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: 14-1308	Period: From 05/01/2016 To 04/30/2017	Worksheet S Parts I-III Date/Time Prepared: 9/18/2017 4:37 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 9/18/2017 Time: 4:37 pm
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by WASHINGTON COUNTY HOSPITAL (14-1308) for the cost reporting period beginning 05/01/2016 and ending 04/30/2017 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	13,074	-30,898	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	-13,554	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
10.00	RURAL HEALTH CLINIC I	0		24,171		0	10.00
200.00	Total	0	-480	-6,727	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: 14-1308 | Period: From 05/01/2016 To 04/30/2017 | Worksheet S-2 Part I | Date/Time Prepared: 9/18/2017 2:08 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 705 SOUTH GRAND AVENUE	PO Box:			1.00
2.00	City: NASHVILLE	State: IL	Zip Code: 62263	County: WASHINGTON	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	WASHINGTON COUNTY HOSPITAL	141308	99914	1	12/01/2000	N	O	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	WASHINGTON COUNTY SWING BED	14Z308	99914		08/18/2000	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	WASHINTON COUNTY EXTENDED CARE								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	GRAND STREET RHC	143472	99914		08/01/2005	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)	05/01/2016	04/30/2017	20.00
21.00	Type of Control (see instructions)	11		21.00
	Inpatient PPS Information			
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	N	N	22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	N	N	22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N	22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.	N	N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	3	N	23.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1308 | Period: From 05/01/2016 To 04/30/2017 | Worksheet S-2 Part I Date/Time Prepared: 9/18/2017 2:08 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)	N			0.00	0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00	0.00			61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)		0.00	0.00			61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)		0.00	0.00			61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).		0.00	0.00			61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)		0.00	0.00			61.05

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1308 | Period: From 05/01/2016 To 04/30/2017 | Worksheet S-2 Part I Date/Time Prepared: 9/18/2017 2:08 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: 14-1308 | Period: From 05/01/2016 To 04/30/2017 | Worksheet S-2 Part I Date/Time Prepared: 9/18/2017 2:08 pm

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

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

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

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

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

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

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

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

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

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	11,696	0	0	118.01

		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain state health or similar taxes? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N		122.00
	Transplant Center Information			
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1308 | Period: From 05/01/2016 To 04/30/2017 | Worksheet S-2 Part I | Date/Time Prepared: 9/18/2017 2:08 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)	0	168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)		168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	0.00	169.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 14-1308	Period: From 05/01/2016 To 04/30/2017	Worksheet S-2 Part I Date/Time Prepared: 9/18/2017 2:08 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)	05/01/2016	04/30/2017	170.00
		1.00	2.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)	N	0	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 14-1308 | Period: From 05/01/2016 To 04/30/2017 | Worksheet S-2 Part II | Date/Time Prepared: 9/18/2017 2:08 pm

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

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

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

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

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

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	N		N		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	08/01/2017	Y	08/01/2017	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 14-1308 | Period: From 05/01/2016 To 04/30/2017 | Worksheet S-2 Part II Date/Time Prepared: 9/18/2017 2:08 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				N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				N	27.00
	Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				Y	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				N	31.00
	Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.					33.00
	Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				N	35.00
				Y/N	Date	
				1.00	2.00	
	Home Office Costs					
36.00	Were home office costs claimed on the cost report?			N		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.					37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.					38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.					39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.					40.00
		1.00		2.00		
	Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	VALERIE		TEPE		41.00
42.00	Enter the employer/company name of the cost report preparer.	WASHINGTON COUNTY HOSPITAL				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	618-327-2303		VTEPE@WASHINGTONCOUNTYHOSPITAL.ORG		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 14-1308	Period: From 05/01/2016 To 04/30/2017	Worksheet S-2 Part II Date/Time Prepared: 9/18/2017 2:08 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.	ACCOUNTING MANAGER		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: 14-1308 | Period: From 05/01/2016 To 04/30/2017 | Worksheet S-3 Part I Date/Time Prepared: 9/18/2017 2:08 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	22	8,030	5,844.00	0	1.00
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		22	8,030	5,844.00	0	7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)		22	8,030	5,844.00	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	28	10,220			21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)	115.00					23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	88.00				0	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		50				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: 14-1308 | Period: From 05/01/2016 To 04/30/2017 | Worksheet S-3 Part I | Date/Time Prepared: 9/18/2017 2:08 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)	199	2	261			1.00
2.00	HMO and other (see instructions)	0	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	959	0	1,089			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	59			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,158	2	1,409			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)	1,158	2	1,409	0.00	98.91	14.00
15.00	CAH visits	8,964	3,915	24,733			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			7,712	0.00	16.96	21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)				0.00	0.00	23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	0	0	0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	2,226	0	8,056	0.00	12.77	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	128.64	27.00
28.00	Observation Bed Days		0	31			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 14-1308 | Period: From 05/01/2016 To 04/30/2017 | Worksheet S-3 Part I Date/Time Prepared: 9/18/2017 2:08 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	63	1	83	1.00
2.00	HMO and other (see instructions)			0	0		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				0		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	63	1	83	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				24	21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)	0.00					23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	0.00					26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 14-1308 | Component CCN: 14-3472 | Period: From 05/01/2016 To 04/30/2017 | Worksheet S-8 | Date/Time Prepared: 9/18/2017 2:08 pm

RHC I | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			705 SOUTH GRAND AVE		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	NASHVILLE		IL	62263	2.00
					1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0	3.00
			Grant Award		Date	
			1.00		2.00	
	Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)					4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)					5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)					6.00
7.00	Appalachian Regional Commission					7.00
8.00	Look-Alikes					8.00
9.00	OTHER (SPECIFY)					9.00
				1.00	2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N	0	10.00

		Sunday		Monday		Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
	Facility hours of operations (1)						
11.00	Clinic			07:30	19:00	07:30	11.00

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

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

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

			County				
			4.00				
2.00	City, State, ZIP Code, County		WASHINGTON				2.00
		Tuesday	Wednesday		Thursday		
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)						
11.00	Clinic	19:00	07:30	19:00	07:30	19:00	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-1308
Component CCN: 14-3472

Period:
From 05/01/2016
To 04/30/2017

Worksheet S-8
Date/Time Prepared:
9/18/2017 2:08 pm

RHC I | Cost

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	Clinic	07:30	19:00	08:00	14:00		11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 14-1308 | Period: From 05/01/2016 To 04/30/2017 | Worksheet S-10 | Date/Time Prepared: 9/18/2017 2:08 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)	0.729482	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	1,662,086	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?	Y	4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	2,573,156	6.00
7.00	Medicaid cost (line 1 times line 6)	1,877,071	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)	214,985	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
	Uncompensated care (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	214,985	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
20.00	Charity care charges for the entire facility (see instructions)	13,432	22,208	35,640	20.00
21.00	Cost of patients approved for charity care (line 1 times line 20)	9,798	16,200	25,998	21.00
22.00	Partial payment by patients approved for charity care	50	1,067	1,117	22.00
23.00	Cost of charity care (line 21 minus line 22)	9,748	15,133	24,881	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," charges for patient days beyond an indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	381,588	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	35,210	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	346,378	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	252,677	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	277,558	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	492,543	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-1308 | Period: From 05/01/2016 To 04/30/2017 | Worksheet A | Date/Time Prepared: 9/18/2017 2:08 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	CAP REL COSTS-BLDG & FIXT		261,014	261,014	53,312	314,326	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		230,368	230,368	0	230,368	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	84,472	2,375,083	2,459,555	0	2,459,555	4.00
5.01	00550	INFORMATION SYSTEMS	262,953	279,677	542,630	-54,152	488,478	5.01
5.02	00591	OTHER ADMINISTRATIVE AND GENERAL	688,790	504,759	1,193,549	38,191	1,231,740	5.02
6.00	00600	MAINTENANCE & REPAIRS	117,451	438,259	555,710	0	555,710	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	91,235	91,235	0	91,235	8.00
9.00	00900	HOUSEKEEPING	195,770	22,629	218,399	0	218,399	9.00
10.00	01000	DIETARY	228,478	124,113	352,591	-36,951	315,640	10.00
11.00	01100	CAFETERIA	0	0	0	36,951	36,951	11.00
13.00	01300	NURSING ADMINISTRATION	46,707	501	47,208	0	47,208	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	57,637	15,288	72,925	0	72,925	14.00
15.00	01500	PHARMACY	123,597	30,610	154,207	0	154,207	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	195,144	34,302	229,446	0	229,446	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	4,842	4,842	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	221	0	221	74,200	74,421	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	579,596	28,586	608,182	-4,842	603,340	30.00
46.00	04600	OTHER LONG TERM CARE	548,518	23,039	571,557	0	571,557	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	137,730	97,867	235,597	0	235,597	50.00
53.00	05300	ANESTHESIOLOGY	0	80,316	80,316	-74,200	6,116	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	316,708	337,354	654,062	54,152	708,214	54.00
60.00	06000	LABORATORY	400,614	556,157	956,771	0	956,771	60.00
65.00	06500	RESPIRATORY THERAPY	12,272	46,315	58,587	0	58,587	65.00
66.00	06600	PHYSICAL THERAPY	817,784	38,132	855,916	0	855,916	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
68.01	06801	CARDIAC REHAB	49,784	5,399	55,183	0	55,183	68.01
69.00	06900	ELECTROCARDIOLOGY	5,733	11,245	16,978	0	16,978	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	59,616	59,616	-11,026	48,590	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	11,026	11,026	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	618,783	618,783	0	618,783	73.00
76.00	03480	ONCOLOGY	3,273	117	3,390	0	3,390	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,304,999	246,865	1,551,864	-38,191	1,513,673	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	428,060	1,301,065	1,729,125	0	1,729,125	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		55,927	55,927	-55,927	0	113.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	6,606,291	7,914,621	14,520,912	-2,615	14,518,297	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	7,548	7,548	2,615	10,163	190.00
190.01	19001	OUTPATIENT CLINIC	450	97	547	0	547	190.01
190.02	19003	NON-REIMBURSEABLE OUTPATIENT MEALS	0	0	0	0	0	190.02
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		TOTAL (SUM OF LINES 118-199)	6,606,741	7,922,266	14,529,007	0	14,529,007	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-1308 | Period: From 05/01/2016 To 04/30/2017 | Worksheet A | Date/Time Prepared: 9/18/2017 2:08 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	0	314,326		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-36,251	194,117		2.00
3.00	00300	OTHER CAP REL COSTS	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-10,022	2,449,533		4.00
5.01	00550	INFORMATION SYSTEMS	0	488,478		5.01
5.02	00591	OTHER ADMINISTRATIVE AND GENERAL	-29,129	1,202,611		5.02
6.00	00600	MAINTENANCE & REPAIRS	0	555,710		6.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	91,235		8.00
9.00	00900	HOUSEKEEPING	0	218,399		9.00
10.00	01000	DIETARY	0	315,640		10.00
11.00	01100	CAFETERIA	-19,097	17,854		11.00
13.00	01300	NURSING ADMINISTRATION	0	47,208		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	-236	72,689		14.00
15.00	01500	PHARMACY	0	154,207		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-6,886	222,560		16.00
17.00	01700	SOCIAL SERVICE	0	4,842		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	74,421		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	603,340		30.00
46.00	04600	OTHER LONG TERM CARE	0	571,557		46.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	235,597		50.00
53.00	05300	ANESTHESIOLOGY	0	6,116		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-4,583	703,631		54.00
60.00	06000	LABORATORY	-9,075	947,696		60.00
65.00	06500	RESPIRATORY THERAPY	-358	58,229		65.00
66.00	06600	PHYSICAL THERAPY	-300	855,616		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
68.01	06801	CARDIAC REHAB	0	55,183		68.01
69.00	06900	ELECTROCARDIOLOGY	-10,815	6,163		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	48,590		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	11,026		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-44,659	574,124		73.00
76.00	03480	ONCOLOGY	0	3,390		76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	-79,660	1,434,013		88.00
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	-195,872	1,533,253		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0	0		93.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0	0		95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0		98.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0		115.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-446,943	14,071,354		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	10,163		190.00
190.01	19001	OUTPATIENT CLINIC	0	547		190.01
190.02	19003	NON-REIMBURSEABLE OUTPATIENT MEALS	0	0		190.02
191.00	19100	RESEARCH	0	0		191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0		192.00
193.00	19300	NONPAID WORKERS	0	0		193.00
200.00		TOTAL (SUM OF LINES 118-199)	-446,943	14,082,064		200.00

