	0.109056	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	110,513	645,923	0.171093	0	0	69.00
69.01	06901	PULMONARY REHAB	29,189	170,178	0.171520	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	69,889	996,221	0.070154	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	6,025	203,909	0.029547	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	169,007	1,885,275	0.089646	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	339,352	6,040,520	0.056179	0	0	88.00
90.00	09000	CLINIC	169,427	398,882	0.424755	0	0	90.00
91.00	09100	EMERGENCY	294,727	2,489,624	0.118382	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	163,191	735,743	0.221804	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0.000000	0	0	93.00
93.01	04950	DIABETIC EDUCATION	22,356	26,951	0.829505	0	0	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	2,847,054	41,015,981		0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 14-1305 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D Part III Date/Time Prepared: 11/27/2017 8:13 pm

Title XIX | Hospital | PPS

		Cost Center Description	Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
43.00	04300	NURSERY	0	0	0		0	43.00
200.00		Total (lines 30-199)	0	0	0		0	200.00
		Cost Center Description	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)		
			6.00	7.00	8.00	9.00		
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	1,430	0.00	275	0		30.00
43.00	04300	NURSERY	254	0.00	140	0		43.00
200.00		Total (lines 30-199)	1,684		415	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 14-1305 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D Part IV Date/Time Prepared: 11/27/2017 8:13 pm

Title XIX | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	766,395	0	0	0	766,395	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
60.02	06002	GEO PSYCH	0	0	0	0	0	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901	PULMONARY REHAB	0	0	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
93.01	04950	DIABETIC EDUCATION	0	0	0	0	0	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	766,395	0	0	0	766,395	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1305 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D Part IV Date/Time Prepared: 11/27/2017 8:13 pm

Title XIX | Hospital | PPS

		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	2,368,355	0.000000	0.000000	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	143,911	0.000000	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0	1,682,327	0.455557	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	10,148,121	0.000000	0.000000	0	54.00
56.00	05600	RADIOISOTOPE	0	618,413	0.000000	0.000000	0	56.00
60.00	06000	LABORATORY	0	10,739,602	0.000000	0.000000	0	60.00
60.02	06002	GEO PSYCH	0	604,597	0.000000	0.000000	0	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	63,753	0.000000	0.000000	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	769,868	0.000000	0.000000	0	65.00
66.00	06600	PHYSICAL THERAPY	0	283,808	0.000000	0.000000	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	645,923	0.000000	0.000000	0	69.00
69.01	06901	PULMONARY REHAB	0	170,178	0.000000	0.000000	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	996,221	0.000000	0.000000	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	203,909	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,885,275	0.000000	0.000000	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	6,040,520	0.000000	0.000000	0	88.00
90.00	09000	CLINIC	0	398,882	0.000000	0.000000	0	90.00
91.00	09100	EMERGENCY	0	2,489,624	0.000000	0.000000	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	735,743	0.000000	0.000000	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0.000000	0.000000	0	93.00
93.01	04950	DIABETIC EDUCATION	0	26,951	0.000000	0.000000	0	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	41,015,981			0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1305 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D Part IV Date/Time Prepared: 11/27/2017 8:13 pm

Title XIX | Hospital | PPS

		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
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
56.00	05600	RADIOISOTOPE	0	0	0		56.00
60.00	06000	LABORATORY	0	0	0		60.00
60.02	06002	GEO PSYCH	0	0	0		60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0		62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
69.01	06901	PULMONARY REHAB	0	0	0		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	0		88.00
90.00	09000	CLINIC	0	0	0		90.00
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0		93.00
93.01	04950	DIABETIC EDUCATION	0	0	0		93.01
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES					95.00
200.00		Total (lines 50-199)	0	0	0		200.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 14-1305	Period: From 07/01/2016 To 06/30/2017	Worksheet D-1 Date/Time Prepared: 11/27/2017 8:13 pm
	Title XVIII	Hospital	Cost

