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: 14-1313	Period: From 10/01/2016 To 09/30/2017	Worksheet S Parts I-III Date/Time Prepared: 2/10/2018 2:03 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 2/10/2018 Time: 2:03 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 CHIEF FINANCIAL 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 MASON DISTRICT HOSPITAL (14-1313) for the cost reporting period beginning 10/01/2016 and ending 09/30/2017 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.

[ ] I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification statement to be the legally binding equivalent of my original signature.

(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	-181,557	-386,397	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	-172,278	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
9.00	HOME HEALTH AGENCY I	0	0	8		0	9.00
10.00	RURAL HEALTH CLINIC I	0		190,911		0	10.00
10.01	RURAL HEALTH CLINIC II	0		15,435		0	10.01
200.00	Total	0	-353,835	-180,043	0	0	200.00

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1313 | Period: From 10/01/2016 To 09/30/2017 | Worksheet S-2 Part I | Date/Time Prepared: 2/10/2018 11:06 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 615 NORTH PROMENADE STREET	PO Box:			1.00
2.00	City: HAVANA	State: IL	Zip Code: 62644-0530	County: MASON	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	MASON DISTRICT HOSPITAL	141313	99914	1	07/01/2001	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	MASON DISTRICT HOSPITAL	14Z313	99914		07/01/2001	N	O	N	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA	MASON DISTRICT HHA	147202	99914		01/09/1982	N	P	N	12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC	HAVANA MEDICAL ASSOCIATES RHC	143457	99914		02/01/2001	O	O	O	15.00
15.01	Hospital-Based Health Clinic - RHC II	MASON CITY MEDICAL ASSOCIATES	143462	99914		03/03/2003	O	O	O	15.01
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From: 1.00	To: 2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	10/01/2016	09/30/2017	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: 14-1313 | Period: From 10/01/2016 To 09/30/2017 | Worksheet S-2 Part I Date/Time Prepared: 2/10/2018 11:06 am

		Urban/Rural S	Date of Geogr	
		1.00	2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	2		26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	2		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0		35.00
		Beginning:	Ending:	
		1.00	2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.			36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.	0		37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)	N		37.01
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.			38.00
		Y/N	Y/N	
		1.00	2.00	
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i) or (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)(i) or (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(b) PPS capital? Enter "Y for yes or "N" for no.	N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00
	Teaching Hospitals				
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N			56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.				57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.	N			58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59.00

		NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code	
		1.00	2.00	3.00	
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under §413.85? (see instructions)	N			60.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1313 | Period: From 10/01/2016 To 09/30/2017 | Worksheet S-2 Part I Date/Time Prepared: 2/10/2018 11:06 am

		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).		0.00	0.00			61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)		0.00	0.00			61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)		0.00	0.00			61.06

		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1.00	2.00	3.00	4.00	
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the 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. Enter in column 4, the 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 through 67. (see instructions)	N	63.00

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

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1313 | Period: From 10/01/2016 To 09/30/2017 | Worksheet S-2 Part I Date/Time Prepared: 2/10/2018 11:06 am

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

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

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

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

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		1.00	2.00	3.00	
76.00	If line 75 is 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
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
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.06
	Rural Providers			
105.00	Does this hospital qualify as a 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

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		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.	Y	Y	N	N	109.00

		1.00	
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration)for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.	N	110.00

		1.00	2.00	
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N		111.00

		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:	71,486	0	0	118.01

		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	N		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N		122.00
	Transplant Center Information			
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 14-1313	Period: From 10/01/2016 To 09/30/2017	Worksheet S-2 Part I Date/Time Prepared: 2/10/2018 11:06 am

		1.00	2.00	
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

		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)	04/01/2017	06/30/2017	170.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 14-1313	Period: From 10/01/2016 To 09/30/2017	Worksheet S-2 Part I Date/Time Prepared: 2/10/2018 11:06 am

		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: 14-1313 | Period: From 10/01/2016 To 09/30/2017 | Worksheet S-2 Part II | Date/Time Prepared: 2/10/2018 11:06 am

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

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

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

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

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

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	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	12/20/2017	Y	12/20/2017	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: 14-1313 | Period: From 10/01/2016 To 09/30/2017 | Worksheet S-2 Part II Date/Time Prepared: 2/10/2018 11:06 am

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

		1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)		
	Capital Related Cost		
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions	N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.	N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions	N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.	N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.	N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.	N	27.00
	Interest Expense		
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.	N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions	Y	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.	N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.	N	31.00
	Purchased Services		
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.	N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.	N	33.00
	Provider-Based Physicians		
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.	Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.	Y	35.00

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

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	DAN	LINHART	41.00
42.00	Enter the employer/company name of the cost report preparer.	RSM US LLP		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	563.888.4404	DAN.LINHART@RSMUS.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 14-1313	Period: From 10/01/2016 To 09/30/2017	Worksheet S-2 Part II Date/Time Prepared: 2/10/2018 11:06 am

		3.00		
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	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: 14-1313 | Period: From 10/01/2016 To 09/30/2017 | Worksheet S-3 Part I | Date/Time Prepared: 2/10/2018 11:06 am

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	25	9,125	14,826.30	0	1.00
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		25	9,125	14,826.30	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	0	0	0.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)		25	9,125	14,826.30	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	101.00				0	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	88.00				0	26.00
26.01	RURAL HEALTH CLINIC II	88.01				0	26.01
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		25				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00
33.01	LTCH site neutral days and discharges						33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 14-1313 | Period: From 10/01/2016 To 09/30/2017 | Worksheet S-3 Part I | Date/Time Prepared: 2/10/2018 11:06 am

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	471	30	637			1.00
2.00	HMO and other (see instructions)	75	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	543	0	603			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	46			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,014	30	1,286			7.00
8.00	INTENSIVE CARE UNIT	0	0	0			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)	1,014	30	1,286	0.00	173.68	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	5,552	916	19,474	0.00	10.85	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	0	0	0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	4,610	4,811	14,565	0.00	35.41	26.00
26.01	RURAL HEALTH CLINIC II	218	631	1,617	0.00	4.07	26.01
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	224.01	27.00
28.00	Observation Bed Days		0	156			28.00
29.00	Ambulance Trips	782					29.00
30.00	Employee discount days (see instruction)			6			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
33.01	LTCH site neutral days and discharges	0					33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 14-1313 | Period: From 10/01/2016 To 09/30/2017 | Worksheet S-3 Part I | Date/Time Prepared: 2/10/2018 11:06 am

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	152	13	205	1.00
2.00	HMO and other (see instructions)			17	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	152	13	205	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0.00					22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	0.00					26.00
26.01	RURAL HEALTH CLINIC II	0.00					26.01
26.25	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			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01

HOME HEALTH AGENCY STATISTICAL DATA | Provider CCN: 14-1313 | Component CCN: 14-7202 | Period: From 10/01/2016 To 09/30/2017 | Worksheet S-4 | Date/Time Prepared: 2/10/2018 11:06 am

Home Health Agency I | PPS

						1.00	
0.00	County				MASON		0.00
		Title V	Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	5.00	
	HOME HEALTH AGENCY STATISTICAL DATA						
1.00	Home Health Aide Hours	0	969	48	366	1,383	1.00
2.00	Unduplicated Census Count (see instructions)	0.00	187.00	9.00	71.00	267.00	2.00
				Number of Employees (Full Time Equivalent)			
		Enter the number of hours in your normal work week		Staff	Contract	Total	
		0		1.00	2.00	3.00	
	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES						
3.00	Administrator and Assistant Administrator(s)		40.00	1.00	0.00	1.00	3.00
4.00	Director(s) and Assistant Director(s)			0.00	0.00	0.00	4.00
5.00	Other Administrative Personnel			2.40	0.00	2.40	5.00
6.00	Direct Nursing Service			6.77	0.00	6.77	6.00
7.00	Nursing Supervisor			0.00	0.00	0.00	7.00
8.00	Physical Therapy Service			0.00	0.00	0.00	8.00
9.00	Physical Therapy Supervisor			0.00	0.00	0.00	9.00
10.00	Occupational Therapy Service			0.00	0.00	0.00	10.00
11.00	Occupational Therapy Supervisor			0.00	0.00	0.00	11.00
12.00	Speech Pathology Service			0.00	0.00	0.00	12.00
13.00	Speech Pathology Supervisor			0.00	0.00	0.00	13.00
14.00	Medical Social Service			0.01	0.00	0.01	14.00
15.00	Medical Social Service Supervisor			0.00	0.00	0.00	15.00
16.00	Home Health Aide			0.66	0.00	0.66	16.00
17.00	Home Health Aide Supervisor			0.00	0.00	0.00	17.00
18.00	Other (specify)			0.00	0.00	0.00	18.00
	HOME HEALTH AGENCY CBSA CODES						
19.00	Enter in column 1 the number of CBSAs where you provided services during the cost reporting period.			2			19.00
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).			99914			20.00
20.01				99917			20.01
		Full Episodes					
		Without Outliers	With Outliers	LUPA Episodes	PEP Only Episodes	Total (cols. 1-4)	
		1.00	2.00	3.00	4.00	5.00	
	PPS ACTIVITY DATA						
21.00	Skilled Nursing Visits	3,057	97	50	26	3,230	21.00
22.00	Skilled Nursing Visit Charges	822,045	25,890	13,470	7,020	868,425	22.00
23.00	Physical Therapy Visits	1,151	19	5	5	1,180	23.00
24.00	Physical Therapy Visit Charges	341,672	5,662	1,490	1,490	350,314	24.00
25.00	Occupational Therapy Visits	531	17	7	30	585	25.00
26.00	Occupational Therapy Visit Charges	157,405	5,049	2,086	8,940	173,480	26.00
27.00	Speech Pathology Visits	65	0	1	0	66	27.00
28.00	Speech Pathology Visit Charges	19,353	0	298	0	19,651	28.00
29.00	Medical Social Service Visits	9	0	0	0	9	29.00
30.00	Medical Social Service Visit Charges	2,682	0	0	0	2,682	30.00
31.00	Home Health Aide Visits	458	22	2	0	482	31.00
32.00	Home Health Aide Visit Charges	68,207	3,278	298	0	71,783	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	5,271	155	65	61	5,552	33.00
34.00	Other Charges	0	0	0	0	0	34.00
35.00	Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)	1,411,364	39,879	17,642	17,450	1,486,335	35.00
36.00	Total Number of Episodes (standard/non outlier)	270		23	5	298	36.00
37.00	Total Number of Outlier Episodes		4		0	4	37.00
38.00	Total Non-Routine Medical Supply Charges	11,154	169	527	575	12,425	38.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 14-1313 | Component CCN: 14-3457 | Period: From 10/01/2016 To 09/30/2017 | Worksheet S-8 | Date/Time Prepared: 2/10/2018 11:06 am

RHC I | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			615 PROMENADE BOX 530		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	HAVANA		IL	62644-0530	2.00
					1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0	3.00
			Grant Award		Date	
			1.00		2.00	
	Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)					4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)					5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)					6.00
7.00	Appalachian Regional Commission					7.00
8.00	Look-Alikes					8.00
9.00	OTHER (SPECIFY)					9.00
				1.00	2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N	0	10.00

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

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

		Tuesday	Wednesday		Thursday		
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)						
11.00	Clinic	17:00	08:00	17:00	08:00	17:00	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-1313
Component CCN: 14-3457

Period:
From 10/01/2016
To 09/30/2017

Worksheet S-8

Date/Time Prepared:
2/10/2018 11:06 am

RHC I

Cost

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	Clinic	08:00	17:00				11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 14-1313 | Component CCN: 14-3462 | Period: From 10/01/2016 To 09/30/2017 | Worksheet S-8 | Date/Time Prepared: 2/10/2018 11:06 am

RHC II | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			615 N PROMENADE		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	HAVANA		IL	62644-0530	2.00
					1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0	3.00
			Grant Award		Date	
			1.00		2.00	
	Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)					4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)					5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)					6.00
7.00	Appalachian Regional Commission					7.00
8.00	Look-Alikes					8.00
9.00	OTHER (SPECIFY)					9.00
				1.00	2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N	0	10.00

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

		1.00	2.00	
12.00	Have you received an approval for an exception to the productivity standard?	N		12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.	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		MASON				2.00
		Tuesday	Wednesday		Thursday		
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)						
11.00	Clinic	17:00	08:00	17:00			11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-1313
Component CCN: 14-3462

Period:
From 10/01/2016
To 09/30/2017

Worksheet S-8

Date/Time Prepared:
2/10/2018 11:06 am

RHC II

Cost

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	Clinic	08:00	17:00				11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 14-1313 | Period: From 10/01/2016 To 09/30/2017 | Worksheet S-10 | Date/Time Prepared: 2/10/2018 11:06 am

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.551651	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	1,634,793	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 and/or supplemental payments from Medicaid?		4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	1,676,846	5.00
6.00	Medicaid charges	4,473,900	6.00
7.00	Medicaid cost (line 1 times line 6)	2,468,031	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)	0	8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone CHIP	14,667	9.00
10.00	Stand-alone CHIP charges	31,181	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	17,201	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)	2,534	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	1,146,748	18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	2,534	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
	Uncompensated Care (see instructions for each line)				
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	32,655	25,277	57,932	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	18,014	25,277	43,291	21.00
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	18,014	25,277	43,291	23.00

		1.00	
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	1,229,369	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	152,283	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	234,282	27.01
28.00	Non-Medicare bad debt expense (line 26 minus line 27.01)	995,087	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	630,940	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	674,231	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	676,765	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-1313 | Period: From 10/01/2016 To 09/30/2017 | Worksheet A | Date/Time Prepared: 2/10/2018 11:06 am

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		0	0	374,615	374,615	1.00
1.01	00101	NEW CAP REL COSTS-CLINIC BUILDING		0	0	60,535	60,535	1.01
1.02	00102	NEW CAP REL COSTS-NEW MED SURG		0	0	503,483	503,483	1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP		1,282,340	1,282,340	-651,588	630,752	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	3,272,397	3,272,397	0	3,272,397	4.00
5.01	00590	ADMINISTRATIVE AND GENERAL	980,227	1,086,533	2,066,760	0	2,066,760	5.01
5.02	00591	A&G HOSPITAL ONLY	329,475	164,926	494,401	0	494,401	5.02
6.00	00600	MAINTENANCE & REPAIRS	288,089	241,639	529,728	0	529,728	6.00
7.00	00700	OPERATION OF PLANT	0	238,852	238,852	0	238,852	7.00
7.01	00701	OPERATION OF PLANT-CLINIC	0	27,485	27,485	0	27,485	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	26,045	16,580	42,625	0	42,625	8.00
9.00	00900	HOUSEKEEPING	225,192	73,400	298,592	0	298,592	9.00
10.00	01000	DIETARY	214,259	205,351	419,610	0	419,610	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	181,268	23,077	204,345	0	204,345	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	66,747	2,958	69,705	0	69,705	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	159,721	67,396	227,117	0	227,117	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	303,775	303,775	0	303,775	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	929,797	180,860	1,110,657	0	1,110,657	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	170,157	39,430	209,587	0	209,587	50.00
53.00	05300	ANESTHESIOLOGY	0	1,878	1,878	0	1,878	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	565,548	282,455	848,003	-74,703	773,300	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	66,327	60,957	127,284	2,451	129,735	54.01
56.00	05600	RADIOISOTOPE	25,605	80,160	105,765	387	106,152	56.00
58.00	05800	MRI	0	93,559	93,559	1,027	94,586	58.00
60.00	06000	LABORATORY	614,273	603,862	1,218,135	56,658	1,274,793	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	104,063	104,063	0	104,063	62.00
64.00	06400	INTRAVENOUS THERAPY	0	22,402	22,402	0	22,402	64.00
66.00	06600	PHYSICAL THERAPY	481,689	172,831	654,520	0	654,520	66.00
67.00	06700	OCCUPATIONAL THERAPY	162,868	88,298	251,166	0	251,166	67.00
68.00	06800	SPEECH PATHOLOGY	25,235	2,921	28,156	0	28,156	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	392,712	110,695	503,407	14,180	517,587	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	364,800	364,800	0	364,800	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	297,583	479,994	777,577	0	777,577	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	186,985	123,958	310,943	0	310,943	76.00
76.01	03952	TELEMEDICINE PSYCH SERVICES	6,934	19,606	26,540	0	26,540	76.01
76.02	03950	DIABETIC EDUCATION	116,241	17,132	133,373	0	133,373	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	3,096,586	553,989	3,650,575	-116,823	3,533,752	88.00
88.01	08801	RURAL HEALTH CLINIC II	302,049	70,138	372,187	0	372,187	88.01
91.00	09100	EMERGENCY	417,286	1,840,672	2,257,958	596,026	2,853,984	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	907,174	102,796	1,009,970	-596,026	413,944	95.00
101.00	10100	HOME HEALTH AGENCY	573,895	117,547	691,442	0	691,442	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		287,045	287,045	-287,045	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	11,809,967	12,828,757	24,638,724	-116,823	24,521,901	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	34,767	5,313	40,080	116,823	156,903	192.00
194.00	07950	HOSPICE	0	0	0	0	0	194.00
194.01	07951	FAMILY MEDICAL CENTER	0	0	0	0	0	194.01
194.02	07952	MEALS ON WHEELS	0	0	0	0	0	194.02
194.03	07954	MANITO MED ASSOCIATES	326,430	149,012	475,442	0	475,442	194.03
194.04	07953	OTHER NONREIMBURSABLE COST AREAS	0	0	0	0	0	194.04
200.00		TOTAL (SUM OF LINES 118 through 199)	12,171,164	12,983,082	25,154,246	0	25,154,246	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-1313 | Period: From 10/01/2016 To 09/30/2017 | Worksheet A | Date/Time Prepared: 2/10/2018 11:06 am