RECLASSIFICATIONS | Provider CCN: 14-1308 | Period: From 05/01/2016 To 04/30/2017 | Worksheet A-6 | Date/Time Prepared: 9/18/2017 2:08 pm

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - RECLASSIFY CAFETERIA COSTS					
1.00	CAFETERIA	11.00	23,944	13,007		1.00
	TOTALS		23,944	13,007		
	B - RECLASS SOCIAL SERVICE COST					
1.00	SOCIAL SERVICE	17.00	4,842	0		1.00
	TOTALS		4,842	0		
	C - RECLASS PROFESSIONAL LIABILITY INSUR					
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.02	0	38,191		1.00
	TOTALS		0	38,191		
	D - RECLASSIFY XRAY DIRECTORS SALARY					
1.00	RADIOLOGY-DIAGNOSTIC	54.00	54,152	0		1.00
	TOTALS		54,152	0		
	E - RECLASSIFY ANESTHESIA PRO FEES					
1.00	NONPHYSICIAN ANESTHETISTS	19.00	0	74,200		1.00
	TOTALS		0	74,200		
	F - INTEREST EXPENSE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	55,927		1.00
	TOTALS		0	55,927		
	G - TO RECLASS INTEROCULAR LENS					
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	11,026		1.00
	TOTALS		0	11,026		
	H - TO RECLASS ANNEX BLDG DEPRECIATION					
1.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00	0	2,615		1.00
	TOTALS		0	2,615		
500.00	Grand Total: Increases		82,938	194,966		500.00

RECLASSIFICATIONS | Provider CCN: 14-1308 | Period: From 05/01/2016 To 04/30/2017 | Worksheet A-6 | Date/Time Prepared: 9/18/2017 2:08 pm

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - RECLASSIFY CAFETERIA COSTS						
1.00	DIETARY	10.00	23,944	13,007	0		1.00
	TOTALS		23,944	13,007			
	B - RECLASS SOCIAL SERVICE COST						
1.00	ADULTS & PEDIATRICS	30.00	4,842	0	0		1.00
	TOTALS		4,842	0			
	C - RECLASS PROFESSIONAL LIABILITY INSUR						
1.00	RURAL HEALTH CLINIC	88.00	0	38,191	0		1.00
	TOTALS		0	38,191			
	D - RECLASSIFY XRAY DIRECTORS SALARY						
1.00	INFORMATION SYSTEMS	5.01	54,152	0	0		1.00
	TOTALS		54,152	0			
	E - RECLASSIFY ANESTHESIA PRO FEES						
1.00	ANESTHESIOLOGY	53.00	0	74,200	0		1.00
	TOTALS		0	74,200			
	F - INTEREST EXPENSE						
1.00	INTEREST EXPENSE	113.00	0	55,927	9		1.00
	TOTALS		0	55,927			
	G - TO RECLASS INTEROCULAR LENS						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	11,026	0		1.00
	TOTALS		0	11,026			
	H - TO RECLASS ANNEX BLDG DEPRECIATION						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	2,615	9		1.00
	TOTALS		0	2,615			
500.00	Grand Total: Decreases		82,938	194,966			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1308 | Period: From 05/01/2016 To 04/30/2017 | Worksheet A-7 Part I | Date/Time Prepared: 9/18/2017 2:08 pm

			Acquisitions				
		Beginning Balances	Purchases	Donation	Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	62,855	0	0	0	0	1.00
2.00	Land Improvements	419,030	0	0	0	0	2.00
3.00	Buildings and Fixtures	9,460,894	19,005	0	19,005	434	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	5,421,579	0	0	0	0	6.00
7.00	HIT designated Assets	927,041	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	16,291,399	19,005	0	19,005	434	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	16,291,399	19,005	0	19,005	434	10.00

		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	62,855	0				1.00
2.00	Land Improvements	419,030	0				2.00
3.00	Buildings and Fixtures	9,479,465	0				3.00
4.00	Building Improvements	0	0				4.00
5.00	Fixed Equipment	0	0				5.00
6.00	Movable Equipment	5,421,579	0				6.00
7.00	HIT designated Assets	927,041	0				7.00
8.00	Subtotal (sum of lines 1-7)	16,309,970	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	16,309,970	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1308 | Period: From 05/01/2016 To 04/30/2017 | Worksheet A-7 Part II | Date/Time Prepared: 9/18/2017 2:08 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	CAP REL COSTS-BLDG & FIXT	261,014	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	230,368	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	491,382	0	0	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
		14.00	15.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	261,014	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	230,368	2.00
3.00	Total (sum of lines 1-2)	0	491,382	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1308 | Period: From 05/01/2016 To 04/30/2017 | Worksheet A-7 Part III | Date/Time Prepared: 9/18/2017 2:08 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	CAP REL COSTS-BLDG & FIXT	9,961,350	0	9,961,350	0.610752	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	6,348,620	0	6,348,620	0.389248	0	2.00
3.00	Total (sum of lines 1-2)	16,309,970	0	16,309,970	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	314,326	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	194,117	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	508,443	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	0	314,326	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	194,117	2.00
3.00	Total (sum of lines 1-2)	0	0	0	0	508,443	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-1308 | Period: From 05/01/2016 To 04/30/2017 | Worksheet A-8 | Date/Time Prepared: 9/18/2017 2:08 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 - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)	B	-14,360	OTHER ADMINISTRATIVE AND GENERAL	5.02	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)	B	-236	CENTRAL SERVICES & SUPPLY	14.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		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	-211,928			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	-19,097	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	-6,886	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	A	-36,251	CAP REL COSTS-MVBLE EQUIP	2.00	9	32.00
33.00	MISCELLANEOUS REVENUE - UNEMPLOYMENT	B	-10,022	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-1308 | Period: From 05/01/2016 To 04/30/2017 | Worksheet A-8 | Date/Time Prepared: 9/18/2017 2:08 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	
33.01	MISCELLANEOUS REVENUE - OTHER	B	-1,125	OTHER ADMINISTRATIVE AND GENERAL	5.02	0	33.01
34.00	LAB FEES	A	-9,075	LABORATORY	60.00	0	34.00
35.00	EDUCATION FEES	B	-780	OTHER ADMINISTRATIVE AND GENERAL	5.02	0	35.00
36.00	NONALLOWABLE PUBLIC RELATIONS	A	-11,936	OTHER ADMINISTRATIVE AND GENERAL	5.02	0	36.00
37.00	HEALTHLINK ADMIN FEES	A	19,901	OTHER ADMINISTRATIVE AND GENERAL	5.02	0	37.00
38.00	LOBBYING PORTION OF DUES	A	-14,160	OTHER ADMINISTRATIVE AND GENERAL	5.02	0	38.00
39.00	NON-RHC SERVICES	A	-69,086	RURAL HEALTH CLINIC	88.00	0	39.00
40.00	NON-RHC BENEFITS	A	-10,574	RURAL HEALTH CLINIC	88.00	0	40.00
41.00	TELEPHONE SERVICE	B	-6,669	OTHER ADMINISTRATIVE AND GENERAL	5.02	0	41.00
42.00			0		0.00	0	42.00
43.00	340B PHARMACY	A	-44,659	DRUGS CHARGED TO PATIENTS	73.00	0	43.00
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-446,943				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: 14-1308 | Period: From 05/01/2016 To 04/30/2017 | Worksheet A-8-2 | Date/Time Prepared: 9/18/2017 2:08 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	54.00	RADIOLOGY-DIAGNOSTIC	4,583	4,583	0	0	0	1.00
2.00	60.00	LABORATORY	18,755	0	18,755	0	0	2.00
3.00	69.00	ELECTROCARDIOLOGY	10,815	10,815	0	0	0	3.00
4.00	91.00	EMERGENCY	1,277,923	195,872	1,082,051	0	0	4.00
5.00	65.00	RESPIRATORY THERAPY	358	358	0	0	0	5.00
6.00	66.00	PHYSICAL THERAPY	300	300	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			1,312,734	211,928	1,100,806		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	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	1.00
2.00	60.00	LABORATORY	0	0	0	0	0	2.00
3.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	3.00
4.00	91.00	EMERGENCY	0	0	0	0	0	4.00
5.00	65.00	RESPIRATORY THERAPY	0	0	0	0	0	5.00
6.00	66.00	PHYSICAL THERAPY	0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	4,583		1.00
2.00	60.00	LABORATORY	0	0	0	0		2.00
3.00	69.00	ELECTROCARDIOLOGY	0	0	0	10,815		3.00
4.00	91.00	EMERGENCY	0	0	0	195,872		4.00
5.00	65.00	RESPIRATORY THERAPY	0	0	0	358		5.00
6.00	66.00	PHYSICAL THERAPY	0	0	0	300		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	211,928		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1308 | Period: From 05/01/2016 To 04/30/2017 | Worksheet B Part I | Date/Time Prepared: 9/18/2017 2:08 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	INFORMATION SYSTEMS	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	4.00	5.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	314,326	314,326				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	194,117		194,117			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,449,533	576	0	2,450,109		4.00
5.01	00550	INFORMATION SYSTEMS	488,478	4,197	30,952	78,437	602,064	5.01
5.02	00591	OTHER ADMINISTRATIVE AND GENERAL	1,202,611	66,894	1,740	258,746	107,345	5.02
6.00	00600	MAINTENANCE & REPAIRS	555,710	50,136	1,258	44,121	9,334	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	91,235	3,953	0	0	0	8.00
9.00	00900	HOUSEKEEPING	218,399	1,811	0	73,542	9,334	9.00
10.00	01000	DIETARY	315,640	7,417	597	76,834	14,001	10.00
11.00	01100	CAFETERIA	17,854	3,643	0	8,995	0	11.00
13.00	01300	NURSING ADMINISTRATION	47,208	576	0	17,546	4,667	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	72,689	3,316	6,416	21,652	9,334	14.00
15.00	01500	PHARMACY	154,207	4,057	3,013	46,430	18,669	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	222,560	4,249	79	73,306	28,003	16.00
17.00	01700	SOCIAL SERVICE	4,842	384	0	1,819	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	74,421	0	0	83	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	603,340	27,982	7,075	215,908	56,006	30.00
46.00	04600	OTHER LONG TERM CARE	571,557	39,836	465	206,052	18,669	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	235,597	14,741	2,715	51,739	23,336	50.00
53.00	05300	ANESTHESIOLOGY	6,116	0	2,514	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	703,631	19,527	109,061	139,315	56,006	54.00
60.00	06000	LABORATORY	947,696	8,804	1,483	150,492	23,336	60.00
65.00	06500	RESPIRATORY THERAPY	58,229	2,077	3,030	4,610	0	65.00
66.00	06600	PHYSICAL THERAPY	855,616	8,608	6,153	307,203	74,675	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
68.01	06801	CARDIAC REHAB	55,183	1,837	6,901	18,702	4,667	68.01
69.00	06900	ELECTROCARDIOLOGY	6,163	253	1,817	2,154	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	48,590	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	11,026	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	574,124	0	0	0	0	73.00
76.00	03480	ONCOLOGY	3,390	1,034	0	1,230	4,667	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,434,013	10,518	56	490,222	88,676	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	1,533,253	15,034	6,759	160,802	28,003	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	14,071,354	301,460	192,084	2,449,940	578,728	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	10,163	0	0	0	0	190.00
190.01	19001	OUTPATIENT CLINIC	547	12,866	2,033	169	23,336	190.01
190.02	19003	NON-REIMBURSEABLE OUTPATIENT MEALS	0	0	0	0	0	190.02
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	14,082,064	314,326	194,117	2,450,109	602,064	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1308 | Period: From 05/01/2016 To 04/30/2017 | Worksheet B Part I Date/Time Prepared: 9/18/2017 2:08 pm