	Cost Center Description		
		1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	2,214	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,430	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	1,128	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	287	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)	436	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	35	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)	26	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	530	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)	274	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)	412	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	142.74	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	147.02	20.00
21.00	Total general inpatient routine service cost (see instructions)	4,312,419	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	4,996	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)	3,823	25.00
26.00	Total swing-bed cost (see instructions)	1,454,016	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	2,858,403	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	2,858,403	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)	1,998.89	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,059,412	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	1,059,412	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1305 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D-1 | Date/Time Prepared: 11/27/2017 8:13 pm

Title XVIII | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	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)	546,685	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	1,606,097	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)	547,696	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	823,543	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	1,371,239	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)	302	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,998.88	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	603,662	89.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 14-1305	Period: From 07/01/2016 To 06/30/2017	Worksheet D-1 Date/Time Prepared: 11/27/2017 8:13 pm
	Title XVIII	Hospital	Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	1,163,413	4,312,419	0.269782	603,662	162,857	90.00
91.00	Nursing School cost	0	4,312,419	0.000000	603,662	0	91.00
92.00	Allied health cost	0	4,312,419	0.000000	603,662	0	92.00
93.00	All other Medical Education	0	4,312,419	0.000000	603,662	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 14-1305	Period: From 07/01/2016 To 06/30/2017	Worksheet D-1 Date/Time Prepared: 11/27/2017 8:13 pm
	Title XIX	Hospital	PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	2,214	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,430	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	1,128	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	723	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	19	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)	42	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	275	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	254	15.00
16.00	Nursery days (title V or XIX only)	140	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	4,312,419	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	1,448,155	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	2,864,264	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	2,864,264	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	2,002.98	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	550,820	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)	550,820	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1305 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D-1 | Date/Time Prepared: 11/27/2017 8:13 pm

Title XIX | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	350,470	254	1,379.80	140	193,172	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description	1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	0	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	743,992	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)	169,536	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)	169,536	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	574,456	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	302	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	2,002.98	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	604,900	89.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 14-1305	Period: From 07/01/2016 To 06/30/2017	Worksheet D-1 Date/Time Prepared: 11/27/2017 8:13 pm
	Title XIX	Hospital	PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	1,163,413	4,312,419	0.269782	604,900	163,191	90.00
91.00	Nursing School cost	0	4,312,419	0.000000	604,900	0	91.00
92.00	Allied health cost	0	4,312,419	0.000000	604,900	0	92.00
93.00	All other Medical Education	0	4,312,419	0.000000	604,900	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 14-1305 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D-3 | Date/Time Prepared: 11/27/2017 8:13 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		718,590		30.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.625300	79,190	49,518	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.511934	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.464718	41,283	19,185	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.201074	262,919	52,866	54.00
56.00	05600	RADIOISOTOPE	0.243239	5,162	1,256	56.00
60.00	06000	LABORATORY	0.176228	250,988	44,231	60.00
60.02	06002	GEO PSYCH	0.520620	0	0	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.742710	10,791	8,015	62.00
65.00	06500	RESPIRATORY THERAPY	0.627237	95,540	59,926	65.00
66.00	06600	PHYSICAL THERAPY	0.628552	11,331	7,122	66.00
69.00	06900	ELECTROCARDIOLOGY	0.355059	14,586	5,179	69.00
69.01	06901	PULMONARY REHAB	1.214217	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.912920	167,152	152,596	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.644302	54,318	34,997	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.657700	166,767	109,683	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000	CLINIC	2.872240	0	0	90.00
91.00	09100	EMERGENCY	1.110191	647	718	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.820479	1,698	1,393	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	93.00
93.01	04950	DIABETIC EDUCATION	6.550592	0	0	93.01
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		1,162,372	546,685	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		1,162,372		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 14-1305 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D-3

