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: 14-1315	Period: From 10/01/2016 To 09/30/2017	Worksheet S Parts I-III Date/Time Prepared: 2/28/2018 1:29 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 2/28/2018 Time: 1:29 am
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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

PART II - CERTIFICATION

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

CERTIFICATION BY 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 BCC DBA ILLINI COMMUNITY HOSPITAL (14-1315) 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	126,233	65,361	0	0	1.00
2.00	Subprovider - IPF	0	25,816	98		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	69,081	-174		0	5.00
6.00	Swing bed - NF	0				0	6.00
10.00	RURAL HEALTH CLINIC I	0		-63,211		0	10.00
200.00	Total	0	221,130	2,074	0	0	200.00

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

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0050. The time required to complete and review the information collection is estimated 673 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving the form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.
Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents , please contact 1-800-MEDICARE.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1315 | Period: From 10/01/2016 To 09/30/2017 | Worksheet S-2 Part I Date/Time Prepared: 2/28/2018 1:27 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 640 WEST WASHINGTON	PO Box:			1.00
2.00	City: PITTSFIELD	State: IL	Zip Code: 62363	County: PIKE	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	BCC DBA ILLINI COMMUNITY HOSPITAL	141315	99914	1	09/01/2001	N	O	N	3.00
4.00	Subprovider - IPF	BCC DBS ILLINI COMM HOSP GERIPSYCH	14M315	99914	4	10/01/2015	N	P	N	4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	BCC DBA ILLINI COMM HOSP-SWINGBED	14Z315	99914		09/01/2001	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									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC	BCC DBA ILLINI COMM HOSP-RHC	143482	99914		07/03/2006	N	O	N	15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	10/01/2016	09/30/2017	20.00
21.00	Type of Control (see instructions)	2		21.00
	Inpatient PPS Information			
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	N	N	22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	N	N	22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N	22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.	N	N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	0		23.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1315 | Period: From 10/01/2016 To 09/30/2017 | Worksheet S-2 Part I Date/Time Prepared: 2/28/2018 1:27 am

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

		Urban/Rural S	Date of Geogr	
		1.00	2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	2		26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	2		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0		35.00

		Beginning:	Ending:	
		1.00	2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.			36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.	0		37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)			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.				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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1315 | Period: From 10/01/2016 To 09/30/2017 | Worksheet S-2 Part I | Date/Time Prepared: 2/28/2018 1:27 am

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1315 | Period: From 10/01/2016 To 09/30/2017 | Worksheet S-2 Part I | Date/Time Prepared: 2/28/2018 1:27 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.	Y			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)	N		0	71.00
	Inpatient Rehabilitation Facility PPS				
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	N			75.00
76.00	If line 75 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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 14-1315	Period: From 10/01/2016 To 09/30/2017	Worksheet S-2 Part I Date/Time Prepared: 2/28/2018 1:27 am

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

		V	XIX	
		1.00	2.00	
	Title V and XIX Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
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)	N		106.00
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II.	N		107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	Y		108.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1315 | Period: From 10/01/2016 To 09/30/2017 | Worksheet S-2 Part I Date/Time Prepared: 2/28/2018 1:27 am

		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:	91,717	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			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	14H132	140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1315 | Period: From 10/01/2016 To 09/30/2017 | Worksheet S-2 Part I Date/Time Prepared: 2/28/2018 1:27 am

	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: BLESSING CORPORATE SERVICES	Contractor's Name: NATIONAL GOVERNMENT SERVICES	Contractor's Number: 131	141.00
142.00	Street: BROADWAY AT 11TH STREET	PO Box:		142.00
143.00	City: QUINCY	State: IL	Zip Code: 62301	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.			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)	10/01/2015	09/30/2016	170.00

		1.00	2.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)	N	0	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 14-1315 | Period: From 10/01/2016 To 09/30/2017 | Worksheet S-2 Part II | Date/Time Prepared: 2/28/2018 1:27 am

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

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

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

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

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

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	N		N		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	12/31/2017	Y	12/31/2017	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: 14-1315 | Period: From 10/01/2016 To 09/30/2017 | Worksheet S-2 Part II Date/Time Prepared: 2/28/2018 1:27 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				N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				N	31.00
	Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				N	33.00
	Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				N	35.00
				Y/N	Date	
				1.00	2.00	
	Home Office Costs					
36.00	Were home office costs claimed on the cost report?			Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			Y		37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.			N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			N		40.00
		1.00		2.00		
	Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	CONNIE		ZIEGLER		41.00
42.00	Enter the employer/company name of the cost report preparer.	BLESSING CORPORATE SERVICES				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	217-223-8400, X4159		CZIEGLER@BLESSINGHOSPITAL.COM		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 14-1315	Period: From 10/01/2016 To 09/30/2017	Worksheet S-2 Part II Date/Time Prepared: 2/28/2018 1:27 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.	REIMBURSEMENT COORDINATOR		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: 14-1315 | Period: From 10/01/2016 To 09/30/2017 | Worksheet S-3 Part I Date/Time Prepared: 2/28/2018 1:27 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	22,056.00	0	1.00
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		25	9,125	22,056.00	0	7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)		25	9,125	22,056.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF	40.00	10	3,650		0	16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	88.00				0	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		35				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: 14-1315 | Period: From 10/01/2016 To 09/30/2017 | Worksheet S-3 Part I | Date/Time Prepared: 2/28/2018 1:27 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)	658	64	918			1.00
2.00	HMO and other (see instructions)	77	2				2.00
3.00	HMO IPF Subprovider	73	13				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	248	0	248			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	57			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	906	64	1,223			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)	906	64	1,223	0.00	150.73	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF	976	297	1,632	0.00	21.13	16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	0	0	0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	2,329	0	8,806	0.00	11.59	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	183.45	27.00
28.00	Observation Bed Days		10	101			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			1			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: 14-1315 | Period: From 10/01/2016 To 09/30/2017 | Worksheet S-3 Part I | Date/Time Prepared: 2/28/2018 1:27 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	194	24	259	1.00
2.00	HMO and other (see instructions)			21	1		2.00
3.00	HMO IPF Subprovider				2		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	194	24	259	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF	0.00	0	121	61	231	16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	0.00					26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 14-1315 | Component CCN: 14-3482 | Period: From 10/01/2016 To 09/30/2017 | Worksheet S-8 | Date/Time Prepared: 2/28/2018 1:27 am

RHC I | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			640 WEST WASHINGTON		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	PITTSFIELD		IL	62363	2.00
					1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0	3.00
			Grant Award		Date	
			1.00		2.00	
	Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)					4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)					5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)					6.00
7.00	Appalachian Regional Commission					7.00
8.00	Look-Alikes					8.00
9.00	OTHER (SPECIFY)					9.00
				1.00	2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N	0	10.00
		Sunday		Monday		Tuesday
		from	to	from	to	from
		1.00	2.00	3.00	4.00	5.00
	Facility hours of operations (1)					
11.00	Clinic			07:00	17:30	07:00	11.00
					1.00	2.00	
12.00	Have you received an approval for an exception to the productivity standard?				N		12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.				N	0	13.00
				Provider name		CCN number	
				1.00		2.00	
14.00	RHC/FQHC name, CCN number						14.00
		Y/N	V	XVIII	XIX	Total Visits	
		1.00	2.00	3.00	4.00	5.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)						15.00
			County				
			4.00				
2.00	City, State, ZIP Code, County		PIKE				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	17:30	07:00	17:30	07:00	17:30	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-1315
Component CCN: 14-3482

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

Worksheet S-8
Date/Time Prepared:
2/28/2018 1:27 am

RHC I

Cost

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	Clinic	07:00	17:30	07:00	12:00		11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 14-1315 | Period: From 10/01/2016 To 09/30/2017 | Worksheet S-10 | Date/Time Prepared: 2/28/2018 1:27 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)			0.407112	1.00
	Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid			2,786,217	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?			N	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid			2,205,245	5.00
6.00	Medicaid charges			12,992,880	6.00
7.00	Medicaid cost (line 1 times line 6)			5,289,557	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)			298,095	8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)				
9.00	Net revenue from stand-alone CHIP			0	9.00
10.00	Stand-alone CHIP charges			0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)			0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)			0	12.00
	Other state or local government indigent care program (see instructions for each line)				
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)			0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)			0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)			0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)			0	16.00
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)				
17.00	Private grants, donations, or endowment income restricted to funding charity care			0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations			0	18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)			298,095	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)	473,398	497,369	970,767	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	192,726	497,369	690,095	21.00
22.00	Payments received from patients for amounts previously written off as charity care	1,461	8,888	10,349	22.00
23.00	Cost of charity care (line 21 minus line 22)	191,265	488,481	679,746	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)			1,099,190	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)			362,860	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)			558,246	27.01
28.00	Non-Medicare bad debt expense (line 26 minus line 27.01)			540,944	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)			415,611	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)			1,095,357	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)			1,393,452	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-1315 | Period: From 10/01/2016 To 09/30/2017 | Worksheet A | Date/Time Prepared: 2/28/2018 1:27 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		631,954	631,954	124,845	756,799	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		407,298	407,298	3,248	410,546	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	4,029,238	4,029,238	0	4,029,238	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,661,103	1,703,038	3,364,141	104,403	3,468,544	5.00
6.00	00600	MAINTENANCE & REPAIRS	461,259	299,792	761,051	0	761,051	6.00
7.00	00700	OPERATION OF PLANT	0	359,549	359,549	39,131	398,680	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	51,224	51,224	0	51,224	8.00
9.00	00900	HOUSEKEEPING	300,386	122,485	422,871	0	422,871	9.00
10.00	01000	DIETARY	182,219	137,152	319,371	0	319,371	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	363,172	15,389	378,561	-119,576	258,985	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	129,398	69,806	199,204	0	199,204	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	43,219	43,219	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	781,516	182,939	964,455	-5,701	958,754	30.00
40.00	04000	SUBPROVIDER - IPF	1,047,236	29,420	1,076,656	-23,583	1,053,073	40.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	425,737	178,958	604,695	-30,712	573,983	50.00
53.00	05300	ANESTHESIOLOGY	33,487	13,958	47,445	-47,445	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	734,441	491,879	1,226,320	-1,341	1,224,979	54.00
54.01	05401	NUCLEAR MEDICINE-DIAGNOSTIC	58,023	24,982	83,005	-13,655	69,350	54.01
60.00	06000	LABORATORY	517,033	827,923	1,344,956	-37,734	1,307,222	60.00
65.00	06500	RESPIRATORY THERAPY	138,996	45,671	184,667	-13,479	171,188	65.00
65.01	06501	SLEEP STUDIES	0	40,779	40,779	0	40,779	65.01
66.00	06600	PHYSICAL THERAPY	24,294	167,814	192,108	0	192,108	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	49,186	103,791	152,977	130,296	283,273	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	401,485	2,814,272	3,215,757	-10,505	3,205,252	73.00
73.01	07301	ONCOLOGY	143,765	263,423	407,188	0	407,188	73.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	736,445	621,741	1,358,186	22,669	1,380,855	88.00
91.00	09100	EMERGENCY	834,667	2,127,588	2,962,255	-22,472	2,939,783	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		106,751	106,751	-75,193	31,558	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	9,023,848	15,868,814	24,892,662	66,415	24,959,077	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	70,676	26,195	96,871	0	96,871	192.00
192.01	19201	XPRESS CARE	342,674	52,172	394,846	0	394,846	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	RETAIL PHARMACY	0	0	0	10,320	10,320	193.01
193.02	19302	RENAL	0	0	0	0	0	193.02
193.03	19303	LEASED SPACE	0	0	0	0	0	193.03
193.04	19304	UNUSED SPACE	0	0	0	0	0	193.04
193.05	19305	WELLNESS	157,720	58,198	215,918	-76,735	139,183	193.05
200.00		TOTAL (SUM OF LINES 118 through 199)	9,594,918	16,005,379	25,600,297	0	25,600,297	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-1315 | Period: From 10/01/2016 To 09/30/2017 | Worksheet A | Date/Time Prepared: 2/28/2018 1:27 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	191,771	948,570		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	113,462	524,008		2.00
3.00	00300	OTHER CAP REL COSTS	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-550,277	3,478,961		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,812,972	5,281,516		5.00
6.00	00600	MAINTENANCE & REPAIRS	-12,593	748,458		6.00
7.00	00700	OPERATION OF PLANT	-3,651	395,029		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	5,076	56,300		8.00
9.00	00900	HOUSEKEEPING	0	422,871		9.00
10.00	01000	DIETARY	-51,858	267,513		10.00
11.00	01100	CAFETERIA	0	0		11.00
13.00	01300	NURSING ADMINISTRATION	205,737	464,722		13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	111,079	310,283		16.00
17.00	01700	SOCIAL SERVICE	0	0		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	43,219		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	34,898	993,652		30.00
40.00	04000	SUBPROVIDER - IPF	0	1,053,073		40.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-1,009	572,974		50.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-35,783	1,189,196		54.00
54.01	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0	69,350		54.01
60.00	06000	LABORATORY	-210,727	1,096,495		60.00
65.00	06500	RESPIRATORY THERAPY	0	171,188		65.00
65.01	06501	SLEEP STUDIES	-12,285	28,494		65.01
66.00	06600	PHYSICAL THERAPY	0	192,108		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	55,080	338,353		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	57,308	3,262,560		73.00
73.01	07301	ONCOLOGY	-272,250	134,938		73.01
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	-21,042	1,359,813		88.00
91.00	09100	EMERGENCY	-1,540,341	1,399,442		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	-31,558	0		113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-155,991	24,803,086		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	-324	96,547		192.00
192.01	19201	XPRESS CARE	-282	394,564		192.01
193.00	19300	NONPAID WORKERS	0	0		193.00
193.01	19301	RETAIL PHARMACY	0	10,320		193.01
193.02	19302	RENAL	0	0		193.02
193.03	19303	LEASED SPACE	0	0		193.03
193.04	19304	UNUSED SPACE	0	0		193.04
193.05	19305	WELLNESS	0	139,183		193.05
200.00		TOTAL (SUM OF LINES 118 through 199)	-156,597	25,443,700		200.00