		Cost Center Description	Subtotal	OTHER ADMINISTRATIVE AND GENERAL	MAINTENANCE & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5A.01	5.02	6.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	INFORMATION SYSTEMS						5.01
5.02	00591	OTHER ADMINISTRATIVE AND GENERAL	1,637,336	1,637,336				5.02
6.00	00600	MAINTENANCE & REPAIRS	660,559	86,909	747,468			6.00
8.00	00800	LAUNDRY & LINEN SERVICE	95,188	12,524	15,346	123,058		8.00
9.00	00900	HOUSEKEEPING	303,086	39,877	7,029	0	349,992	9.00
10.00	01000	DIETARY	414,489	54,534	28,795	0	13,899	10.00
11.00	01100	CAFETERIA	30,492	4,012	14,143	0	6,827	11.00
13.00	01300	NURSING ADMINISTRATION	69,997	9,209	2,236	0	1,079	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	113,407	14,921	12,873	0	6,214	14.00
15.00	01500	PHARMACY	226,376	29,784	15,753	0	7,604	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	328,197	43,181	16,498	0	7,963	16.00
17.00	01700	SOCIAL SERVICE	7,045	927	1,491	0	719	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	74,504	9,802	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	910,311	119,769	108,642	13,054	52,440	30.00
46.00	04600	OTHER LONG TERM CARE	836,579	110,068	154,664	80,177	74,653	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	328,128	43,171	57,234	5,291	27,626	50.00
53.00	05300	ANESTHESIOLOGY	8,630	1,135	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,027,540	135,192	75,816	4,135	36,595	54.00
60.00	06000	LABORATORY	1,131,811	148,911	34,181	0	16,499	60.00
65.00	06500	RESPIRATORY THERAPY	67,946	8,940	8,063	234	3,892	65.00
66.00	06600	PHYSICAL THERAPY	1,252,255	164,758	33,419	11,880	16,131	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
68.01	06801	CARDIAC REHAB	87,290	11,485	7,131	0	3,442	68.01
69.00	06900	ELECTROCARDIOLOGY	10,387	1,367	982	0	474	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	48,590	6,393	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	11,026	1,451	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	574,124	75,537	0	0	0	73.00
76.00	03480	ONCOLOGY	10,321	1,358	4,014	0	1,938	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	2,023,485	266,222	40,838	279	19,712	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	1,743,851	229,437	58,369	7,689	28,174	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0					92.00
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	14,032,950	1,630,874	697,517	122,739	325,881	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	10,163	1,337	0	0	0	190.00
190.01	19001	OUTPATIENT CLINIC	38,951	5,125	49,951	319	24,111	190.01
190.02	19003	NON-REIMBURSEABLE OUTPATIENT MEALS	0	0	0	0	0	190.02
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments	0					200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	14,082,064	1,637,336	747,468	123,058	349,992	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1308 | Period: From 05/01/2016 To 04/30/2017 | Worksheet B Part I | Date/Time Prepared: 9/18/2017 2:08 pm

		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	INFORMATION SYSTEMS						5.01
5.02	00591	OTHER ADMINISTRATIVE AND GENERAL						5.02
6.00	00600	MAINTENANCE & REPAIRS						6.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	511,717					10.00
11.00	01100	CAFETERIA	0	55,474				11.00
13.00	01300	NURSING ADMINISTRATION	0	339	82,860			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,036	0	148,451		14.00
15.00	01500	PHARMACY	0	628	0	217	280,362	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	3,040	0	104	0	16.00
17.00	01700	SOCIAL SERVICE	0	63	0	0	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	94,798	7,354	25,770	30,421	227	30.00
46.00	04600	OTHER LONG TERM CARE	414,740	10,651	0	19,906	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	1,570	6,378	18,871	37	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	3,587	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	3,762	0	2,828	158	54.00
60.00	06000	LABORATORY	0	4,767	0	3,527	112	60.00
65.00	06500	RESPIRATORY THERAPY	0	170	691	107	0	65.00
66.00	06600	PHYSICAL THERAPY	0	7,894	0	2,405	366	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
68.01	06801	CARDIAC REHAB	0	0	0	1,764	0	68.01
69.00	06900	ELECTROCARDIOLOGY	0	672	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	21,291	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	17,323	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	278,538	73.00
76.00	03480	ONCOLOGY	0	38	0	167	5	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	8,020	29,659	4,842	663	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	5,464	20,362	20,939	256	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	509,538	55,468	82,860	148,299	280,362	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	OUTPATIENT CLINIC	0	6	0	152	0	190.01
190.02	19003	NON-REIMBURSEABLE OUTPATIENT MEALS	2,179	0	0	0	0	190.02
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	511,717	55,474	82,860	148,451	280,362	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1308 | Period: From 05/01/2016 To 04/30/2017 | Worksheet B Part I Date/Time Prepared: 9/18/2017 2:08 pm

		Cost Center Description	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			16.00	17.00	19.00	24.00	25.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	INFORMATION SYSTEMS						5.01
5.02	00591	OTHER ADMINISTRATIVE AND GENERAL						5.02
6.00	00600	MAINTENANCE & REPAIRS						6.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	398,983					16.00
17.00	01700	SOCIAL SERVICE	0	10,245				17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	84,306			19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	18,456	9,220	0	1,390,462	-43,603	30.00
46.00	04600	OTHER LONG TERM CARE	20,830	1,025	0	1,723,293	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	33,970	0	0	522,276	0	50.00
53.00	05300	ANESTHESIOLOGY	1,789	0	84,306	99,447	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	106,045	0	0	1,392,071	0	54.00
60.00	06000	LABORATORY	77,302	0	0	1,417,110	0	60.00
65.00	06500	RESPIRATORY THERAPY	5,659	0	0	95,702	0	65.00
66.00	06600	PHYSICAL THERAPY	51,450	0	0	1,540,558	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
68.01	06801	CARDIAC REHAB	2,019	0	0	113,131	0	68.01
69.00	06900	ELECTROCARDIOLOGY	3,778	0	0	17,660	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,710	0	0	77,984	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	576	0	0	30,376	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	24,922	0	0	953,121	0	73.00
76.00	03480	ONCOLOGY	835	0	0	18,676	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	18,617	0	0	2,412,337	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	31,025	0	0	2,145,566	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	43,603	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	398,983	10,245	84,306	13,949,770	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	11,500	0	190.00
190.01	19001	OUTPATIENT CLINIC	0	0	0	118,615	0	190.01
190.02	19003	NON-REIMBURSEABLE OUTPATIENT MEALS	0	0	0	2,179	0	190.02
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments			0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	398,983	10,245	84,306	14,082,064	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1308 | Period: From 05/01/2016 To 04/30/2017 | Worksheet B Part I | Date/Time Prepared: 9/18/2017 2:08 pm