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	-31,781	342,834		1.00
1.01	00101	NEW CAP REL COSTS-CLINIC BUILDING	0	60,535		1.01
1.02	00102	NEW CAP REL COSTS-NEW MED SURG	-36,479	467,004		1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-125,856	504,896		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-1,005,988	2,266,409		4.00
5.01	00590	ADMINISTRATIVE AND GENERAL	-54,552	2,012,208		5.01
5.02	00591	A&G HOSPITAL ONLY	-350	494,051		5.02
6.00	00600	MAINTENANCE & REPAIRS	0	529,728		6.00
7.00	00700	OPERATION OF PLANT	-436	238,416		7.00
7.01	00701	OPERATION OF PLANT-CLINIC	0	27,485		7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	42,625		8.00
9.00	00900	HOUSEKEEPING	0	298,592		9.00
10.00	01000	DIETARY	-146,880	272,730		10.00
11.00	01100	CAFETERIA	0	0		11.00
13.00	01300	NURSING ADMINISTRATION	0	204,345		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	69,705		14.00
15.00	01500	PHARMACY	0	0		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-2,329	224,788		16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	-37,384	266,391		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	1,110,657		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	209,587		50.00
53.00	05300	ANESTHESIOLOGY	0	1,878		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-20,653	752,647		54.00
54.01	05401	RADIOLOGY-ULTRASOUND	0	129,735		54.01
56.00	05600	RADIOISOTOPE	0	106,152		56.00
58.00	05800	MRI	0	94,586		58.00
60.00	06000	LABORATORY	-148	1,274,645		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	104,063		62.00
64.00	06400	INTRAVENOUS THERAPY	0	22,402		64.00
66.00	06600	PHYSICAL THERAPY	0	654,520		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	251,166		67.00
68.00	06800	SPEECH PATHOLOGY	0	28,156		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
69.01	03160	CARDIOPULMONARY	-31,382	486,205		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	364,800		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	777,577		73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	310,943		76.00
76.01	03952	TELEMEDICINE PSYCH SERVICES	0	26,540		76.01
76.02	03950	DIABETIC EDUCATION	0	133,373		76.02
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	-337	3,533,415		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	372,187		88.01
91.00	09100	EMERGENCY	-520,699	2,333,285		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0	413,944		95.00
101.00	10100	HOME HEALTH AGENCY	-2,800	688,642		101.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-2,018,054	22,503,847		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	156,903		192.00
194.00	07950	HOSPICE	0	0		194.00
194.01	07951	FAMILY MEDICAL CENTER	0	0		194.01
194.02	07952	MEALS ON WHEELS	0	0		194.02
194.03	07954	MANITO MED ASSOCIATES	0	475,442		194.03
194.04	07953	OTHER NONREIMBURSABLE COST AREAS	0	0		194.04
200.00		TOTAL (SUM OF LINES 118 through 199)	-2,018,054	23,136,192		200.00

RECLASSIFICATIONS | Provider CCN: 14-1313 | Period: From 10/01/2016 To 09/30/2017 | Worksheet A-6 | Date/Time Prepared: 2/10/2018 11:06 am

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - INTEREST RECLASS					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	63,200		1.00
2.00	NEW CAP REL COSTS-NEW MED SURG	1.02	0	223,845		2.00
	TOTALS		0	287,045		
	B - EMS SALARY TO ER					
1.00	EMERGENCY	91.00	596,026	0		1.00
	TOTALS		596,026	0		
	C - DEPRECIATION					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	311,415		1.00
2.00	NEW CAP REL COSTS-CLINIC BUILDING	1.01	0	60,535		2.00
3.00	NEW CAP REL COSTS-NEW MED SURG	1.02	0	279,638		3.00
	TOTALS		0	651,588		
	D - RHC PHYSICIAN					
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	116,823	0		1.00
	TOTALS		116,823	0		
	E - OP REGISTRATION					
1.00	LABORATORY	60.00	48,619	8,039		1.00
2.00	CARDIOPULMONARY	69.01	12,168	2,012		2.00
3.00	RADIOLOGY-ULTRASOUND	54.01	2,103	348		3.00
4.00	RADIOISOTOPE	56.00	332	55		4.00
5.00	RADIOLOGY-DIAGNOSTIC	54.00	3,898	645		5.00
6.00	MRI	58.00	881	146		6.00
	TOTALS		68,001	11,245		
500.00	Grand Total: Increases		780,850	949,878		500.00

RECLASSIFICATIONS | Provider CCN: 14-1313 | Period: From 10/01/2016 To 09/30/2017 | Worksheet A-6 | Date/Time Prepared: 2/10/2018 11:06 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - INTEREST RECLASS						
1.00	INTEREST EXPENSE	113.00	0	287,045	11		1.00
2.00		0.00	0	0	11		2.00
	TOTALS		0	287,045			
	B - EMS SALARY TO ER						
1.00	AMBULANCE SERVICES	95.00	596,026	0	0		1.00
	TOTALS		596,026	0			
	C - DEPRECIATION						
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	651,588	9		1.00
2.00		0.00	0	0	9		2.00
3.00		0.00	0	0	9		3.00
	TOTALS		0	651,588			
	D - RHC PHYSICIAN						
1.00	RURAL HEALTH CLINIC	88.00	116,823	0	0		1.00
	TOTALS		116,823	0			
	E - OP REGISTRATION						
1.00	RADIOLOGY-DIAGNOSTIC	54.00	68,001	11,245	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
	TOTALS		68,001	11,245			
500.00	Grand Total: Decreases		780,850	949,878			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1313 | Period: From 10/01/2016 To 09/30/2017 | Worksheet A-7 Part I | Date/Time Prepared: 2/10/2018 11:06 am

		Beginning Balances	Acquisitions: Purchases	Acquisitions: Donation	Acquisitions: Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	163,928	0	0	0	0	1.00
2.00	Land Improvements	603,633	0	0	0	0	2.00
3.00	Buildings and Fixtures	16,345,110	103,427	0	103,427	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	3,492,053	86,812	0	86,812	0	5.00
6.00	Movable Equipment	8,854,668	443,761	0	443,761	0	6.00
7.00	HIT designated Assets	810,377	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	30,269,769	634,000	0	634,000	0	8.00
9.00	Reconciling Items	-11,733	-33,161	0	-33,161	0	9.00
10.00	Total (line 8 minus line 9)	30,281,502	667,161	0	667,161	0	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	163,928	0	1.00
2.00	Land Improvements	603,633	0	2.00
3.00	Buildings and Fixtures	16,448,537	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	3,578,865	0	5.00
6.00	Movable Equipment	9,298,429	0	6.00
7.00	HIT designated Assets	810,377	0	7.00
8.00	Subtotal (sum of lines 1-7)	30,903,769	0	8.00
9.00	Reconciling Items	-44,894	0	9.00
10.00	Total (line 8 minus line 9)	30,948,663	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1313 | Period: From 10/01/2016 To 09/30/2017 | Worksheet A-7 Part II | Date/Time Prepared: 2/10/2018 11:06 am

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	0	0	1.00
1.01	NEW CAP REL COSTS-CLINIC BUILDING	0	0	0	0	0	1.01
1.02	NEW CAP REL COSTS-NEW MED SURG	0	0	0	0	0	1.02
2.00	CAP REL COSTS-MVBLE EQUIP	1,282,340	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	1,282,340	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	0	1.00
1.01	NEW CAP REL COSTS-CLINIC BUILDING	0	0	1.01
1.02	NEW CAP REL COSTS-NEW MED SURG	0	0	1.02
2.00	CAP REL COSTS-MVBLE EQUIP	0	1,282,340	2.00
3.00	Total (sum of lines 1-2)	0	1,282,340	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1313 | Period: From 10/01/2016 To 09/30/2017 | Worksheet A-7 Part III | Date/Time Prepared: 2/10/2018 11:06 am

	Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	20,794,963	0	20,794,963	0.672894	0	1.00
1.01	NEW CAP REL COSTS-CLINIC BUILDING	0	0	0	0.000000	0	1.01
1.02	NEW CAP REL COSTS-NEW MED SURG	0	0	0	0.000000	0	1.02
2.00	CAP REL COSTS-MVBLE EQUIP	10,108,806	0	10,108,806	0.327106	0	2.00
3.00	Total (sum of lines 1-2)	30,903,769	0	30,903,769	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	268,170	0	1.00
1.01	NEW CAP REL COSTS-CLINIC BUILDING	0	0	0	60,535	0	1.01
1.02	NEW CAP REL COSTS-NEW MED SURG	0	0	0	278,436	0	1.02
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	504,896	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	1,112,037	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	53,240	0	0	21,424	342,834	1.00
1.01	NEW CAP REL COSTS-CLINIC BUILDING	0	0	0	0	60,535	1.01
1.02	NEW CAP REL COSTS-NEW MED SURG	188,568	0	0	0	467,004	1.02
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	504,896	2.00
3.00	Total (sum of lines 1-2)	241,808	0	0	21,424	1,375,269	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-1313 | Period: From 10/01/2016 To 09/30/2017 | Worksheet A-8 | Date/Time Prepared: 2/10/2018 11:06 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
1.01	Investment income - NEW CAP REL COSTS-CLINIC BUILDING (chapter 2)		0	NEW CAP REL COSTS-CLINIC BUILDING	1.01	0	1.01
1.02	Investment income - NEW CAP REL COSTS-NEW MED SURG (chapter 2)		0	NEW CAP REL COSTS-NEW MED SURG	1.02	0	1.02
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		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	-566,628			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		0		0.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts		0		0.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
26.01	Depreciation - NEW CAP REL COSTS-CLINIC BUILDING		0	NEW CAP REL COSTS-CLINIC BUILDING	1.01	0	26.01
26.02	Depreciation - NEW CAP REL COSTS-NEW MED SURG		0	NEW CAP REL COSTS-NEW MED SURG	1.02	0	26.02

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-1313 | Period: From 10/01/2016 To 09/30/2017 | Worksheet A-8 | Date/Time Prepared: 2/10/2018 11:06 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
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	-125,856	CAP REL COSTS-MVBLE EQUIP	2.00	9	32.00
33.00	MEDICAL RECORD FEES -OTHER OP	B	-2,329	MEDICAL RECORDS & LIBRARY	16.00	0	33.00
33.01	CAFETERIA SALES -OTHER OP	B	-144,408	DIETARY	10.00	0	33.01
33.02	DIETARY CONSULT -OTHER OP	B	-2,472	DIETARY	10.00	0	33.02
33.03	SALE OF NON-PAT SUPP-OTHER OP	B	-4,684	ADMINISTRATIVE AND GENERAL	5.01	0	33.03
33.04	ON-CALL CRNA SERVICES	A	-37,384	NONPHYSICIAN ANESTHETISTS	19.00	0	33.04
33.05	PROF BUILDING RENT -OTHER OP	B	-36,045	CAP REL COSTS-BLDG & FIXT	1.00	9	33.05
33.06	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.06
33.07	RENTAL INCOME	B	-7,200	CAP REL COSTS-BLDG & FIXT	1.00	9	33.07
33.08	COMMUNITY ED FEES -OTHER OP	B	-7,095	ADMINISTRATIVE AND GENERAL	5.01	0	33.08
33.09	LAB OUTREACH REV -OTHER OP	B	-148	LABORATORY	60.00	0	33.09
33.10	INTEREST INCOME -NON OPER	B	-9,960	CAP REL COSTS-BLDG & FIXT	1.00	11	33.10
33.11	INTEREST INCOME -NON OPER	B	-35,277	NEW CAP REL COSTS-NEW MED SURG	1.02	11	33.11
33.12	FITNESS REV OTHER	B	-6,036	CARDIOPULMONARY	69.01	0	33.12
33.13	FITNESS CENTER REV	B	-70	CARDIOPULMONARY	69.01	0	33.13
33.14	HOME HEALTH BLDG RENT	B	-2,800	HOME HEALTH AGENCY	101.00	0	33.14
33.15	TELEPHONE OFFSET - OPERATIONS	A	-436	OPERATION OF PLANT	7.00	0	33.15
33.16	TELEPHONE OFFSET - SALARIES	A	-115	ADMINISTRATIVE AND GENERAL	5.01	0	33.16
33.17	TELEPHONE OFFSET - BENEFITS	A	-19	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.17
33.18	MEDICAR - EXPENSES	A	-17,443	ADMINISTRATIVE AND GENERAL	5.01	0	33.18
33.19	MEDICAR - BENEFITS	A	-2,041	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.19
33.20	LOBBYING DUES	A	-9,570	ADMINISTRATIVE AND GENERAL	5.01	0	33.20
33.21	ADVERTISING	A	-6,539	ADMINISTRATIVE AND GENERAL	5.01	0	33.21
33.22	ADVERTISING	A	-350	A&G HOSPITAL ONLY	5.02	0	33.22
33.25	ADVERTISING	A	-337	RURAL HEALTH CLINIC	88.00	0	33.25
33.27	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.27
33.34	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.34
33.35	TELEVISIONS	A	-1,202	NEW CAP REL COSTS-NEW MED SURG	1.02	9	33.35
33.36	SELF INSURANCE	A	-485,170	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.36
33.37	UNFUNDED POST-EMPLOYMENT BENEFIT	A	-24,225	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.37
33.38	NON-ALLOW DONATION EXP	A	-9,106	ADMINISTRATIVE AND GENERAL	5.01	0	33.38
33.39	BOND AMORTIZTION COST FY14	A	21,424	CAP REL COSTS-BLDG & FIXT	1.00	14	33.39
33.40	IMRF CONTRIBUTION	A	-494,533	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.40
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-2,018,054				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: 14-1313 | Period: From 10/01/2016 To 09/30/2017 | Worksheet A-8-2 | Date/Time Prepared: 2/10/2018 11:06 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	91.00	EMERGENCY	1,655,640	520,699	1,134,941	0	0	1.00
2.00	60.00	LABORATORY	48,000	0	48,000	0	0	2.00
3.00	69.01	CARDIOPULMONARY	25,276	25,276	0	0	0	3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	20,653	20,653	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			1,749,569	566,628	1,182,941		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	91.00	EMERGENCY	0	0	0	0	0	1.00
2.00	60.00	LABORATORY	0	0	0	0	0	2.00
3.00	69.01	CARDIOPULMONARY	0	0	0	0	0	3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	91.00	EMERGENCY	0	0	0	520,699		1.00
2.00	60.00	LABORATORY	0	0	0	0		2.00
3.00	69.01	CARDIOPULMONARY	0	0	0	25,276		3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	20,653		4.00
5.00	0.00		0	0	0	0		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	566,628		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS	Provider CCN: 14-1313	Period: From 10/01/2016 To 09/30/2017	Worksheet A-8-3 Parts I-VI Date/Time Prepared: 2/10/2018 11:06 am

Physical Therapy — Cost

							1.00	
	PART I - GENERAL INFORMATION							
1.00	Total number of weeks worked (excluding aides) (see instructions)						16	1.00
2.00	Line 1 multiplied by 15 hours per week						240	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)						0	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)						0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)						0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)						0	6.00
7.00	Standard travel expense rate						0.00	7.00
8.00	Optional travel expense rate per mile						0.00	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees		
		1.00	2.00	3.00	4.00	5.00		
9.00	Total hours worked	0.00	650.00	0.00	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	79.57	0.00	0.00	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	39.79	39.79	0.00				11.00
12.00	Number of travel hours (provider site)	0	0	0				12.00
12.01	Number of travel hours (offsite)	0	0	0				12.01
13.00	Number of miles driven (provider site)	0	0	0				13.00
13.01	Number of miles driven (offsite)	0	0	0				13.01
							1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION							
14.00	Supervisors (column 1, line 9 times column 1, line 10)						0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)						51,721	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)						0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)						51,721	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)						0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)						0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)						51,721	20.00
	If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.							
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)						0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)						0	22.00
23.00	Total salary equivalency (see instructions)						51,721	23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE							
	Standard Travel Allowance							
24.00	Therapists (line 3 times column 2, line 11)						0	24.00
25.00	Assistants (line 4 times column 3, line 11)						0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)						0	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)						0	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)						0	28.00
	Optional Travel Allowance and Optional Travel Expense							
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)						0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)						0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)						0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)						0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)						0	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)						0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)						0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE							
	Standard Travel Expense							
36.00	Therapists (line 5 times column 2, line 11)						0	36.00
37.00	Assistants (line 6 times column 3, line 11)						0	37.00
38.00	Subtotal (sum of lines 36 and 37)						0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)						0	39.00
	Optional Travel Allowance and Optional Travel Expense							
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)						0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)						0	41.00
42.00	Subtotal (sum of lines 40 and 41)						0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)						0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.							
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)						0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)						0	45.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 14-1313 | Period: From 10/01/2016 To 09/30/2017 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 2/10/2018 11:06 am

Physical Therapy — Cost

						1.00	
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00
		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	79.57	0.00	0.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00

		1.00		
	Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT			
57.00	Salary equivalency amount (from line 23)	51,721		57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	0		58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)	0		59.00
60.00	Overtime allowance (from column 5, line 56)	0		60.00
61.00	Equipment cost (see instructions)	0		61.00
62.00	Supplies (see instructions)	0		62.00
63.00	Total allowance (sum of lines 57-62)	51,721		63.00
64.00	Total cost of outside supplier services (from your records)	44,764		64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)	0		65.00
	LINE 33 CALCULATION			
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others	0		100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	0		100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	0		100.02
	LINE 34 CALCULATION			
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	0		101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0		101.01
101.02	Line 34 = sum of lines 27 and 31	0		101.02
	LINE 35 CALCULATION			
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0		102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others	0		102.01
102.02	Line 35 = sum of lines 31 and 32	0		102.02

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS	Provider CCN: 14-1313	Period: From 10/01/2016 To 09/30/2017	Worksheet A-8-3 Parts I-VI Date/Time Prepared: 2/10/2018 11:06 am

		Occupational Therapy	Cost	
			1.00	
	PART I - GENERAL INFORMATION			
1.00	Total number of weeks worked (excluding aides) (see instructions)		23	1.00
2.00	Line 1 multiplied by 15 hours per week		345	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)		0	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)		0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)		0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)		0	6.00
7.00	Standard travel expense rate		0.00	7.00
8.00	Optional travel expense rate per mile		0.00	8.00

		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	910.00	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	75.41	0.00	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	37.71	37.71	0.00			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01