RECLASSIFICATIONS | Provider CCN: 14-1315 | Period: From 10/01/2016 To 09/30/2017 | Worksheet A-6 | Date/Time Prepared: 2/28/2018 1:27 am

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - RECLASS PROPERTY INSURANCE				
1.00	OTHER CAP REL COSTS	3.00	0	10,000	1.00
	TOTALS		0	10,000	
	B - RECLASS UTILITIES				
1.00	OPERATION OF PLANT	7.00	0	39,131	1.00
2.00		0.00	0	0	2.00
	TOTALS		0	39,131	
	C - RECLASS MEDICAL SUPPLIES EXPENSE				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	130,296	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
	TOTALS		0	130,296	
	D - RECLASS INTEREST EXPENSE				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	75,193	1.00
	TOTALS		0	75,193	
	E - RECLASS NURSING MANAGER SALARY				
1.00	ADMINISTRATIVE & GENERAL	5.00	19,964	0	1.00
	TOTALS		19,964	0	
	F - RECLASS MISCELLANEOUS ANESTH EXPENSE				
1.00	OPERATING ROOM	50.00	0	3,199	1.00
2.00	NONPHYSICIAN ANESTHETISTS	19.00	0	9,732	2.00
	TOTALS		0	12,931	
	G - RECLASS RHC NP WAGES				
1.00	RURAL HEALTH CLINIC	88.00	23,436	0	1.00
	TOTALS		23,436	0	
	H - RECLASS CRNA COSTS				
1.00	NONPHYSICIAN ANESTHETISTS	19.00	33,487	0	1.00
	TOTALS		33,487	0	
	I - RECLASS UR COORDINATOR SALARY				
1.00	ADMINISTRATIVE & GENERAL	5.00	35,377	0	1.00
	TOTALS		35,377	0	
	J - RECLASS NURSING MANAGER SALARY				
1.00	ADMINISTRATIVE & GENERAL	5.00	64,235	0	1.00
	TOTALS		64,235	0	
	K - RECLASS BUILDING RENT				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	42,900	1.00
	TOTALS		0	42,900	
	L - RECLASS EMPLOYEE BENEFIT PERCENTAGE				
1.00	ADMINISTRATIVE & GENERAL	5.00	24,715	9,120	1.00
	TOTALS		24,715	9,120	
	M - RECLASS COST OF RETAIL PHARMACY				
1.00	RETAIL PHARMACY	193.01	0	10,320	1.00
	TOTALS		0	10,320	
500.00	Grand Total: Increases		201,214	329,891	500.00

RECLASSIFICATIONS | Provider CCN: 14-1315 | Period: From 10/01/2016 To 09/30/2017 | Worksheet A-6 | Date/Time Prepared: 2/28/2018 1:27 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - RECLASS PROPERTY INSURANCE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	10,000	0		1.00
	TOTALS		0	10,000			
	B - RECLASS UTILITIES						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	39,008	0		1.00
2.00	DRUGS CHARGED TO PATIENTS	73.00	0	123	0		2.00
	TOTALS		0	39,131			
	C - RECLASS MEDICAL SUPPLIES EXPENSE						
1.00	ADULTS & PEDIATRICS	30.00	0	5,701	0		1.00
2.00	SUBPROVIDER - IPF	40.00	0	147	0		2.00
3.00	OPERATING ROOM	50.00	0	33,911	0		3.00
4.00	ANESTHESIOLOGY	53.00	0	1,027	0		4.00
5.00	RADIOLOGY-DIAGNOSTIC	54.00	0	1,341	0		5.00
6.00	NUCLEAR MEDICINE-DIAGNOSTIC	54.01	0	13,655	0		6.00
7.00	LABORATORY	60.00	0	37,734	0		7.00
8.00	RESPIRATORY THERAPY	65.00	0	13,479	0		8.00
9.00	DRUGS CHARGED TO PATIENTS	73.00	0	62	0		9.00
10.00	EMERGENCY	91.00	0	22,472	0		10.00
11.00	RURAL HEALTH CLINIC	88.00	0	767	0		11.00
	TOTALS		0	130,296			
	D - RECLASS INTEREST EXPENSE						
1.00	INTEREST EXPENSE	113.00	0	75,193	11		1.00
	TOTALS		0	75,193			
	E - RECLASS NURSING MANAGER SALARY						
1.00	NURSING ADMINISTRATION	13.00	19,964	0	0		1.00
	TOTALS		19,964	0			
	F - RECLASS MISCELLANEOUS ANESTH EXPENSE						
1.00	ANESTHESIOLOGY	53.00	0	12,931	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		0	12,931			
	G - RECLASS RHC NP WAGES						
1.00	SUBPROVIDER - IPF	40.00	23,436	0	0		1.00
	TOTALS		23,436	0			
	H - RECLASS CRNA COSTS						
1.00	ANESTHESIOLOGY	53.00	33,487	0	0		1.00
	TOTALS		33,487	0			
	I - RECLASS UR COORDINATOR SALARY						
1.00	NURSING ADMINISTRATION	13.00	35,377	0	0		1.00
	TOTALS		35,377	0			
	J - RECLASS NURSING MANAGER SALARY						
1.00	NURSING ADMINISTRATION	13.00	64,235	0	0		1.00
	TOTALS		64,235	0			
	K - RECLASS BUILDING RENT						
1.00	WELLNESS	193.05	0	42,900	10		1.00
	TOTALS		0	42,900			
	L - RECLASS EMPLOYEE BENEFIT PERCENTAGE						
1.00	WELLNESS	193.05	24,715	9,120	0		1.00
	TOTALS		24,715	9,120			
	M - RECLASS COST OF RETAIL PHARMACY						
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	10,320	0		1.00
	TOTALS		0	10,320			
500.00	Grand Total: Decreases		201,214	329,891			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1315 | Period: From 10/01/2016 To 09/30/2017 | Worksheet A-7 Part I | Date/Time Prepared: 2/28/2018 1:27 am

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	279,691	0	0	0	0	1.00
2.00	Land Improvements	576,987	14,500	0	14,500	41,000	2.00
3.00	Buildings and Fixtures	12,805,883	0	0	0	0	3.00
4.00	Building Improvements	1,266,955	1,464,243	0	1,464,243	4,384	4.00
5.00	Fixed Equipment	46,901	15,898	0	15,898	0	5.00
6.00	Movable Equipment	7,288,924	248,438	0	248,438	67,139	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	22,265,341	1,743,079	0	1,743,079	112,523	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	22,265,341	1,743,079	0	1,743,079	112,523	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	279,691	0	1.00
2.00	Land Improvements	550,487	0	2.00
3.00	Buildings and Fixtures	12,805,883	0	3.00
4.00	Building Improvements	2,726,814	0	4.00
5.00	Fixed Equipment	62,799	0	5.00
6.00	Movable Equipment	7,470,223	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	23,895,897	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	23,895,897	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1315 | Period: From 10/01/2016 To 09/30/2017 | Worksheet A-7 Part II | Date/Time Prepared: 2/28/2018 1:27 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	631,954	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	407,298	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	1,039,252	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	631,954	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	407,298	2.00
3.00	Total (sum of lines 1-2)	0	1,039,252	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1315 | Period: From 10/01/2016 To 09/30/2017 | Worksheet A-7 Part III Date/Time Prepared: 2/28/2018 1:27 am