		Cost Center Description	Total		
			26.00		
		GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.01	00550	INFORMATION SYSTEMS			5.01
5.02	00591	OTHER ADMINISTRATIVE AND GENERAL			5.02
6.00	00600	MAINTENANCE & REPAIRS			6.00
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
13.00	01300	NURSING ADMINISTRATION			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY			14.00
15.00	01500	PHARMACY			15.00
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	1,346,859		30.00
46.00	04600	OTHER LONG TERM CARE	1,723,293		46.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	522,276		50.00
53.00	05300	ANESTHESIOLOGY	99,447		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,392,071		54.00
60.00	06000	LABORATORY	1,417,110		60.00
65.00	06500	RESPIRATORY THERAPY	95,702		65.00
66.00	06600	PHYSICAL THERAPY	1,540,558		66.00
67.00	06700	OCCUPATIONAL THERAPY	0		67.00
68.00	06800	SPEECH PATHOLOGY	0		68.00
68.01	06801	CARDIAC REHAB	113,131		68.01
69.00	06900	ELECTROCARDIOLOGY	17,660		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	77,984		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	30,376		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	953,121		73.00
76.00	03480	ONCOLOGY	18,676		76.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	2,412,337		88.00
90.00	09000	CLINIC	0		90.00
91.00	09100	EMERGENCY	2,145,566		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	43,603		93.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0		95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0		98.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0		115.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	13,949,770		118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	11,500		190.00
190.01	19001	OUTPATIENT CLINIC	118,615		190.01
190.02	19003	NON-REIMBURSEABLE OUTPATIENT MEALS	2,179		190.02
191.00	19100	RESEARCH	0		191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0		192.00
193.00	19300	NONPAID WORKERS	0		193.00
200.00		Cross Foot Adjustments	0		200.00
201.00		Negative Cost Centers	0		201.00
202.00		TOTAL (sum lines 118-201)	14,082,064		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1308 | Period: From 05/01/2016 To 04/30/2017 | Worksheet B Part II | Date/Time Prepared: 9/18/2017 2:08 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	576	0	576	576	4.00
5.01	00550	INFORMATION SYSTEMS	0	4,197	30,952	35,149	18	5.01
5.02	00591	OTHER ADMINISTRATIVE AND GENERAL	0	66,894	1,740	68,634	61	5.02
6.00	00600	MAINTENANCE & REPAIRS	0	50,136	1,258	51,394	10	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	3,953	0	3,953	0	8.00
9.00	00900	HOUSEKEEPING	0	1,811	0	1,811	17	9.00
10.00	01000	DIETARY	0	7,417	597	8,014	18	10.00
11.00	01100	CAFETERIA	0	3,643	0	3,643	2	11.00
13.00	01300	NURSING ADMINISTRATION	0	576	0	576	4	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	3,316	6,416	9,732	5	14.00
15.00	01500	PHARMACY	0	4,057	3,013	7,070	11	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	4,249	79	4,328	17	16.00
17.00	01700	SOCIAL SERVICE	0	384	0	384	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	27,982	7,075	35,057	51	30.00
46.00	04600	OTHER LONG TERM CARE	0	39,836	465	40,301	48	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	14,741	2,715	17,456	12	50.00
53.00	05300	ANESTHESIOLOGY	0	0	2,514	2,514	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	19,527	109,061	128,588	33	54.00
60.00	06000	LABORATORY	0	8,804	1,483	10,287	35	60.00
65.00	06500	RESPIRATORY THERAPY	0	2,077	3,030	5,107	1	65.00
66.00	06600	PHYSICAL THERAPY	0	8,608	6,153	14,761	72	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
68.01	06801	CARDIAC REHAB	0	1,837	6,901	8,738	4	68.01
69.00	06900	ELECTROCARDIOLOGY	0	253	1,817	2,070	1	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03480	ONCOLOGY	0	1,034	0	1,034	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	10,518	56	10,574	118	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	15,034	6,759	21,793	38	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	301,460	192,084	493,544	576	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	OUTPATIENT CLINIC	0	12,866	2,033	14,899	0	190.01
190.02	19003	NON-REIMBURSEABLE OUTPATIENT MEALS	0	0	0	0	0	190.02
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	0	314,326	194,117	508,443	576	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1308 | Period: From 05/01/2016 To 04/30/2017 | Worksheet B Part II | Date/Time Prepared: 9/18/2017 2:08 pm

		Cost Center Description	INFORMATION SYSTEMS	OTHER ADMINISTRATIVE AND GENERAL	MAINTENANCE & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.01	5.02	6.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	INFORMATION SYSTEMS	35,167					5.01
5.02	00591	OTHER ADMINISTRATIVE AND GENERAL	6,270	74,965				5.02
6.00	00600	MAINTENANCE & REPAIRS	545	3,979	55,928			6.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	573	1,148	5,674		8.00
9.00	00900	HOUSEKEEPING	545	1,826	526	0	4,725	9.00
10.00	01000	DIETARY	818	2,497	2,155	0	188	10.00
11.00	01100	CAFETERIA	0	184	1,058	0	92	11.00
13.00	01300	NURSING ADMINISTRATION	273	422	167	0	15	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	545	683	963	0	84	14.00
15.00	01500	PHARMACY	1,090	1,364	1,179	0	103	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,636	1,977	1,234	0	108	16.00
17.00	01700	SOCIAL SERVICE	0	42	112	0	10	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	449	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,271	5,484	8,129	602	708	30.00
46.00	04600	OTHER LONG TERM CARE	1,090	5,040	11,572	3,695	1,006	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,363	1,977	4,282	244	373	50.00
53.00	05300	ANESTHESIOLOGY	0	52	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,271	6,190	5,673	191	494	54.00
60.00	06000	LABORATORY	1,363	6,818	2,558	0	223	60.00
65.00	06500	RESPIRATORY THERAPY	0	409	603	11	53	65.00
66.00	06600	PHYSICAL THERAPY	4,362	7,544	2,501	548	218	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
68.01	06801	CARDIAC REHAB	273	526	534	0	46	68.01
69.00	06900	ELECTROCARDIOLOGY	0	63	74	0	6	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	293	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	66	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,459	0	0	0	73.00
76.00	03480	ONCOLOGY	273	62	300	0	26	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	5,180	12,185	3,056	13	266	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	1,636	10,505	4,367	355	380	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	33,804	74,669	52,191	5,659	4,399	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	61	0	0	0	190.00
190.01	19001	OUTPATIENT CLINIC	1,363	235	3,737	15	326	190.01
190.02	19003	NON-REIMBURSEABLE OUTPATIENT MEALS	0	0	0	0	0	190.02
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	35,167	74,965	55,928	5,674	4,725	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1308 | Period: From 05/01/2016 To 04/30/2017 | Worksheet B Part II | Date/Time Prepared: 9/18/2017 2:08 pm

		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	INFORMATION SYSTEMS						5.01
5.02	00591	OTHER ADMINISTRATIVE AND GENERAL						5.02
6.00	00600	MAINTENANCE & REPAIRS						6.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	13,690					10.00
11.00	01100	CAFETERIA	0	4,979				11.00
13.00	01300	NURSING ADMINISTRATION	0	30	1,487			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	93	0	12,105		14.00
15.00	01500	PHARMACY	0	56	0	18	10,891	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	273	0	8	0	16.00
17.00	01700	SOCIAL SERVICE	0	6	0	0	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	2,536	660	462	2,480	9	30.00
46.00	04600	OTHER LONG TERM CARE	11,096	956	0	1,623	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	141	114	1,539	1	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	292	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	338	0	231	6	54.00
60.00	06000	LABORATORY	0	428	0	288	4	60.00
65.00	06500	RESPIRATORY THERAPY	0	15	12	9	0	65.00
66.00	06600	PHYSICAL THERAPY	0	709	0	196	14	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
68.01	06801	CARDIAC REHAB	0	0	0	144	0	68.01
69.00	06900	ELECTROCARDIOLOGY	0	60	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	1,736	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1,413	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	10,821	73.00
76.00	03480	ONCOLOGY	0	3	0	14	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	720	534	395	26	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	490	365	1,707	10	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	13,632	4,978	1,487	12,093	10,891	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	OUTPATIENT CLINIC	0	1	0	12	0	190.01
190.02	19003	NON-REIMBURSEABLE OUTPATIENT MEALS	58	0	0	0	0	190.02
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	13,690	4,979	1,487	12,105	10,891	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1308 | Period: From 05/01/2016 To 04/30/2017 | Worksheet B Part II Date/Time Prepared: 9/18/2017 2:08 pm

		Cost Center Description	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			16.00	17.00	19.00	24.00	25.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	INFORMATION SYSTEMS						5.01
5.02	00591	OTHER ADMINISTRATIVE AND GENERAL						5.02
6.00	00600	MAINTENANCE & REPAIRS						6.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	9,581					16.00
17.00	01700	SOCIAL SERVICE	0	554				17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	449			19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	443	499		60,391	0	30.00
46.00	04600	OTHER LONG TERM CARE	500	55		76,982	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	816	0		28,318	0	50.00
53.00	05300	ANESTHESIOLOGY	43	0		2,901	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,548	0		147,563	0	54.00
60.00	06000	LABORATORY	1,856	0		23,860	0	60.00
65.00	06500	RESPIRATORY THERAPY	136	0		6,356	0	65.00
66.00	06600	PHYSICAL THERAPY	1,235	0		32,160	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0		0	0	68.00
68.01	06801	CARDIAC REHAB	48	0		10,313	0	68.01
69.00	06900	ELECTROCARDIOLOGY	91	0		2,365	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	41	0		2,070	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	14	0		1,493	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	598	0		14,878	0	73.00
76.00	03480	ONCOLOGY	20	0		1,732	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	447	0		33,514	0	88.00
90.00	09000	CLINIC	0	0		0	0	90.00
91.00	09100	EMERGENCY	745	0		42,391	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0	0		0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0		0	0	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0		0	0	98.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0		0	0	115.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	9,581	554	0	487,287	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		61	0	190.00
190.01	19001	OUTPATIENT CLINIC	0	0		20,588	0	190.01
190.02	19003	NON-REIMBURSEABLE OUTPATIENT MEALS	0	0		58	0	190.02
191.00	19100	RESEARCH	0	0		0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0		0	0	192.00
193.00	19300	NONPAID WORKERS	0	0		0	0	193.00
200.00		Cross Foot Adjustments			449	449	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	9,581	554	449	508,443	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1308 | Period: From 05/01/2016 To 04/30/2017 | Worksheet B Part II | Date/Time Prepared: 9/18/2017 2:08 pm