		1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION		
14.00	Supervisors (column 1, line 9 times column 1, line 10)	0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)	68,623	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)	0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)	68,623	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)	0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)	0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)	68,623	20.00
	If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.		
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)	0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)	0	22.00
23.00	Total salary equivalency (see instructions)	68,623	23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE		
	Standard Travel Allowance		
24.00	Therapists (line 3 times column 2, line 11)	0	24.00
25.00	Assistants (line 4 times column 3, line 11)	0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)	0	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)	0	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)	0	28.00
	Optional Travel Allowance and Optional Travel Expense		
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)	0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)	0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)	0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)	0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)	0	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)	0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)	0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE		
	Standard Travel Expense		
36.00	Therapists (line 5 times column 2, line 11)	0	36.00
37.00	Assistants (line 6 times column 3, line 11)	0	37.00
38.00	Subtotal (sum of lines 36 and 37)	0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)	0	39.00
	Optional Travel Allowance and Optional Travel Expense		
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)	0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)	0	41.00
42.00	Subtotal (sum of lines 40 and 41)	0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)	0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.		
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)	0	44.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 14-1313 | Period: From 10/01/2016 To 09/30/2017 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 2/10/2018 11:06 am

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

		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	75.41	0.00	0.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00

		1.00	
	Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT		
57.00	Salary equivalency amount (from line 23)	68,623	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	0	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)	0	59.00
60.00	Overtime allowance (from column 5, line 56)	0	60.00
61.00	Equipment cost (see instructions)	0	61.00
62.00	Supplies (see instructions)	0	62.00
63.00	Total allowance (sum of lines 57-62)	68,623	63.00
64.00	Total cost of outside supplier services (from your records)	64,918	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)	0	65.00
	LINE 33 CALCULATION		
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others	0	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	0	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	0	100.02
	LINE 34 CALCULATION		
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	0	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0	101.01
101.02	Line 34 = sum of lines 27 and 31	0	101.02
	LINE 35 CALCULATION		
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others	0	102.01
102.02	Line 35 = sum of lines 31 and 32	0	102.02

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1313 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B Part I | Date/Time Prepared: 2/10/2018 11:06 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	NEW CLINIC BUILDING	NEW NEW MED SURG	MVBLE EQUIP	
			0	1.00	1.01	1.02	2.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	342,834	342,834				1.00
1.01	00101	NEW CAP REL COSTS-CLINIC BUILDING	60,535	0	60,535			1.01
1.02	00102	NEW CAP REL COSTS-NEW MED SURG	467,004	0	0	467,004		1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP	504,896				504,896	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,266,409	0	0	0	0	4.00
5.01	00590	ADMINISTRATIVE AND GENERAL	2,012,208	77,824	3,211	0	62,533	5.01
5.02	00591	A&G HOSPITAL ONLY	494,051	3,858	3,955	3,833	0	5.02
6.00	00600	MAINTENANCE & REPAIRS	529,728	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	238,416	33,653	507	10,222	2,570	7.00
7.01	00701	OPERATION OF PLANT-CLINIC	27,485	0	0	0	0	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	42,625	10,131	0	3,799	3,186	8.00
9.00	00900	HOUSEKEEPING	298,592	1,214	0	2,245	0	9.00
10.00	01000	DIETARY	272,730	16,469	0	0	742	10.00
11.00	01100	CAFETERIA	0	7,001	0	2,590	0	11.00
13.00	01300	NURSING ADMINISTRATION	204,345	5,143	0	5,560	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	69,705	8,806	0	0	0	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	224,788	7,657	615	0	43,253	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	266,391	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,110,657	5,007	0	364,058	34,615	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	209,587	40,537	0	0	76,617	50.00
53.00	05300	ANESTHESIOLOGY	1,878	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	752,647	31,601	0	0	96,177	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	129,735	1,578	0	0	0	54.01
56.00	05600	RADIOISOTOPE	106,152	3,429	0	0	0	56.00
58.00	05800	MRI	94,586	0	0	0	0	58.00
60.00	06000	LABORATORY	1,274,645	17,827	0	0	13,392	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	104,063	0	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	22,402	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	654,520	6,689	0	0	66,278	66.00
67.00	06700	OCCUPATIONAL THERAPY	251,166	1,403	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	28,156	1,013	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	486,205	31,601	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	364,800	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	777,577	0	0	64,579	1,567	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	310,943	0	2,576	0	0	76.00
76.01	03952	TELEMEDICINE PSYCH SERVICES	26,540	0	0	0	0	76.01
76.02	03950	DIABETIC EDUCATION	133,373	3,851	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	3,533,415	0	44,426	0	10,602	88.00
88.01	08801	RURAL HEALTH CLINIC II	372,187	0	0	0	1,785	88.01
91.00	09100	EMERGENCY	2,333,285	26,542	0	0	2,116	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	413,944	0	0	0	82,760	95.00
101.00	10100	HOME HEALTH AGENCY	688,642	0	5,245	0	6,703	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	22,503,847	342,834	60,535	456,886	504,896	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	10,118	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	156,903	0	0	0	0	192.00
194.00	07950	HOSPICE	0	0	0	0	0	194.00
194.01	07951	FAMILY MEDICAL CENTER	0	0	0	0	0	194.01
194.02	07952	MEALS ON WHEELS	0	0	0	0	0	194.02
194.03	07954	MANITO MED ASSOCIATES	475,442	0	0	0	0	194.03
194.04	07953	OTHER NONREIMBURSABLE COST AREAS	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	23,136,192	342,834	60,535	467,004	504,896	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1313 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B Part I | Date/Time Prepared: 2/10/2018 11:06 am

		Cost Center Description	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE AND GENERAL	Subtotal	A&G HOSPITAL ONLY	
			4.00	4A	5.01	5A.01	5.02	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-CLINIC BUILDING						1.01
1.02	00102	NEW CAP REL COSTS-NEW MED SURG						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,266,409					4.00
5.01	00590	ADMINISTRATIVE AND GENERAL	187,017	2,342,793	2,342,793			5.01
5.02	00591	A&G HOSPITAL ONLY	63,671	569,368	64,151	633,519	633,519	5.02
6.00	00600	MAINTENANCE & REPAIRS	55,673	585,401	65,957	651,358	26,319	6.00
7.00	00700	OPERATION OF PLANT	0	285,368	32,152	317,520	12,830	7.00
7.01	00701	OPERATION OF PLANT-CLINIC	0	27,485	3,097	30,582	1,236	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	5,033	64,774	7,298	72,072	2,912	8.00
9.00	00900	HOUSEKEEPING	43,518	345,569	38,935	384,504	15,536	9.00
10.00	01000	DIETARY	41,406	331,347	37,333	368,680	14,897	10.00
11.00	01100	CAFETERIA	0	9,591	1,081	10,672	431	11.00
13.00	01300	NURSING ADMINISTRATION	35,030	250,078	28,176	278,254	11,243	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	12,899	91,410	10,299	101,709	4,110	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	30,866	307,179	34,610	341,789	13,810	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	266,391	30,014	296,405	11,977	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	179,683	1,694,020	190,865	1,884,885	76,161	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	32,883	359,624	40,519	400,143	16,168	50.00
53.00	05300	ANESTHESIOLOGY	0	1,878	212	2,090	84	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	96,904	977,329	110,116	1,087,445	43,939	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	13,224	144,537	16,285	160,822	6,498	54.01
56.00	05600	RADIOISOTOPE	0	109,581	12,346	121,927	4,927	56.00
58.00	05800	MRI	170	94,756	10,676	105,432	4,260	58.00
60.00	06000	LABORATORY	128,104	1,433,968	161,565	1,595,533	64,469	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	104,063	11,725	115,788	4,679	62.00
64.00	06400	INTRAVENOUS THERAPY	0	22,402	2,524	24,926	1,007	64.00
66.00	06600	PHYSICAL THERAPY	93,086	820,573	92,454	913,027	36,892	66.00
67.00	06700	OCCUPATIONAL THERAPY	31,474	284,043	32,003	316,046	12,770	67.00
68.00	06800	SPEECH PATHOLOGY	4,877	34,046	3,836	37,882	1,531	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	0	517,806	58,341	576,147	23,280	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	364,800	41,102	405,902	16,401	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	57,508	901,231	101,542	1,002,773	40,518	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	36,135	349,654	39,396	389,050	15,720	76.00
76.01	03952	TELEMEDICINE PSYCH SERVICES	1,340	27,880	3,141	31,021	1,253	76.01
76.02	03950	DIABETIC EDUCATION	22,464	159,688	17,992	177,680	7,179	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	575,838	4,164,281	469,191	4,633,472	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	58,371	432,343	48,712	481,055	0	88.01
91.00	09100	EMERGENCY	195,823	2,557,766	288,183	2,845,949	114,993	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0		0		92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	60,129	556,833	62,738	619,571	25,034	95.00
101.00	10100	HOME HEALTH AGENCY	110,905	811,495	91,431	902,926	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,174,031	22,401,351	2,259,998	22,318,556	633,064	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	10,118	1,140	11,258	455	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	29,295	186,198	20,979	207,177	0	192.00
194.00	07950	HOSPICE	0	0	0	0	0	194.00
194.01	07951	FAMILY MEDICAL CENTER	0	0	0	0	0	194.01
194.02	07952	MEALS ON WHEELS	0	0	0	0	0	194.02
194.03	07954	MANITO MED ASSOCIATES	63,083	538,525	60,676	599,201	0	194.03
194.04	07953	OTHER NONREIMBURSABLE COST AREAS	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments		0		0		200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	2,266,409	23,136,192	2,342,793	23,136,192	633,519	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1313 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B Part I | Date/Time Prepared: 2/10/2018 11:06 am

		Cost Center Description	MAINTENANCE & REPAIRS	OPERATION OF PLANT	OPERATION OF PLANT-CLINIC	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			6.00	7.00	7.01	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-CLINIC BUILDING						1.01
1.02	00102	NEW CAP REL COSTS-NEW MED SURG						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	ADMINISTRATIVE AND GENERAL						5.01
5.02	00591	A&G HOSPITAL ONLY						5.02
6.00	00600	MAINTENANCE & REPAIRS	677,677					6.00
7.00	00700	OPERATION OF PLANT	54,509	384,859				7.00
7.01	00701	OPERATION OF PLANT-CLINIC	0	0	31,818			7.01
8.00	00800	LAUNDRY & LINEN SERVICE	16,153	13,293	0	104,430		8.00
9.00	00900	HOUSEKEEPING	2,449	2,015	0	0	404,504	9.00
10.00	01000	DIETARY	24,545	20,198	0	0	16,422	10.00
11.00	01100	CAFETERIA	11,159	9,183	0	0	7,466	11.00
13.00	01300	NURSING ADMINISTRATION	9,224	7,590	0	0	6,171	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	13,124	10,800	0	0	8,781	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	13,221	9,390	411	0	8,846	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	109,493	90,106	0	47,958	73,259	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	60,413	49,715	0	12,525	40,421	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	47,095	38,756	0	12,716	31,511	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	2,352	1,935	0	0	1,574	54.01
56.00	05600	RADIOISOTOPE	5,110	4,205	0	0	3,419	56.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	26,567	21,863	0	116	17,776	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	9,969	8,204	0	3,186	6,670	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,091	1,720	0	0	1,399	67.00
68.00	06800	SPEECH PATHOLOGY	1,510	1,242	0	0	1,010	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	47,095	38,756	0	1,922	31,511	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	18,099	14,894	0	0	12,110	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	7,578	0	1,721	0	5,070	76.00
76.01	03952	TELEMEDICINE PSYCH SERVICES	0	0	0	0	0	76.01
76.02	03950	DIABETIC EDUCATION	7,423	6,109	0	0	4,967	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	130,679	0	29,686	617	87,436	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	32	0	88.01
91.00	09100	EMERGENCY	39,556	32,551	0	24,630	26,466	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	469	0	95.00
101.00	10100	HOME HEALTH AGENCY	15,427	0	0	201	10,322	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	674,841	382,525	31,818	104,372	402,607	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,836	2,334	0	0	1,897	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	58	0	192.00
194.00	07950	HOSPICE	0	0	0	0	0	194.00
194.01	07951	FAMILY MEDICAL CENTER	0	0	0	0	0	194.01
194.02	07952	MEALS ON WHEELS	0	0	0	0	0	194.02
194.03	07954	MANITO MED ASSOCIATES	0	0	0	0	0	194.03
194.04	07953	OTHER NONREIMBURSABLE COST AREAS	0	0	0	0	0	194.04
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 through 201)	677,677	384,859	31,818	104,430	404,504	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1313 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B Part I | Date/Time Prepared: 2/10/2018 11:06 am

		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
1.01	00101	NEW CAP REL COSTS-CLINIC BUILDING						1.01
1.02	00102	NEW CAP REL COSTS-NEW MED SURG						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	ADMINISTRATIVE AND GENERAL						5.01
5.02	00591	A&G HOSPITAL ONLY						5.02
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT-CLINIC						7.01
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	444,742					10.00
11.00	01100	CAFETERIA	348,850	387,761				11.00
13.00	01300	NURSING ADMINISTRATION	0	4,879	317,361			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	6,884	0	145,408		14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	10,998	0	0	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	72,208	52,538	169,730	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	472	8,414	28,694	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	26,981	0	1,822	0	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	0	2,901	0	77	0	54.01
56.00	05600	RADIOISOTOPE	0	1,002	0	9,809	0	56.00
58.00	05800	MRI	0	105	0	494	0	58.00
60.00	06000	LABORATORY	0	38,692	0	50,038	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	17,800	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	2,970	0	64.00
66.00	06600	PHYSICAL THERAPY	0	17,592	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	5,460	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	897	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	0	19,649	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	62,398	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	9,838	0	0	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	22,069	9,521	32,521	0	0	76.00
76.01	03952	TELEMEDICINE PSYCH SERVICES	0	422	0	0	0	76.01
76.02	03950	DIABETIC EDUCATION	0	4,563	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	92,734	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
91.00	09100	EMERGENCY	1,143	73,691	86,416	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	444,742	387,761	317,361	145,408	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	HOSPICE	0	0	0	0	0	194.00
194.01	07951	FAMILY MEDICAL CENTER	0	0	0	0	0	194.01
194.02	07952	MEALS ON WHEELS	0	0	0	0	0	194.02
194.03	07954	MANITO MED ASSOCIATES	0	0	0	0	0	194.03
194.04	07953	OTHER NONREIMBURSABLE COST AREAS	0	0	0	0	0	194.04
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 through 201)	444,742	387,761	317,361	145,408	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1313 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B Part I | Date/Time Prepared: 2/10/2018 11:06 am

		Cost Center Description	MEDICAL RECORDS & LIBRARY	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			16.00	19.00	24.00	25.00	26.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-CLINIC BUILDING						1.01
1.02	00102	NEW CAP REL COSTS-NEW MED SURG						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	ADMINISTRATIVE AND GENERAL						5.01
5.02	00591	A&G HOSPITAL ONLY						5.02
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT-CLINIC						7.01
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	398,465					16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	308,382				19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	24,851	0	2,601,189	0	2,601,189	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	12,728	0	629,693	0	629,693	50.00
53.00	05300	ANESTHESIOLOGY	8,186	308,382	318,742	0	318,742	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	62,418	0	1,352,683	0	1,352,683	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	6,714	0	182,873	0	182,873	54.01
56.00	05600	RADIOISOTOPE	5,029	0	155,428	0	155,428	56.00
58.00	05800	MRI	10,820	0	121,111	0	121,111	58.00
60.00	06000	LABORATORY	74,697	0	1,889,751	0	1,889,751	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	1,920	0	140,187	0	140,187	62.00
64.00	06400	INTRAVENOUS THERAPY	5,190	0	34,093	0	34,093	64.00
66.00	06600	PHYSICAL THERAPY	18,071	0	1,013,611	0	1,013,611	66.00
67.00	06700	OCCUPATIONAL THERAPY	8,488	0	347,974	0	347,974	67.00
68.00	06800	SPEECH PATHOLOGY	623	0	44,695	0	44,695	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	17,709	0	756,069	0	756,069	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	8,119	0	492,820	0	492,820	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	12,557	0	1,110,789	0	1,110,789	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	10,972	0	494,222	0	494,222	76.00
76.01	03952	TELEMEDICINE PSYCH SERVICES	465	0	33,161	0	33,161	76.01
76.02	03950	DIABETIC EDUCATION	460	0	208,381	0	208,381	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	33,332	0	5,007,956	0	5,007,956	88.00
88.01	08801	RURAL HEALTH CLINIC II	2,787	0	483,874	0	483,874	88.01
91.00	09100	EMERGENCY	29,089	0	3,274,484	0	3,274,484	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	23,741	0	668,815	0	668,815	95.00
101.00	10100	HOME HEALTH AGENCY	19,499	0	948,375	0	948,375	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	398,465	308,382	22,310,976	0	22,310,976	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	18,780	0	18,780	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	207,235	0	207,235	192.00
194.00	07950	HOSPICE	0	0	0	0	0	194.00
194.01	07951	FAMILY MEDICAL CENTER	0	0	0	0	0	194.01
194.02	07952	MEALS ON WHEELS	0	0	0	0	0	194.02
194.03	07954	MANITO MED ASSOCIATES	0	0	599,201	0	599,201	194.03
194.04	07953	OTHER NONREIMBURSABLE COST AREAS	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments		0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	398,465	308,382	23,136,192	0	23,136,192	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1313 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B Part II | Date/Time Prepared: 2/10/2018 11:06 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	NEW CLINIC BUILDING	NEW NEW MED SURG	MVBLE EQUIP	
			0	1.00	1.01	1.02	2.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-CLINIC BUILDING						1.01
1.02	00102	NEW CAP REL COSTS-NEW MED SURG						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	4.00
5.01	00590	ADMINISTRATIVE AND GENERAL	0	77,824	3,211	0	62,533	5.01
5.02	00591	A&G HOSPITAL ONLY	0	3,858	3,955	3,833	0	5.02
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	0	33,653	507	10,222	2,570	7.00
7.01	00701	OPERATION OF PLANT-CLINIC	0	0	0	0	0	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	10,131	0	3,799	3,186	8.00
9.00	00900	HOUSEKEEPING	0	1,214	0	2,245	0	9.00
10.00	01000	DIETARY	0	16,469	0	0	742	10.00
11.00	01100	CAFETERIA	0	7,001	0	2,590	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	5,143	0	5,560	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	8,806	0	0	0	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	7,657	615	0	43,253	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	5,007	0	364,058	34,615	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	40,537	0	0	76,617	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	31,601	0	0	96,177	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	0	1,578	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	3,429	0	0	0	56.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	17,827	0	0	13,392	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0	6,689	0	0	66,278	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,403	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	1,013	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	0	31,601	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	64,579	1,567	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	2,576	0	0	76.00
76.01	03952	TELEMEDICINE PSYCH SERVICES	0	0	0	0	0	76.01
76.02	03950	DIABETIC EDUCATION	0	3,851	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	44,426	0	10,602	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	1,785	88.01
91.00	09100	EMERGENCY	0	26,542	0	0	2,116	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	82,760	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	5,245	0	6,703	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	342,834	60,535	456,886	504,896	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	10,118	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	HOSPICE	0	0	0	0	0	194.00
194.01	07951	FAMILY MEDICAL CENTER	0	0	0	0	0	194.01
194.02	07952	MEALS ON WHEELS	0	0	0	0	0	194.02
194.03	07954	MANITO MED ASSOCIATES	0	0	0	0	0	194.03
194.04	07953	OTHER NONREIMBURSABLE COST AREAS	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	342,834	60,535	467,004	504,896	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1313 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B Part II | Date/Time Prepared: 2/10/2018 11:06 am