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	COMPUTATION OF RATIOS: Capitalized Leases	COMPUTATION OF RATIOS: Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	ALLOCATION OF OTHER CAPITAL: 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	15,532,696	0	15,532,696	0.675249	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	7,470,223	0	7,470,223	0.324751	0	2.00
3.00	Total (sum of lines 1-2)	23,002,919	0	23,002,919	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	ALLOCATION OF OTHER CAPITAL: Other Capital-Related Costs	ALLOCATION OF OTHER CAPITAL: Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	SUMMARY OF CAPITAL: 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	6,752	6,752	823,725	42,900	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	3,248	3,248	520,760	0	2.00
3.00	Total (sum of lines 1-2)	0	10,000	10,000	1,344,485	42,900	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	SUMMARY OF CAPITAL: Insurance (see instructions)	SUMMARY OF CAPITAL: Taxes (see instructions)	SUMMARY OF CAPITAL: Other Capital-Related Costs (see instructions)	SUMMARY OF CAPITAL: 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	75,193	0	0	6,752	948,570	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	3,248	524,008	2.00
3.00	Total (sum of lines 1-2)	75,193	0	0	10,000	1,472,578	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-1315 | Period: From 10/01/2016 To 09/30/2017 | Worksheet A-8 | Date/Time Prepared: 2/28/2018 1:27 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)	B	-31,558	INTEREST EXPENSE	113.00	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	-1,811,996			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	1,714,631			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	B	-40	MEDICAL RECORDS & LIBRARY	16.00	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	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	MISCELLANEOUS INCOME	B	-78,727	ADMINISTRATIVE & GENERAL	5.00	0	33.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-1315 | Period: From 10/01/2016 To 09/30/2017 | Worksheet A-8 | Date/Time Prepared: 2/28/2018 1:27 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.01	MISCELLANEOUS SUPPLIES INCOME	B	-5,122	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	33.01
33.02	PHYSICIAN RECRUITMENT	A	-1,574	ADMINISTRATIVE & GENERAL	5.00	0	33.02
33.03	CABLE TELEVISION	A	-3,651	OPERATION OF PLANT	7.00	0	33.03
33.04	MISCELLANEOUS EXPENSE	A	-5,138	ADMINISTRATIVE & GENERAL	5.00	0	33.04
33.05	PUBLIC RELATIONS SALARIES	A	-48,563	ADMINISTRATIVE & GENERAL	5.00	0	33.05
33.06	PUBLIC RELATIONS BENEFITS	A	-20,393	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.06
33.07	PUBLIC RELATIONS EXPENSES	A	-102,889	ADMINISTRATIVE & GENERAL	5.00	0	33.07
33.08	ASSET RELIFING	A	191,771	CAP REL COSTS-BLDG & FIXT	1.00	9	33.08
33.09	ASSET RELIFING	A	113,462	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.09
33.10	COFFEE SHOP RECEIPTS	B	-50,639	DIETARY	10.00	0	33.10
33.11	MEALS ON WHEELS	B	-1,924	DIETARY	10.00	0	33.11
33.12	LOBBYING EXPENSE	A	-9,003	ADMINISTRATIVE & GENERAL	5.00	0	33.12
33.13	MISCELLANEOUS	B	-32	ADMINISTRATIVE & GENERAL	5.00	0	33.13
33.14	ACCOUNTING FEES	B	-1,321	ADMINISTRATIVE & GENERAL	5.00	0	33.14
33.15	SALE OF MEDICAL RECORDS	B	-3,891	MEDICAL RECORDS & LIBRARY	16.00	0	33.15
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-156,597				50.00

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 14-1315 | Period: From 10/01/2016 To 09/30/2017 | Worksheet A-8-1 | Date/Time Prepared: 2/28/2018 1:27 am

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE	2,832,388	747,910	1.00
2.00	16.00	MEDICAL RECORDS & LIBRARY	MEDICAL RECORDS	244,926	129,916	2.00
3.00	10.00	DIETARY	DIETICIAN	5,417	4,712	3.00
4.00	8.00	LAUNDRY & LINEN SERVICE	LAUNDRY SERVICES	88,980	83,904	4.00
4.01	4.00	EMPLOYEE BENEFITS DEPARTMENT	HEALTH INSURANCE	0	529,884	4.01
4.02	88.00	RURAL HEALTH CLINIC	RHC PHYSICIAN	327,075	348,133	4.02
4.03	5.00	ADMINISTRATIVE & GENERAL	ACCOUNTS PAYABLE	6,751	10,170	4.03
4.04	54.00	RADIOLOGY-DIAGNOSTIC	ECHO SERVICES	14,944	47,386	4.04
4.05	73.00	DRUGS CHARGED TO PATIENTS	PHARMACY SERVICES	93,308	36,000	4.05
4.06	5.00	ADMINISTRATIVE & GENERAL	INFORMATICS	0	6,465	4.06
4.07	13.00	NURSING ADMINISTRATION	INFORMATICS	205,737	0	4.07
4.08	5.00	ADMINISTRATIVE & GENERAL	CARE MANAGEMENT	0	14,236	4.08
4.09	60.00	LABORATORY	LABORATORY TESTS	105,695	316,398	4.09
4.10	65.01	SLEEP STUDIES	SLEEP STUDIES	28,002	40,287	4.10
4.11	30.00	ADULTS & PEDIATRICS	BIO-MED	412	775	4.11
4.12	50.00	OPERATING ROOM	BIO-MED	226	426	4.12
4.13	91.00	EMERGENCY	BIO-MED	675	1,270	4.13
4.14	192.00	PHYSICIANS' PRIVATE OFFICES	BIO-MED	369	693	4.14
4.15	50.00	OPERATING ROOM	BIO-MED	919	1,728	4.15
4.16	192.01	XPRESS CARE	BIO-MED	319	601	4.16
4.17	88.00	RURAL HEALTH CLINIC	BIO-MED	26	50	4.17
4.18	60.00	LABORATORY	BIO-MED	26	50	4.18
4.19	54.00	RADIOLOGY-DIAGNOSTIC	BIO-MED	3,794	7,135	4.19
4.20	6.00	MAINTENANCE & REPAIRS	BIO-MED	14,309	26,902	4.20
4.21	5.00	ADMINISTRATIVE & GENERAL	BIO-MED	158	297	4.21
4.22	30.00	ADULTS & PEDIATRICS	TELEMETRY SERVICES	46,271	11,010	4.22
4.23	88.00	RURAL HEALTH CLINIC	CARE COORDINATION	51,055	51,015	4.23
4.24	71.00	MEDICAL SUPPLIES CHARGED TO	LOGISTICS MANAGER	60,202	0	4.24
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			4,131,984	2,417,353	5.00

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

				Related Organization(s) and/or Home Office		
	Symbol (1)	Name	Percentage of Ownership	Name	Percentage of Ownership	
	1.00	2.00	3.00	4.00	5.00	
	B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:					

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

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

6.00	B		0.00	BLESSING CORP S	0.00	6.00
7.00	G		0.00	BLESSING HOSP	0.00	7.00
8.00	G		0.00	DENMAN SERVICES	0.00	8.00
9.00	G		0.00	DENMAN SERVICES	0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:	BROTHER/SISTER				100.00

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 14-1315 | Period: From 10/01/2016 To 09/30/2017 | Worksheet A-8-1 | Date/Time Prepared: 2/28/2018 1:27 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	2,084,478	0		1.00
2.00	115,010	0		2.00
3.00	705	0		3.00
4.00	5,076	0		4.00
4.01	-529,884	0		4.01
4.02	-21,058	0		4.02
4.03	-3,419	0		4.03
4.04	-32,442	0		4.04
4.05	57,308	0		4.05
4.06	-6,465	0		4.06
4.07	205,737	0		4.07
4.08	-14,236	0		4.08
4.09	-210,703	0		4.09
4.10	-12,285	0		4.10
4.11	-363	0		4.11
4.12	-200	0		4.12
4.13	-595	0		4.13
4.14	-324	0		4.14
4.15	-809	0		4.15
4.16	-282	0		4.16
4.17	-24	0		4.17
4.18	-24	0		4.18
4.19	-3,341	0		4.19
4.20	-12,593	0		4.20
4.21	-139	0		4.21
4.22	35,261	0		4.22
4.23	40	0		4.23
4.24	60,202	0		4.24
5.00	1,714,631			5.00

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

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

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

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

6.00	HOME OFFICE		6.00
7.00	HOSPITAL		7.00
8.00	LAUNDRY		8.00
9.00	BIO-MED		9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 14-1315 | Period: From 10/01/2016 To 09/30/2017 | Worksheet A-8-2 | Date/Time Prepared: 2/28/2018 1:27 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	60.00	LABORATORY	12,128	0	12,128	0	0	1.00
2.00	73.01	ONCOLOGY	272,250	272,250	0	0	0	2.00
3.00	91.00	EMERGENCY	2,062,727	1,539,746	522,981	0	0	3.00
4.00	13.00	NURSING ADMINISTRATION	2,950	0	2,950	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			2,350,055	1,811,996	538,059		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	60.00	LABORATORY	0	0	0	0	0	1.00
2.00	73.01	ONCOLOGY	0	0	0	0	0	2.00
3.00	91.00	EMERGENCY	0	0	0	0	0	3.00
4.00	13.00	NURSING ADMINISTRATION	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	60.00	LABORATORY	0	0	0	0		1.00
2.00	73.01	ONCOLOGY	0	0	0	272,250		2.00
3.00	91.00	EMERGENCY	0	0	0	1,539,746		3.00
4.00	13.00	NURSING ADMINISTRATION	0	0	0	0		4.00
5.00	0.00		0	0	0	0		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	1,811,996		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 14-1315 | Period: From 10/01/2016 To 09/30/2017 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 2/28/2018 1:27 am