Component CCN: 14-Z305 | Date/Time Prepared: 11/27/2017 8:13 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.625300	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.511934	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.464718	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.201074	28,810	5,793	54.00
56.00	05600	RADIOISOTOPE	0.243239	0	0	56.00
60.00	06000	LABORATORY	0.176228	129,086	22,749	60.00
60.02	06002	GEO PSYCH	0.520620	0	0	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.742710	1,394	1,035	62.00
65.00	06500	RESPIRATORY THERAPY	0.627237	82,724	51,888	65.00
66.00	06600	PHYSICAL THERAPY	0.628552	227,751	143,153	66.00
69.00	06900	ELECTROCARDIOLOGY	0.355059	1,719	610	69.00
69.01	06901	PULMONARY REHAB	1.214217	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.912920	100,558	91,801	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.644302	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.657700	102,372	67,330	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000	CLINIC	2.872240	0	0	90.00
91.00	09100	EMERGENCY	1.110191	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.820479	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	93.00
93.01	04950	DIABETIC EDUCATION	6.550592	0	0	93.01
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		674,414	384,359	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)		674,414		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 14-1305 | Period: From 07/01/2016 To 06/30/2017 | Worksheet E Part B Date/Time Prepared: 11/27/2017 8:13 pm

Title XVIII | Hospital | Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	4,462,840	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	PPS payments	0	3.00
4.00	Outlier payment (see instructions)	0	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	4,462,840	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	0	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)	4,507,468	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)	54,346	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	1,459,757	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)	2,993,365	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)	2,993,365	30.00
31.00	Primary payer payments	2,062	31.00
32.00	Subtotal (line 30 minus line 31)	2,991,303	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)	175,734	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	114,227	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	175,734	36.00
37.00	Subtotal (see instructions)	3,105,530	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00		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)	3,105,530	40.00
40.01	Sequestration adjustment (see instructions)	62,111	40.01
41.00	Interim payments	3,014,119	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	29,300	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: 14-1305 | Period: From 07/01/2016 To 06/30/2017 | Worksheet E-1 Part I Date/Time Prepared: 11/27/2017 8:13 pm

Title XVIII | Hospital | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,198,421		3,053,244	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	02/19/2017	58,884		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0	02/19/2017	39,125	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)		58,884		-39,125	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,257,305		3,014,119	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		149,655		29,300	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,406,960		3,043,419	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: 14-1305 | Component CCN: 14-Z305 | Period: From 07/01/2016 To 06/30/2017 | Worksheet E-1 Part I | Date/Time Prepared: 11/27/2017 8:13 pm

Title XVIII | Swing Beds - SNF | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,519,054		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	02/19/2017	47,198		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		47,198		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,566,252		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		159,935		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,726,187		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: 14-1305	Period: From 07/01/2016 To 06/30/2017	Worksheet E-1 Part II Date/Time Prepared: 11/27/2017 8:13 pm
	Title XVIII	Hospital	Cost

		1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS		
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION		
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14	464	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12	530	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2	100	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12	1,128	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200	43,410,527	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20	371,612	6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168	1	7.00
8.00	Calculation of the HIT incentive payment (see instructions)	1	8.00
9.00	Sequestration adjustment amount (see instructions)	0	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)	1	10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH		
30.00	Initial/interim HIT payment adjustment (see instructions)	1	30.00
31.00	Other Adjustment (specify)	0	31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)	0	32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS	Provider CCN: 14-1305 Component CCN: 14-Z305	Period: From 07/01/2016 To 06/30/2017	Worksheet E-2 Date/Time Prepared: 11/27/2017 8:13 pm
	Title XVIII	Swing Beds - SNF	Cost

