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: 14-1323	Period: From 04/01/2016 To 03/31/2017	Worksheet S Parts I-III Date/Time Prepared: 8/31/2017 1:25 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 8/31/2017 Time: 1:25 pm
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

5. [1] Cost Report Status
   (1) As Submitted
   (2) Settled without Audit
   (3) Settled with Audit
   (4) Reopened
   (5) Amended
6. Date Received:
7. Contractor No. 15101
8. [N] Initial Report for this Provider CCN
9. [N] Final Report for this Provider CCN
10. NPR Date:
11. Contractor's Vendor Code: 4
12. [0] If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by MASSAC MEMORIAL HOSPITAL (14-1323) for the cost reporting period beginning 04/01/2016 and ending 03/31/2017 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

(Signed)_____
Officer or Administrator of Provider(s)

_____
Title

_____
Date

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	540,398	-110,682	1	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	173,825	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
10.00	RURAL HEALTH CLINIC I	0		-44,104		0	10.00
200.00	Total	0	714,223	-154,786	1	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: 14-1323 | Period: From 04/01/2016 To 03/31/2017 | Worksheet S-2 Part I | Date/Time Prepared: 8/31/2017 1:24 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 28 CHICK STREET	PO Box:			1.00
2.00	City: METROPOLIS	State: IL	Zip Code: 62960-	County: MASSAC	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	MASSAC MEMORIAL HOSPITAL	141323	99914	1	02/01/2003	N	O	N	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	MASSAC MEMORIAL HOSPITAL	14Z323	99916		02/01/2003	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	MASSAC MEMORIAL MEDICAL CLINIC	143478	99916		02/07/2006	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)	04/01/2016	03/31/2017	20.00
21.00	Type of Control (see instructions)	11		21.00
	Inpatient PPS Information			
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	N	N	22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	N	N	22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N	22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.	N	N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	3	N	23.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1323 | Period: From 04/01/2016 To 03/31/2017 | Worksheet S-2 Part I Date/Time Prepared: 8/31/2017 1:24 pm

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1323 | Period: From 04/01/2016 To 03/31/2017 | Worksheet S-2 Part I Date/Time Prepared: 8/31/2017 1:24 pm

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

		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1.00	2.00	3.00	4.00	
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column 4, direct GME FTE unweighted count.			0.00	0.00	61.10
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column 4, direct GME FTE unweighted count.			0.00	0.00	61.20
					1.00	
	ACA Provisions Affecting the Health Resources and Services Administration (HRSA)					
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)				0.00	62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)				0.00	62.01
	Teaching Hospitals that Claim Residents in Nonprovider Settings					
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions)				N	63.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1323 | Period: From 04/01/2016 To 03/31/2017 | Worksheet S-2 Part I Date/Time Prepared: 8/31/2017 1:24 pm

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

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

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

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

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

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

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

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

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

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	171,816	0	0	118.01

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1323 | Period: From 04/01/2016 To 03/31/2017 | Worksheet S-2 Part I | Date/Time Prepared: 8/31/2017 1:24 pm

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

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

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

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

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

		Part A	Part B	Title V	Title XIX	
		1.00	2.00	3.00	4.00	
	Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)					
155.00	Hospital	N	N	N	N	155.00
156.00	Subprovider - IPF	N	N	N	N	156.00
157.00	Subprovider - IRF	N	N	N	N	157.00
158.00	SUBPROVIDER					158.00
159.00	SNF	N	N	N	N	159.00
160.00	HOME HEALTH AGENCY	N	N	N	N	160.00
161.00	CMHC		N	N	N	161.00

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

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

		1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act		
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.	Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)	1	168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)		168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	0.00	169.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 14-1323	Period: From 04/01/2016 To 03/31/2017	Worksheet S-2 Part I Date/Time Prepared: 8/31/2017 1:24 pm

		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	10/01/2013	09/30/2014	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: 14-1323 | Period: From 04/01/2016 To 03/31/2017 | Worksheet S-2 Part II | Date/Time Prepared: 8/31/2017 1:24 pm

			Y/N	Date	
			1.00	2.00	
	General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.				
	COMPLETED BY ALL HOSPITALS				
	Provider Organization and Operation				
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)		N		1.00
		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N			3.00
		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	09/30/2017	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)	Y	08/30/2017	Y	08/30/2017
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N	
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	
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	