Physical Therapy | Cost

						1.00	
	PART I - GENERAL INFORMATION						
1.00	Total number of weeks worked (excluding aides) (see instructions)					52	1.00
2.00	Line 1 multiplied by 15 hours per week					780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					210	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					3.45	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	299.75	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	80.04	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)	40.02	40.02	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)					23,992	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)					23,992	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)					23,992	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)					80.04	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					62,431	22.00
23.00	Total salary equivalency (see instructions)					62,431	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)					8,404	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)					8,404	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)					725	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					9,129	28.00
	Optional Travel Allowance and Optional Travel Expense						
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)					0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)					0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)					0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)					9,129	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: 14-1315 | Period: From 10/01/2016 To 09/30/2017 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 2/28/2018 1:27 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)	80.04	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)	62,431		57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	9,129		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)	71,560		63.00
64.00	Total cost of outside supplier services (from your records)	28,476		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	8,404		100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	725		100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	9,129		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	725		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	725		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: 14-1315 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B Part I | Date/Time Prepared: 2/28/2018 1:27 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	948,570	948,570				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	524,008		524,008			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	3,478,961	0	0	3,478,961		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5,281,516	249,607	146,822	640,241	6,318,186	5.00
6.00	00600	MAINTENANCE & REPAIRS	748,458	165,719	97,476	168,096	1,179,749	6.00
7.00	00700	OPERATION OF PLANT	395,029	0	0	0	395,029	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	56,300	7,310	4,299	0	67,909	8.00
9.00	00900	HOUSEKEEPING	422,871	15,717	9,245	109,469	557,302	9.00
10.00	01000	DIETARY	267,513	14,971	8,806	66,406	357,696	10.00
11.00	01100	CAFETERIA	0	4,245	2,497	0	6,742	11.00
13.00	01300	NURSING ADMINISTRATION	464,722	1,426	839	88,773	555,760	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	310,283	10,284	6,049	47,156	373,772	16.00
17.00	01700	SOCIAL SERVICE	0	1,024	603	0	1,627	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	43,219	0	0	12,204	55,423	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	993,652	57,223	33,658	284,807	1,369,340	30.00
40.00	04000	SUBPROVIDER - IPF	1,053,073	45,676	26,867	373,101	1,498,717	40.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	572,974	44,070	25,922	155,150	798,116	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,189,196	27,902	16,412	267,651	1,501,161	54.00
54.01	05401	NUCLEAR MEDICINE-DIAGNOSTIC	69,350	3,606	2,121	21,145	96,222	54.01
60.00	06000	LABORATORY	1,096,495	16,348	9,616	188,421	1,310,880	60.00
65.00	06500	RESPIRATORY THERAPY	171,188	9,514	5,596	50,654	236,952	65.00
65.01	06501	SLEEP STUDIES	28,494	901	530	0	29,925	65.01
66.00	06600	PHYSICAL THERAPY	192,108	0	0	8,853	200,961	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	338,353	6,998	4,116	17,925	367,392	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,262,560	11,104	6,531	146,312	3,426,507	73.00
73.01	07301	ONCOLOGY	134,938	25,346	14,908	52,392	227,584	73.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,359,813	47,610	28,005	276,922	1,712,350	88.00
91.00	09100	EMERGENCY	1,399,442	41,301	24,293	304,176	1,769,212	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	24,803,086	807,902	475,211	3,279,854	24,414,514	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	96,547	25,485	14,990	25,756	162,778	192.00
192.01	19201	XPRESS CARE	394,564	0	9,336	124,880	528,780	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	RETAIL PHARMACY	10,320	0	0	0	10,320	193.01
193.02	19302	RENAL	0	14,152	0	0	14,152	193.02
193.03	19303	LEASED SPACE	0	55,387	0	0	55,387	193.03
193.04	19304	UNUSED SPACE	0	4,040	0	0	4,040	193.04
193.05	19305	WELLNESS	139,183	41,604	24,471	48,471	253,729	193.05
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	25,443,700	948,570	524,008	3,478,961	25,443,700	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1315 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B Part I Date/Time Prepared: 2/28/2018 1:27 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	6,318,186					5.00
6.00	00600	MAINTENANCE & REPAIRS	389,735	1,569,484				6.00
7.00	00700	OPERATION OF PLANT	130,499	0	525,528			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	22,434	21,047	7,204	118,594		8.00
9.00	00900	HOUSEKEEPING	184,107	45,256	15,490	0	802,155	9.00
10.00	01000	DIETARY	118,166	43,108	14,755	0	23,004	10.00
11.00	01100	CAFETERIA	2,227	12,222	4,183	0	6,522	11.00
13.00	01300	NURSING ADMINISTRATION	183,598	4,106	1,405	0	2,191	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	123,477	29,612	10,135	0	15,802	16.00
17.00	01700	SOCIAL SERVICE	537	2,949	1,009	0	1,574	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	18,309	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	452,367	164,767	56,396	50,790	87,926	30.00
40.00	04000	SUBPROVIDER - IPF	495,107	131,520	45,015	67,804	70,184	40.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	263,661	126,895	43,433	0	67,716	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	495,915	80,342	27,499	0	42,873	54.00
54.01	05401	NUCLEAR MEDICINE-DIAGNOSTIC	31,787	10,382	3,553	0	5,540	54.01
60.00	06000	LABORATORY	433,054	47,072	16,112	0	25,120	60.00
65.00	06500	RESPIRATORY THERAPY	78,278	27,394	9,376	0	14,619	65.00
65.01	06501	SLEEP STUDIES	9,886	2,595	888	0	1,385	65.01
66.00	06600	PHYSICAL THERAPY	66,388	0	0	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	121,369	20,150	6,897	0	10,753	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,131,959	31,972	10,943	0	17,061	73.00
73.01	07301	ONCOLOGY	75,183	72,980	24,979	0	38,945	73.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	565,682	137,088	46,921	0	73,156	88.00
91.00	09100	EMERGENCY	584,466	118,920	40,703	0	63,460	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	5,978,191	1,130,377	386,896	118,594	567,831	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	53,774	73,381	25,116	0	39,159	192.00
192.01	19201	XPRESS CARE	174,685	45,704	0	0	24,389	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	RETAIL PHARMACY	3,409	0	0	0	0	193.01
193.02	19302	RENAL	4,675	40,749	13,947	0	21,745	193.02
193.03	19303	LEASED SPACE	18,297	159,480	54,586	0	85,105	193.03
193.04	19304	UNUSED SPACE	1,335	0	3,981	0	0	193.04
193.05	19305	WELLNESS	83,820	119,793	41,002	0	63,926	193.05
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)	6,318,186	1,569,484	525,528	118,594	802,155	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1315 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B Part I Date/Time Prepared: 2/28/2018 1:27 am

		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
			10.00	11.00	13.00	16.00	17.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	556,729					10.00
11.00	01100	CAFETERIA	0	31,896				11.00
13.00	01300	NURSING ADMINISTRATION	0	1,220	748,280			13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	648	0	553,446		16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	7,696	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	168	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	238,431	3,913	182,184	23,890	3,296	30.00
40.00	04000	SUBPROVIDER - IPF	318,298	5,126	133,426	34,207	4,400	40.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	2,132	89,650	21,620	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	1,401	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	3,677	150	165,996	0	54.00
54.01	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0	291	6,061	7,479	0	54.01
60.00	06000	LABORATORY	0	2,589	0	86,174	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	696	20,815	20,553	0	65.00
65.01	06501	SLEEP STUDIES	0	0	0	4,324	0	65.01
66.00	06600	PHYSICAL THERAPY	0	122	0	4,380	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	246	0	13,776	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,010	0	95,139	0	73.00
73.01	07301	ONCOLOGY	0	720	23,740	6,046	0	73.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	3,805	70,515	0	0	88.00
91.00	09100	EMERGENCY	0	4,179	204,713	68,461	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	556,729	31,542	731,254	553,446	7,696	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	354	14,724	0	0	192.00
192.01	19201	XPRESS CARE	0	0	2,302	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	RETAIL PHARMACY	0	0	0	0	0	193.01
193.02	19302	RENAL	0	0	0	0	0	193.02
193.03	19303	LEASED SPACE	0	0	0	0	0	193.03
193.04	19304	UNUSED SPACE	0	0	0	0	0	193.04
193.05	19305	WELLNESS	0	0	0	0	0	193.05
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)	556,729	31,896	748,280	553,446	7,696	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1315 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B Part I | Date/Time Prepared: 2/28/2018 1:27 am

		Cost Center Description	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			19.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE						17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	73,900					19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	2,633,300	0	2,633,300		30.00
40.00	04000	SUBPROVIDER - IPF	0	2,803,804	0	2,803,804		40.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	1,413,223	0	1,413,223		50.00
53.00	05300	ANESTHESIOLOGY	73,900	75,301	0	75,301		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,317,613	0	2,317,613		54.00
54.01	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0	161,315	0	161,315		54.01
60.00	06000	LABORATORY	0	1,921,001	0	1,921,001		60.00
65.00	06500	RESPIRATORY THERAPY	0	408,683	0	408,683		65.00
65.01	06501	SLEEP STUDIES	0	49,003	0	49,003		65.01
66.00	06600	PHYSICAL THERAPY	0	271,851	0	271,851		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	540,583	0	540,583		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	4,715,591	0	4,715,591		73.00
73.01	07301	ONCOLOGY	0	470,177	0	470,177		73.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	2,609,517	0	2,609,517		88.00
91.00	09100	EMERGENCY	0	2,854,114	0	2,854,114		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0			92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	73,900	23,245,076	0	23,245,076		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	369,286	0	369,286		192.00
192.01	19201	XPRESS CARE	0	775,860	0	775,860		192.01
193.00	19300	NONPAID WORKERS	0	0	0	0		193.00
193.01	19301	RETAIL PHARMACY	0	13,729	0	13,729		193.01
193.02	19302	RENAL	0	95,268	0	95,268		193.02
193.03	19303	LEASED SPACE	0	372,855	0	372,855		193.03
193.04	19304	UNUSED SPACE	0	9,356	0	9,356		193.04
193.05	19305	WELLNESS	0	562,270	0	562,270		193.05
200.00		Cross Foot Adjustments	0	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	73,900	25,443,700	0	25,443,700		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1315 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B Part II Date/Time Prepared: 2/28/2018 1:27 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	249,607	146,822	396,429	0	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	165,719	97,476	263,195	0	6.00
7.00	00700	OPERATION OF PLANT	0	0	0	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	7,310	4,299	11,609	0	8.00
9.00	00900	HOUSEKEEPING	0	15,717	9,245	24,962	0	9.00
10.00	01000	DIETARY	0	14,971	8,806	23,777	0	10.00
11.00	01100	CAFETERIA	0	4,245	2,497	6,742	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	1,426	839	2,265	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	10,284	6,049	16,333	0	16.00
17.00	01700	SOCIAL SERVICE	0	1,024	603	1,627	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	57,223	33,658	90,881	0	30.00
40.00	04000	SUBPROVIDER - IPF	0	45,676	26,867	72,543	0	40.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	44,070	25,922	69,992	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	27,902	16,412	44,314	0	54.00
54.01	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0	3,606	2,121	5,727	0	54.01
60.00	06000	LABORATORY	0	16,348	9,616	25,964	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	9,514	5,596	15,110	0	65.00
65.01	06501	SLEEP STUDIES	0	901	530	1,431	0	65.01
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	6,998	4,116	11,114	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	11,104	6,531	17,635	0	73.00
73.01	07301	ONCOLOGY	0	25,346	14,908	40,254	0	73.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	47,610	28,005	75,615	0	88.00
91.00	09100	EMERGENCY	0	41,301	24,293	65,594	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	807,902	475,211	1,283,113	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	25,485	14,990	40,475	0	192.00
192.01	19201	XPRESS CARE	21,180	0	9,336	30,516	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	RETAIL PHARMACY	0	0	0	0	0	193.01
193.02	19302	RENAL	0	14,152	0	14,152	0	193.02
193.03	19303	LEASED SPACE	0	55,387	0	55,387	0	193.03
193.04	19304	UNUSED SPACE	0	4,040	0	4,040	0	193.04
193.05	19305	WELLNESS	0	41,604	24,471	66,075	0	193.05
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	21,180	948,570	524,008	1,493,758	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1315 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B Part II | Date/Time Prepared: 2/28/2018 1:27 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	396,429					5.00
6.00	00600	MAINTENANCE & REPAIRS	24,454	287,649				6.00
7.00	00700	OPERATION OF PLANT	8,188	0	8,188			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,408	3,857	112	16,986		8.00
9.00	00900	HOUSEKEEPING	11,552	8,294	241	0	45,049	9.00
10.00	01000	DIETARY	7,414	7,901	230	0	1,292	10.00
11.00	01100	CAFETERIA	140	2,240	65	0	366	11.00
13.00	01300	NURSING ADMINISTRATION	11,520	752	22	0	123	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	7,748	5,427	158	0	887	16.00
17.00	01700	SOCIAL SERVICE	34	541	16	0	88	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	1,149	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	28,384	30,198	882	7,275	4,939	30.00
40.00	04000	SUBPROVIDER - IPF	31,065	24,104	701	9,711	3,942	40.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	16,543	23,257	677	0	3,803	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	31,116	14,725	428	0	2,408	54.00
54.01	05401	NUCLEAR MEDICINE-DIAGNOSTIC	1,994	1,903	55	0	311	54.01
60.00	06000	LABORATORY	27,172	8,627	251	0	1,411	60.00
65.00	06500	RESPIRATORY THERAPY	4,912	5,021	146	0	821	65.00
65.01	06501	SLEEP STUDIES	620	476	14	0	78	65.01
66.00	06600	PHYSICAL THERAPY	4,166	0	0	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	7,615	3,693	107	0	604	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	71,019	5,860	170	0	958	73.00
73.01	07301	ONCOLOGY	4,717	13,376	389	0	2,187	73.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	35,494	25,125	731	0	4,108	88.00
91.00	09100	EMERGENCY	36,672	21,795	634	0	3,564	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	375,096	207,172	6,029	16,986	31,890	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	3,374	13,449	391	0	2,199	192.00
192.01	19201	XPRESS CARE	10,961	8,376	0	0	1,370	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	RETAIL PHARMACY	214	0	0	0	0	193.01
193.02	19302	RENAL	293	7,468	217	0	1,221	193.02
193.03	19303	LEASED SPACE	1,148	29,229	850	0	4,779	193.03
193.04	19304	UNUSED SPACE	84	0	62	0	0	193.04
193.05	19305	WELLNESS	5,259	21,955	639	0	3,590	193.05
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)	396,429	287,649	8,188	16,986	45,049	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1315 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B Part II Date/Time Prepared: 2/28/2018 1:27 am