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	1,384,951	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)	388,203	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	686	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)	1,773,154	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	1,773,154	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)	1,773,154	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	11,739	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)	1,761,415	0	15.00
16.00		0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	0	16.50
16.55	410A RURAL DEMONSTRATION PROJECT	0		16.55
17.00	Allowable bad debts (see instructions)	0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (see instructions)	1,761,415	0	19.00
19.01	Sequestration adjustment (see instructions)	35,228	0	19.01
20.00	Interim payments	1,566,252	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)	159,935	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: 14-1305	Period: From 07/01/2016 To 06/30/2017	Worksheet E-3 Part V Date/Time Prepared: 11/27/2017 8:13 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	1,606,097	1.00
2.00	Nursing and Allied Health Managed Care payment (see instructions)	0	2.00
3.00	Organ acquisition	0	3.00
4.00	Subtotal (sum of lines 1 through 3)	1,606,097	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	1,622,158	6.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
7.00	Routine service charges	0	7.00
8.00	Ancillary service charges	0	8.00
9.00	Organ acquisition charges, net of revenue	0	9.00
10.00	Total reasonable charges	0	10.00
	Customary charges		
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)	0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)	0.000000	13.00
14.00	Total customary charges (see instructions)	0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)	0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)	0	16.00
17.00	Cost of physicians' services in a teaching hospital (see instructions)	0	17.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)	0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)	1,622,158	19.00
20.00	Deductibles (exclude professional component)	198,216	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	1,423,942	22.00
23.00	Coinsurance	0	23.00
24.00	Subtotal (line 22 minus line 23)	1,423,942	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	18,048	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	11,731	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	18,048	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	1,435,673	28.00
29.00		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)	1,435,673	30.00
30.01	Sequestration adjustment (see instructions)	28,713	30.01
31.00	Interim payments	1,257,305	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)	149,655	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: 14-1305 | Period: From 07/01/2016 To 06/30/2017 | Worksheet G | Date/Time Prepared: 11/27/2017 8:13 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	3,236,180	0	0	0	1.00
2.00	Temporary investments	3,516,257	0	0	0	2.00
3.00	Notes receivable	247,725	0	0	0	3.00
4.00	Accounts receivable	5,993,448	0	0	0	4.00
5.00	Other receivable	1,253,107	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-955,399	0	0	0	6.00
7.00	Inventory	324,502	0	0	0	7.00
8.00	Prepaid expenses	195,270	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	13,811,090	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	499,957	0	0	0	12.00
13.00	Land improvements	1,326,180	0	0	0	13.00
14.00	Accumulated depreciation	-288,980	0	0	0	14.00
15.00	Buildings	24,881,625	0	0	0	15.00
16.00	Accumulated depreciation	-9,780,348	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	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	6,510,685	0	0	0	23.00
24.00	Accumulated depreciation	-4,533,363	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	1,968,769	0	0	0	27.00
28.00	Accumulated depreciation	-1,775,183	0	0	0	28.00
29.00	Minor equipment-nondepreciable	14,996	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	18,824,338	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	7,883,180	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	925,153	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	8,808,333	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	41,443,761	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	853,209	0	0	0	37.00
38.00	Salaries, wages, and fees payable	798,803	0	0	0	38.00
39.00	Payroll taxes payable	91,025	0	0	0	39.00
40.00	Notes and loans payable (short term)	4,481,872	0	0	0	40.00
41.00	Deferred income	31,094	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	79,794	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	6,335,797	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	21,370,438	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	33,952	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	21,404,390	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	27,740,187	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	13,703,574				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)	13,703,574	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	41,443,761	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 14-1305 | Period: From 07/01/2016 To 06/30/2017 | Worksheet G-1 | Date/Time Prepared: 11/27/2017 8:13 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		14,330,101		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-662,225				2.00
3.00	Total (sum of line 1 and line 2)		13,667,876		0		3.00
4.00		0		0		0	4.00
5.00	RESTRICTED CONTRIBUTIONS	46,300		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)		46,300		0		10.00
11.00	Subtotal (line 3 plus line 10)		13,714,176		0		11.00
12.00	CAPITAL CAMPAIGN EXPENSE	10,602		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)		10,602		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		13,703,574		0		19.00