		Cost Center Description	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE AND GENERAL	A&G HOSPITAL ONLY	MAINTENANCE & REPAIRS	
			2A	4.00	5.01	5.02	6.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-CLINIC BUILDING						1.01
1.02	00102	NEW CAP REL COSTS-NEW MED SURG						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0				4.00
5.01	00590	ADMINISTRATIVE AND GENERAL	143,568	0	143,568			5.01
5.02	00591	A&G HOSPITAL ONLY	11,646	0	3,931	15,577		5.02
6.00	00600	MAINTENANCE & REPAIRS	0	0	4,042	647	4,689	6.00
7.00	00700	OPERATION OF PLANT	46,952	0	1,970	316	377	7.00
7.01	00701	OPERATION OF PLANT-CLINIC	0	0	190	30	0	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	17,116	0	447	72	112	8.00
9.00	00900	HOUSEKEEPING	3,459	0	2,386	382	17	9.00
10.00	01000	DIETARY	17,211	0	2,288	366	170	10.00
11.00	01100	CAFETERIA	9,591	0	66	11	77	11.00
13.00	01300	NURSING ADMINISTRATION	10,703	0	1,727	277	64	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	8,806	0	631	101	91	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	51,525	0	2,121	340	91	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	1,839	295	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	403,680	0	11,696	1,874	758	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	117,154	0	2,483	398	418	50.00
53.00	05300	ANESTHESIOLOGY	0	0	13	2	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	127,778	0	6,747	1,081	326	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	1,578	0	998	160	16	54.01
56.00	05600	RADIOISOTOPE	3,429	0	757	121	35	56.00
58.00	05800	MRI	0	0	654	105	0	58.00
60.00	06000	LABORATORY	31,219	0	9,900	1,586	184	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	718	115	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	155	25	0	64.00
66.00	06600	PHYSICAL THERAPY	72,967	0	5,665	908	69	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,403	0	1,961	314	14	67.00
68.00	06800	SPEECH PATHOLOGY	1,013	0	235	38	10	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	31,601	0	3,575	573	326	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	2,519	403	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	66,146	0	6,222	997	125	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	2,576	0	2,414	387	52	76.00
76.01	03952	TELEMEDICINE PSYCH SERVICES	0	0	192	31	0	76.01
76.02	03950	DIABETIC EDUCATION	3,851	0	1,102	177	51	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	55,028	0	28,759	0	905	88.00
88.01	08801	RURAL HEALTH CLINIC II	1,785	0	2,985	0	0	88.01
91.00	09100	EMERGENCY	28,658	0	17,659	2,818	274	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0					92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	82,760	0	3,844	616	0	95.00
101.00	10100	HOME HEALTH AGENCY	11,948	0	5,603	0	107	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,365,151	0	138,494	15,566	4,669	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	10,118	0	70	11	20	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	1,286	0	0	192.00
194.00	07950	HOSPICE	0	0	0	0	0	194.00
194.01	07951	FAMILY MEDICAL CENTER	0	0	0	0	0	194.01
194.02	07952	MEALS ON WHEELS	0	0	0	0	0	194.02
194.03	07954	MANITO MED ASSOCIATES	0	0	3,718	0	0	194.03
194.04	07953	OTHER NONREIMBURSABLE COST AREAS	0	0	0	0	0	194.04
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 through 201)	1,375,269	0	143,568	15,577	4,689	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1313 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B Part II | Date/Time Prepared: 2/10/2018 11:06 am

		Cost Center Description	OPERATION OF PLANT	OPERATION OF PLANT-CLINIC	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			7.00	7.01	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-CLINIC BUILDING						1.01
1.02	00102	NEW CAP REL COSTS-NEW MED SURG						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	ADMINISTRATIVE AND GENERAL						5.01
5.02	00591	A&G HOSPITAL ONLY						5.02
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT	49,615					7.00
7.01	00701	OPERATION OF PLANT-CLINIC	0	220				7.01
8.00	00800	LAUNDRY & LINEN SERVICE	1,714	0	19,461			8.00
9.00	00900	HOUSEKEEPING	260	0	0	6,504		9.00
10.00	01000	DIETARY	2,604	0	0	264	22,903	10.00
11.00	01100	CAFETERIA	1,184	0	0	120	17,965	11.00
13.00	01300	NURSING ADMINISTRATION	979	0	0	99	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,392	0	0	141	0	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,211	3	0	142	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	11,614	0	8,937	1,178	3,719	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,409	0	2,334	650	24	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,996	0	2,370	507	0	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	250	0	0	25	0	54.01
56.00	05600	RADIOISOTOPE	542	0	0	55	0	56.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	2,819	0	22	286	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	1,058	0	594	107	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	222	0	0	22	0	67.00
68.00	06800	SPEECH PATHOLOGY	160	0	0	16	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	4,996	0	358	507	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,920	0	0	195	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	12	0	82	1,136	76.00
76.01	03952	TELEMEDICINE PSYCH SERVICES	0	0	0	0	0	76.01
76.02	03950	DIABETIC EDUCATION	788	0	0	80	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	205	115	1,405	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	6	0	0	88.01
91.00	09100	EMERGENCY	4,196	0	4,590	426	59	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	87	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	37	166	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	49,314	220	19,450	6,473	22,903	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	301	0	0	31	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	11	0	0	192.00
194.00	07950	HOSPICE	0	0	0	0	0	194.00
194.01	07951	FAMILY MEDICAL CENTER	0	0	0	0	0	194.01
194.02	07952	MEALS ON WHEELS	0	0	0	0	0	194.02
194.03	07954	MANITO MED ASSOCIATES	0	0	0	0	0	194.03
194.04	07953	OTHER NONREIMBURSABLE COST AREAS	0	0	0	0	0	194.04
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 through 201)	49,615	220	19,461	6,504	22,903	202.00

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		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-CLINIC BUILDING						1.01
1.02	00102	NEW CAP REL COSTS-NEW MED SURG						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	ADMINISTRATIVE AND GENERAL						5.01
5.02	00591	A&G HOSPITAL ONLY						5.02
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT-CLINIC						7.01
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	29,014					11.00
13.00	01300	NURSING ADMINISTRATION	365	14,214				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	515	0	11,677			14.00
15.00	01500	PHARMACY	0	0	0	0		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	823	0	0	0	56,256	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,931	7,602	0	0	3,509	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	630	1,285	0	0	1,797	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	1,156	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,019	0	146	0	8,813	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	217	0	6	0	948	54.01
56.00	05600	RADIOISOTOPE	75	0	788	0	710	56.00
58.00	05800	MRI	8	0	40	0	1,528	58.00
60.00	06000	LABORATORY	2,895	0	4,018	0	10,544	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	1,429	0	271	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	239	0	733	64.00
66.00	06600	PHYSICAL THERAPY	1,316	0	0	0	2,551	66.00
67.00	06700	OCCUPATIONAL THERAPY	409	0	0	0	1,198	67.00
68.00	06800	SPEECH PATHOLOGY	67	0	0	0	88	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	1,470	0	0	0	2,500	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	5,011	0	1,146	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	736	0	0	0	1,773	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	712	1,457	0	0	1,549	76.00
76.01	03952	TELEMEDICINE PSYCH SERVICES	32	0	0	0	66	76.01
76.02	03950	DIABETIC EDUCATION	341	0	0	0	65	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	6,939	0	0	0	4,706	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	393	88.01
91.00	09100	EMERGENCY	5,514	3,870	0	0	4,107	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	3,352	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	2,753	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	29,014	14,214	11,677	0	56,256	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	HOSPICE	0	0	0	0	0	194.00
194.01	07951	FAMILY MEDICAL CENTER	0	0	0	0	0	194.01
194.02	07952	MEALS ON WHEELS	0	0	0	0	0	194.02
194.03	07954	MANITO MED ASSOCIATES	0	0	0	0	0	194.03
194.04	07953	OTHER NONREIMBURSABLE COST AREAS	0	0	0	0	0	194.04
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 through 201)	29,014	14,214	11,677	0	56,256	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1313 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B Part II | Date/Time Prepared: 2/10/2018 11:06 am

		Cost Center Description	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			19.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-CLINIC BUILDING						1.01
1.02	00102	NEW CAP REL COSTS-NEW MED SURG						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	ADMINISTRATIVE AND GENERAL						5.01
5.02	00591	A&G HOSPITAL ONLY						5.02
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT-CLINIC						7.01
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	2,134					19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS		458,498	0	458,498		30.00
31.00	03100	INTENSIVE CARE UNIT		0	0	0		31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM		133,582	0	133,582		50.00
53.00	05300	ANESTHESIOLOGY		1,171	0	1,171		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		154,783	0	154,783		54.00
54.01	05401	RADIOLOGY-ULTRASOUND		4,198	0	4,198		54.01
56.00	05600	RADIOISOTOPE		6,512	0	6,512		56.00
58.00	05800	MRI		2,335	0	2,335		58.00
60.00	06000	LABORATORY		63,473	0	63,473		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL		2,533	0	2,533		62.00
64.00	06400	INTRAVENOUS THERAPY		1,152	0	1,152		64.00
66.00	06600	PHYSICAL THERAPY		85,235	0	85,235		66.00
67.00	06700	OCCUPATIONAL THERAPY		5,543	0	5,543		67.00
68.00	06800	SPEECH PATHOLOGY		1,627	0	1,627		68.00
69.00	06900	ELECTROCARDIOLOGY		0	0	0		69.00
69.01	03160	CARDIOPULMONARY		45,906	0	45,906		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		9,079	0	9,079		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS		78,114	0	78,114		73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES		10,377	0	10,377		76.00
76.01	03952	TELEMEDICINE PSYCH SERVICES		321	0	321		76.01
76.02	03950	DIABETIC EDUCATION		6,455	0	6,455		76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC		98,062	0	98,062		88.00
88.01	08801	RURAL HEALTH CLINIC II		5,169	0	5,169		88.01
91.00	09100	EMERGENCY		72,171	0	72,171		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			0			92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES		90,659	0	90,659		95.00
101.00	10100	HOME HEALTH AGENCY		20,614	0	20,614		101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	1,357,569	0	1,357,569		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN		10,551	0	10,551		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES		1,297	0	1,297		192.00
194.00	07950	HOSPICE		0	0	0		194.00
194.01	07951	FAMILY MEDICAL CENTER		0	0	0		194.01
194.02	07952	MEALS ON WHEELS		0	0	0		194.02
194.03	07954	MANITO MED ASSOCIATES		3,718	0	3,718		194.03
194.04	07953	OTHER NONREIMBURSABLE COST AREAS		0	0	0		194.04
200.00		Cross Foot Adjustments	2,134	2,134	0	2,134		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	2,134	1,375,269	0	1,375,269		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1313 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B-1 | Date/Time Prepared: 2/10/2018 11:06 am

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	NEW CLINIC BUILDING (SQUARE FEET)	NEW NEW MED SURG (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIE)	
			1.00	1.01	1.02	2.00	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	52,791					1.00
1.01	00101	NEW CAP REL COSTS-CLINIC BUILDING	0	18,398				1.01
1.02	00102	NEW CAP REL COSTS-NEW MED SURG	0	0	13,523			1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP				486,319		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	11,727,870	4.00
5.01	00590	ADMINISTRATIVE AND GENERAL	11,984	976	0	60,232	967,749	5.01
5.02	00591	A&G HOSPITAL ONLY	594	1,202	111	0	329,475	5.02
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	288,089	6.00
7.00	00700	OPERATION OF PLANT	5,182	154	296	2,475	0	7.00
7.01	00701	OPERATION OF PLANT-CLINIC	0	0	0	0	0	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	1,560	0	110	3,069	26,045	8.00
9.00	00900	HOUSEKEEPING	187	0	65	0	225,192	9.00
10.00	01000	DIETARY	2,536	0	0	715	214,259	10.00
11.00	01100	CAFETERIA	1,078	0	75	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	792	0	161	0	181,268	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,356	0	0	0	66,747	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,179	187	0	41,662	159,721	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	771	0	10,542	33,341	929,797	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,242	0	0	73,798	170,157	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,866	0	0	92,640	501,446	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	243	0	0	0	68,430	54.01
56.00	05600	RADIOISOTOPE	528	0	0	0	0	56.00
58.00	05800	MRI	0	0	0	0	881	58.00
60.00	06000	LABORATORY	2,745	0	0	12,899	662,892	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	1,030	0	0	63,839	481,689	66.00
67.00	06700	OCCUPATIONAL THERAPY	216	0	0	0	162,868	67.00
68.00	06800	SPEECH PATHOLOGY	156	0	0	0	25,235	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	4,866	0	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	1,870	1,509	297,583	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	783	0	0	186,985	76.00
76.01	03952	TELEMEDICINE PSYCH SERVICES	0	0	0	0	6,934	76.01
76.02	03950	DIABETIC EDUCATION	593	0	0	0	116,241	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	13,502	0	10,212	2,979,763	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	1,719	302,049	88.01
91.00	09100	EMERGENCY	4,087	0	0	2,038	1,013,312	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	79,715	311,148	95.00
101.00	10100	HOME HEALTH AGENCY	0	1,594	0	6,456	573,895	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	52,791	18,398	13,230	486,319	11,249,850	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	293	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	151,590	192.00
194.00	07950	HOSPICE	0	0	0	0	0	194.00
194.01	07951	FAMILY MEDICAL CENTER	0	0	0	0	0	194.01
194.02	07952	MEALS ON WHEELS	0	0	0	0	0	194.02
194.03	07954	MANITO MED ASSOCIATES	0	0	0	0	326,430	194.03
194.04	07953	OTHER NONREIMBURSABLE COST AREAS	0	0	0	0	0	194.04
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)	342,834	60,535	467,004	504,896	2,266,409	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	6.494175	3.290303	34.534053	1.038199	0.193250	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)					0	204.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1313 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B-1 | Date/Time Prepared: 2/10/2018 11:06 am

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	NEW CLINIC BUILDING (SQUARE FEET)	NEW NEW MED SURG (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIE)	
			1.00	1.01	1.02	2.00	4.00	
205.00		Unit cost multiplier (Wkst. B, Part II)					0.000000	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1313 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B-1 | Date/Time Prepared: 2/10/2018 11:06 am

		Cost Center Description	Reconciliation	ADMINISTRATIVE AND GENERAL (ACCUM. COST)	Reconciliation	A&G HOSPITAL ONLY (ACCUM. COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	
			5A.01	5.01	5A.02	5.02	6.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-CLINIC BUILDING						1.01
1.02	00102	NEW CAP REL COSTS-NEW MED SURG						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	ADMINISTRATIVE AND GENERAL	-2,342,793	20,793,399				5.01
5.02	00591	A&G HOSPITAL ONLY	0	569,368	-633,519	15,678,842		5.02
6.00	00600	MAINTENANCE & REPAIRS	0	585,401	0	651,358	70,019	6.00
7.00	00700	OPERATION OF PLANT	0	285,368	0	317,520	5,632	7.00
7.01	00701	OPERATION OF PLANT-CLINIC	0	27,485	0	30,582	0	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	64,774	0	72,072	1,669	8.00
9.00	00900	HOUSEKEEPING	0	345,569	0	384,504	253	9.00
10.00	01000	DIETARY	0	331,347	0	368,680	2,536	10.00
11.00	01100	CAFETERIA	0	9,591	0	10,672	1,153	11.00
13.00	01300	NURSING ADMINISTRATION	0	250,078	0	278,254	953	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	91,410	0	101,709	1,356	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	307,179	0	341,789	1,366	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	266,391	0	296,405	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	1,694,020	0	1,884,885	11,313	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	359,624	0	400,143	6,242	50.00
53.00	05300	ANESTHESIOLOGY	0	1,878	0	2,090	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	977,329	0	1,087,445	4,866	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	0	144,537	0	160,822	243	54.01
56.00	05600	RADIOISOTOPE	0	109,581	0	121,927	528	56.00
58.00	05800	MRI	0	94,756	0	105,432	0	58.00
60.00	06000	LABORATORY	0	1,433,968	0	1,595,533	2,745	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	104,063	0	115,788	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	22,402	0	24,926	0	64.00
66.00	06600	PHYSICAL THERAPY	0	820,573	0	913,027	1,030	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	284,043	0	316,046	216	67.00
68.00	06800	SPEECH PATHOLOGY	0	34,046	0	37,882	156	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	0	517,806	0	576,147	4,866	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	364,800	0	405,902	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	901,231	0	1,002,773	1,870	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	349,654	0	389,050	783	76.00
76.01	03952	TELEMEDICINE PSYCH SERVICES	0	27,880	0	31,021	0	76.01
76.02	03950	DIABETIC EDUCATION	0	159,688	0	177,680	767	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	4,164,281	-4,633,472	0	13,502	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	432,343	-481,055	0	0	88.01
91.00	09100	EMERGENCY	0	2,557,766	0	2,845,949	4,087	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	556,833	0	619,571	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	811,495	-902,926	0	1,594	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-2,342,793	20,058,558	-6,650,972	15,667,584	69,726	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	10,118	0	11,258	293	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	186,198	-207,177	0	0	192.00
194.00	07950	HOSPICE	0	0	0	0	0	194.00
194.01	07951	FAMILY MEDICAL CENTER	0	0	0	0	0	194.01
194.02	07952	MEALS ON WHEELS	0	0	0	0	0	194.02
194.03	07954	MANITO MED ASSOCIATES	0	538,525	-599,201	0	0	194.03
194.04	07953	OTHER NONREIMBURSABLE COST AREAS	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)		2,342,793		633,519	677,677	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)		0.112670		0.040406	9.678473	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)		143,568		15,577	4,689	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)		0.006904		0.000994	0.066968	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1313 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B-1 | Date/Time Prepared: 2/10/2018 11:06 am