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 14-1323 | Period: From 04/01/2016 To 03/31/2017 | Worksheet S-2 Part II Date/Time Prepared: 8/31/2017 1:24 pm

		Description		Y/N	Y/N	
		0		1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
	Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions				N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				Y	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				Y	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				N	27.00
	Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				Y	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				Y	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				N	31.00
	Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				N	33.00
	Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				N	35.00
				Y/N	Date	
				1.00	2.00	
	Home Office Costs					
36.00	Were home office costs claimed on the cost report?			N		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			N		37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.			N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			N		40.00
		1.00		2.00		
	Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	KYLE		LEE		41.00
42.00	Enter the employer/company name of the cost report preparer.	MEDTRACK, INC				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	417-268-5953		KYLE.LEE@EDPTS.COM		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 14-1323	Period: From 04/01/2016 To 03/31/2017	Worksheet S-2 Part II Date/Time Prepared: 8/31/2017 1:24 pm

		3.00		
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	PRIN		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: 14-1323 | Period: From 04/01/2016 To 03/31/2017 | Worksheet S-3 Part I Date/Time Prepared: 8/31/2017 1:24 pm

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	25	9,125	79,251.61	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	79,251.61	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	79,251.61	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	88.00				0	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		25				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 14-1323 | Period: From 04/01/2016 To 03/31/2017 | Worksheet S-3 Part I | Date/Time Prepared: 8/31/2017 1:24 pm

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	1,648	293	2,610			1.00
2.00	HMO and other (see instructions)	143	0				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	558	0	558			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		167	167			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	2,206	460	3,335			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)	2,206	460	3,335	0.00	167.33	14.00
15.00	CAH visits	7,198	0	26,048			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	0	0	0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	2,629	0	12,200	0.00	12.50	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	179.83	27.00
28.00	Observation Bed Days		0	201			28.00
29.00	Ambulance Trips	917					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 14-1323 | Period: From 04/01/2016 To 03/31/2017 | Worksheet S-3 Part I | Date/Time Prepared: 8/31/2017 1:24 pm

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	430	139	722	1.00
2.00	HMO and other (see instructions)			36	0		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				0		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	430	139	722	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	0.00					26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 14-1323 | Component CCN: 14-3478 | Period: From 04/01/2016 To 03/31/2017 | Worksheet S-8 | Date/Time Prepared: 8/31/2017 1:24 pm

RHC I | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			28 CHICK STREET		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	METROPOLIS		IL	62960	2.00
					1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0	3.00
			Grant Award		Date	
			1.00		2.00	
	Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)					4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)					5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)					6.00
7.00	Appalachian Regional Commission					7.00
8.00	Look-Alikes					8.00
9.00	OTHER (SPECIFY)					9.00
				1.00	2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N	0	10.00

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

				1.00	2.00	
12.00	Have you received an approval for an exception to the productivity standard?			N		12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.			N	0	13.00
			Provider name		CCN number	
			1.00		2.00	
14.00	RHC/FQHC name, CCN number					14.00

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

			County				
			4.00				
2.00	City, State, ZIP Code, County		MASSAC				2.00
		Tuesday	Wednesday		Thursday		
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)						
11.00	Clinic	17:00	08:00	17:00	08:00	17:00	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-1323
Component CCN: 14-3478

Period:
From 04/01/2016
To 03/31/2017

Worksheet S-8

Date/Time Prepared:
8/31/2017 1:24 pm

RHC I

Cost

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	Clinic	08:00	16:30				11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 14-1323 | Period: From 04/01/2016 To 03/31/2017 | Worksheet S-10 | Date/Time Prepared: 8/31/2017 1:24 pm

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.437605	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	9,043,532	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?	Y	4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	15,951,691	6.00
7.00	Medicaid cost (line 1 times line 6)	6,980,540	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)	0	8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone CHIP	0	9.00
10.00	Stand-alone CHIP charges	0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	Uncompensated care (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	0	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
20.00	Charity care charges for the entire facility (see instructions)	435,751	0	435,751	20.00
21.00	Cost of patients approved for charity care (line 1 times line 20)	190,687	0	190,687	21.00
22.00	Partial payment by patients approved for charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	190,687	0	190,687	23.00