		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
			10.00	11.00	13.00	16.00	17.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	40,614					10.00
11.00	01100	CAFETERIA	0	9,553				11.00
13.00	01300	NURSING ADMINISTRATION	0	365	15,047			13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	194	0	30,747		16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	2,306	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	50	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	17,394	1,172	3,663	1,327	988	30.00
40.00	04000	SUBPROVIDER - IPF	23,220	1,534	2,683	1,900	1,318	40.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	639	1,803	1,201	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	78	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,102	3	9,225	0	54.00
54.01	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0	87	122	415	0	54.01
60.00	06000	LABORATORY	0	776	0	4,787	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	208	419	1,142	0	65.00
65.01	06501	SLEEP STUDIES	0	0	0	240	0	65.01
66.00	06600	PHYSICAL THERAPY	0	36	0	243	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	74	0	765	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	602	0	5,285	0	73.00
73.01	07301	ONCOLOGY	0	216	477	336	0	73.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	1,140	1,418	0	0	88.00
91.00	09100	EMERGENCY	0	1,252	4,117	3,803	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	40,614	9,447	14,705	30,747	2,306	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	106	296	0	0	192.00
192.01	19201	XPRESS CARE	0	0	46	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	RETAIL PHARMACY	0	0	0	0	0	193.01
193.02	19302	RENAL	0	0	0	0	0	193.02
193.03	19303	LEASED SPACE	0	0	0	0	0	193.03
193.04	19304	UNUSED SPACE	0	0	0	0	0	193.04
193.05	19305	WELLNESS	0	0	0	0	0	193.05
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)	40,614	9,553	15,047	30,747	2,306	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1315 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B Part II | Date/Time Prepared: 2/28/2018 1:27 am

		Cost Center Description	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			19.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE						17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	1,199					19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS		187,103	0	187,103		30.00
40.00	04000	SUBPROVIDER - IPF		172,721	0	172,721		40.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM		117,915	0	117,915		50.00
53.00	05300	ANESTHESIOLOGY		78	0	78		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		103,321	0	103,321		54.00
54.01	05401	NUCLEAR MEDICINE-DIAGNOSTIC		10,614	0	10,614		54.01
60.00	06000	LABORATORY		68,988	0	68,988		60.00
65.00	06500	RESPIRATORY THERAPY		27,779	0	27,779		65.00
65.01	06501	SLEEP STUDIES		2,859	0	2,859		65.01
66.00	06600	PHYSICAL THERAPY		4,445	0	4,445		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS		23,972	0	23,972		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS		101,529	0	101,529		73.00
73.01	07301	ONCOLOGY		61,952	0	61,952		73.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC		143,631	0	143,631		88.00
91.00	09100	EMERGENCY		137,431	0	137,431		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0			92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	1,164,338	0	1,164,338		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN		0	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES		60,290	0	60,290		192.00
192.01	19201	XPRESS CARE		51,269	0	51,269		192.01
193.00	19300	NONPAID WORKERS		0	0	0		193.00
193.01	19301	RETAIL PHARMACY		214	0	214		193.01
193.02	19302	RENAL		23,351	0	23,351		193.02
193.03	19303	LEASED SPACE		91,393	0	91,393		193.03
193.04	19304	UNUSED SPACE		4,186	0	4,186		193.04
193.05	19305	WELLNESS		97,518	0	97,518		193.05
200.00		Cross Foot Adjustments	1,199	1,199	0	1,199		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	1,199	1,493,758	0	1,493,758		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1315 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B-1 | Date/Time Prepared: 2/28/2018 1:27 am

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	115,756					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		108,714				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	9,546,355			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	30,460	30,460	1,756,831	-6,318,186	19,125,514	5.00
6.00	00600	MAINTENANCE & REPAIRS	20,223	20,223	461,259	0	1,179,749	6.00
7.00	00700	OPERATION OF PLANT	0	0	0	0	395,029	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	892	892	0	0	67,909	8.00
9.00	00900	HOUSEKEEPING	1,918	1,918	300,386	0	557,302	9.00
10.00	01000	DIETARY	1,827	1,827	182,219	0	357,696	10.00
11.00	01100	CAFETERIA	518	518	0	0	6,742	11.00
13.00	01300	NURSING ADMINISTRATION	174	174	243,596	0	555,760	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,255	1,255	129,398	0	373,772	16.00
17.00	01700	SOCIAL SERVICE	125	125	0	0	1,627	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	33,487	0	55,423	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,983	6,983	781,517	0	1,369,340	30.00
40.00	04000	SUBPROVIDER - IPF	5,574	5,574	1,023,800	0	1,498,717	40.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,378	5,378	425,737	0	798,116	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,405	3,405	734,441	0	1,501,161	54.00
54.01	05401	NUCLEAR MEDICINE-DIAGNOSTIC	440	440	58,023	0	96,222	54.01
60.00	06000	LABORATORY	1,995	1,995	517,033	0	1,310,880	60.00
65.00	06500	RESPIRATORY THERAPY	1,161	1,161	138,996	0	236,952	65.00
65.01	06501	SLEEP STUDIES	110	110	0	0	29,925	65.01
66.00	06600	PHYSICAL THERAPY	0	0	24,294	0	200,961	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	854	854	49,186	0	367,392	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,355	1,355	401,485	0	3,426,507	73.00
73.01	07301	ONCOLOGY	3,093	3,093	143,765	0	227,584	73.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	5,810	5,810	759,880	0	1,712,350	88.00
91.00	09100	EMERGENCY	5,040	5,040	834,667	0	1,769,212	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	98,590	98,590	9,000,000	-6,318,186	18,096,328	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	3,110	3,110	70,676	0	162,778	192.00
192.01	19201	XPRESS CARE	0	1,937	342,674	0	528,780	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	RETAIL PHARMACY	0	0	0	0	10,320	193.01
193.02	19302	RENAL	1,727	0	0	0	14,152	193.02
193.03	19303	LEASED SPACE	6,759	0	0	0	55,387	193.03
193.04	19304	UNUSED SPACE	493	0	0	0	4,040	193.04
193.05	19305	WELLNESS	5,077	5,077	133,005	0	253,729	193.05
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)	948,570	524,008	3,478,961		6,318,186	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	8.194564	4.820060	0.364428		0.330354	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			0		396,429	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000000		0.020728	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1315 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B-1 | Date/Time Prepared: 2/28/2018 1:27 am

		Cost Center Description	MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (PATIENT DAYS)	
			6.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS	66,517					6.00
7.00	00700	OPERATION OF PLANT	0	65,073				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	892	892	2,858			8.00
9.00	00900	HOUSEKEEPING	1,918	1,918	0	63,707		9.00
10.00	01000	DIETARY	1,827	1,827	0	1,827	2,858	10.00
11.00	01100	CAFETERIA	518	518	0	518	0	11.00
13.00	01300	NURSING ADMINISTRATION	174	174	0	174	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,255	1,255	0	1,255	0	16.00
17.00	01700	SOCIAL SERVICE	125	125	0	125	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,983	6,983	1,224	6,983	1,224	30.00
40.00	04000	SUBPROVIDER - IPF	5,574	5,574	1,634	5,574	1,634	40.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,378	5,378	0	5,378	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,405	3,405	0	3,405	0	54.00
54.01	05401	NUCLEAR MEDICINE-DIAGNOSTIC	440	440	0	440	0	54.01
60.00	06000	LABORATORY	1,995	1,995	0	1,995	0	60.00
65.00	06500	RESPIRATORY THERAPY	1,161	1,161	0	1,161	0	65.00
65.01	06501	SLEEP STUDIES	110	110	0	110	0	65.01
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	854	854	0	854	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,355	1,355	0	1,355	0	73.00
73.01	07301	ONCOLOGY	3,093	3,093	0	3,093	0	73.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	5,810	5,810	0	5,810	0	88.00
91.00	09100	EMERGENCY	5,040	5,040	0	5,040	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	47,907	47,907	2,858	45,097	2,858	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	3,110	3,110	0	3,110	0	192.00
192.01	19201	XPRESS CARE	1,937	0	0	1,937	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	RETAIL PHARMACY	0	0	0	0	0	193.01
193.02	19302	RENAL	1,727	1,727	0	1,727	0	193.02
193.03	19303	LEASED SPACE	6,759	6,759	0	6,759	0	193.03
193.04	19304	UNUSED SPACE	0	493	0	0	0	193.04
193.05	19305	WELLNESS	5,077	5,077	0	5,077	0	193.05
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,569,484	525,528	118,594	802,155	556,729	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	23.595231	8.075976	41.495451	12.591316	194.796711	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	287,649	8,188	16,986	45,049	40,614	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	4.324443	0.125828	5.943317	0.707128	14.210637	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1315 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B-1 | Date/Time Prepared: 2/28/2018 1:27 am