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	OPERATION OF PLANT-CLINIC (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	
			7.00	7.01	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-CLINIC BUILDING						1.01
1.02	00102	NEW CAP REL COSTS-NEW MED SURG						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	ADMINISTRATIVE AND GENERAL						5.01
5.02	00591	A&G HOSPITAL ONLY						5.02
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT	48,321					7.00
7.01	00701	OPERATION OF PLANT-CLINIC	0	14,472				7.01
8.00	00800	LAUNDRY & LINEN SERVICE	1,669	0	65,028			8.00
9.00	00900	HOUSEKEEPING	253	0	0	62,465		9.00
10.00	01000	DIETARY	2,536	0	0	2,536	35,791	10.00
11.00	01100	CAFETERIA	1,153	0	0	1,153	28,074	11.00
13.00	01300	NURSING ADMINISTRATION	953	0	0	953	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,356	0	0	1,356	0	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,179	187	0	1,366	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	11,313	0	29,864	11,313	5,811	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,242	0	7,799	6,242	38	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,866	0	7,918	4,866	0	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	243	0	0	243	0	54.01
56.00	05600	RADIOISOTOPE	528	0	0	528	0	56.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	2,745	0	72	2,745	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	1,030	0	1,984	1,030	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	216	0	0	216	0	67.00
68.00	06800	SPEECH PATHOLOGY	156	0	0	156	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	4,866	0	1,197	4,866	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,870	0	0	1,870	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	783	0	783	1,776	76.00
76.01	03952	TELEMEDICINE PSYCH SERVICES	0	0	0	0	0	76.01
76.02	03950	DIABETIC EDUCATION	767	0	0	767	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	13,502	384	13,502	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	20	0	0	88.01
91.00	09100	EMERGENCY	4,087	0	15,337	4,087	92	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	292	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	125	1,594	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	48,028	14,472	64,992	62,172	35,791	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	293	0	0	293	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	36	0	0	192.00
194.00	07950	HOSPICE	0	0	0	0	0	194.00
194.01	07951	FAMILY MEDICAL CENTER	0	0	0	0	0	194.01
194.02	07952	MEALS ON WHEELS	0	0	0	0	0	194.02
194.03	07954	MANITO MED ASSOCIATES	0	0	0	0	0	194.03
194.04	07953	OTHER NONREIMBURSABLE COST AREAS	0	0	0	0	0	194.04
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)	384,859	31,818	104,430	404,504	444,742	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	7.964632	2.198590	1.605924	6.475690	12.426085	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	49,615	220	19,461	6,504	22,903	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	1.026779	0.015202	0.299271	0.104122	0.639909	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1313 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B-1 | Date/Time Prepared: 2/10/2018 11:06 am

		Cost Center Description	CAFETERIA (FTE'S)	NURSING ADMINISTRATION (HOURS OF SERVICE)	CENTRAL SERVICES & SUPPLY (COSTED REQUISI)	PHARMACY (COSTED REQUISI)	MEDICAL RECORDS & LIBRARY (GROSS REVENUE)	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-CLINIC BUILDING						1.01
1.02	00102	NEW CAP REL COSTS-NEW MED SURG						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	ADMINISTRATIVE AND GENERAL						5.01
5.02	00591	A&G HOSPITAL ONLY						5.02
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT-CLINIC						7.01
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	14,702					11.00
13.00	01300	NURSING ADMINISTRATION	185	73,306				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	261	0	850,102			14.00
15.00	01500	PHARMACY	0	0	0	0		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	417	0	0	0	40,444,018	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,992	39,205	0	0	2,522,444	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	319	6,628	0	0	1,291,926	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	830,863	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,023	0	10,650	0	6,335,582	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	110	0	452	0	681,460	54.01
56.00	05600	RADIOISOTOPE	38	0	57,347	0	510,443	56.00
58.00	05800	MRI	4	0	2,889	0	1,098,283	58.00
60.00	06000	LABORATORY	1,467	0	292,537	0	7,580,880	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	104,063	0	194,900	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	17,364	0	526,808	64.00
66.00	06600	PHYSICAL THERAPY	667	0	0	0	1,834,197	66.00
67.00	06700	OCCUPATIONAL THERAPY	207	0	0	0	861,554	67.00
68.00	06800	SPEECH PATHOLOGY	34	0	0	0	63,201	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	745	0	0	0	1,797,469	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	364,800	0	824,096	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	373	0	0	0	1,274,589	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	361	7,512	0	0	1,113,663	76.00
76.01	03952	TELEMEDICINE PSYCH SERVICES	16	0	0	0	47,227	76.01
76.02	03950	DIABETIC EDUCATION	173	0	0	0	46,703	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	3,516	0	0	0	3,383,268	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	282,869	88.01
91.00	09100	EMERGENCY	2,794	19,961	0	0	2,952,649	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	2,409,760	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	1,979,184	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	14,702	73,306	850,102	0	40,444,018	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	HOSPICE	0	0	0	0	0	194.00
194.01	07951	FAMILY MEDICAL CENTER	0	0	0	0	0	194.01
194.02	07952	MEALS ON WHEELS	0	0	0	0	0	194.02
194.03	07954	MANITO MED ASSOCIATES	0	0	0	0	0	194.03
194.04	07953	OTHER NONREIMBURSABLE COST AREAS	0	0	0	0	0	194.04
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)	387,761	317,361	145,408	0	398,465	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	26.374711	4.329264	0.171048	0.000000	0.009852	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	29,014	14,214	11,677	0	56,256	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	1.973473	0.193900	0.013736	0.000000	0.001391	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1313 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B-1 | Date/Time Prepared: 2/10/2018 11:06 am

		Cost Center Description	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	
			19.00	
		GENERAL SERVICE COST CENTERS		
1.00	00100	CAP REL COSTS-BLDG & FIXT		1.00
1.01	00101	NEW CAP REL COSTS-CLINIC BUILDING		1.01
1.02	00102	NEW CAP REL COSTS-NEW MED SURG		1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT		4.00
5.01	00590	ADMINISTRATIVE AND GENERAL		5.01
5.02	00591	A&G HOSPITAL ONLY		5.02
6.00	00600	MAINTENANCE & REPAIRS		6.00
7.00	00700	OPERATION OF PLANT		7.00
7.01	00701	OPERATION OF PLANT-CLINIC		7.01
8.00	00800	LAUNDRY & LINEN SERVICE		8.00
9.00	00900	HOUSEKEEPING		9.00
10.00	01000	DIETARY		10.00
11.00	01100	CAFETERIA		11.00
13.00	01300	NURSING ADMINISTRATION		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY		14.00
15.00	01500	PHARMACY		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY		16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	100	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	31.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0	50.00
53.00	05300	ANESTHESIOLOGY	100	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	0	54.01
56.00	05600	RADIOISOTOPE	0	56.00
58.00	05800	MRI	0	58.00
60.00	06000	LABORATORY	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	64.00
66.00	06600	PHYSICAL THERAPY	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	69.00
69.01	03160	CARDIOPULMONARY	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	76.00
76.01	03952	TELEMEDICINE PSYCH SERVICES	0	76.01
76.02	03950	DIABETIC EDUCATION	0	76.02
		OUTPATIENT SERVICE COST CENTERS		
88.00	08800	RURAL HEALTH CLINIC	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	88.01
91.00	09100	EMERGENCY	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		92.00
		OTHER REIMBURSABLE COST CENTERS		
95.00	09500	AMBULANCE SERVICES	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	101.00
		SPECIAL PURPOSE COST CENTERS		
113.00	11300	INTEREST EXPENSE		113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	100	118.00
		NONREIMBURSABLE COST CENTERS		
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	192.00
194.00	07950	HOSPICE	0	194.00
194.01	07951	FAMILY MEDICAL CENTER	0	194.01
194.02	07952	MEALS ON WHEELS	0	194.02
194.03	07954	MANITO MED ASSOCIATES	0	194.03
194.04	07953	OTHER NONREIMBURSABLE COST AREAS	0	194.04
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)	308,382	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	3,083.820000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	2,134	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	21.340000	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1313 | Period: From 10/01/2016 To 09/30/2017 | Worksheet C Part I Date/Time Prepared: 2/10/2018 11:06 am

Title XVIII | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,601,189		2,601,189	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0		0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	629,693		629,693	0	0	50.00
53.00	05300	ANESTHESIOLOGY	318,742		318,742	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,352,683		1,352,683	0	0	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	182,873		182,873	0	0	54.01
56.00	05600	RADIOISOTOPE	155,428		155,428	0	0	56.00
58.00	05800	MRI	121,111		121,111	0	0	58.00
60.00	06000	LABORATORY	1,889,751		1,889,751	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	140,187		140,187	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	34,093		34,093	0	0	64.00
66.00	06600	PHYSICAL THERAPY	1,013,611	0	1,013,611	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	347,974	0	347,974	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	44,695	0	44,695	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0		0	0	0	69.00
69.01	03160	CARDIOPULMONARY	756,069		756,069	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	492,820		492,820	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,110,789		1,110,789	0	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	494,222		494,222	0	0	76.00
76.01	03952	TELEMEDICINE PSYCH SERVICES	33,161		33,161	0	0	76.01
76.02	03950	DIABETIC EDUCATION	208,381		208,381	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	5,007,956		5,007,956	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	483,874		483,874	0	0	88.01
91.00	09100	EMERGENCY	3,274,484		3,274,484	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	289,889		289,889		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	668,815		668,815	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	948,375		948,375		0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	22,600,865	0	22,600,865	0	0	200.00
201.00		Less Observation Beds	289,889		289,889		0	201.00
202.00		Total (see instructions)	22,310,976	0	22,310,976	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1313 | Period: From 10/01/2016 To 09/30/2017 | Worksheet C Part I Date/Time Prepared: 2/10/2018 11:06 am

Title XVIII | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,966,990		1,966,990			30.00
31.00	03100	INTENSIVE CARE UNIT	0		0			31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	35,028	1,256,898	1,291,926	0.487406	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	20,424	810,439	830,863	0.383628	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	240,224	6,095,358	6,335,582	0.213506	0.000000	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	39,436	642,024	681,460	0.268355	0.000000	54.01
56.00	05600	RADIOISOTOPE	11,780	498,663	510,443	0.304496	0.000000	56.00
58.00	05800	MRI	15,878	1,082,405	1,098,283	0.110273	0.000000	58.00
60.00	06000	LABORATORY	633,570	6,947,310	7,580,880	0.249279	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	32,730	162,170	194,900	0.719277	0.000000	62.00
64.00	06400	INTRAVENOUS THERAPY	42,634	484,174	526,808	0.064716	0.000000	64.00
66.00	06600	PHYSICAL THERAPY	341,831	1,492,366	1,834,197	0.552618	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	307,653	553,901	861,554	0.403891	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	17,551	45,650	63,201	0.707188	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	0.000000	69.00
69.01	03160	CARDIOPULMONARY	361,880	1,435,589	1,797,469	0.420630	0.000000	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	298,968	525,128	824,096	0.598013	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	340,021	934,568	1,274,589	0.871488	0.000000	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	1,113,663	1,113,663	0.443781	0.000000	76.00
76.01	03952	TELEMEDICINE PSYCH SERVICES	0	47,227	47,227	0.702162	0.000000	76.01
76.02	03950	DIABETIC EDUCATION	0	46,703	46,703	4.461833	0.000000	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	3,383,268	3,383,268			88.00
88.01	08801	RURAL HEALTH CLINIC II	0	282,869	282,869			88.01
91.00	09100	EMERGENCY	6,966	2,945,683	2,952,649	1.108999	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	935	554,519	555,454	0.521896	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	837	2,408,923	2,409,760	0.277544	0.000000	95.00
101.00	10100	HOME HEALTH AGENCY	0	1,979,184	1,979,184			101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	4,715,336	35,728,682	40,444,018			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	4,715,336	35,728,682	40,444,018			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1313 | Period: From 10/01/2016 To 09/30/2017 | Worksheet C Part I Date/Time Prepared: 2/10/2018 11:06 am

Title XVIII | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
		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
54.01	05401	RADIOLOGY-ULTRASOUND	0.000000	54.01
56.00	05600	RADIOISOTOPE	0.000000	56.00
58.00	05800	MRI	0.000000	58.00
60.00	06000	LABORATORY	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000	62.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	64.00
66.00	06600	PHYSICAL THERAPY	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	69.00
69.01	03160	CARDIOPULMONARY	0.000000	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000	76.00
76.01	03952	TELEMEDICINE PSYCH SERVICES	0.000000	76.01
76.02	03950	DIABETIC EDUCATION	0.000000	76.02
		OUTPATIENT SERVICE COST CENTERS		
88.00	08800	RURAL HEALTH CLINIC		88.00
88.01	08801	RURAL HEALTH CLINIC II		88.01
91.00	09100	EMERGENCY	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS		
95.00	09500	AMBULANCE SERVICES	0.000000	95.00
101.00	10100	HOME HEALTH AGENCY		101.00
		SPECIAL PURPOSE COST CENTERS		
113.00	11300	INTEREST EXPENSE		113.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1313 | Period: From 10/01/2016 To 09/30/2017 | Worksheet C Part I Date/Time Prepared: 2/10/2018 11:06 am

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,601,189		2,601,189	0	2,601,189	30.00
31.00	03100	INTENSIVE CARE UNIT	0		0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	629,693		629,693	0	629,693	50.00
53.00	05300	ANESTHESIOLOGY	318,742		318,742	0	318,742	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,352,683		1,352,683	0	1,352,683	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	182,873		182,873	0	182,873	54.01
56.00	05600	RADIOISOTOPE	155,428		155,428	0	155,428	56.00
58.00	05800	MRI	121,111		121,111	0	121,111	58.00
60.00	06000	LABORATORY	1,889,751		1,889,751	0	1,889,751	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	140,187		140,187	0	140,187	62.00
64.00	06400	INTRAVENOUS THERAPY	34,093		34,093	0	34,093	64.00
66.00	06600	PHYSICAL THERAPY	1,013,611	0	1,013,611	0	1,013,611	66.00
67.00	06700	OCCUPATIONAL THERAPY	347,974	0	347,974	0	347,974	67.00
68.00	06800	SPEECH PATHOLOGY	44,695	0	44,695	0	44,695	68.00
69.00	06900	ELECTROCARDIOLOGY	0		0	0	0	69.00
69.01	03160	CARDIOPULMONARY	756,069		756,069	0	756,069	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	492,820		492,820	0	492,820	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,110,789		1,110,789	0	1,110,789	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	494,222		494,222	0	494,222	76.00
76.01	03952	TELEMEDICINE PSYCH SERVICES	33,161		33,161	0	33,161	76.01
76.02	03950	DIABETIC EDUCATION	208,381		208,381	0	208,381	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	5,007,956		5,007,956	0	5,007,956	88.00
88.01	08801	RURAL HEALTH CLINIC II	483,874		483,874	0	483,874	88.01
91.00	09100	EMERGENCY	3,274,484		3,274,484	0	3,274,484	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	289,889		289,889		289,889	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	668,815		668,815	0	668,815	95.00
101.00	10100	HOME HEALTH AGENCY	948,375		948,375		948,375	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	22,600,865	0	22,600,865	0	22,600,865	200.00
201.00		Less Observation Beds	289,889		289,889		289,889	201.00
202.00		Total (see instructions)	22,310,976	0	22,310,976	0	22,310,976	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1313 | Period: From 10/01/2016 To 09/30/2017 | Worksheet C Part I Date/Time Prepared: 2/10/2018 11:06 am

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,966,990		1,966,990			30.00
31.00	03100	INTENSIVE CARE UNIT	0		0			31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	35,028	1,256,898	1,291,926	0.487406	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	20,424	810,439	830,863	0.383628	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	240,224	6,095,358	6,335,582	0.213506	0.000000	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	39,436	642,024	681,460	0.268355	0.000000	54.01
56.00	05600	RADIOISOTOPE	11,780	498,663	510,443	0.304496	0.000000	56.00
58.00	05800	MRI	15,878	1,082,405	1,098,283	0.110273	0.000000	58.00
60.00	06000	LABORATORY	633,570	6,947,310	7,580,880	0.249279	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	32,730	162,170	194,900	0.719277	0.000000	62.00
64.00	06400	INTRAVENOUS THERAPY	42,634	484,174	526,808	0.064716	0.000000	64.00
66.00	06600	PHYSICAL THERAPY	341,831	1,492,366	1,834,197	0.552618	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	307,653	553,901	861,554	0.403891	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	17,551	45,650	63,201	0.707188	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	0.000000	69.00
69.01	03160	CARDIOPULMONARY	361,880	1,435,589	1,797,469	0.420630	0.000000	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	298,968	525,128	824,096	0.598013	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	340,021	934,568	1,274,589	0.871488	0.000000	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	1,113,663	1,113,663	0.443781	0.000000	76.00
76.01	03952	TELEMEDICINE PSYCH SERVICES	0	47,227	47,227	0.702162	0.000000	76.01
76.02	03950	DIABETIC EDUCATION	0	46,703	46,703	4.461833	0.000000	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	3,383,268	3,383,268	1.480213	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	282,869	282,869	1.710594	0.000000	88.01
91.00	09100	EMERGENCY	6,966	2,945,683	2,952,649	1.108999	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	935	554,519	555,454	0.521896	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	837	2,408,923	2,409,760	0.277544	0.000000	95.00
101.00	10100	HOME HEALTH AGENCY	0	1,979,184	1,979,184			101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	4,715,336	35,728,682	40,444,018			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	4,715,336	35,728,682	40,444,018			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1313 | Period: From 10/01/2016 To 09/30/2017 | Worksheet C Part I Date/Time Prepared: 2/10/2018 11:06 am