		Cost Center Description	Total		
			26.00		
		GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.01	00550	INFORMATION SYSTEMS			5.01
5.02	00591	OTHER ADMINISTRATIVE AND GENERAL			5.02
6.00	00600	MAINTENANCE & REPAIRS			6.00
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
13.00	01300	NURSING ADMINISTRATION			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY			14.00
15.00	01500	PHARMACY			15.00
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	60,391		30.00
46.00	04600	OTHER LONG TERM CARE	76,982		46.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	28,318		50.00
53.00	05300	ANESTHESIOLOGY	2,901		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	147,563		54.00
60.00	06000	LABORATORY	23,860		60.00
65.00	06500	RESPIRATORY THERAPY	6,356		65.00
66.00	06600	PHYSICAL THERAPY	32,160		66.00
67.00	06700	OCCUPATIONAL THERAPY	0		67.00
68.00	06800	SPEECH PATHOLOGY	0		68.00
68.01	06801	CARDIAC REHAB	10,313		68.01
69.00	06900	ELECTROCARDIOLOGY	2,365		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,070		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,493		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	14,878		73.00
76.00	03480	ONCOLOGY	1,732		76.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	33,514		88.00
90.00	09000	CLINIC	0		90.00
91.00	09100	EMERGENCY	42,391		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0		93.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0		95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0		98.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0		115.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	487,287		118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	61		190.00
190.01	19001	OUTPATIENT CLINIC	20,588		190.01
190.02	19003	NON-REIMBURSEABLE OUTPATIENT MEALS	58		190.02
191.00	19100	RESEARCH	0		191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0		192.00
193.00	19300	NONPAID WORKERS	0		193.00
200.00		Cross Foot Adjustments	449		200.00
201.00		Negative Cost Centers	0		201.00
202.00		TOTAL (sum lines 118-201)	508,443		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1308 | Period: From 05/01/2016 To 04/30/2017 | Worksheet B-1 | Date/Time Prepared: 9/18/2017 2:08 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	INFORMATION SYSTEMS (# OF COMPUTERS)	Reconciliation	
			1.00	2.00	4.00	5.01	5A.02	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	72,049					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		192,635				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	132	0	6,522,269			4.00
5.01	00550	INFORMATION SYSTEMS	962	30,716	208,801	129		5.01
5.02	00591	OTHER ADMINISTRATIVE AND GENERAL	15,334	1,727	688,790	23	-1,637,336	5.02
6.00	00600	MAINTENANCE & REPAIRS	11,492	1,248	117,451	2	0	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	906	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	415	0	195,770	2	0	9.00
10.00	01000	DIETARY	1,700	592	204,534	3	0	10.00
11.00	01100	CAFETERIA	835	0	23,944	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	132	0	46,707	1	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	760	6,367	57,637	2	0	14.00
15.00	01500	PHARMACY	930	2,990	123,597	4	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	974	78	195,144	6	0	16.00
17.00	01700	SOCIAL SERVICE	88	0	4,842	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	221	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,414	7,021	574,754	12	0	30.00
46.00	04600	OTHER LONG TERM CARE	9,131	461	548,518	4	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,379	2,694	137,730	5	0	50.00
53.00	05300	ANESTHESIOLOGY	0	2,495	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,476	108,230	370,860	12	0	54.00
60.00	06000	LABORATORY	2,018	1,472	400,614	5	0	60.00
65.00	06500	RESPIRATORY THERAPY	476	3,007	12,272	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,973	6,106	817,784	16	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
68.01	06801	CARDIAC REHAB	421	6,848	49,784	1	0	68.01
69.00	06900	ELECTROCARDIOLOGY	58	1,803	5,733	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03480	ONCOLOGY	237	0	3,273	1	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	2,411	56	1,304,999	19	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	3,446	6,707	428,060	6	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	69,100	190,618	6,521,819	124	-1,637,336	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	OUTPATIENT CLINIC	2,949	2,017	450	5	0	190.01
190.02	19003	NON-REIMBURSEABLE OUTPATIENT MEALS	0	0	0	0	0	190.02
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	314,326	194,117	2,450,109	602,064		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	4.362670	1.007693	0.375653	4,667.162791		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			576	35,167		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000088	272.612403		205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1308 | Period: From 05/01/2016 To 04/30/2017 | Worksheet B-1 | Date/Time Prepared: 9/18/2017 2:08 pm

		Cost Center Description	OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	
			5.02	6.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	INFORMATION SYSTEMS						5.01
5.02	00591	OTHER ADMINISTRATIVE AND GENERAL	12,444,728					5.02
6.00	00600	MAINTENANCE & REPAIRS	660,559	44,129				6.00
8.00	00800	LAUNDRY & LINEN SERVICE	95,188	906	21,607			8.00
9.00	00900	HOUSEKEEPING	303,086	415	0	42,808		9.00
10.00	01000	DIETARY	414,489	1,700	0	1,700	30,995	10.00
11.00	01100	CAFETERIA	30,492	835	0	835	0	11.00
13.00	01300	NURSING ADMINISTRATION	69,997	132	0	132	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	113,407	760	0	760	0	14.00
15.00	01500	PHARMACY	226,376	930	0	930	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	328,197	974	0	974	0	16.00
17.00	01700	SOCIAL SERVICE	7,045	88	0	88	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	74,504	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	910,311	6,414	2,292	6,414	5,742	30.00
46.00	04600	OTHER LONG TERM CARE	836,579	9,131	14,078	9,131	25,121	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	328,128	3,379	929	3,379	0	50.00
53.00	05300	ANESTHESIOLOGY	8,630	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,027,540	4,476	726	4,476	0	54.00
60.00	06000	LABORATORY	1,131,811	2,018	0	2,018	0	60.00
65.00	06500	RESPIRATORY THERAPY	67,946	476	41	476	0	65.00
66.00	06600	PHYSICAL THERAPY	1,252,255	1,973	2,086	1,973	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
68.01	06801	CARDIAC REHAB	87,290	421	0	421	0	68.01
69.00	06900	ELECTROCARDIOLOGY	10,387	58	0	58	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	48,590	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	11,026	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	574,124	0	0	0	0	73.00
76.00	03480	ONCOLOGY	10,321	237	0	237	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	2,023,485	2,411	49	2,411	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	1,743,851	3,446	1,350	3,446	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	12,395,614	41,180	21,551	39,859	30,863	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	10,163	0	0	0	0	190.00
190.01	19001	OUTPATIENT CLINIC	38,951	2,949	56	2,949	0	190.01
190.02	19003	NON-REIMBURSEABLE OUTPATIENT MEALS	0	0	0	0	132	190.02
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,637,336	747,468	123,058	349,992	511,717	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.131569	16.938249	5.695284	8.175855	16.509663	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	74,965	55,928	5,674	4,725	13,690	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.006024	1.267375	0.262600	0.110377	0.441684	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1308 | Period: From 05/01/2016 To 04/30/2017 | Worksheet B-1 | Date/Time Prepared: 9/18/2017 2:08 pm

		Cost Center Description	CAFETERIA (FTE'S)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	INFORMATION SYSTEMS						5.01
5.02	00591	OTHER ADMINISTRATIVE AND GENERAL						5.02
6.00	00600	MAINTENANCE & REPAIRS						6.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	8,833					11.00
13.00	01300	NURSING ADMINISTRATION	54	64,722				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	165	0	94,486			14.00
15.00	01500	PHARMACY	100	0	138	577,884		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	484	0	66	0	19,122,834	16.00
17.00	01700	SOCIAL SERVICE	10	0	0	0	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	1,171	20,129	19,362	467	884,562	30.00
46.00	04600	OTHER LONG TERM CARE	1,696	0	12,670	0	998,382	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	250	4,982	12,011	76	1,628,157	50.00
53.00	05300	ANESTHESIOLOGY	0	0	2,283	0	85,752	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	599	0	1,800	326	5,082,527	54.00
60.00	06000	LABORATORY	759	0	2,245	231	3,705,044	60.00
65.00	06500	RESPIRATORY THERAPY	27	540	68	0	271,255	65.00
66.00	06600	PHYSICAL THERAPY	1,257	0	1,531	755	2,465,948	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
68.01	06801	CARDIAC REHAB	0	0	1,123	0	96,749	68.01
69.00	06900	ELECTROCARDIOLOGY	107	0	0	0	181,061	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	13,551	0	81,979	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	11,026	0	27,602	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	574,124	1,194,489	73.00
76.00	03480	ONCOLOGY	6	0	106	11	40,033	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,277	23,166	3,082	1,367	892,279	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	870	15,905	13,327	527	1,487,015	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	8,832	64,722	94,389	577,884	19,122,834	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	OUTPATIENT CLINIC	1	0	97	0	0	190.01
190.02	19003	NON-REIMBURSEABLE OUTPATIENT MEALS	0	0	0	0	0	190.02
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	55,474	82,860	148,451	280,362	398,983	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	6.280312	1.280245	1.571143	0.485153	0.020864	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	4,979	1,487	12,105	10,891	9,581	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.563682	0.022975	0.128114	0.018846	0.000501	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1308 | Period: From 05/01/2016 To 04/30/2017 | Worksheet B-1 | Date/Time Prepared: 9/18/2017 2:08 pm

		Cost Center Description	SOCIAL SERVICE (TIME SPENT)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)		
			17.00	19.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.01	00550	INFORMATION SYSTEMS				5.01
5.02	00591	OTHER ADMINISTRATIVE AND GENERAL				5.02
6.00	00600	MAINTENANCE & REPAIRS				6.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
17.00	01700	SOCIAL SERVICE	100			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	100		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	90	0		30.00
46.00	04600	OTHER LONG TERM CARE	10	0		46.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
53.00	05300	ANESTHESIOLOGY	0	100		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
60.00	06000	LABORATORY	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
68.01	06801	CARDIAC REHAB	0	0		68.01
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
76.00	03480	ONCOLOGY	0	0		76.00
		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)				92.00
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0	0		93.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0	0		95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0		98.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE				113.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0		115.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	100	100		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
190.01	19001	OUTPATIENT CLINIC	0	0		190.01
190.02	19003	NON-REIMBURSEABLE OUTPATIENT MEALS	0	0		190.02
191.00	19100	RESEARCH	0	0		191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0		192.00
193.00	19300	NONPAID WORKERS	0	0		193.00
200.00		Cross Foot Adjustments				200.00
201.00		Negative Cost Centers				201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	10,245	84,306		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	102.450000	843.060000		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	554	449		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	5.540000	4.490000		205.00