		Cost Center Description	CAFETERIA (GROSS SALARIES)	NURSING ADMINISTRATION (NURSING SALARIES)	MEDICAL RECORDS & LIBRARY (TOTAL CHARGES)	SOCIAL SERVICE (PATIENT DAYS)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	
			11.00	13.00	16.00	17.00	19.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	6,369,981					11.00
13.00	01300	NURSING ADMINISTRATION	243,596	2,496,553				13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	129,398	0	54,801,740			16.00
17.00	01700	SOCIAL SERVICE	0	0	0	2,858		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	33,487	0	0	0	100	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	781,517	607,838	2,365,581	1,224	0	30.00
40.00	04000	SUBPROVIDER - IPF	1,023,800	445,162	3,387,120	1,634	0	40.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	425,737	299,108	2,140,852	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	138,739	0	100	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	734,441	501	16,436,545	0	0	54.00
54.01	05401	NUCLEAR MEDICINE-DIAGNOSTIC	58,023	20,223	740,543	0	0	54.01
60.00	06000	LABORATORY	517,033	0	8,532,954	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	138,996	69,447	2,035,178	0	0	65.00
65.01	06501	SLEEP STUDIES	0	0	428,128	0	0	65.01
66.00	06600	PHYSICAL THERAPY	24,294	0	433,698	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	49,186	0	1,364,083	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	401,485	0	9,420,649	0	0	73.00
73.01	07301	ONCOLOGY	143,765	79,207	598,663	0	0	73.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	759,880	235,266	0	0	0	88.00
91.00	09100	EMERGENCY	834,667	682,995	6,779,007	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	6,299,305	2,439,747	54,801,740	2,858	100	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	70,676	49,125	0	0	0	192.00
192.01	19201	XPRESS CARE	0	7,681	0	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	RETAIL PHARMACY	0	0	0	0	0	193.01
193.02	19302	RENAL	0	0	0	0	0	193.02
193.03	19303	LEASED SPACE	0	0	0	0	0	193.03
193.04	19304	UNUSED SPACE	0	0	0	0	0	193.04
193.05	19305	WELLNESS	0	0	0	0	0	193.05
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)	31,896	748,280	553,446	7,696	73,900	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.005007	0.299725	0.010099	2.692792	739.000000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	9,553	15,047	30,747	2,306	1,199	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.001500	0.006027	0.000561	0.806858	11.990000	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1315 | Period: From 10/01/2016 To 09/30/2017 | Worksheet C Part I Date/Time Prepared: 2/28/2018 1:27 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	2,633,300		2,633,300	0	2,633,300	30.00
40.00	04000	SUBPROVIDER - IPF	2,803,804		2,803,804	0	2,803,804	40.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,413,223		1,413,223	0	1,413,223	50.00
53.00	05300	ANESTHESIOLOGY	75,301		75,301	0	75,301	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,317,613		2,317,613	0	2,317,613	54.00
54.01	05401	NUCLEAR MEDICINE-DIAGNOSTIC	161,315		161,315	0	161,315	54.01
60.00	06000	LABORATORY	1,921,001		1,921,001	0	1,921,001	60.00
65.00	06500	RESPIRATORY THERAPY	408,683	0	408,683	0	408,683	65.00
65.01	06501	SLEEP STUDIES	49,003	0	49,003	0	49,003	65.01
66.00	06600	PHYSICAL THERAPY	271,851	0	271,851	0	271,851	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	540,583		540,583	0	540,583	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,715,591		4,715,591	0	4,715,591	73.00
73.01	07301	ONCOLOGY	470,177		470,177	0	470,177	73.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	2,609,517		2,609,517	0	2,609,517	88.00
91.00	09100	EMERGENCY	2,854,114		2,854,114	0	2,854,114	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	209,245		209,245		209,245	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	23,454,321	0	23,454,321	0	23,454,321	200.00
201.00		Less Observation Beds	209,245		209,245		209,245	201.00
202.00		Total (see instructions)	23,245,076	0	23,245,076	0	23,245,076	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1315 | Period: From 10/01/2016 To 09/30/2017 | Worksheet C Part I Date/Time Prepared: 2/28/2018 1:27 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	2,000,859		2,000,859			30.00
40.00	04000	SUBPROVIDER - IPF	3,387,120		3,387,120			40.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	9,151	2,131,701	2,140,852	0.660122	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	138,739	138,739	0.542753	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	562,320	15,874,225	16,436,545	0.141004	0.000000	54.00
54.01	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0	740,543	740,543	0.217833	0.000000	54.01
60.00	06000	LABORATORY	731,813	7,801,141	8,532,954	0.225127	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	591,241	1,443,937	2,035,178	0.200809	0.000000	65.00
65.01	06501	SLEEP STUDIES	0	428,128	428,128	0.114459	0.000000	65.01
66.00	06600	PHYSICAL THERAPY	387,511	46,187	433,698	0.626821	0.000000	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	159,579	1,204,504	1,364,083	0.396298	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	758,081	8,662,568	9,420,649	0.500559	0.000000	73.00
73.01	07301	ONCOLOGY	0	598,663	598,663	0.785378	0.000000	73.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	2,295,774	2,295,774			88.00
91.00	09100	EMERGENCY	22,621	6,756,386	6,779,007	0.421022	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	364,722	364,722	0.573711	0.000000	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	8,610,296	48,487,218	57,097,514			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	8,610,296	48,487,218	57,097,514			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1315 | Period: From 10/01/2016 To 09/30/2017 | Worksheet C Part I Date/Time Prepared: 2/28/2018 1:27 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
40.00	04000	SUBPROVIDER - IPF			40.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.660122		50.00
53.00	05300	ANESTHESIOLOGY	0.542753		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.141004		54.00
54.01	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0.217833		54.01
60.00	06000	LABORATORY	0.225127		60.00
65.00	06500	RESPIRATORY THERAPY	0.200809		65.00
65.01	06501	SLEEP STUDIES	0.114459		65.01
66.00	06600	PHYSICAL THERAPY	0.626821		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.396298		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.500559		73.00
73.01	07301	ONCOLOGY	0.785378		73.01
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC			88.00
91.00	09100	EMERGENCY	0.421022		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.573711		92.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 14-1315 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part II Date/Time Prepared: 2/28/2018 1:27 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	117,915	2,140,852	0.055079	9,008	496	50.00
53.00	05300	ANESTHESIOLOGY	78	138,739	0.000562	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	103,321	16,436,545	0.006286	286,127	1,799	54.00
54.01	05401	NUCLEAR MEDICINE-DIAGNOSTIC	10,614	740,543	0.014333	0	0	54.01
60.00	06000	LABORATORY	68,988	8,532,954	0.008085	332,843	2,691	60.00
65.00	06500	RESPIRATORY THERAPY	27,779	2,035,178	0.013649	363,789	4,965	65.00
65.01	06501	SLEEP STUDIES	2,859	428,128	0.006678	0	0	65.01
66.00	06600	PHYSICAL THERAPY	4,445	433,698	0.010249	118,354	1,213	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	23,972	1,364,083	0.017574	103,330	1,816	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	101,529	9,420,649	0.010777	278,772	3,004	73.00
73.01	07301	ONCOLOGY	61,952	598,663	0.103484	0	0	73.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	143,631	2,295,774	0.062563	0	0	88.00
91.00	09100	EMERGENCY	137,431	6,779,007	0.020273	1,502	30	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	14,867	364,722	0.040763	0	0	92.00
200.00		Total (lines 50 through 199)	819,381	51,709,535		1,493,725	16,014	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1315 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part IV | Date/Time Prepared: 2/28/2018 1:27 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	73,900	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0	0	0	0	0	54.01
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
65.01	06501	SLEEP STUDIES	0	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
73.01	07301	ONCOLOGY	0	0	0	0	0	73.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00		Total (lines 50 through 199)	73,900	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1315 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part IV | Date/Time Prepared: 2/28/2018 1:27 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	2,140,852	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	73,900	0	138,739	0.532655	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	16,436,545	0.000000	54.00
54.01	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0	0	0	740,543	0.000000	54.01
60.00	06000	LABORATORY	0	0	0	8,532,954	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	2,035,178	0.000000	65.00
65.01	06501	SLEEP STUDIES	0	0	0	428,128	0.000000	65.01
66.00	06600	PHYSICAL THERAPY	0	0	0	433,698	0.000000	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	1,364,083	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	9,420,649	0.000000	73.00
73.01	07301	ONCOLOGY	0	0	0	598,663	0.000000	73.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	2,295,774	0.000000	88.00
91.00	09100	EMERGENCY	0	0	0	6,779,007	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	364,722	0.000000	92.00
200.00		Total (lines 50 through 199)	0	73,900	0	51,709,535		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1315 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part IV | Date/Time Prepared: 2/28/2018 1:27 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	9,008	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	286,127	0	0	0	54.00
54.01	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0.000000	0	0	0	0	54.01
60.00	06000	LABORATORY	0.000000	332,843	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	363,789	0	0	0	65.00
65.01	06501	SLEEP STUDIES	0.000000	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0.000000	118,354	0	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	103,330	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	278,772	0	0	0	73.00
73.01	07301	ONCOLOGY	0.000000	0	0	0	0	73.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
91.00	09100	EMERGENCY	0.000000	1,502	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		1,493,725	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-1315 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part V Date/Time Prepared: 2/28/2018 1:27 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	0.660122	0	1,108,427	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.542753	0	19,594	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.141004	0	6,016,243	0	0	54.00
54.01	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0.217833	0	451,938	0	0	54.01
60.00	06000	LABORATORY	0.225127	0	2,707,575	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.200809	0	675,817	0	0	65.00
65.01	06501	SLEEP STUDIES	0.114459	0	165,714	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0.626821	0	20,017	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.396298	0	591,956	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.500559	0	5,502,626	2,732	0	73.00
73.01	07301	ONCOLOGY	0.785378	0	343,782	0	0	73.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
91.00	09100	EMERGENCY	0.421022	0	2,577,791	1,587	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.573711	0	222,182	0	0	92.00
200.00		Subtotal (see instructions)		0	20,403,662	4,319	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	20,403,662	4,319	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-1315 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part V Date/Time Prepared: 2/28/2018 1:27 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	731,697	0		50.00
53.00	05300	ANESTHESIOLOGY	10,635	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	848,314	0		54.00
54.01	05401	NUCLEAR MEDICINE-DIAGNOSTIC	98,447	0		54.01
60.00	06000	LABORATORY	609,548	0		60.00
65.00	06500	RESPIRATORY THERAPY	135,710	0		65.00
65.01	06501	SLEEP STUDIES	18,967	0		65.01
66.00	06600	PHYSICAL THERAPY	12,547	0		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	234,591	0		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,754,389	1,368		73.00
73.01	07301	ONCOLOGY	269,999	0		73.01
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
91.00	09100	EMERGENCY	1,085,307	668		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	127,468	0		92.00
200.00		Subtotal (see instructions)	6,937,619	2,036		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	6,937,619	2,036		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-1315 | Component CCN: 14-M315 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part II | Date/Time Prepared: 2/28/2018 1:27 am

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	117,915	2,140,852	0.055079	0	0	50.00
53.00	05300	ANESTHESIOLOGY	78	138,739	0.000562	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	103,321	16,436,545	0.006286	79,350	499	54.00
54.01	05401	NUCLEAR MEDICINE-DIAGNOSTIC	10,614	740,543	0.014333	0	0	54.01
60.00	06000	LABORATORY	68,988	8,532,954	0.008085	110,526	894	60.00
65.00	06500	RESPIRATORY THERAPY	27,779	2,035,178	0.013649	17,901	244	65.00
65.01	06501	SLEEP STUDIES	2,859	428,128	0.006678	0	0	65.01
66.00	06600	PHYSICAL THERAPY	4,445	433,698	0.010249	8,760	90	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	23,972	1,364,083	0.017574	2,601	46	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	101,529	9,420,649	0.010777	185,495	1,999	73.00
73.01	07301	ONCOLOGY	61,952	598,663	0.103484	0	0	73.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	143,631	2,295,774	0.062563	0	0	88.00
91.00	09100	EMERGENCY	137,431	6,779,007	0.020273	1,290	26	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	364,722	0.000000	0	0	92.00
200.00		Total (lines 50 through 199)	804,514	51,709,535		405,923	3,798	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1315 | Component CCN: 14-M315 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part IV | Date/Time Prepared: 2/28/2018 1:27 am

Title XVIII | Subprovider - IPF | PPS

		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	73,900	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0	0	0	0	0	54.01
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
65.01	06501	SLEEP STUDIES	0	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
73.01	07301	ONCOLOGY	0	0	0	0	0	73.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00		Total (lines 50 through 199)	73,900	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1315 | Component CCN: 14-M315 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part IV | Date/Time Prepared: 2/28/2018 1:27 am

Title XVIII | Subprovider - IPF | PPS

		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	2,140,852	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	73,900	0	138,739	0.532655	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	16,436,545	0.000000	54.00
54.01	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0	0	0	740,543	0.000000	54.01
60.00	06000	LABORATORY	0	0	0	8,532,954	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	2,035,178	0.000000	65.00
65.01	06501	SLEEP STUDIES	0	0	0	428,128	0.000000	65.01
66.00	06600	PHYSICAL THERAPY	0	0	0	433,698	0.000000	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	1,364,083	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	9,420,649	0.000000	73.00
73.01	07301	ONCOLOGY	0	0	0	598,663	0.000000	73.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	2,295,774	0.000000	88.00
91.00	09100	EMERGENCY	0	0	0	6,779,007	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	364,722	0.000000	92.00
200.00		Total (lines 50 through 199)	0	73,900	0	51,709,535		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1315 | Component CCN: 14-M315 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part IV | Date/Time Prepared: 2/28/2018 1:27 am