		1.00	
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?		24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	5,479,746	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	467,640	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	5,012,106	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	2,193,323	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	2,384,010	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	2,384,010	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-1323 | Period: From 04/01/2016 To 03/31/2017 | Worksheet A | Date/Time Prepared: 8/31/2017 1:24 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		1,116,197	1,116,197	370,733	1,486,930	1.00
1.01	00101	NEW CAP REL COSTS-BLDG AMBULANCE		0	0	0	0	1.01
1.02	00102	NEW CAP REL COSTS-BLDG EKG		0	0	0	0	1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP		1,520,798	1,520,798	135,970	1,656,768	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	4,605,744	4,605,744	0	4,605,744	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,471,353	1,359,671	2,831,024	-42,586	2,788,438	5.00
7.00	00700	OPERATION OF PLANT	199,043	796,365	995,408	0	995,408	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	8,226	108,730	116,956	0	116,956	8.00
9.00	00900	HOUSEKEEPING	275,829	53,636	329,465	0	329,465	9.00
10.00	01000	DIETARY	286,742	187,167	473,909	-205,857	268,052	10.00
11.00	01100	CAFETERIA	0	0	0	205,119	205,119	11.00
13.00	01300	NURSING ADMINISTRATION	145,092	10,211	155,303	-2,512	152,791	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	228,399	21,246	249,645	0	249,645	16.00
17.00	01700	SOCIAL SERVICE	158,946	5,752	164,698	0	164,698	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,354,592	315,115	1,669,707	46,180	1,715,887	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	330,470	249,241	579,711	-106,871	472,840	50.00
53.00	05300	ANESTHESIOLOGY	0	332,080	332,080	0	332,080	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	570,996	445,110	1,016,106	-40,077	976,029	54.00
60.00	06000	LABORATORY	472,206	767,892	1,240,098	-438	1,239,660	60.00
65.00	06500	RESPIRATORY THERAPY	365,335	116,313	481,648	-28,797	452,851	65.00
66.00	06600	PHYSICAL THERAPY	390,099	25,849	415,948	-281	415,667	66.00
69.00	06900	ELECTROCARDIOLOGY	57,598	237,678	295,276	17,452	312,728	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	44,199	-13,889	30,310	15,105	45,415	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	30,374	30,374	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	303,326	465,162	768,488	38,540	807,028	73.00
76.00	03020	GERIATRIC PSYCH	212,622	168,399	381,021	0	381,021	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	873,659	264,001	1,137,660	-71,014	1,066,646	88.00
90.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	90.00
90.01	04951	WOUND CARE	0	59,300	59,300	0	59,300	90.01
91.00	09100	EMERGENCY	688,589	771,122	1,459,711	-15,486	1,444,225	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0	0	0	17,903	17,903	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	596,166	83,873	680,039	-9,030	671,009	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		362,307	362,307	-362,307	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	9,033,487	14,435,070	23,468,557	-7,880	23,460,677	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	7,880	7,880	192.00
192.01	19201	PROMOTION	0	0	0	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		TOTAL (SUM OF LINES 118-199)	9,033,487	14,435,070	23,468,557	0	23,468,557	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-1323 | Period: From 04/01/2016 To 03/31/2017 | Worksheet A | Date/Time Prepared: 8/31/2017 1:24 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	-92,953	1,393,977		1.00
1.01	00101	NEW CAP REL COSTS-BLDG AMBULANCE	0	0		1.01
1.02	00102	NEW CAP REL COSTS-BLDG EKG	0	0		1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-986,207	670,561		2.00
3.00	00300	OTHER CAP REL COSTS	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-243	4,605,501		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-73,849	2,714,589		5.00
7.00	00700	OPERATION OF PLANT	0	995,408		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	116,956		8.00
9.00	00900	HOUSEKEEPING	0	329,465		9.00
10.00	01000	DIETARY	-1,946	266,106		10.00
11.00	01100	CAFETERIA	0	205,119		11.00
13.00	01300	NURSING ADMINISTRATION	0	152,791		13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-1,470	248,175		16.00
17.00	01700	SOCIAL SERVICE	0	164,698		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-153,970	1,561,917		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	472,840		50.00
53.00	05300	ANESTHESIOLOGY	-243,743	88,337		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	976,029		54.00
60.00	06000	LABORATORY	0	1,239,660		60.00
65.00	06500	RESPIRATORY THERAPY	0	452,851		65.00
66.00	06600	PHYSICAL THERAPY	0	415,667		66.00
69.00	06900	ELECTROCARDIOLOGY	-139,258	173,470		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	-1,223	44,192		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	30,374		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-24,337	782,691		73.00
76.00	03020	GERIATRIC PSYCH	-844	380,177		76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	-260	1,066,386		88.00
90.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0	0		90.00
90.01	04951	WOUND CARE	0	59,300		90.01
91.00	09100	EMERGENCY	0	1,444,225		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0	17,903		93.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0	671,009		95.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-1,720,303	21,740,374		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	7,880		192.00
192.01	19201	PROMOTION	0	0		192.01
193.00	19300	NONPAID WORKERS	0	0		193.00
200.00		TOTAL (SUM OF LINES 118-199)	-1,720,303	21,748,254		200.00