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
		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
54.01	05401	RADIOLOGY-ULTRASOUND	0.000000		54.01
56.00	05600	RADIOISOTOPE	0.000000		56.00
58.00	05800	MRI	0.000000		58.00
60.00	06000	LABORATORY	0.000000		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000		62.00
64.00	06400	INTRAVENOUS THERAPY	0.000000		64.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
69.01	03160	CARDIOPULMONARY	0.000000		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000		76.00
76.01	03952	TELEMEDICINE PSYCH SERVICES	0.000000		76.01
76.02	03950	DIABETIC EDUCATION	0.000000		76.02
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	0.000000		88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000		88.01
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0.000000		95.00
101.00	10100	HOME HEALTH AGENCY			101.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 14-1313 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part II Date/Time Prepared: 2/10/2018 11:06 am

Title XVIII | Hospital | Cost

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	133,582	1,291,926	0.103398	26,614	2,752	50.00
53.00	05300	ANESTHESIOLOGY	1,171	830,863	0.001409	14,618	21	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	154,783	6,335,582	0.024431	153,114	3,741	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	4,198	681,460	0.006160	23,860	147	54.01
56.00	05600	RADIOISOTOPE	6,512	510,443	0.012758	11,780	150	56.00
58.00	05800	MRI	2,335	1,098,283	0.002126	11,840	25	58.00
60.00	06000	LABORATORY	63,473	7,580,880	0.008373	331,899	2,779	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	2,533	194,900	0.012996	18,880	245	62.00
64.00	06400	INTRAVENOUS THERAPY	1,152	526,808	0.002187	13,579	30	64.00
66.00	06600	PHYSICAL THERAPY	85,235	1,834,197	0.046470	76,242	3,543	66.00
67.00	06700	OCCUPATIONAL THERAPY	5,543	861,554	0.006434	50,962	328	67.00
68.00	06800	SPEECH PATHOLOGY	1,627	63,201	0.025743	2,473	64	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0	0	69.00
69.01	03160	CARDIOPULMONARY	45,906	1,797,469	0.025539	189,953	4,851	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	9,079	824,096	0.011017	157,750	1,738	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	78,114	1,274,589	0.061286	123,432	7,565	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	10,377	1,113,663	0.009318	0	0	76.00
76.01	03952	TELEMEDICINE PSYCH SERVICES	321	47,227	0.006797	0	0	76.01
76.02	03950	DIABETIC EDUCATION	6,455	46,703	0.138214	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	98,062	3,383,268	0.028984	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	5,169	282,869	0.018273	0	0	88.01
91.00	09100	EMERGENCY	72,171	2,952,649	0.024443	995	24	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	51,097	555,454	0.091991	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	838,895	34,088,084		1,207,991	28,003	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1313 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part IV | Date/Time Prepared: 2/10/2018 11:06 am

Title XVIII | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	308,382	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	0	0	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	76.00
76.01	03952	TELEMEDICINE PSYCH SERVICES	0	0	0	0	0	76.01
76.02	03950	DIABETIC EDUCATION	0	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	308,382	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1313 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part IV Date/Time Prepared: 2/10/2018 11:06 am

Title XVIII | Hospital | Cost

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	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)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	1,291,926	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	308,382	0	830,863	0.371159	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	6,335,582	0.000000	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	0	0	0	681,460	0.000000	54.01
56.00	05600	RADIOISOTOPE	0	0	0	510,443	0.000000	56.00
58.00	05800	MRI	0	0	0	1,098,283	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	7,580,880	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	194,900	0.000000	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	526,808	0.000000	64.00
66.00	06600	PHYSICAL THERAPY	0	0	0	1,834,197	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	861,554	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	63,201	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0.000000	69.00
69.01	03160	CARDIOPULMONARY	0	0	0	1,797,469	0.000000	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	824,096	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,274,589	0.000000	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	1,113,663	0.000000	76.00
76.01	03952	TELEMEDICINE PSYCH SERVICES	0	0	0	47,227	0.000000	76.01
76.02	03950	DIABETIC EDUCATION	0	0	0	46,703	0.000000	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	3,383,268	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	282,869	0.000000	88.01
91.00	09100	EMERGENCY	0	0	0	2,952,649	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	555,454	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	308,382	0	34,088,084		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 14-1313 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part IV Date/Time Prepared: 2/10/2018 11:06 am

Title XVIII | Hospital | Cost

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	26,614	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	14,618	5,426	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	153,114	0	0	0	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	0.000000	23,860	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	11,780	0	0	0	56.00
58.00	05800	MRI	0.000000	11,840	0	0	0	58.00
60.00	06000	LABORATORY	0.000000	331,899	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000	18,880	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	13,579	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0.000000	76,242	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	50,962	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	2,473	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	0.000000	189,953	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	157,750	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	123,432	0	0	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000	0	0	0	0	76.00
76.01	03952	TELEMEDICINE PSYCH SERVICES	0.000000	0	0	0	0	76.01
76.02	03950	DIABETIC EDUCATION	0.000000	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000	0	0	0	0	88.01
91.00	09100	EMERGENCY	0.000000	995	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)		1,207,991	5,426	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-1313 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part V Date/Time Prepared: 2/10/2018 11:06 am

Title XVIII | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.487406	0	523,227	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.383628	0	343,664	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.213506	0	2,821,626	0	0	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	0.268355	0	255,457	0	0	54.01
56.00	05600	RADIOISOTOPE	0.304496	0	173,968	0	0	56.00
58.00	05800	MRI	0.110273	0	411,767	0	0	58.00
60.00	06000	LABORATORY	0.249279	0	3,439,791	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.719277	0	154,974	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0.064716	0	206,816	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0.552618	0	627,185	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.403891	0	92,654	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.707188	0	18,477	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	0.420630	0	748,352	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.598013	0	246,234	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.871488	0	472,946	0	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.443781	0	1,112,537	0	0	76.00
76.01	03952	TELEMEDICINE PSYCH SERVICES	0.702162	0	0	0	0	76.01
76.02	03950	DIABETIC EDUCATION	4.461833	0	10,358	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000				0	88.01
91.00	09100	EMERGENCY	1.108999	0	1,150,068	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.521896	0	141,640	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.277544		0			95.00
200.00		Subtotal (see instructions)		0	12,951,741	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	12,951,741	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-1313 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part V Date/Time Prepared: 2/10/2018 11:06 am

Title XVIII | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	255,024	0		50.00
53.00	05300	ANESTHESIOLOGY	131,839	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	602,434	0		54.00
54.01	05401	RADIOLOGY-ULTRASOUND	68,553	0		54.01
56.00	05600	RADIOISOTOPE	52,973	0		56.00
58.00	05800	MRI	45,407	0		58.00
60.00	06000	LABORATORY	857,468	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	111,469	0		62.00
64.00	06400	INTRAVENOUS THERAPY	13,384	0		64.00
66.00	06600	PHYSICAL THERAPY	346,594	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	37,422	0		67.00
68.00	06800	SPEECH PATHOLOGY	13,067	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
69.01	03160	CARDIOPULMONARY	314,779	0		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	147,251	0		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	412,167	0		73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	493,723	0		76.00
76.01	03952	TELEMEDICINE PSYCH SERVICES	0	0		76.01
76.02	03950	DIABETIC EDUCATION	46,216	0		76.02
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0		88.01
91.00	09100	EMERGENCY	1,275,424	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	73,921	0		92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	5,299,115	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	5,299,115	0		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1313 | Component CCN: 14-Z313 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part V Date/Time Prepared: 2/10/2018 11:06 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.487406	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.383628	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.213506	0	0	0	0	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	0.268355	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0.304496	0	0	0	0	56.00
58.00	05800	MRI	0.110273	0	0	0	0	58.00
60.00	06000	LABORATORY	0.249279	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.719277	0	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0.064716	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0.552618	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.403891	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.707188	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	0.420630	0	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.598013	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.871488	0	0	0	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.443781	0	0	0	0	76.00
76.01	03952	TELEMEDICINE PSYCH SERVICES	0.702162	0	0	0	0	76.01
76.02	03950	DIABETIC EDUCATION	4.461833	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000				0	88.01
91.00	09100	EMERGENCY	1.108999	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.521896	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.277544		0			95.00
200.00		Subtotal (see instructions)		0	0	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1313 | Component CCN: 14-Z313 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part V | Date/Time Prepared: 2/10/2018 11:06 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
54.01	05401	RADIOLOGY-ULTRASOUND	0	0		54.01
56.00	05600	RADIOISOTOPE	0	0		56.00
58.00	05800	MRI	0	0		58.00
60.00	06000	LABORATORY	0	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		62.00
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
69.01	03160	CARDIOPULMONARY	0	0		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0		76.00
76.01	03952	TELEMEDICINE PSYCH SERVICES	0	0		76.01
76.02	03950	DIABETIC EDUCATION	0	0		76.02
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0		88.01
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	0	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	0		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1313 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D-1 | Date/Time Prepared: 2/10/2018 11:06 am

Title XVIII | Hospital

	Cost Center Description	Cost	
		1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	1,442	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	793	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.	23	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	614	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	151	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)	452	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	12	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)	34	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	471	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)	136	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)	407	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)	17	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	147.52	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	155.41	20.00
21.00	Total general inpatient routine service cost (see instructions)	2,601,189	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)	1,770	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	5,284	25.00
26.00	Total swing-bed cost (see instructions)	1,127,585	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	1,473,604	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	1,100,039	28.00
29.00	Private room charges (excluding swing-bed charges)	49,187	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	1,050,852	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	1.339593	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	2,138.57	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	1,711.49	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	427.08	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	572.11	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	13,159	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	1,460,445	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,841.67	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	867,427	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	9,726	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	877,153	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1313 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D-1 | Date/Time Prepared: 2/10/2018 11:06 am

Title XVIII | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	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)	507,136	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	1,384,289	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)	250,467	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	749,560	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	1,000,027	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)	156	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,858.26	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	289,889	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1313 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D-1 | Date/Time Prepared: 2/10/2018 11:06 am

Title XVIII | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	458,498	2,601,189	0.176265	289,889	51,097	90.00
91.00	Nursing School cost	0	2,601,189	0.000000	289,889	0	91.00
92.00	Allied health cost	0	2,601,189	0.000000	289,889	0	92.00
93.00	All other Medical Education	0	2,601,189	0.000000	289,889	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 14-1313 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D-3 | Date/Time Prepared: 2/10/2018 11:06 am

Title XVIII | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		855,649		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.487406	26,614	12,972	50.00
53.00	05300	ANESTHESIOLOGY	0.383628	14,618	5,608	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.213506	153,114	32,691	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	0.268355	23,860	6,403	54.01
56.00	05600	RADIOISOTOPE	0.304496	11,780	3,587	56.00
58.00	05800	MRI	0.110273	11,840	1,306	58.00
60.00	06000	LABORATORY	0.249279	331,899	82,735	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.719277	18,880	13,580	62.00
64.00	06400	INTRAVENOUS THERAPY	0.064716	13,579	879	64.00
66.00	06600	PHYSICAL THERAPY	0.552618	76,242	42,133	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.403891	50,962	20,583	67.00
68.00	06800	SPEECH PATHOLOGY	0.707188	2,473	1,749	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	69.00
69.01	03160	CARDIOPULMONARY	0.420630	189,953	79,900	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.598013	157,750	94,337	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.871488	123,432	107,570	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.443781	0	0	76.00
76.01	03952	TELEMEDICINE PSYCH SERVICES	0.702162	0	0	76.01
76.02	03950	DIABETIC EDUCATION	4.461833	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000		0	88.01
91.00	09100	EMERGENCY	1.108999	995	1,103	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.521896	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		1,207,991	507,136	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		1,207,991		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 14-1313 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D-3

Component CCN: 14-Z313 | Date/Time Prepared: 2/10/2018 11:06 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.487406	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.383628	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.213506	26,261	5,607	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	0.268355	8,025	2,154	54.01
56.00	05600	RADIOISOTOPE	0.304496	0	0	56.00
58.00	05800	MRI	0.110273	0	0	58.00
60.00	06000	LABORATORY	0.249279	166,166	41,422	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.719277	9,233	6,641	62.00
64.00	06400	INTRAVENOUS THERAPY	0.064716	26,251	1,699	64.00
66.00	06600	PHYSICAL THERAPY	0.552618	200,437	110,765	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.403891	195,822	79,091	67.00
68.00	06800	SPEECH PATHOLOGY	0.707188	14,260	10,085	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	69.00
69.01	03160	CARDIOPULMONARY	0.420630	80,557	33,885	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.598013	77,802	46,527	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.871488	168,736	147,051	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.443781	0	0	76.00
76.01	03952	TELEMEDICINE PSYCH SERVICES	0.702162	0	0	76.01
76.02	03950	DIABETIC EDUCATION	4.461833	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000		0	88.01
91.00	09100	EMERGENCY	1.108999	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.521896	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		973,550	484,927	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)		973,550		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-1313	Period: From 10/01/2016 To 09/30/2017	Worksheet E Part B Date/Time Prepared: 2/10/2018 11:06 am
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	5,299,115	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	OPPS payments	0	3.00
4.00	Outlier payment (see instructions)	0	4.00
4.01	Outlier reconciliation amount (see instructions)	0	4.01
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 lines 3, 4, and 4.01, 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)	5,299,115	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) (see instructions)	5,352,106	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, 4.01, 8 and 9)	0	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	45,438	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	1,927,708	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)	3,378,960	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)	3,378,960	30.00
31.00	Primary payer payments	179	31.00
32.00	Subtotal (line 30 minus line 31)	3,378,781	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)	150,785	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	98,010	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	148,605	36.00
37.00	Subtotal (see instructions)	3,476,791	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
39.97	Demonstration payment adjustment amount before sequestration	0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	3,476,791	40.00
40.01	Sequestration adjustment (see instructions)	69,536	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
41.00	Interim payments	3,793,652	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	-386,397	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: 14-1313 | Period: From 10/01/2016 To 09/30/2017 | Worksheet E-1 Part I | Date/Time Prepared: 2/10/2018 11:06 am

Title XVIII | Hospital | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,418,856		3,793,652	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		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)		0		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)		1,418,856		3,793,652	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		181,557		386,397	6.02
7.00	Total Medicare program liability (see instructions)		1,237,299		3,407,255	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: 14-1313 | Component CCN: 14-Z313 | Period: From 10/01/2016 To 09/30/2017 | Worksheet E-1 Part I | Date/Time Prepared: 2/10/2018 11:06 am

Title XVIII | Swing Beds - SNF | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,626,773		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		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)		0		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)		1,626,773		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		172,278		0	6.02
7.00	Total Medicare program liability (see instructions)		1,454,495		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: 14-1313	Period: From 10/01/2016 To 09/30/2017	Worksheet E-1 Part II Date/Time Prepared: 2/10/2018 11:06 am
	Title XVIII	Hospital	Cost

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

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS	Provider CCN: 14-1313 Component CCN: 14-Z313	Period: From 10/01/2016 To 09/30/2017	Worksheet E-2 Date/Time Prepared: 2/10/2018 11:06 am
	Title XVIII	Swing Beds - SNF	Cost