Title XVIII | Subprovider - IPF | PPS

		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	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	79,350	0	0	0	54.00
54.01	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0.000000	0	0	0	0	54.01
60.00	06000	LABORATORY	0.000000	110,526	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	17,901	0	0	0	65.00
65.01	06501	SLEEP STUDIES	0.000000	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0.000000	8,760	0	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	2,601	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	185,495	0	0	0	73.00
73.01	07301	ONCOLOGY	0.000000	0	0	0	0	73.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
91.00	09100	EMERGENCY	0.000000	1,290	0	724	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		405,923	0	724	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1315 | Component CCN: 14-M315 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part V | Date/Time Prepared: 2/28/2018 1:27 am

Title XVIII | Subprovider - IPF | PPS

		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	0.660122	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.542753	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.141004	0	0	0	0	54.00
54.01	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0.217833	0	0	0	0	54.01
60.00	06000	LABORATORY	0.225127	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.200809	0	0	0	0	65.00
65.01	06501	SLEEP STUDIES	0.114459	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0.626821	0	0	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.396298	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.500559	0	0	754	0	73.00
73.01	07301	ONCOLOGY	0.785378	0	0	0	0	73.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
91.00	09100	EMERGENCY	0.421022	724	0	0	305	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.573711	0	0	0	0	92.00
200.00		Subtotal (see instructions)		724	0	754	305	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		724	0	754	305	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1315 | Component CCN: 14-M315 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part V | Date/Time Prepared: 2/28/2018 1:27 am

Title XVIII | Subprovider - IPF | PPS

		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	NUCLEAR MEDICINE-DIAGNOSTIC	0	0		54.01
60.00	06000	LABORATORY	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
65.01	06501	SLEEP STUDIES	0	0		65.01
66.00	06600	PHYSICAL THERAPY	0	0		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	377		73.00
73.01	07301	ONCOLOGY	0	0		73.01
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
200.00		Subtotal (see instructions)	0	377		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	377		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1315 | Component CCN: 14-Z315 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part V Date/Time Prepared: 2/28/2018 1:27 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	0.660122	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.542753	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.141004	0	0	0	0	54.00
54.01	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0.217833	0	0	0	0	54.01
60.00	06000	LABORATORY	0.225127	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.200809	0	0	0	0	65.00
65.01	06501	SLEEP STUDIES	0.114459	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0.626821	0	0	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.396298	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.500559	0	0	298	0	73.00
73.01	07301	ONCOLOGY	0.785378	0	0	0	0	73.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
91.00	09100	EMERGENCY	0.421022	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.573711	0	0	0	0	92.00
200.00		Subtotal (see instructions)		0	0	298	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	298	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1315 | Component CCN: 14-Z315 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part V | Date/Time Prepared: 2/28/2018 1:27 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	NUCLEAR MEDICINE-DIAGNOSTIC	0	0		54.01
60.00	06000	LABORATORY	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
65.01	06501	SLEEP STUDIES	0	0		65.01
66.00	06600	PHYSICAL THERAPY	0	0		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	149		73.00
73.01	07301	ONCOLOGY	0	0		73.01
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
200.00		Subtotal (see instructions)	0	149		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	149		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1315 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D-1 | Date/Time Prepared: 2/28/2018 1:27 am

Title XVIII | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	1,324	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,019	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	918	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	62	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)	186	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	14	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)	43	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	658	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)	62	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)	186	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	143.81	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	149.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	2,633,300	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)	2,013	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)	6,407	25.00
26.00	Total swing-bed cost (see instructions)	522,209	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	2,111,091	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	2,111,091	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	2,071.73	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,363,198	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	1,363,198	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1315 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D-1 | Date/Time Prepared: 2/28/2018 1:27 am

Title XVIII | Hospital | Cost

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	449,585	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	1,812,783	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)	128,447	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	385,342	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	513,789	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)	101	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	2,071.73	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	209,245	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1315 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D-1 | Date/Time Prepared: 2/28/2018 1:27 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	187,103	2,633,300	0.071053	209,245	14,867	90.00
91.00	Nursing School cost	0	2,633,300	0.000000	209,245	0	91.00
92.00	Allied health cost	0	2,633,300	0.000000	209,245	0	92.00
93.00	All other Medical Education	0	2,633,300	0.000000	209,245	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 14-1315 Component CCN: 14-M315	Period: From 10/01/2016 To 09/30/2017	Worksheet D-1 Date/Time Prepared: 2/28/2018 1:27 am
	Title XVIII	Subprovider - IPF	PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	1,632	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,632	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	1,632	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	976	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	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	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	2,803,804	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	2,803,804	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	2,803,804	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)	1,718.02	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,676,788	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	1,676,788	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1315 | Component CCN: 14-M315 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D-1 | Date/Time Prepared: 2/28/2018 1:27 am

Title XVIII | Subprovider - IPF | PPS

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	139,582	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	1,816,370	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)	3,798	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	3,798	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	1,812,572	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1315 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D-1

Component CCN: 14-M315 | Date/Time Prepared: 2/28/2018 1:27 am

Title XVIII | Subprovider - IPF | PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	0	2,803,804	0.000000	0	0	90.00
91.00	Nursing School cost	0	2,803,804	0.000000	0	0	91.00
92.00	Allied health cost	0	2,803,804	0.000000	0	0	92.00
93.00	All other Medical Education	0	2,803,804	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 14-1315 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D-3 | Date/Time Prepared: 2/28/2018 1:27 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		1,293,441		30.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.660122	9,008	5,946	50.00
53.00	05300	ANESTHESIOLOGY	0.542753	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.141004	286,127	40,345	54.00
54.01	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0.217833	0	0	54.01
60.00	06000	LABORATORY	0.225127	332,843	74,932	60.00
65.00	06500	RESPIRATORY THERAPY	0.200809	363,789	73,052	65.00
65.01	06501	SLEEP STUDIES	0.114459	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0.626821	118,354	74,187	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.396298	103,330	40,949	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.500559	278,772	139,542	73.00
73.01	07301	ONCOLOGY	0.785378	0	0	73.01
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
91.00	09100	EMERGENCY	0.421022	1,502	632	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.573711	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		1,493,725	449,585	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)		1,493,725		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 14-1315 | Component CCN: 14-M315 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D-3 | Date/Time Prepared: 2/28/2018 1:27 am

Title XVIII | Subprovider - IPF | PPS

		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
40.00	04000	SUBPROVIDER - IPF		2,018,544		40.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.660122	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.542753	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.141004	79,350	11,189	54.00
54.01	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0.217833	0	0	54.01
60.00	06000	LABORATORY	0.225127	110,526	24,882	60.00
65.00	06500	RESPIRATORY THERAPY	0.200809	17,901	3,595	65.00
65.01	06501	SLEEP STUDIES	0.114459	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0.626821	8,760	5,491	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.396298	2,601	1,031	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.500559	185,495	92,851	73.00
73.01	07301	ONCOLOGY	0.785378	0	0	73.01
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
91.00	09100	EMERGENCY	0.421022	1,290	543	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.573711	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		405,923	139,582	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)		405,923		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 14-1315 | Component CCN: 14-Z315 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D-3 | Date/Time Prepared: 2/28/2018 1:27 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
40.00	04000	SUBPROVIDER - IPF		0		40.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.660122	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.542753	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.141004	11,733	1,654	54.00
54.01	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0.217833	0	0	54.01
60.00	06000	LABORATORY	0.225127	67,621	15,223	60.00
65.00	06500	RESPIRATORY THERAPY	0.200809	90,700	18,213	65.00
65.01	06501	SLEEP STUDIES	0.114459	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0.626821	154,744	96,997	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.396298	18,789	7,446	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.500559	68,355	34,216	73.00
73.01	07301	ONCOLOGY	0.785378	0	0	73.01
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
91.00	09100	EMERGENCY	0.421022	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.573711	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		411,942	173,749	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)		411,942		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-1315	Period: From 10/01/2016 To 09/30/2017	Worksheet E Part B Date/Time Prepared: 2/28/2018 1:27 am
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	6,939,655	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)	6,939,655	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)	7,009,052	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)	33,655	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	3,458,001	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)	3,517,396	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)	3,517,396	30.00
31.00	Primary payer payments	345	31.00
32.00	Subtotal (line 30 minus line 31)	3,517,051	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)	472,552	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	307,159	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	231,343	36.00
37.00	Subtotal (see instructions)	3,824,210	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)	3,824,210	40.00
40.01	Sequestration adjustment (see instructions)	76,484	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
41.00	Interim payments	3,682,365	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	65,361	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

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-1315 Component CCN: 14-M315	Period: From 10/01/2016 To 09/30/2017	Worksheet E Part B Date/Time Prepared: 2/28/2018 1:27 am
	Title XVIII	Subprovider - IPF	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	377	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	305	2.00
3.00	OPPS payments	267	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)	377	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	754	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)	754	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)	754	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	377	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)	377	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)	267	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	0	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)	644	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)	644	30.00
31.00	Primary payer payments	0	31.00
32.00	Subtotal (line 30 minus line 31)	644	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)	0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	36.00
37.00	Subtotal (see instructions)	644	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)	644	40.00
40.01	Sequestration adjustment (see instructions)	13	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
41.00	Interim payments	533	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	98	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: 14-1315 | Period: From 10/01/2016 To 09/30/2017 | Worksheet E-1 Part I | Date/Time Prepared: 2/28/2018 1:27 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		1,504,972		3,699,406	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	09/28/2017	41,765		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	09/28/2017	17,041	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)		41,765		-17,041	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)		1,546,737		3,682,365	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		126,233		65,361	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,672,970		3,747,726	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: 14-1315 | Component CCN: 14-M315 | Period: From 10/01/2016 To 09/30/2017 | Worksheet E-1 Part I | Date/Time Prepared: 2/28/2018 1:27 am

Title XVIII | Subprovider - IPF | 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		938,152		533	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)		938,152		533	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		25,816		98	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		963,968		631	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: 14-1315 | Component CCN: 14-Z315 | Period: From 10/01/2016 To 09/30/2017 | Worksheet E-1 Part I | Date/Time Prepared: 2/28/2018 1:27 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		606,350		292	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)		606,350		292	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		69,081		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		174	6.02
7.00	Total Medicare program liability (see instructions)		675,431		118	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: 14-1315	Period: From 10/01/2016 To 09/30/2017	Worksheet E-1 Part II Date/Time Prepared: 2/28/2018 1:27 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: 14-1315 | Component CCN: 14-Z315 | Period: From 10/01/2016 To 09/30/2017 | Worksheet E-2 | Date/Time Prepared: 2/28/2018 1:27 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)	518,927	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)	175,486	150	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	248	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)	694,413	150	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	694,413	150	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)	694,413	150	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	5,198	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		120	14.00
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)	689,215	120	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)	689,215	120	19.00
19.01	Sequestration adjustment (see instructions)	13,784	2	19.01
19.02	Demonstration payment adjustment amount after sequestration)	0	0	19.02
20.00	Interim payments	606,350	292	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)	69,081	-174	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: 14-1315	Period: From 10/01/2016 To 09/30/2017	Worksheet E-3 Part V Date/Time Prepared: 2/28/2018 1:27 am
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	1,812,783	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)	1,812,783	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	1,830,911	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)	1,830,911	19.00
20.00	Deductibles (exclude professional component)	150,528	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	1,680,383	22.00
23.00	Coinsurance	2,632	23.00
24.00	Subtotal (line 22 minus line 23)	1,677,751	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	45,171	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	29,361	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	26,086	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	1,707,112	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)	1,707,112	30.00
30.01	Sequestration adjustment (see instructions)	34,142	30.01
30.02	Demonstration payment adjustment amount after sequestration	0	30.02
31.00	Interim payments	1,546,737	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)	126,233	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-1315 Component CCN: 14-M315	Period: From 10/01/2016 To 09/30/2017	Worksheet E-3 Part II Date/Time Prepared: 2/28/2018 1:27 am
	Title XVIII	Subprovider - IPF	PPS