RECLASSIFICATIONS | Provider CCN: 14-1323 | Period: From 04/01/2016 To 03/31/2017 | Worksheet A-6 | Date/Time Prepared: 8/31/2017 1:24 pm

		Increases				
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - INTEREST RECLASS					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	342,044		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	20,263		2.00
	TOTALS		0	362,307		
	B - CAFETERIA RECLASS					
1.00	CAFETERIA	11.00	124,109	81,010		1.00
	TOTALS		124,109	81,010		
	C - RENTAL EXPENSE RECLASS					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	115,707		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
	TOTALS		0	115,707		
	D - MED SUPPLIES RECLASS					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	15,105		1.00
2.00	ADULTS & PEDIATRICS	30.00	0	7,072		2.00
3.00		0.00	0	0		3.00
	TOTALS		0	22,177		
	E - DRUGS CHARGED RECLASS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	38,540		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
	TOTALS		0	38,540		
	F - POB REAL ESTATE TAXES					
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	7,880		1.00
	TOTALS		0	7,880		
	G - IMPLANTABLE SUPPLIES					
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	30,374		1.00
	TOTALS		0	30,374		
	I - RECLASS EKG SALARIES					
1.00	ELECTROCARDIOLOGY	69.00	24,652	0		1.00
	TOTALS		24,652	0		
	J - RECLASS RHC BLDG DEPRECIATION					
1.00	RURAL HEALTH CLINIC	88.00	0	6,017		1.00
	TOTALS		0	6,017		
	K - PROPERTY INSURANCE RECLASS					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	34,706		1.00
	TOTALS		0	34,706		
	L - HOSPITALIST					
1.00	ADULTS & PEDIATRICS	30.00	55,540	0		1.00
	TOTALS		55,540	0		
	M - BLOOD TRANSFUSION					
1.00	OTHER OUTPATIENT SERVICES	93.00	17,903	0		1.00
2.00		0.00	0	0		2.00
	TOTALS		17,903	0		
500.00	Grand Total: Increases		222,204	698,718		500.00