		Endowment Fund	Plant Fund		
		6.00	7.00	8.00	
1.00	Fund balances at beginning of period	0		0	1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)				2.00
3.00	Total (sum of line 1 and line 2)	0		0	3.00
4.00			0		4.00
5.00	RESTRICTED CONTRIBUTIONS		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	CAPITAL CAMPAIGN EXPENSE		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: 14-1305	Period: From 07/01/2016 To 06/30/2017	Worksheet G-2 Parts I & II Date/Time Prepared: 11/27/2017 8:13 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	2,649,423		2,649,423	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE	0		0	9.00
10.00	Total general inpatient care services (sum of lines 1-9)	2,649,423		2,649,423	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)	2,649,423		2,649,423	17.00
18.00	Ancillary services	4,609,711	26,552,054	31,161,765	18.00
19.00	Outpatient services	35,238	8,270,166	8,305,404	19.00
20.00	RURAL HEALTH CLINIC	0	6,923,679	6,923,679	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES	0	0	0	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PHYSICIAN OFFICE	0	368,776	368,776	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	7,294,372	42,114,675	49,409,047	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		27,759,851		29.00
30.00		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		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)		27,759,851		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 14-1305	Period: From 07/01/2016 To 06/30/2017	Worksheet G-3 Date/Time Prepared: 11/27/2017 8:13 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	49,409,047	1.00
2.00	Less contractual allowances and discounts on patients' accounts	24,303,647	2.00
3.00	Net patient revenues (line 1 minus line 2)	25,105,400	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	27,759,851	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-2,654,451	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	65,563	6.00
7.00	Income from investments	502,049	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	2,666	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	32,984	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	4,549	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	55,546	22.00
23.00	Governmental appropriations	44,290	23.00
24.00	HOSPITAL OTHER INCOME	1,945	24.00
24.01	EQUITY EARNINGS ON INVESTMENTS	0	24.01
24.02		0	24.02
24.03	RELEASED FROM RESTRICTION	10,602	24.03
24.04	340B PHARMACY REVENUE	1,146,998	24.04
24.05	SALARY REIMBURSEMENTS	33,348	24.05
24.06	EHR INCENTIVE	149,502	24.06
25.00	Total other income (sum of lines 6-24)	2,050,042	25.00
26.00	Total (line 5 plus line 25)	-604,409	26.00
27.00	LOSS ON DISPOSAL	42,620	27.00
27.01	EQUITY IN EARNINGS OF UNCONCOLIDATED	15,196	27.01
28.00	Total other expenses (sum of line 27 and subscripts)	57,816	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-662,225	29.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1305 | Component CCN: 14-3456 | Period: From 07/01/2016 To 06/30/2017 | Worksheet M-1 | Date/Time Prepared: 11/27/2017 8:13 pm

RHC I | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	1,671,340	0	1,671,340	-369,774	1,301,566	1.00
2.00	Physician Assistant	1,038,163	0	1,038,163	-364,181	673,982	2.00
3.00	Nurse Practitioner	0	0	0	0	0	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	0	0	0	0	0	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	1,195,530	0	1,195,530	-844,212	351,318	9.00
10.00	Subtotal (sum of lines 1 through 9)	3,905,033	0	3,905,033	-1,578,167	2,326,866	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	234,906	234,906	0	234,906	12.00
13.00	Other Costs Under Agreement	0	63,618	63,618	-30,215	33,403	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	298,524	298,524	-30,215	268,309	14.00
15.00	Medical Supplies	0	364,729	364,729	-120,536	244,193	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	17,420	17,420	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	79,499	79,499	-41,298	38,201	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	444,228	444,228	-144,414	299,814	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	3,905,033	742,752	4,647,785	-1,752,796	2,894,989	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
25.01	Telehealth	0	0	0	0	0	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	0	0	0	0	29.00
30.00	Administrative Costs	0	407,510	407,510	-112,079	295,431	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	407,510	407,510	-112,079	295,431	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	3,905,033	1,150,262	5,055,295	-1,864,875	3,190,420	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1305 | Component CCN: 14-3456 | Period: From 07/01/2016 To 06/30/2017 | Worksheet M-1 | Date/Time Prepared: 11/27/2017 8:13 pm