POST STEPDOWN ADJUSTMENTS | Provider CCN: 14-1308 | Period: From 05/01/2016 To 04/30/2017 | Worksheet B-2 | Date/Time Prepared: 9/18/2017 2:08 pm

		Description	Worksheet Part	Line No.	Amount	
		1.00	2.00	3.00	4.00	
1.00		ADJ FOR EPO COSTS IN RENAL DIALYSIS	1	74.00	0	1.00
2.00		ADJ FOR EPO COSTS IN HOME PROGRAM	1	94.00	0	2.00
3.00		ADJ FOR ARANESP COSTS IN RENAL DIALYSIS	1	74.00	0	3.00
4.00		ADJ FOR ARANESP COSTS IN HOME PROGRAM	1	94.00	0	4.00
5.00		ADJ FOR ESA COSTS IN RENAL DIALYSIS	1	74.00	0	5.00
6.00		ADJ FOR ESA COSTS IN HOME PROGRAM	1	94.00	0	6.00
7.00		ADULTS AND PEDIATRICS	1	30.00	-43,603	7.00
8.00		OTHER OUTPATIENT SERVICES	1	93.00	43,603	8.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1308 | Period: From 05/01/2016 To 04/30/2017 | Worksheet C Part I Date/Time Prepared: 9/18/2017 2:08 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,346,859		1,346,859	0	0	30.00
46.00	04600	OTHER LONG TERM CARE	1,723,293		1,723,293	0	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	522,276		522,276	0	0	50.00
53.00	05300	ANESTHESIOLOGY	99,447		99,447	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,392,071		1,392,071	0	0	54.00
60.00	06000	LABORATORY	1,417,110		1,417,110	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	95,702	0	95,702	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,540,558	0	1,540,558	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
68.01	06801	CARDIAC REHAB	113,131	0	113,131	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	17,660		17,660	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	77,984		77,984	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	30,376		30,376	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	953,121		953,121	0	0	73.00
76.00	03480	ONCOLOGY	18,676		18,676	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	2,412,337		2,412,337	0	0	88.00
90.00	09000	CLINIC	0		0	0	0	90.00
91.00	09100	EMERGENCY	2,145,566		2,145,566	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	30,038		30,038		0	92.00
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	43,603		43,603	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0		0	0	0	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0		0	0	0	98.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0		0		0	115.00
200.00		Subtotal (see instructions)	13,979,808	0	13,979,808	0	0	200.00
201.00		Less Observation Beds	30,038		30,038		0	201.00
202.00		Total (see instructions)	13,949,770	0	13,949,770	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1308 | Period: From 05/01/2016 To 04/30/2017 | Worksheet C Part I Date/Time Prepared: 9/18/2017 2:08 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	515,012		515,012			30.00
46.00	04600	OTHER LONG TERM CARE	998,382		998,382			46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,125	1,622,032	1,628,157	0.320777	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	85,752	85,752	1.159705	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	65,302	5,017,225	5,082,527	0.273893	0.000000	54.00
60.00	06000	LABORATORY	143,236	3,561,808	3,705,044	0.382481	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	141,590	129,665	271,255	0.352812	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	383,129	2,082,819	2,465,948	0.624733	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	0.000000	68.00
68.01	06801	CARDIAC REHAB	0	96,749	96,749	1.169325	0.000000	68.01
69.00	06900	ELECTROCARDIOLOGY	2,595	178,466	181,061	0.097536	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	9,545	72,434	81,979	0.951268	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	27,602	27,602	1.100500	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	207,726	986,763	1,194,489	0.797932	0.000000	73.00
76.00	03480	ONCOLOGY	0	40,033	40,033	0.466515	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	892,279	892,279			88.00
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
91.00	09100	EMERGENCY	0	1,487,015	1,487,015	1.442868	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	24,165	24,165	1.243037	0.000000	92.00
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	2,777	342,608	345,385	0.126245	0.000000	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0.000000	0.000000	98.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0			115.00
200.00		Subtotal (see instructions)	2,475,419	16,647,415	19,122,834			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	2,475,419	16,647,415	19,122,834			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1308 | Period: From 05/01/2016 To 04/30/2017 | Worksheet C Part I Date/Time Prepared: 9/18/2017 2:08 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
46.00	04600	OTHER LONG TERM CARE		46.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	54.00
60.00	06000	LABORATORY	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	68.00
68.01	06801	CARDIAC REHAB	0.000000	68.01
69.00	06900	ELECTROCARDIOLOGY	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	73.00
76.00	03480	ONCOLOGY	0.000000	76.00
		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	04950	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	93.00
		OTHER REIMBURSABLE COST CENTERS		
95.00	09500	AMBULANCE SERVICES	0.000000	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0.000000	98.00
		SPECIAL PURPOSE COST CENTERS		
113.00	11300	INTEREST EXPENSE		113.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)		115.00
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: 14-1308 | Period: From 05/01/2016 To 04/30/2017 | Worksheet C Part I Date/Time Prepared: 9/18/2017 2:08 pm

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,346,859		1,346,859	0	1,346,859	30.00
46.00	04600	OTHER LONG TERM CARE	1,723,293		1,723,293	0	1,723,293	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	522,276		522,276	0	522,276	50.00
53.00	05300	ANESTHESIOLOGY	99,447		99,447	0	99,447	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,392,071		1,392,071	0	1,392,071	54.00
60.00	06000	LABORATORY	1,417,110		1,417,110	0	1,417,110	60.00
65.00	06500	RESPIRATORY THERAPY	95,702	0	95,702	0	95,702	65.00
66.00	06600	PHYSICAL THERAPY	1,540,558	0	1,540,558	0	1,540,558	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
68.01	06801	CARDIAC REHAB	113,131	0	113,131	0	113,131	68.01
69.00	06900	ELECTROCARDIOLOGY	17,660		17,660	0	17,660	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	77,984		77,984	0	77,984	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	30,376		30,376	0	30,376	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	953,121		953,121	0	953,121	73.00
76.00	03480	ONCOLOGY	18,676		18,676	0	18,676	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	2,412,337		2,412,337	0	2,412,337	88.00
90.00	09000	CLINIC	0		0	0	0	90.00
91.00	09100	EMERGENCY	2,145,566		2,145,566	0	2,145,566	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	30,038		30,038		30,038	92.00
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	43,603		43,603	0	43,603	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0		0	0	0	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0		0	0	0	98.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0		0		0	115.00
200.00		Subtotal (see instructions)	13,979,808	0	13,979,808	0	13,979,808	200.00
201.00		Less Observation Beds	30,038		30,038		30,038	201.00
202.00		Total (see instructions)	13,949,770	0	13,949,770	0	13,949,770	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1308 | Period: From 05/01/2016 To 04/30/2017 | Worksheet C Part I Date/Time Prepared: 9/18/2017 2:08 pm

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	515,012		515,012			30.00
46.00	04600	OTHER LONG TERM CARE	998,382		998,382			46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,125	1,622,032	1,628,157	0.320777	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	85,752	85,752	1.159705	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	65,302	5,017,225	5,082,527	0.273893	0.000000	54.00
60.00	06000	LABORATORY	143,236	3,561,808	3,705,044	0.382481	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	141,590	129,665	271,255	0.352812	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	383,129	2,082,819	2,465,948	0.624733	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	0.000000	68.00
68.01	06801	CARDIAC REHAB	0	96,749	96,749	1.169325	0.000000	68.01
69.00	06900	ELECTROCARDIOLOGY	2,595	178,466	181,061	0.097536	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	9,545	72,434	81,979	0.951268	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	27,602	27,602	1.100500	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	207,726	986,763	1,194,489	0.797932	0.000000	73.00
76.00	03480	ONCOLOGY	0	40,033	40,033	0.466515	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	892,279	892,279	2.703568	0.000000	88.00
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
91.00	09100	EMERGENCY	0	1,487,015	1,487,015	1.442868	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	24,165	24,165	1.243037	0.000000	92.00
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	2,777	342,608	345,385	0.126245	0.000000	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0.000000	0.000000	98.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0			115.00
200.00		Subtotal (see instructions)	2,475,419	16,647,415	19,122,834			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	2,475,419	16,647,415	19,122,834			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1308 | Period: From 05/01/2016 To 04/30/2017 | Worksheet C Part I Date/Time Prepared: 9/18/2017 2:08 pm