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	1,010,027	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)	489,776	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	543	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)	1,499,803	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	1,499,803	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)	1,499,803	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	15,624	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)	1,484,179	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	Rural community hospital demonstration project (§410A Demonstration) payment adjustment (see instructions)	0		16.55
16.99	Demonstration payment adjustment amount before sequestration	0	0	16.99
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)	1,484,179	0	19.00
19.01	Sequestration adjustment (see instructions)	29,684	0	19.01
19.02	Demonstration payment adjustment amount after sequestration)	0	0	19.02
20.00	Interim payments	1,626,773	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)	-172,278	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
	Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment			
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
	Cost Reimbursement			
201.00	Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital))			201.00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))			202.00
203.00	Total (sum of lines 201 and 202)			203.00
204.00	Medicare swing-bed SNF discharges (see instructions)			204.00
	Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)			
205.00	Medicare swing-bed SNF target amount			205.00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)			206.00
	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement			
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)			208.00
209.00	Adjustment to Medicare swing-bed SNF PPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
	Comparision of PPS versus Cost Reimbursement			
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see instructions)			215.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-1313	Period: From 10/01/2016 To 09/30/2017	Worksheet E-3 Part V Date/Time Prepared: 2/10/2018 11:06 am
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	1,384,289	1.00
2.00	Nursing and Allied Health Managed Care payment (see instructions)	0	2.00
3.00	Organ acquisition	0	3.00
4.00	Subtotal (sum of lines 1 through 3)	1,384,289	4.00
5.00	Primary payer payments	184	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	1,397,948	6.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
7.00	Routine service charges	0	7.00
8.00	Ancillary service charges	0	8.00
9.00	Organ acquisition charges, net of revenue	0	9.00
10.00	Total reasonable charges	0	10.00
	Customary charges		
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)	0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)	0.000000	13.00
14.00	Total customary charges (see instructions)	0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)	0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)	0	16.00
17.00	Cost of physicians' services in a teaching hospital (see instructions)	0	17.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)	0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)	1,397,948	19.00
20.00	Deductibles (exclude professional component)	153,020	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	1,244,928	22.00
23.00	Coinsurance	0	23.00
24.00	Subtotal (line 22 minus line 23)	1,244,928	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	27,111	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	17,622	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	27,111	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	1,262,550	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	Demonstration payment adjustment amount before sequestration	0	29.99
30.00	Subtotal (see instructions)	1,262,550	30.00
30.01	Sequestration adjustment (see instructions)	25,251	30.01
30.02	Demonstration payment adjustment amount after sequestration	0	30.02
31.00	Interim payments	1,418,856	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, 30.02, 31, and 32)	-181,557	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: 14-1313 | Period: From 10/01/2016 To 09/30/2017 | Worksheet G | Date/Time Prepared: 2/10/2018 11:06 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	6,215,293	0	0	0	1.00
2.00	Temporary investments	550,120	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	4,656,760	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	484,188	0	0	0	7.00
8.00	Prepaid expenses	166,881	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)	12,073,242	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	0	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	10,142,658	0	0	0	15.00
16.00	Accumulated depreciation	0	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	0	0	0	0	23.00
24.00	Accumulated depreciation	0	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	10,142,658	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	1,431,226	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	3,645,982	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	5,077,208	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	27,293,108	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	917,334	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,608,878	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	694,742	0	0	0	40.00
41.00	Deferred income	940,190	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	975,767	0	0	0	43.00
44.00	Other current liabilities	327,872	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	5,464,783	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	6,092,237	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	4,842,300	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	10,934,537	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	16,399,320	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	10,893,788				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)	10,893,788	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	27,293,108	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 14-1313 | Period: From 10/01/2016 To 09/30/2017 | Worksheet G-1 | Date/Time Prepared: 2/10/2018 11:06 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		10,858,149		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		65,414				2.00
3.00	Total (sum of line 1 and line 2)		10,923,563		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)		10,923,563		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)		10,923,563		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: 14-1313 | Period: From 10/01/2016 To 09/30/2017 | Worksheet G-2 Parts I & II Date/Time Prepared: 2/10/2018 11:06 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	2,834,189		2,834,189	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	2,834,189		2,834,189	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	0		0	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	2,834,189		2,834,189	17.00
18.00	Ancillary services	2,765,870	24,881,519	27,647,389	18.00
19.00	Outpatient services	9,818	5,466,541	5,476,359	19.00
20.00	RURAL HEALTH CLINIC	0	3,383,268	3,383,268	20.00
20.01	RURAL HEALTH CLINIC II	0	282,869	282,869	20.01
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		1,979,184	1,979,184	22.00
23.00	AMBULANCE SERVICES	837	2,413,319	2,414,156	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER NRCC	0	51,867	51,867	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	5,610,714	38,458,567	44,069,281	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		25,154,246		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	EMPLOYEE PHYSICALS	6,292			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)		6,292		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		25,147,954		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 14-1313 | Period: From 10/01/2016 To 09/30/2017 | Worksheet G-3 | Date/Time Prepared: 2/10/2018 11:06 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	44,069,281	1.00
2.00	Less contractual allowances and discounts on patients' accounts	19,211,738	2.00
3.00	Net patient revenues (line 1 minus line 2)	24,857,543	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	25,147,954	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-290,411	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	111,534	6.00
7.00	Income from investments	99,298	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	847,191	23.00
24.00	OTHER REVENUE	533,439	24.00
24.01	GRANT REVENUE	31,896	24.01
24.02	ELECTRONIC HEALTH RECORDS INCENTIVE	806	24.02
24.03	OTHER (SPECIFY)	0	24.03
24.04	OTHER (SPECIFY)	0	24.04
25.00	Total other income (sum of lines 6-24)	1,624,164	25.00
26.00	Total (line 5 plus line 25)	1,333,753	26.00
27.00	BAD DEBTS	1,268,339	27.00
27.01	OTHER EXPENSES (SPECIFY)	0	27.01
27.02	OTHER EXPENSES (SPECIFY)	0	27.02
27.03	OTHER EXPENSES (SPECIFY)	0	27.03
28.00	Total other expenses (sum of line 27 and subscripts)	1,268,339	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	65,414	29.00

ANALYSIS OF HOSPITAL-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 14-1313 HHA CCN: 14-7202 | Period: From 10/01/2016 To 09/30/2017 | Worksheet H | Date/Time Prepared: 2/10/2018 11:06 am

Home Health Agency I | PPS

		Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased Services	Other Costs	Total (sum of cols. 1 thru 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures			0		0	0	1.00
2.00	Capital Related - Movable Equipment			0		0	0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0	0	0	3.00
4.00	Transportation	0	0	0	0	0	0	4.00
5.00	Administrative and General	158,372	11,311	44,086	0	32,473	246,242	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	394,149	28,150	0	0	0	422,299	6.00
7.00	Physical Therapy	0	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	0	8.00
9.00	Speech Pathology	0	0	0	0	0	0	9.00
10.00	Medical Social Services	835	60	0	0	0	895	10.00
11.00	Home Health Aide	20,539	1,467	0	0	0	22,006	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	573,895	40,988	44,086	0	32,473	691,442	24.00

		Reclassification	Reclassified Trial Balance (col. 6 + col.7)	Adjustments	Net Expenses for Allocation (col. 8 + col. 9)			
		7.00	8.00	9.00	10.00			
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0	0	0			1.00
2.00	Capital Related - Movable Equipment	0	0	0	0			2.00
3.00	Plant Operation & Maintenance	0	0	0	0			3.00
4.00	Transportation	0	0	0	0			4.00
5.00	Administrative and General	0	246,242	-2,800	243,442			5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	422,299	0	422,299			6.00
7.00	Physical Therapy	0	0	0	0			7.00
8.00	Occupational Therapy	0	0	0	0			8.00
9.00	Speech Pathology	0	0	0	0			9.00
10.00	Medical Social Services	0	895	0	895			10.00
11.00	Home Health Aide	0	22,006	0	22,006			11.00
12.00	Supplies (see instructions)	0	0	0	0			12.00
13.00	Drugs	0	0	0	0			13.00
14.00	DME	0	0	0	0			14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0			15.00
16.00	Respiratory Therapy	0	0	0	0			16.00
17.00	Private Duty Nursing	0	0	0	0			17.00
18.00	Clinic	0	0	0	0			18.00
19.00	Health Promotion Activities	0	0	0	0			19.00
20.00	Day Care Program	0	0	0	0			20.00
21.00	Home Delivered Meals Program	0	0	0	0			21.00
22.00	Homemaker Service	0	0	0	0			22.00
23.00	All Others (specify)	0	0	0	0			23.00
23.50	Telemedicine	0	0	0	0			23.50
24.00	Total (sum of lines 1-23)	0	691,442	-2,800	688,642			24.00

Column, 6 line 24 should agree with the Worksheet A, column 3, line 101, or subscript as applicable.

COST ALLOCATION - HHA GENERAL SERVICE COST | Provider CCN: 14-1313 | HHA CCN: 14-7202 | Period: From 10/01/2016 To 09/30/2017 | Worksheet H-1 Part I | Date/Time Prepared: 2/10/2018 11:06 am

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			Capital Related Costs					
		Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Bldgs & Fixtures	Movable Equipment	Plant Operation & Maintenance	Transportation	Subtotal (cols. 0-4)	
		0	1.00	2.00	3.00	4.00	4A.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0				0	1.00
2.00	Capital Related - Movable Equipment	0		0			0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0		0	3.00
4.00	Transportation	0	0	0	0	0		4.00
5.00	Administrative and General	243,442	0	0	0	0	243,442	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	422,299	0	0	0	0	422,299	6.00
7.00	Physical Therapy	0	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	0	8.00
9.00	Speech Pathology	0	0	0	0	0	0	9.00
10.00	Medical Social Services	895	0	0	0	0	895	10.00
11.00	Home Health Aide	22,006	0	0	0	0	22,006	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0		0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	688,642	0	0	0	0	688,642	24.00

		Administrative & General	Total (cols. 4A + 5)					
		5.00	6.00					
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures							1.00
2.00	Capital Related - Movable Equipment							2.00
3.00	Plant Operation & Maintenance							3.00
4.00	Transportation							4.00
5.00	Administrative and General	243,442						5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	230,920	653,219					6.00
7.00	Physical Therapy	0	0					7.00
8.00	Occupational Therapy	0	0					8.00
9.00	Speech Pathology	0	0					9.00
10.00	Medical Social Services	489	1,384					10.00
11.00	Home Health Aide	12,033	34,039					11.00
12.00	Supplies (see instructions)	0	0					12.00
13.00	Drugs	0	0					13.00
14.00	DME	0	0					14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0					15.00
16.00	Respiratory Therapy	0	0					16.00
17.00	Private Duty Nursing	0	0					17.00
18.00	Clinic	0	0					18.00
19.00	Health Promotion Activities	0	0					19.00
20.00	Day Care Program	0	0					20.00
21.00	Home Delivered Meals Program	0	0					21.00
22.00	Homemaker Service	0	0					22.00
23.00	All Others (specify)	0	0					23.00
23.50	Telemedicine	0	0					23.50
24.00	Total (sum of lines 1-23)		688,642					24.00

COST ALLOCATION - HHA STATISTICAL BASIS | Provider CCN: 14-1313 | HHA CCN: 14-7202 | Period: From 10/01/2016 To 09/30/2017 | Worksheet H-1 Part II | Date/Time Prepared: 2/10/2018 11:06 am

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		Capital Related Costs						
		Bldgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)	Plant Operation & Maintenance (SQUARE FEET)	Transportation (MILEAGE)	Reconciliation	Administrative & General (ACCUM. COST)	
		1.00	2.00	3.00	4.00	5A.00	5.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0				0		1.00
2.00	Capital Related - Movable Equipment		0			0		2.00
3.00	Plant Operation & Maintenance	0	0	0		0		3.00
4.00	Transportation (see instructions)	0	0	0	0			4.00
5.00	Administrative and General	0	0	0	0	-243,442	445,200	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	0	422,299	6.00
7.00	Physical Therapy	0	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	0	8.00
9.00	Speech Pathology	0	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	895	10.00
11.00	Home Health Aide	0	0	0	0	0	22,006	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	0	12.00
13.00	Drugs	0	0	0		0	0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	0	0	0	0	-243,442	445,200	24.00
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0	0		243,442	25.00
26.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000		0.546815	26.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 14-1313 | HHA CCN: 14-7202 | Period: From 10/01/2016 To 09/30/2017 | Worksheet H-2 Part I | Date/Time Prepared: 2/10/2018 11:06 am

Home Health Agency I | PPS

	Cost Center Description	HHA Trial Balance (1)	CAPITAL RELATED COSTS BLDG & FIXT	NEW CLINIC BUILDING	NEW NEW MED SURG	MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	
		0	1.00	1.01	1.02	2.00	4.00	
1.00	Administrative and General	0	0	5,245	0	6,703	110,905	1.00
2.00	Skilled Nursing Care	653,219	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	1,384	0	0	0	0	0	6.00
7.00	Home Health Aide	34,039	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	688,642	0	5,245	0	6,703	110,905	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

	Cost Center Description	Subtotal	ADMINISTRATIVE AND GENERAL	Subtotal	A&G HOSPITAL ONLY	MAINTENANCE & REPAIRS	OPERATION OF PLANT	
		4A	5.01	5A.01	5.02	6.00	7.00	
1.00	Administrative and General	122,853	13,842	136,695	0	15,427	0	1.00
2.00	Skilled Nursing Care	653,219	73,598	726,817	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	1,384	156	1,540	0	0	0	6.00
7.00	Home Health Aide	34,039	3,835	37,874	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	811,495	91,431	902,926	0	15,427	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.	0.000000		0.000000				21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 14-1313 | HHA CCN: 14-7202 | Period: From 10/01/2016 To 09/30/2017 | Worksheet H-2 Part I | Date/Time Prepared: 2/10/2018 11:06 am

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	Cost Center Description	OPERATION OF PLANT-CLINIC	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
		7.01	8.00	9.00	10.00	11.00	13.00	
1.00	Administrative and General	0	201	10,322	0	0	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	0	201	10,322	0	0	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

	Cost Center Description	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
		14.00	15.00	16.00	19.00	24.00	25.00	
1.00	Administrative and General	0	0	19,499	0	182,144	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	726,817	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	1,540	0	6.00
7.00	Home Health Aide	0	0	0	0	37,874	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	0	0	19,499	0	948,375	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 14-1313 | HHA CCN: 14-7202 | Period: From 10/01/2016 To 09/30/2017 | Worksheet H-2 Part I | Date/Time Prepared: 2/10/2018 11:06 am

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	Cost Center Description	Subtotal	Allocated HHA A&G (see Part II)	Total HHA Costs			
		26.00	27.00	28.00			
1.00	Administrative and General	182,144					1.00
2.00	Skilled Nursing Care	726,817	172,775	899,592			2.00
3.00	Physical Therapy	0	0	0			3.00
4.00	Occupational Therapy	0	0	0			4.00
5.00	Speech Pathology	0	0	0			5.00
6.00	Medical Social Services	1,540	366	1,906			6.00
7.00	Home Health Aide	37,874	9,003	46,877			7.00
8.00	Supplies (see instructions)	0	0	0			8.00
9.00	Drugs	0	0	0			9.00
10.00	DME	0	0	0			10.00
11.00	Home Dialysis Aide Services	0	0	0			11.00
12.00	Respiratory Therapy	0	0	0			12.00
13.00	Private Duty Nursing	0	0	0			13.00
14.00	Clinic	0	0	0			14.00
15.00	Health Promotion Activities	0	0	0			15.00
16.00	Day Care Program	0	0	0			16.00
17.00	Home Delivered Meals Program	0	0	0			17.00
18.00	Homemaker Service	0	0	0			18.00
19.00	All Others (specify)	0	0	0			19.00
19.50	Telemedicine	0	0	0			19.50
20.00	Total (sum of lines 1-19) (2)	948,375	182,144	948,375			20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.		0.237714				21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 14-1313 | HHA CCN: 14-7202 | Period: From 10/01/2016 To 09/30/2017 | Worksheet H-2 Part II | Date/Time Prepared: 2/10/2018 11:06 am

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	Cost Center Description	CAPITAL RELATED COSTS						
		BLDG & FIXT (SQUARE FEET)	NEW CLINIC BUILDING (SQUARE FEET)	NEW NEW MED SURG (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIE)	Reconciliation	
		1.00	1.01	1.02	2.00	4.00	5A.01	
1.00	Administrative and General	0	1,594	0	6,456	573,895	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	0	1,594	0	6,456	573,895		20.00
21.00	Total cost to be allocated	0	5,245	0	6,703	110,905		21.00
22.00	Unit cost multiplier	0.000000	3.290464	0.000000	1.038259	0.193250		22.00

	Cost Center Description	ADMINISTRATIVE AND GENERAL (ACCUM. COST)	Reconciliation	A&G HOSPITAL ONLY (ACCUM. COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	OPERATION OF PLANT-CLINIC (SQUARE FEET)	
		5.01	5A.02	5.02	6.00	7.00	7.01	
1.00	Administrative and General	122,853	-136,695	0	1,594	0	0	1.00
2.00	Skilled Nursing Care	653,219	-726,817	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	1,384	-1,540	0	0	0	0	6.00
7.00	Home Health Aide	34,039	-37,874	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	811,495		0	1,594	0	0	20.00
21.00	Total cost to be allocated	91,431		0	15,427	0	0	21.00
22.00	Unit cost multiplier	0.112670		0.000000	9.678168	0.000000	0.000000	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 14-1313 | HHA CCN: 14-7202 | Period: From 10/01/2016 To 09/30/2017 | Worksheet H-2 Part II | Date/Time Prepared: 2/10/2018 11:06 am

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	Cost Center Description	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	NURSING ADMINISTRATION (HOURS OF SERVICE)	CENTRAL SERVICES & SUPPLY (COSTED REQ UISI)	
		8.00	9.00	10.00	11.00	13.00	14.00	
1.00	Administrative and General	125	1,594	0	0	0	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	125	1,594	0	0	0	0	20.00
21.00	Total cost to be allocated	201	10,322	0	0	0	0	21.00
22.00	Unit cost multiplier	1.608000	6.475533	0.000000	0.000000	0.000000	0.000000	22.00

	Cost Center Description	PHARMACY (COSTED REQ UISI)	MEDICAL RECORDS & LIBRARY (GROSS REVENUE)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)				
		15.00	16.00	19.00				
1.00	Administrative and General	0	1,979,184	0				1.00
2.00	Skilled Nursing Care	0	0	0				2.00
3.00	Physical Therapy	0	0	0				3.00
4.00	Occupational Therapy	0	0	0				4.00
5.00	Speech Pathology	0	0	0				5.00
6.00	Medical Social Services	0	0	0				6.00
7.00	Home Health Aide	0	0	0				7.00
8.00	Supplies (see instructions)	0	0	0				8.00
9.00	Drugs	0	0	0				9.00
10.00	DME	0	0	0				10.00
11.00	Home Dialysis Aide Services	0	0	0				11.00
12.00	Respiratory Therapy	0	0	0				12.00
13.00	Private Duty Nursing	0	0	0				13.00
14.00	Clinic	0	0	0				14.00
15.00	Health Promotion Activities	0	0	0				15.00
16.00	Day Care Program	0	0	0				16.00
17.00	Home Delivered Meals Program	0	0	0				17.00
18.00	Homemaker Service	0	0	0				18.00
19.00	All Others (specify)	0	0	0				19.00
19.50	Telemedicine	0	0	0				19.50
20.00	Total (sum of lines 1-19)	0	1,979,184	0				20.00
21.00	Total cost to be allocated	0	19,499	0				21.00
22.00	Unit cost multiplier	0.000000	0.009852	0.000000				22.00

APPORTIONMENT OF PATIENT SERVICE COSTS | Provider CCN: 14-1313 HHA CCN: 14-7202 | Period: From 10/01/2016 To 09/30/2017 | Worksheet H-3 Part I Date/Time Prepared: 2/10/2018 11:06 am

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	Cost Center Description	From, Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Visits	Average Cost Per Visit (col. 3 ÷ col. 4)	
		0	1.00	2.00	3.00	4.00	5.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	2.00	899,592		899,592	10,435	86.21	1.00
2.00	Physical Therapy	3.00	0	262,006	262,006	4,175	62.76	2.00
3.00	Occupational Therapy	4.00	0	93,392	93,392	2,482	37.63	3.00
4.00	Speech Pathology	5.00	0	14,144	14,144	212	66.72	4.00
5.00	Medical Social Services	6.00	1,906		1,906	32	59.56	5.00
6.00	Home Health Aide	7.00	46,877		46,877	2,138	21.93	6.00
7.00	Total (sum of lines 1-6)		948,375	369,542	1,317,917	19,474		7.00