RHC I | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
		6.00	7.00	
	FACILITY HEALTH CARE STAFF COSTS			
1.00	Physician	0	1,301,566	1.00
2.00	Physician Assistant	0	673,982	2.00
3.00	Nurse Practitioner	0	0	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	0	5.00
6.00	Clinical Psychologist	0	0	6.00
7.00	Clinical Social Worker	0	0	7.00
8.00	Laboratory Technician	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	351,318	9.00
10.00	Subtotal (sum of lines 1 through 9)	0	2,326,866	10.00
11.00	Physician Services Under Agreement	0	0	11.00
12.00	Physician Supervision Under Agreement	0	234,906	12.00
13.00	Other Costs Under Agreement	0	33,403	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	268,309	14.00
15.00	Medical Supplies	0	244,193	15.00
16.00	Transportation (Health Care Staff)	0	0	16.00
17.00	Depreciation-Medical Equipment	0	17,420	17.00
18.00	Professional Liability Insurance	0	0	18.00
19.00	Other Health Care Costs	0	38,201	19.00
20.00	Allowable GME Costs			20.00
21.00	Subtotal (sum of lines 15 through 20)	0	299,814	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	2,894,989	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES			
23.00	Pharmacy	0	0	23.00
24.00	Dental	0	0	24.00
25.00	Optometry	0	0	25.00
25.01	Telehealth	0	0	25.01
25.02	Chronic Care Management	0	0	25.02
26.00	All other nonreimbursable costs	0	0	26.00
27.00	Nonallowable GME costs			27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	28.00
	FACILITY OVERHEAD			
29.00	Facility Costs	0	0	29.00
30.00	Administrative Costs	-20,719	274,712	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-20,719	274,712	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-20,719	3,169,701	32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES | Provider CCN: 14-1305 | Component CCN: 14-3456 | Period: From 07/01/2016 To 06/30/2017 | Worksheet M-2 | Date/Time Prepared: 11/27/2017 8:13 pm

RHC I | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	2.27	8,421	4,200	9,534		1.00
2.00	Physician Assistant	0.77	2,543	2,100	1,617		2.00
3.00	Nurse Practitioner	4.75	12,860	2,100	9,975		3.00
4.00	Subtotal (sum of lines 1 through 3)	7.79	23,824		21,126	23,824	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	7.79	23,824			23,824	8.00
9.00	Physician Services Under Agreements		0			0	9.00

		1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES		
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)	2,894,989	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)	0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)	2,894,989	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)	1.000000	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)	274,712	14.00
15.00	Parent provider overhead allocated to facility (see instructions)	1,734,544	15.00
16.00	Total overhead (sum of lines 14 and 15)	2,009,256	16.00
17.00	Allowable GME overhead (see instructions)	0	17.00
18.00	Enter the amount from line 16	2,009,256	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)	2,009,256	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)	4,904,245	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 14-1305 Component CCN: 14-3456	Period: From 07/01/2016 To 06/30/2017	Worksheet M-3 Date/Time Prepared: 11/27/2017 8:13 pm
	Title XVIII	RHC I	Cost

			1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES			
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)		4,904,245	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)		68,912	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		4,835,333	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		23,824	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)		23,824	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		202.96	7.00
		Calculation of Limit (1)		
		Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	81.32	82.30	8.00
9.00	Rate for Program covered visits (see instructions)	202.96	202.96	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	3,430	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	696,153	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	696,153	16.00
16.01	Total program charges (see instructions)(from contractor's records)		684,420	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		60,738	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		61,779	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.)		464,066	16.04
16.05	Total program cost (see instructions)	0	525,845	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		54,292	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		113,249	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		525,845	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		17,932	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		543,777	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			0	25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	25.50
26.00	Net reimbursable amount (see instructions)		543,777	26.00
26.01	Sequestration adjustment (see instructions)		10,876	26.01
27.00	Interim payments		466,663	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)		66,238	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: 14-1305 Component CCN: 14-3456	Period: From 07/01/2016 To 06/30/2017	Worksheet M-4 Date/Time Prepared: 11/27/2017 8:13 pm
	Title XVIII	RHC I	Cost

		Pneumococcal	Influenza	
		1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	2,326,866	2,326,866	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000873	0.001019	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	2,031	2,371	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	30,785	5,493	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	32,816	7,864	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	2,894,989	2,894,989	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	2,009,256	2,009,256	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.011335	0.002716	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	22,775	5,457	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	55,591	13,321	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	222	259	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	250.41	51.43	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	56	76	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	14,023	3,909	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)		68,912	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)		17,932	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 14-1305 Component CCN: 14-3456	Period: From 07/01/2016 To 06/30/2017	Worksheet M-5 Date/Time Prepared: 11/27/2017 8:13 pm
		RHC I	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		443,534	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		02/19/2017	23,129	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
	Provider to Program			
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		23,129	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		466,663	4.00
	TO BE COMPLETED BY CONTRACTOR			
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			5.00
	Program to Provider			
5.01			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		66,238	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		532,901	7.00

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