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
46.00	04600	OTHER LONG TERM CARE			46.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	06000	LABORATORY	0.000000		60.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
68.01	06801	CARDIAC REHAB	0.000000		68.01
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
76.00	03480	ONCOLOGY	0.000000		76.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	0.000000		88.00
90.00	09000	CLINIC	0.000000		90.00
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0.000000		93.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0.000000		95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0.000000		98.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)			115.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 14-1308 | Period: From 05/01/2016 To 04/30/2017 | Worksheet D Part II Date/Time Prepared: 9/18/2017 2:08 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	28,318	1,628,157	0.017393	5,804	101	50.00
53.00	05300	ANESTHESIOLOGY	2,901	85,752	0.033830	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	147,563	5,082,527	0.029033	37,149	1,079	54.00
60.00	06000	LABORATORY	23,860	3,705,044	0.006440	52,957	341	60.00
65.00	06500	RESPIRATORY THERAPY	6,356	271,255	0.023432	31,619	741	65.00
66.00	06600	PHYSICAL THERAPY	32,160	2,465,948	0.013042	5,539	72	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0	0	68.00
68.01	06801	CARDIAC REHAB	10,313	96,749	0.106595	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	2,365	181,061	0.013062	1,384	18	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,070	81,979	0.025250	2,152	54	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,493	27,602	0.054090	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	14,878	1,194,489	0.012456	48,231	601	73.00
76.00	03480	ONCOLOGY	1,732	40,033	0.043264	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	33,514	892,279	0.037560	0	0	88.00
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
91.00	09100	EMERGENCY	42,391	1,487,015	0.028507	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,347	24,165	0.055742	0	0	92.00
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0	345,385	0.000000	1,561	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0.000000	0	0	98.00
200.00		Total (lines 50-199)	351,261	17,609,440		186,396	3,007	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1308 | Period: From 05/01/2016 To 04/30/2017 | Worksheet D Part IV | Date/Time Prepared: 9/18/2017 2:08 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
53.00	05300	ANESTHESIOLOGY	84,306	0	0	0	84,306	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
68.01	06801	CARDIAC REHAB	0	0	0	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03480	ONCOLOGY	0	0	0	0	0	76.00
		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	04950	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
200.00		Total (lines 50-199)	84,306	0	0	0	84,306	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1308 | Period: From 05/01/2016 To 04/30/2017 | Worksheet D Part IV | Date/Time Prepared: 9/18/2017 2:08 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	1,628,157	0.000000	0.000000	5,804	50.00
53.00	05300	ANESTHESIOLOGY	0	85,752	0.983137	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	5,082,527	0.000000	0.000000	37,149	54.00
60.00	06000	LABORATORY	0	3,705,044	0.000000	0.000000	52,957	60.00
65.00	06500	RESPIRATORY THERAPY	0	271,255	0.000000	0.000000	31,619	65.00
66.00	06600	PHYSICAL THERAPY	0	2,465,948	0.000000	0.000000	5,539	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0.000000	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0.000000	0	68.00
68.01	06801	CARDIAC REHAB	0	96,749	0.000000	0.000000	0	68.01
69.00	06900	ELECTROCARDIOLOGY	0	181,061	0.000000	0.000000	1,384	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	81,979	0.000000	0.000000	2,152	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	27,602	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,194,489	0.000000	0.000000	48,231	73.00
76.00	03480	ONCOLOGY	0	40,033	0.000000	0.000000	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	892,279	0.000000	0.000000	0	88.00
90.00	09000	CLINIC	0	0	0.000000	0.000000	0	90.00
91.00	09100	EMERGENCY	0	1,487,015	0.000000	0.000000	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	24,165	0.000000	0.000000	0	92.00
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0	345,385	0.000000	0.000000	1,561	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0.000000	0.000000	0	98.00
200.00		Total (lines 50-199)	0	17,609,440			186,396	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 14-1308 | Period: From 05/01/2016 To 04/30/2017 | Worksheet D Part IV Date/Time Prepared: 9/18/2017 2:08 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
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
60.00	06000	LABORATORY	0	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
68.01	06801	CARDIAC REHAB	0	0	0		68.01
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
76.00	03480	ONCOLOGY	0	0	0		76.00
		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	04950	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0		93.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES					95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0		98.00
200.00		Total (lines 50-199)	0	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-1308 | Period: From 05/01/2016 To 04/30/2017 | Worksheet D Part V Date/Time Prepared: 9/18/2017 2:08 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.320777	0	801,453	0	0	50.00
53.00	05300	ANESTHESIOLOGY	1.159705	0	43,784	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.273893	0	1,934,838	0	0	54.00
60.00	06000	LABORATORY	0.382481	0	1,512,027	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.352812	0	56,112	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.624733	0	738,961	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
68.01	06801	CARDIAC REHAB	1.169325	0	22,485	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	0.097536	0	96,201	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.951268	0	30,698	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1.100500	0	19,396	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.797932	0	601,630	9,448	0	73.00
76.00	03480	ONCOLOGY	0.466515	0	30,481	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	1.442868	0	441,070	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.243037	0	8,170	0	0	92.00
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0.126245	0	180,542	4,623	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.000000		0			95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0.000000	0	0	0	0	98.00
200.00		Subtotal (see instructions)		0	6,517,848	14,071	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	6,517,848	14,071	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-1308 | Period: From 05/01/2016 To 04/30/2017 | Worksheet D Part V Date/Time Prepared: 9/18/2017 2:08 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	257,088	0		50.00
53.00	05300	ANESTHESIOLOGY	50,777	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	529,939	0		54.00
60.00	06000	LABORATORY	578,322	0		60.00
65.00	06500	RESPIRATORY THERAPY	19,797	0		65.00
66.00	06600	PHYSICAL THERAPY	461,653	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
68.01	06801	CARDIAC REHAB	26,292	0		68.01
69.00	06900	ELECTROCARDIOLOGY	9,383	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	29,202	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	21,345	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	480,060	7,539		73.00
76.00	03480	ONCOLOGY	14,220	0		76.00
		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	636,406	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	10,156	0		92.00
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	22,793	584		93.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0		98.00
200.00		Subtotal (see instructions)	3,147,433	8,123		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	3,147,433	8,123		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1308 | Component CCN: 14-Z308 | Period: From 05/01/2016 To 04/30/2017 | Worksheet D Part V Date/Time Prepared: 9/18/2017 2:08 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.320777	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	1.159705	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.273893	0	0	0	0	54.00
60.00	06000	LABORATORY	0.382481	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.352812	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.624733	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
68.01	06801	CARDIAC REHAB	1.169325	0	0	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	0.097536	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.951268	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1.100500	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.797932	0	0	0	0	73.00
76.00	03480	ONCOLOGY	0.466515	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	1.442868	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.243037	0	0	0	0	92.00
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0.126245	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.000000		0			95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0.000000	0	0	0	0	98.00
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: 14-1308 | Component CCN: 14-Z308 | Period: From 05/01/2016 To 04/30/2017 | Worksheet D Part V | Date/Time Prepared: 9/18/2017 2:08 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
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
60.00	06000	LABORATORY	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
68.01	06801	CARDIAC REHAB	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
76.00	03480	ONCOLOGY	0	0	76.00
		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	04950	OTHER OUTPATIENT SERVICE COST CENTER	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0		95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	98.00
200.00		Subtotal (see instructions)	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 +/- line 201)	0	0	202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1308 | Period: From 05/01/2016 To 04/30/2017 | Worksheet D-1 | Date/Time Prepared: 9/18/2017 2:08 pm

Title XVIII | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	1,440	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	292	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)	261	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	740	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)	349	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	54	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)	5	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	199	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)	692	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)	267	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	147.50	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	151.93	20.00
21.00	Total general inpatient routine service cost (see instructions)	1,346,859	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)	7,965	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)	760	25.00
26.00	Total swing-bed cost (see instructions)	1,063,922	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	282,937	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)	282,937	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)	968.96	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	192,823	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)	192,823	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1308 | Period: From 05/01/2016 To 04/30/2017 | Worksheet D-1 | Date/Time Prepared: 9/18/2017 2:08 pm

Title XVIII | Hospital | Cost

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	87,772	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	280,595	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)	670,520	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	258,712	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	929,232	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)	31	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	968.96	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	30,038	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1308 | Period: From 05/01/2016 To 04/30/2017 | Worksheet D-1 | Date/Time Prepared: 9/18/2017 2:08 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	60,391	1,346,859	0.044838	30,038	1,347	90.00
91.00	Nursing School cost	0	1,346,859	0.000000	30,038	0	91.00
92.00	Allied health cost	0	1,346,859	0.000000	30,038	0	92.00
93.00	All other Medical Education	0	1,346,859	0.000000	30,038	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 14-1308 | Period: From 05/01/2016 To 04/30/2017 | Worksheet D-3 | Date/Time Prepared: 9/18/2017 2:08 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		153,830		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.320777	5,804	1,862	50.00
53.00	05300	ANESTHESIOLOGY	1.159705	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.273893	37,149	10,175	54.00
60.00	06000	LABORATORY	0.382481	52,957	20,255	60.00
65.00	06500	RESPIRATORY THERAPY	0.352812	31,619	11,156	65.00
66.00	06600	PHYSICAL THERAPY	0.624733	5,539	3,460	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	68.00
68.01	06801	CARDIAC REHAB	1.169325	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	0.097536	1,384	135	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.951268	2,152	2,047	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1.100500	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.797932	48,231	38,485	73.00
76.00	03480	ONCOLOGY	0.466515	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000	CLINIC	0.000000	0	0	90.00
91.00	09100	EMERGENCY	1.442868	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.243037	0	0	92.00
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0.126245	1,561	197	93.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0.000000	0	0	98.00
200.00		Total (sum of lines 50-94 and 96-98)		186,396	87,772	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)		186,396		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 14-1308 | Component CCN: 14-Z308 | Period: From 05/01/2016 To 04/30/2017 | Worksheet D-3 | Date/Time Prepared: 9/18/2017 2:08 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.320777	0	0	50.00
53.00	05300	ANESTHESIOLOGY	1.159705	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.273893	19,644	5,380	54.00
60.00	06000	LABORATORY	0.382481	66,305	25,360	60.00
65.00	06500	RESPIRATORY THERAPY	0.352812	87,123	30,738	65.00
66.00	06600	PHYSICAL THERAPY	0.624733	324,496	202,723	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	68.00
68.01	06801	CARDIAC REHAB	1.169325	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	0.097536	519	51	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.951268	6,017	5,724	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1.100500	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.797932	121,064	96,601	73.00
76.00	03480	ONCOLOGY	0.466515	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000	CLINIC	0.000000	0	0	90.00
91.00	09100	EMERGENCY	1.442868	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.243037	0	0	92.00
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0.126245	977	123	93.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0.000000	0	0	98.00
200.00		Total (sum of lines 50-94 and 96-98)		626,145	366,700	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)		626,145		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-1308	Period: From 05/01/2016 To 04/30/2017	Worksheet E Part B Date/Time Prepared: 9/18/2017 2:08 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	3,155,556	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)	3,155,556	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)	3,187,112	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)	0	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	23,486	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	995,529	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)	2,168,097	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)	2,168,097	30.00
31.00	Primary payer payments	135	31.00
32.00	Subtotal (line 30 minus line 31)	2,167,962	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)	42,815	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	27,830	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	42,815	36.00
37.00	Subtotal (see instructions)	2,195,792	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	39.50
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	2,195,792	40.00
40.01	Sequestration adjustment (see instructions)	43,916	40.01
41.00	Interim payments	2,182,774	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	-30,898	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: 14-1308 | Period: From 05/01/2016 To 04/30/2017 | Worksheet E-1 Part I Date/Time Prepared: 9/18/2017 2:08 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		160,426		1,978,995	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0	12/05/2016	25,631	3.01
3.02		04/15/2017	40,360	04/15/2017	120,882	3.02
3.03			0	04/30/2017	57,266	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)		40,360		203,779	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)		200,786		2,182,774	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		13,074		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		30,898	6.02
7.00	Total Medicare program liability (see instructions)		213,860		2,151,876	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: 14-1308 | Component CCN: 14-Z308 | Period: From 05/01/2016 To 04/30/2017 | Worksheet E-1 Part I | Date/Time Prepared: 9/18/2017 2:08 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		955,214		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	12/05/2016	18,602		0	3.01
3.02		04/15/2017	290,497		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)		309,099		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)		1,264,313		0	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		13,554		0	6.02
7.00	Total Medicare program liability (see instructions)		1,250,759		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: 14-1308	Period: From 05/01/2016 To 04/30/2017	Worksheet E-1 Part II Date/Time Prepared: 9/18/2017 2:08 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	83	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12	199	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2	0	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12	261	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200	19,122,834	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20	35,640	6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168	0	7.00
8.00	Calculation of the HIT incentive payment (see instructions)	0	8.00
9.00	Sequestration adjustment amount (see instructions)	0	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)	0	10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH		
30.00	Initial/interim HIT payment adjustment (see instructions)	0	30.00
31.00	Other Adjustment (specify)	0	31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)	0	32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS | Provider CCN: 14-1308 | Component CCN: 14-Z308 | Period: From 05/01/2016 To 04/30/2017 | Worksheet E-2 | Date/Time Prepared: 9/18/2017 2:08 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)	938,524	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)	370,367	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	959	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)	1,308,891	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	1,308,891	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)	1,308,891	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	32,606	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)	1,276,285	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	0	16.50
16.55	410A RURAL DEMONSTRATION PROJECT	0		16.55
17.00	Allowable bad debts (see instructions)	0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (see instructions)	1,276,285	0	19.00
19.01	Sequestration adjustment (see instructions)	25,526	0	19.01
20.00	Interim payments	1,264,313	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)	-13,554	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: 14-1308	Period: From 05/01/2016 To 04/30/2017	Worksheet E-3 Part V Date/Time Prepared: 9/18/2017 2:08 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	280,595	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)	280,595	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	283,401	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)	283,401	19.00
20.00	Deductibles (exclude professional component)	66,998	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	216,403	22.00
23.00	Coinsurance	0	23.00
24.00	Subtotal (line 22 minus line 23)	216,403	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	2,803	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	1,822	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	2,803	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	218,225	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	29.50
29.99	Recovery of Accelerated Depreciation	0	29.99
30.00	Subtotal (see instructions)	218,225	30.00
30.01	Sequestration adjustment (see instructions)	4,365	30.01
31.00	Interim payments	200,786	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)	13,074	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: 14-1308 | Period: From 05/01/2016 To 04/30/2017 | Worksheet G | Date/Time Prepared: 9/18/2017 2:08 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	431,071	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	2,307,239	0	0	0	4.00
5.00	Other receivable	76,401	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-340,000	0	0	0	6.00
7.00	Inventory	329,333	0	0	0	7.00
8.00	Prepaid expenses	92,007	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)	2,896,051	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	62,855	0	0	0	12.00
13.00	Land improvements	419,030	0	0	0	13.00
14.00	Accumulated depreciation	-388,827	0	0	0	14.00
15.00	Buildings	9,479,465	0	0	0	15.00
16.00	Accumulated depreciation	-7,569,356	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	5,421,579	0	0	0	23.00
24.00	Accumulated depreciation	-4,982,419	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	927,041	0	0	0	27.00
28.00	Accumulated depreciation	-900,317	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	2,469,051	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	684,311	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	0	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	684,311	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	6,049,413	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	197,124	0	0	0	37.00
38.00	Salaries, wages, and fees payable	683,495	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	268,280	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	408,906	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	1,557,805	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	1,096,775	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	1,096,775	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	2,654,580	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	3,394,833				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)	3,394,833	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	6,049,413	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 14-1308 | Period: From 05/01/2016 To 04/30/2017 | Worksheet G-1 | Date/Time Prepared: 9/18/2017 2:08 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		4,375,899		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-981,066				2.00
3.00	Total (sum of line 1 and line 2)		3,394,833		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		3,394,833		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		3,394,833		0		19.00