	Cost Center Description	Cost Limits	CBSA No. (1)	Program Visits: Part A	Program Visits: Part B Not Subject to Deductibles & Coinsurance	Program Visits: Part B Subject to Deductibles		
		0	1.00	2.00	3.00	4.00	5.00	
	Limitation Cost Computation							
8.00	Skilled Nursing Care		99914	0	3,230			8.00
8.01	Skilled Nursing Care		99917	0	0			8.01
9.00	Physical Therapy		99914	0	1,180			9.00
9.01	Physical Therapy		99917	0	0			9.01
10.00	Occupational Therapy		99914	0	585			10.00
10.01	Occupational Therapy		99917	0	0			10.01
11.00	Speech Pathology		99914	0	66			11.00
11.01	Speech Pathology		99917	0	0			11.01
12.00	Medical Social Services		99914	0	9			12.00
12.01	Medical Social Services		99917	0	0			12.01
13.00	Home Health Aide		99914	0	482			13.00
13.01	Home Health Aide		99917	0	0			13.01
14.00	Total (sum of lines 8-13)			0	5,552			14.00

	Cost Center Description	From Wkst. H-2 Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Charges (from HHA Records)	Ratio (col. 3 ÷ col. 4)	
		0	1.00	2.00	3.00	4.00	5.00	
	Supplies and Drugs Cost Computations							
15.00	Cost of Medical Supplies	8.00	0	10,272	10,272	17,177	0.598009	15.00
16.00	Cost of Drugs	9.00	0	278	278	319	0.871473	16.00

	Cost Center Description	Program Visits: Part A	Program Visits: Part B Not Subject to Deductibles & Coinsurance	Program Visits: Part B Subject to Deductibles & Coinsurance	Cost of Services: Part A	Cost of Services: Part B Not Subject to Deductibles & Coinsurance	Cost of Services: Part B Subject to Deductibles & Coinsurance	
		6.00	7.00	8.00	9.00	10.00	11.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	0	3,230		0	278,458		1.00
2.00	Physical Therapy	0	1,180		0	74,057		2.00
3.00	Occupational Therapy	0	585		0	22,014		3.00
4.00	Speech Pathology	0	66		0	4,404		4.00
5.00	Medical Social Services	0	9		0	536		5.00
6.00	Home Health Aide	0	482		0	10,570		6.00
7.00	Total (sum of lines 1-6)	0	5,552		0	390,039		7.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 14-1313 HHA CCN: 14-7202 | Period: From 10/01/2016 To 09/30/2017 | Worksheet H-3 Part I Date/Time Prepared: 2/10/2018 11:06 am

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	Cost Center Description							
		6.00	7.00	8.00	9.00	10.00	11.00	
	Limitation Cost Computation							
8.00	Skilled Nursing Care							8.00
8.01	Skilled Nursing Care							8.01
9.00	Physical Therapy							9.00
9.01	Physical Therapy							9.01
10.00	Occupational Therapy							10.00
10.01	Occupational Therapy							10.01
11.00	Speech Pathology							11.00
11.01	Speech Pathology							11.01
12.00	Medical Social Services							12.00
12.01	Medical Social Services							12.01
13.00	Home Health Aide							13.00
13.01	Home Health Aide							13.01
14.00	Total (sum of lines 8-13)							14.00

		Program Covered Charges			Cost of Services			
			Part B			Part B		
	Cost Center Description	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
		6.00	7.00	8.00	9.00	10.00	11.00	
	Supplies and Drugs Cost Computations							
15.00	Cost of Medical Supplies	0	0	0	0	0	0	15.00
16.00	Cost of Drugs	24	0			21	0	16.00

	Cost Center Description	Total Program Cost (sum of cols. 9-10)	
		12.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION		
	Cost Per Visit Computation		
1.00	Skilled Nursing Care	278,458	1.00
2.00	Physical Therapy	74,057	2.00
3.00	Occupational Therapy	22,014	3.00
4.00	Speech Pathology	4,404	4.00
5.00	Medical Social Services	536	5.00
6.00	Home Health Aide	10,570	6.00
7.00	Total (sum of lines 1-6)	390,039	7.00

	Cost Center Description		
		12.00	
	Limitation Cost Computation		
8.00	Skilled Nursing Care		8.00
8.01	Skilled Nursing Care		8.01
9.00	Physical Therapy		9.00
9.01	Physical Therapy		9.01
10.00	Occupational Therapy		10.00
10.01	Occupational Therapy		10.01
11.00	Speech Pathology		11.00
11.01	Speech Pathology		11.01
12.00	Medical Social Services		12.00
12.01	Medical Social Services		12.01
13.00	Home Health Aide		13.00
13.01	Home Health Aide		13.01
14.00	Total (sum of lines 8-13)		14.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 14-1313 | HHA CCN: 14-7202 | Period: From 10/01/2016 To 09/30/2017 | Worksheet H-3 Part II | Date/Time Prepared: 2/10/2018 11:06 am

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	Cost Center Description	From Wkst. C, Part I, col. 9, line	Cost to Charge Ratio	Total HHA Charge (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)	Transfer to Part I as Indicated		
		0	1.00	2.00	3.00	4.00		
	PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS							
1.00	Physical Therapy	66.00	0.552618	474,118	262,006	col. 2, line 2.00		1.00
2.00	Occupational Therapy	67.00	0.403891	231,231	93,392	col. 2, line 3.00		2.00
3.00	Speech Pathology	68.00	0.707188	20,000	14,144	col. 2, line 4.00		3.00
4.00	Cost of Medical Supplies	71.00	0.598013	17,177	10,272	col. 2, line 15.00		4.00
5.00	Cost of Drugs	73.00	0.871488	319	278	col. 2, line 16.00		5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT

Provider CCN: 14-1313 | HHA CCN: 14-7202 | Period: From 10/01/2016 To 09/30/2017 | Worksheet H-4 Part I-II | Date/Time Prepared: 2/10/2018 11:06 am

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		Part A	Part B Not Subject to Deductibles & Coinsurance	Part B Subject to Deductibles & Coinsurance	
		1.00	2.00	3.00	
	PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES				
	Reasonable Cost of Part A & Part B Services				
1.00	Reasonable cost of services (see instructions)	0	21	0	1.00
2.00	Total charges	0	24	0	2.00
	Customary Charges				
3.00	Amount actually collected from patients liable for payment for services on a charge basis (from your records)	0	0	0	3.00
4.00	Amount 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(b)	0	0	0	4.00
5.00	Ratio of line 3 to line 4 (not to exceed 1.000000)	0.000000	0.000000	0.000000	5.00
6.00	Total customary charges (see instructions)	0	24	0	6.00
7.00	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)	0	3	0	7.00
8.00	Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6)	0	0	0	8.00
9.00	Primary payer amounts	0	0	0	9.00

		Part A Services	Part B Services	
		1.00	2.00	
	PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT			
10.00	Total reasonable cost (see instructions)	0	21	10.00
11.00	Total PPS Reimbursement - Full Episodes without Outliers	0	697,333	11.00
12.00	Total PPS Reimbursement - Full Episodes with Outliers	0	12,057	12.00
13.00	Total PPS Reimbursement - LUPA Episodes	0	9,297	13.00
14.00	Total PPS Reimbursement - PEP Episodes	0	6,176	14.00
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers	0	1,802	15.00
16.00	Total PPS Outlier Reimbursement - PEP Episodes	0	0	16.00
17.00	Total Other Payments	0	0	17.00
18.00	DME Payments	0	0	18.00
19.00	Oxygen Payments	0	0	19.00
20.00	Prosthetic and Orthotic Payments	0	0	20.00
21.00	Part B deductibles billed to Medicare patients (exclude coinsurance)		0	21.00
22.00	Subtotal (sum of lines 10 thru 20 minus line 21)	0	726,686	22.00
23.00	Excess reasonable cost (from line 8)	0	0	23.00
24.00	Subtotal (line 22 minus line 23)	0	726,686	24.00
25.00	Coinsurance billed to program patients (from your records)		0	25.00
26.00	Net cost (line 24 minus line 25)	0	726,686	26.00
27.00	Reimbursable bad debts (from your records)			27.00
28.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)			28.00
29.00	Total costs - current cost reporting period (line 26 plus line 27)	0	726,686	29.00
30.00	OTHER ADJUSTMENTS (FROM PS&R)	0	0	30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	0	30.50
30.99	Demonstration payment adjustment amount before sequestration	0	0	30.99
31.00	Subtotal (see instructions)	0	726,686	31.00
31.01	Sequestration adjustment (see instructions)	0	14,533	31.01
31.02	Demonstration payment adjustment amount after sequestration	0	0	31.02
32.00	Interim payments (see instructions)	0	712,145	32.00
33.00	Tentative settlement (for contractor use only)	0	0	33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 32, and 33)	0	8	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	35.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED HHAs FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES

Provider CCN: 14-1313 | HHA CCN: 14-7202 | Period: From 10/01/2016 To 09/30/2017 | Worksheet H-5 | Date/Time Prepared: 2/10/2018 11:06 am

Home Health Agency I | PPS

		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		0		712,145	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			0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50			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)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate, line 32)		0		712,145	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		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50			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		8	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		0		712,153	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1313 | Component CCN: 14-3457 | Period: From 10/01/2016 To 09/30/2017 | Worksheet M-1 | Date/Time Prepared: 2/10/2018 11:06 am

RHC I | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	1,707,895	0	1,707,895	-116,823	1,591,072	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	450,661	0	450,661	0	450,661	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	546,999	0	546,999	0	546,999	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)	2,705,555	0	2,705,555	-116,823	2,588,732	10.00
11.00	Physician Services Under Agreement	0	20,055	20,055	0	20,055	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	7,784	7,784	0	7,784	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	27,839	27,839	0	27,839	14.00
15.00	Medical Supplies	0	69,117	69,117	0	69,117	15.00
16.00	Transportation (Health Care Staff)	0	2,279	2,279	0	2,279	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	71,486	71,486	0	71,486	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	142,882	142,882	0	142,882	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	2,705,555	170,721	2,876,276	-116,823	2,759,453	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
25.01	Telehealth	0	0	0	0	0	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	9,789	9,789	0	9,789	29.00
30.00	Administrative Costs	391,031	373,479	764,510	0	764,510	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	391,031	383,268	774,299	0	774,299	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	3,096,586	553,989	3,650,575	-116,823	3,533,752	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1313 | Component CCN: 14-3457 | Period: From 10/01/2016 To 09/30/2017 | Worksheet M-1 | Date/Time Prepared: 2/10/2018 11:06 am

RHC I | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	1,591,072		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	450,661		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	546,999		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)	0	2,588,732		10.00
11.00	Physician Services Under Agreement	0	20,055		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	7,784		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	27,839		14.00
15.00	Medical Supplies	0	69,117		15.00
16.00	Transportation (Health Care Staff)	0	2,279		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	71,486		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	142,882		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	2,759,453		22.00
	COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
25.01	Telehealth	0	0		25.01
25.02	Chronic Care Management	0	0		25.02
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs				27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	9,789		29.00
30.00	Administrative Costs	-337	764,173		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-337	773,962		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-337	3,533,415		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1313 | Component CCN: 14-3462 | Period: From 10/01/2016 To 09/30/2017 | Worksheet M-1 | Date/Time Prepared: 2/10/2018 11:06 am

RHC II | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	33,881	0	33,881	0	33,881	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	157,634	0	157,634	0	157,634	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	57,045	0	57,045	0	57,045	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)	248,560	0	248,560	0	248,560	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	7,999	7,999	0	7,999	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	7,999	7,999	0	7,999	14.00
15.00	Medical Supplies	0	1,799	1,799	0	1,799	15.00
16.00	Transportation (Health Care Staff)	0	5,893	5,893	0	5,893	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	7,692	7,692	0	7,692	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	248,560	15,691	264,251	0	264,251	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	6,060	6,060	0	6,060	29.00
30.00	Administrative Costs	53,489	48,387	101,876	0	101,876	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	53,489	54,447	107,936	0	107,936	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	302,049	70,138	372,187	0	372,187	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1313 | Component CCN: 14-3462 | Period: From 10/01/2016 To 09/30/2017 | Worksheet M-1 | Date/Time Prepared: 2/10/2018 11:06 am

RHC II | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	33,881		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	157,634		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	57,045		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)	0	248,560		10.00
11.00	Physician Services Under Agreement	0	0		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	7,999		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	7,999		14.00
15.00	Medical Supplies	0	1,799		15.00
16.00	Transportation (Health Care Staff)	0	5,893		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	7,692		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	264,251		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	6,060		29.00
30.00	Administrative Costs	0	101,876		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	107,936		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	372,187		32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1313 | Component CCN: 14-3457 | Period: From 10/01/2016 To 09/30/2017 | Worksheet M-2 | Date/Time Prepared: 2/10/2018 11:06 am

RHC I | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	1.99	8,721	4,200	8,358		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	2.23	4,661	2,100	4,683		3.00
4.00	Subtotal (sum of lines 1 through 3)	4.22	13,382		13,041	13,382	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	0.95	1,183			1,183	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	5.17	14,565			14,565	8.00
9.00	Physician Services Under Agreements		0			0	9.00
						1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)					2,759,453	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					2,759,453	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)					773,962	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					1,474,541	15.00
16.00	Total overhead (sum of lines 14 and 15)					2,248,503	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					2,248,503	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					2,248,503	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					5,007,956	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1313 | Component CCN: 14-3462 | Period: From 10/01/2016 To 09/30/2017 | Worksheet M-2 | Date/Time Prepared: 2/10/2018 11:06 am

RHC II | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	0.12	214	4,200	504		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	0.53	1,403	2,100	1,113		3.00
4.00	Subtotal (sum of lines 1 through 3)	0.65	1,617		1,617	1,617	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)	0.65	1,617			1,617	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)					264,251	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)					264,251	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)					107,936	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					111,687	15.00
16.00	Total overhead (sum of lines 14 and 15)					219,623	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					219,623	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					219,623	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					483,874	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 14-1313 Component CCN: 14-3457	Period: From 10/01/2016 To 09/30/2017	Worksheet M-3 Date/Time Prepared: 2/10/2018 11:06 am
	Title XVIII	RHC I	Cost

				1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES				
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			5,007,956	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			95,402	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			4,912,554	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			14,565	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)			14,565	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			337.28	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)	337.28	337.28		9.00
	CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	0	4,610		10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	1,554,861		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	1,554,861		16.00
16.01	Total program charges (see instructions)(from contractor's records)		865,411		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		8,970		16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		16,116		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.)		1,163,642		16.04
16.05	Total program cost (see instructions)	0	1,179,758		16.05
17.00	Primary payer amounts		0		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		84,192		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		154,450		19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		1,179,758		20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		78,833		21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		1,258,591		22.00
23.00	Allowable bad debts (see instructions)		53,762		23.00
23.01	Adjusted reimbursable bad debts (see instructions)		34,945		23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		53,762		24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0		25.50
25.99	Demonstration payment adjustment amount before sequestration		0		25.99
26.00	Net reimbursable amount (see instructions)		1,293,536		26.00
26.01	Sequestration adjustment (see instructions)		25,871		26.01
26.02	Demonstration payment adjustment amount after sequestration		0		26.02
27.00	Interim payments		1,076,754		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, 26.02, 27, and 28)		190,911		29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0		30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 14-1313 Component CCN: 14-3462	Period: From 10/01/2016 To 09/30/2017	Worksheet M-3 Date/Time Prepared: 2/10/2018 11:06 am
	Title XVIII	RHC II	Cost

				1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES				
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			483,874	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			5,897	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			477,977	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			1,617	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)			0	5.00
6.00	Total adjusted visits (line 4 plus line 5)			1,617	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			295.59	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)	295.59	295.59		9.00
	CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	0	218		10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	64,439		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	64,439		16.00
16.01	Total program charges (see instructions)(from contractor's records)		38,579		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.)		47,634		16.04
16.05	Total program cost (see instructions)	0	47,634		16.05
17.00	Primary payer amounts		0		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		4,896		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		6,737		19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		47,634		20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		5,036		21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		52,670		22.00
23.00	Allowable bad debts (see instructions)		2,624		23.00
23.01	Adjusted reimbursable bad debts (see instructions)		1,706		23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		2,624		24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0		25.50
25.99	Demonstration payment adjustment amount before sequestration		0		25.99
26.00	Net reimbursable amount (see instructions)		54,376		26.00
26.01	Sequestration adjustment (see instructions)		1,088		26.01
26.02	Demonstration payment adjustment amount after sequestration		0		26.02
27.00	Interim payments		37,853		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, 26.02, 27, and 28)		15,435		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: 14-1313 | Component CCN: 14-3457 | Period: From 10/01/2016 To 09/30/2017 | Worksheet M-4 | Date/Time Prepared: 2/10/2018 11:06 am

Title XVIII | RHC I | Cost

		Pneumococcal	Influenza	
		1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	2,588,732	2,588,732	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000925	0.001883	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	2,395	4,875	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	33,964	11,334	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	36,359	16,209	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	2,759,453	2,759,453	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	2,248,503	2,248,503	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.013176	0.005874	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	29,626	13,208	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	65,985	29,417	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	226	460	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	291.97	63.95	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	194	347	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	56,642	22,191	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)		95,402	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)		78,833	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA VACCINE COST	Provider CCN: 14-1313 Component CCN: 14-3462	Period: From 10/01/2016 To 09/30/2017	Worksheet M-4 Date/Time Prepared: 2/10/2018 11:06 am
	Title XVIII	RHC II	Cost

		Pneumococcal	Influenza	
		1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	248,560	248,560	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000566	0.000768	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	141	191	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	2,420	468	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	2,561	659	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	264,251	264,251	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	219,623	219,623	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.009692	0.002494	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	2,129	548	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	4,690	1,207	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	14	19	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	335.00	63.53	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	12	16	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	4,020	1,016	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)		5,897	15.00
16.00	Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3, line 21)		5,036	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 14-1313 Component CCN: 14-3457	Period: From 10/01/2016 To 09/30/2017	Worksheet M-5 Date/Time Prepared: 2/10/2018 11:06 am
		RHC I	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		1,076,754	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00
	Program to Provider			
3.01			0	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
	Provider to Program			
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		1,076,754	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		190,911	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		1,267,665	7.00

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

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 14-1313 Component CCN: 14-3462	Period: From 10/01/2016 To 09/30/2017	Worksheet M-5 Date/Time Prepared: 2/10/2018 11:06 am
		RHC II	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		37,853	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00
	Program to Provider			
3.01			0	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
	Provider to Program			
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		37,853	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		15,435	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		53,288	7.00

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