		1.00	
	PART II - MEDICARE PART A SERVICES - IPF PPS		
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)	922,811	1.00
2.00	Net IPF PPS Outlier Payments	149,094	2.00
3.00	Net IPF PPS ECT Payments	0	3.00
4.00	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004. (see instructions)	0.00	4.00
4.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)	0.00	4.01
5.00	New Teaching program adjustment. (see instructions)	0.00	5.00
6.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instuctions)	0.00	6.00
7.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instuctions)	0.00	7.00
8.00	Intern and resident count for IPF PPS medical education adjustment (see instructions)	0.00	8.00
9.00	Average Daily Census (see instructions)	4.471233	9.00
10.00	Teaching Adjustment Factor {((1 + (line 8/line 9)) raised to the power of .5150 -1}.	0.000000	10.00
11.00	Teaching Adjustment (line 1 multiplied by line 10).	0	11.00
12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)	1,071,905	12.00
13.00	Nursing and Allied Health Managed Care payment (see instruction)	0	13.00
14.00	Organ acquisition (DO NOT USE THIS LINE)		14.00
15.00	Cost of physicians' services in a teaching hospital (see instructions)	0	15.00
16.00	Subtotal (see instructions)	1,071,905	16.00
17.00	Primary payer payments	0	17.00
18.00	Subtotal (line 16 less line 17).	1,071,905	18.00
19.00	Deductibles	100,828	19.00
20.00	Subtotal (line 18 minus line 19)	971,077	20.00
21.00	Coinsurance	13,776	21.00
22.00	Subtotal (line 20 minus line 21)	957,301	22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	40,523	23.00
24.00	Adjusted reimbursable bad debts (see instructions)	26,340	24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	40,523	25.00
26.00	Subtotal (sum of lines 22 and 24)	983,641	26.00
27.00	Direct graduate medical education payments (from Wkst. E-4, line 49)	0	27.00
28.00	Other pass through costs (see instructions)	0	28.00
29.00	Outlier payments reconciliation	0	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	30.50
30.99	Demonstration payment adjustment amount before sequestration	0	30.99
31.00	Total amount payable to the provider (see instructions)	983,641	31.00
31.01	Sequestration adjustment (see instructions)	19,673	31.01
31.02	Demonstration payment adjustment amount after sequestration	0	31.02
32.00	Interim payments	938,152	32.00
33.00	Tentative settlement (for contractor use only)	0	33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 31.02, 32 and 33)	25,816	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	35.00
	TO BE COMPLETED BY CONTRACTOR		
50.00	Original outlier amount from Worksheet E-3, Part II, line 2	149,094	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)	0	51.00
52.00	The rate used to calculate the Time Value of Money	0.00	52.00
53.00	Time Value of Money (see instructions)	0	53.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 14-1315 | Period: From 10/01/2016 To 09/30/2017 | Worksheet G | Date/Time Prepared: 2/28/2018 1:27 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	4,679,054	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	16,924,951	0	0	0	4.00
5.00	Other receivable	-638,741	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-11,629,916	0	0	0	6.00
7.00	Inventory	608,538	0	0	0	7.00
8.00	Prepaid expenses	176,482	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)	10,120,368	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	279,691	0	0	0	12.00
13.00	Land improvements	550,487	0	0	0	13.00
14.00	Accumulated depreciation	-351,867	0	0	0	14.00
15.00	Buildings	15,595,496	0	0	0	15.00
16.00	Accumulated depreciation	-5,505,242	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	7,470,223	0	0	0	23.00
24.00	Accumulated depreciation	-5,178,914	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	12,859,874	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	0	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	123,636	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	123,636	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	23,103,878	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	750,009	0	0	0	37.00
38.00	Salaries, wages, and fees payable	803,289	0	0	0	38.00
39.00	Payroll taxes payable	130,867	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	268,168	0	0	0	43.00
44.00	Other current liabilities	1,868,737	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	3,821,070	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	4,211,993	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	88,732	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	4,300,725	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	8,121,795	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	14,982,083				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)	14,982,083	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	23,103,878	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 14-1315 | Period: From 10/01/2016 To 09/30/2017 | Worksheet G-1 | Date/Time Prepared: 2/28/2018 1:27 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		13,739,898		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		1,242,185				2.00
3.00	Total (sum of line 1 and line 2)		14,982,083		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)		14,982,083		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)		14,982,083		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: 14-1315 | Period: From 10/01/2016 To 09/30/2017 | Worksheet G-2 Parts I & II Date/Time Prepared: 2/28/2018 1:27 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	1,728,778		1,728,778	1.00
2.00	SUBPROVIDER - IPF	3,564,911		3,564,911	2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	225,311		225,311	5.00
6.00	Swing bed - NF	51,785		51,785	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)	5,570,785		5,570,785	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	5,570,785		5,570,785	17.00
18.00	Ancillary services	3,390,146	50,616,228	54,006,374	18.00
19.00	Outpatient services	0	0	0	19.00
20.00	RURAL HEALTH CLINIC	0	2,295,774	2,295,774	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PHYSICIAN'S PRIVATE OFFICE	0	287,562	287,562	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	8,960,931	53,199,564	62,160,495	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		25,600,297		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		25,600,297		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 14-1315 | Period: From 10/01/2016 To 09/30/2017 | Worksheet G-3 | Date/Time Prepared: 2/28/2018 1:27 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	62,160,495	1.00
2.00	Less contractual allowances and discounts on patients' accounts	36,162,753	2.00
3.00	Net patient revenues (line 1 minus line 2)	25,997,742	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	25,600,297	4.00
5.00	Net income from service to patients (line 3 minus line 4)	397,445	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	8,118	6.00
7.00	Income from investments	6,697	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	52,563	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	127,607	22.00
23.00	Governmental appropriations	0	23.00
24.00	MISCELLANEOUS INCOME	649,755	24.00
25.00	Total other income (sum of lines 6-24)	844,740	25.00
26.00	Total (line 5 plus line 25)	1,242,185	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	1,242,185	29.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1315 | Component CCN: 14-3482 | Period: From 10/01/2016 To 09/30/2017 | Worksheet M-1 | Date/Time Prepared: 2/28/2018 1:27 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	0	0	0	0	0	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	351,119	0	351,119	23,436	374,555	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	325,470	0	325,470	0	325,470	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)	676,589	0	676,589	23,436	700,025	10.00
11.00	Physician Services Under Agreement	0	348,133	348,133	0	348,133	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	188,673	188,673	0	188,673	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	536,806	536,806	0	536,806	14.00
15.00	Medical Supplies	0	767	767	-767	0	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	46,701	46,701	0	46,701	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	47,468	47,468	-767	46,701	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	676,589	584,274	1,260,863	22,669	1,283,532	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	1,143	1,143	0	1,143	29.00
30.00	Administrative Costs	59,856	36,324	96,180	0	96,180	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	59,856	37,467	97,323	0	97,323	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	736,445	621,741	1,358,186	22,669	1,380,855	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1315 | Component CCN: 14-3482 | Period: From 10/01/2016 To 09/30/2017 | Worksheet M-1 | Date/Time Prepared: 2/28/2018 1:27 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	0		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	374,555		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	325,470		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	700,025		10.00
11.00	Physician Services Under Agreement	-21,058	327,075		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	40	188,713		13.00
14.00	Subtotal (sum of lines 11 through 13)	-21,018	515,788		14.00
15.00	Medical Supplies	0	0		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	46,701		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	46,701		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-21,018	1,262,514		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	-24	1,119		29.00
30.00	Administrative Costs	0	96,180		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-24	97,299		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-21,042	1,359,813		32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1315 | Component CCN: 14-3482 | Period: From 10/01/2016 To 09/30/2017 | Worksheet M-2 | Date/Time Prepared: 2/28/2018 1:27 am

RHC I | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	0.82	1,742	4,200	3,444		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	3.38	6,427	2,100	7,098		3.00
4.00	Subtotal (sum of lines 1 through 3)	4.20	8,169		10,542	10,542	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	637			637	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)	4.20	8,806			11,179	8.00
9.00	Physician Services Under Agreements		0			0	9.00
						1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)					1,262,514	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					1,262,514	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)					97,299	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					1,249,704	15.00
16.00	Total overhead (sum of lines 14 and 15)					1,347,003	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					1,347,003	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					1,347,003	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					2,609,517	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 14-1315 Component CCN: 14-3482	Period: From 10/01/2016 To 09/30/2017	Worksheet M-3 Date/Time Prepared: 2/28/2018 1:27 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)		2,609,517	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)		69,173	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		2,540,344	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		11,179	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)		11,179	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		227.24	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)	227.24	227.24	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	519	1,771	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	117,938	402,442	11.00
12.00	Program covered visits for mental health services (from contractor records)	12	27	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	2,727	6,135	13.00
14.00	Limit adjustment for mental health services (see instructions)	2,727	6,135	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	529,242	16.00
16.01	Total program charges (see instructions)(from contractor's records)		518,446	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		1,866	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		1,905	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.)		388,456	16.04
16.05	Total program cost (see instructions)	0	390,361	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		41,767	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		94,963	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		390,361	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		42,145	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		432,506	22.00
23.00	Allowable bad debts (see instructions)		0	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		0	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	25.50
25.99	Demonstration payment adjustment amount before sequestration		0	25.99
26.00	Net reimbursable amount (see instructions)		432,506	26.00
26.01	Sequestration adjustment (see instructions)		8,650	26.01
26.02	Demonstration payment adjustment amount after sequestration		0	26.02
27.00	Interim payments		487,067	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)		-63,211	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: 14-1315 Component CCN: 14-3482	Period: From 10/01/2016 To 09/30/2017	Worksheet M-4 Date/Time Prepared: 2/28/2018 1:27 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)	700,025	700,025	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.001168	0.002793	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	818	1,955	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	24,941	5,753	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	25,759	7,708	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	1,262,514	1,262,514	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	1,347,003	1,347,003	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.020403	0.006105	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	27,483	8,223	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	53,242	15,931	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	169	404	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	315.04	39.43	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	111	182	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	34,969	7,176	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)		69,173	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)		42,145	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 14-1315 Component CCN: 14-3482	Period: From 10/01/2016 To 09/30/2017	Worksheet M-5 Date/Time Prepared: 2/28/2018 1:27 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		433,241	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		05/11/2017	40,889	3.01
3.02		09/28/2017	12,937	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)		53,826	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		487,067	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		0	6.01
6.02	SETTLEMENT TO PROGRAM		63,211	6.02
7.00	Total Medicare program liability (see instructions)		423,856	7.00

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