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

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 14-1308 | Period: From 05/01/2016 To 04/30/2017 | Worksheet G-2 Parts I & II | Date/Time Prepared: 9/18/2017 2:08 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	213,620		213,620	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	301,392		301,392	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	998,382		998,382	9.00
10.00	Total general inpatient care services (sum of lines 1-9)	1,513,394		1,513,394	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)	1,513,394		1,513,394	17.00
18.00	Ancillary services	956,748	16,415,689	17,372,437	18.00
19.00	Outpatient services	0	345,385	345,385	19.00
20.00	RURAL HEALTH CLINIC	0	1,153,651	1,153,651	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.)	0	0	0	25.00
26.00	HOSPICE				26.00
27.00	CHARITY CARE	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	2,470,142	17,914,725	20,384,867	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		14,529,007		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		14,529,007		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 14-1308	Period: From 05/01/2016 To 04/30/2017	Worksheet G-3 Date/Time Prepared: 9/18/2017 2:08 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	20,384,867	1.00
2.00	Less contractual allowances and discounts on patients' accounts	7,788,912	2.00
3.00	Net patient revenues (line 1 minus line 2)	12,595,955	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	14,529,007	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-1,933,052	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	254,816	6.00
7.00	Income from investments	18,716	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	4,372	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	15,832	22.00
23.00	Governmental appropriations	378,196	23.00
24.00	GRANT INCOME	62,469	24.00
24.01	MEDICARE AND MEDICAID INCENTIVE REV	8,500	24.01
24.02	GAIN ON DISPOSAL OF FIXED ASSETS	50	24.02
24.03	OTHER MISCELLANEOUS INCOME	60,411	24.03
24.04	340B	148,624	24.04
25.00	Total other income (sum of lines 6-24)	951,986	25.00
26.00	Total (line 5 plus line 25)	-981,066	26.00
27.00	OTHER EXPENSES	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-981,066	29.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1308 | Component CCN: 14-3472 | Period: From 05/01/2016 To 04/30/2017 | Worksheet M-1 | Date/Time Prepared: 9/18/2017 2:08 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	785,491	0	785,491	0	785,491	1.00
2.00	Physician Assistant	91,000	0	91,000	0	91,000	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	428,508	0	428,508	0	428,508	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	1,304,999	0	1,304,999	0	1,304,999	10.00
11.00	Physician Services Under Agreement	0	179,820	179,820	0	179,820	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	6,866	6,866	0	6,866	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	186,686	186,686	0	186,686	14.00
15.00	Medical Supplies	0	6,461	6,461	0	6,461	15.00
16.00	Transportation (Health Care Staff)	0	1,540	1,540	0	1,540	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	38,191	38,191	-38,191	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	46,192	46,192	-38,191	8,001	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	1,304,999	232,878	1,537,877	-38,191	1,499,686	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	4,226	4,226	0	4,226	29.00
30.00	Administrative Costs	0	9,761	9,761	0	9,761	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	13,987	13,987	0	13,987	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	1,304,999	246,865	1,551,864	-38,191	1,513,673	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1308 | Component CCN: 14-3472 | Period: From 05/01/2016 To 04/30/2017 | Worksheet M-1 | Date/Time Prepared: 9/18/2017 2:08 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	-47,060	738,431		1.00
2.00	Physician Assistant	0	91,000		2.00
3.00	Nurse Practitioner	0	0		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	428,508		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	0		9.00
10.00	Subtotal (sum of lines 1 through 9)	-47,060	1,257,939		10.00
11.00	Physician Services Under Agreement	-31,500	148,320		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	6,866		13.00
14.00	Subtotal (sum of lines 11 through 13)	-31,500	155,186		14.00
15.00	Medical Supplies	0	6,461		15.00
16.00	Transportation (Health Care Staff)	-1,100	440		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	-1,100	6,901		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-79,660	1,420,026		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	4,226		29.00
30.00	Administrative Costs	0	9,761		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	13,987		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-79,660	1,434,013		32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1308 Component CCN: 14-3472

Period: From 05/01/2016 To 04/30/2017

Worksheet M-2

Date/Time Prepared: 9/18/2017 2:08 pm

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	RHC I Minimum Visits (col. 1 x col. 3)	Cost Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	2.59	6,126	4,200	10,878		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	0.80	1,930	2,100	1,680		3.00
4.00	Subtotal (sum of lines 1 through 3)	3.39	8,056		12,558	12,558	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)	3.39	8,056			12,558	8.00
9.00	Physician Services Under Agreements		0			0	9.00
						1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)					1,420,026	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					1,420,026	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)					13,987	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					978,324	15.00
16.00	Total overhead (sum of lines 14 and 15)					992,311	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					992,311	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					992,311	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					2,412,337	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 14-1308 Component CCN: 14-3472	Period: From 05/01/2016 To 04/30/2017	Worksheet M-3 Date/Time Prepared: 9/18/2017 2:08 pm
	Title XVIII	RHC I	Cost

				1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES				
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			2,412,337	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			27,892	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			2,384,445	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			12,558	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)			12,558	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			189.87	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)	189.87	189.87		9.00
	CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	0	2,226		10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	422,651		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	422,651		16.00
16.01	Total program charges (see instructions)(from contractor's records)		270,057		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		0		16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		0		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.)		313,189		16.04
16.05	Total program cost (see instructions)	0	313,189		16.05
17.00	Primary payer amounts		124		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		31,165		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		47,778		19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		313,065		20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		4,392		21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		317,457		22.00
23.00	Allowable bad debts (see instructions)		8,551		23.00
23.01	Adjusted reimbursable bad debts (see instructions)		5,558		23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		8,551		24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0		25.50
26.00	Net reimbursable amount (see instructions)		323,015		26.00
26.01	Sequestration adjustment (see instructions)		6,460		26.01
27.00	Interim payments		292,384		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)		24,171		29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0		30.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA VACCINE COST

Provider CCN: 14-1308 | Component CCN: 14-3472 | Period: From 05/01/2016 To 04/30/2017 | Worksheet M-4 | Date/Time Prepared: 9/18/2017 2:08 pm

Title XVIII | RHC I | Cost

		Pneumococcal	Influenza	
		1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	1,257,939	1,257,939	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000278	0.000543	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	350	683	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	11,434	3,952	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	11,784	4,635	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	1,420,026	1,420,026	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	992,311	992,311	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.008298	0.003264	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	8,234	3,239	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	20,018	7,874	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	84	164	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	238.31	48.01	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	14	22	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	3,336	1,056	14.00
15.00	Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2)		27,892	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)		4,392	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 14-1308 Component CCN: 14-3472	Period: From 05/01/2016 To 04/30/2017	Worksheet M-5 Date/Time Prepared: 9/18/2017 2:08 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		285,633	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		04/15/2017	6,751	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
	Provider to Program			
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		6,751	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		292,384	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		24,171	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		316,555	7.00

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