RECLASSIFICATIONS | Provider CCN: 14-1323 | Period: From 04/01/2016 To 03/31/2017 | Worksheet A-6 | Date/Time Prepared: 8/31/2017 1:24 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - INTEREST RECLASS						
1.00	INTEREST EXPENSE	113.00	0	362,307	11		1.00
2.00		0.00	0	0	11		2.00
	TOTALS		0	362,307			
	B - CAFETERIA RECLASS						
1.00	DIETARY	10.00	124,109	81,010	0		1.00
	TOTALS		124,109	81,010			
	C - RENTAL EXPENSE RECLASS						
1.00	OPERATING ROOM	50.00	0	74,779	10		1.00
2.00	RADIOLOGY-DIAGNOSTIC	54.00	0	29,145	10		2.00
3.00	LABORATORY	60.00	0	438	0		3.00
4.00	RESPIRATORY THERAPY	65.00	0	4,145	0		4.00
5.00	ELECTROCARDIOLOGY	69.00	0	7,200	0		5.00
	TOTALS		0	115,707			
	D - MED SUPPLIES RECLASS						
1.00	AMBULANCE SERVICES	95.00	0	7,414	0		1.00
2.00	RURAL HEALTH CLINIC	88.00	0	785	0		2.00
3.00	EMERGENCY	91.00	0	13,978	0		3.00
	TOTALS		0	22,177			
	E - DRUGS CHARGED RECLASS						
1.00	DIETARY	10.00	0	738	0		1.00
2.00	NURSING ADMINISTRATION	13.00	0	2,512	0		2.00
3.00	ADULTS & PEDIATRICS	30.00	0	21	0		3.00
4.00	OPERATING ROOM	50.00	0	1,718	0		4.00
5.00	RADIOLOGY-DIAGNOSTIC	54.00	0	10,932	0		5.00
6.00	PHYSICAL THERAPY	66.00	0	281	0		6.00
7.00	RURAL HEALTH CLINIC	88.00	0	20,706	0		7.00
8.00	EMERGENCY	91.00	0	16	0		8.00
9.00	AMBULANCE SERVICES	95.00	0	1,616	0		9.00
	TOTALS		0	38,540			
	F - POB REAL ESTATE TAXES						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	7,880	0		1.00
	TOTALS		0	7,880			
	G - IMPLANTABLE SUPPLIES						
1.00	OPERATING ROOM	50.00	0	30,374	0		1.00
	TOTALS		0	30,374			
	I - RECLASS EKG SALARIES						
1.00	RESPIRATORY THERAPY	65.00	24,652	0	0		1.00
	TOTALS		24,652	0			
	J - RECLASS RHC BLDG DEPRECIATION						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	6,017	9		1.00
	TOTALS		0	6,017			
	K - PROPERTY INSURANCE RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	34,706	12		1.00
	TOTALS		0	34,706			
	L - HOSPITALIST						
1.00	RURAL HEALTH CLINIC	88.00	55,540	0	0		1.00
	TOTALS		55,540	0			
	M - BLOOD TRANSFUSION						
1.00	ADULTS & PEDIATRICS	30.00	16,411	0	0		1.00
2.00	EMERGENCY	91.00	1,492	0	0		2.00
	TOTALS		17,903	0			
500.00	Grand Total: Decreases		222,204	698,718			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1323 | Period: From 04/01/2016 To 03/31/2017 | Worksheet A-7 Part I | Date/Time Prepared: 8/31/2017 1:24 pm

		Beginning Balances	Acquisitions: Purchases	Acquisitions: Donation	Acquisitions: Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	65,980	0	0	0	0	1.00
2.00	Land Improvements	1,054,078	21,342	0	21,342	0	2.00
3.00	Buildings and Fixtures	16,883,008	95,324	0	95,324	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	6,781,884	689,868	0	689,868	0	6.00
7.00	HIT designated Assets	268,242	275,336	0	275,336	118,794	7.00
8.00	Subtotal (sum of lines 1-7)	25,053,192	1,081,870	0	1,081,870	118,794	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	25,053,192	1,081,870	0	1,081,870	118,794	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	65,980	0	1.00
2.00	Land Improvements	1,075,420	0	2.00
3.00	Buildings and Fixtures	16,978,332	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	7,471,752	0	6.00
7.00	HIT designated Assets	424,784	0	7.00
8.00	Subtotal (sum of lines 1-7)	26,016,268	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	26,016,268	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1323 | Period: From 04/01/2016 To 03/31/2017 | Worksheet A-7 Part II Date/Time Prepared: 8/31/2017 1:24 pm

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	1,116,197	0	0	0	0	1.00
1.01	NEW CAP REL COSTS-BLDG AMBULANCE	0	0	0	0	0	1.01
1.02	NEW CAP REL COSTS-BLDG EKG	0	0	0	0	0	1.02
2.00	CAP REL COSTS-MVBLE EQUIP	1,520,798	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	2,636,995	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	1,116,197	1.00
1.01	NEW CAP REL COSTS-BLDG AMBULANCE	0	0	1.01
1.02	NEW CAP REL COSTS-BLDG EKG	0	0	1.02
2.00	CAP REL COSTS-MVBLE EQUIP	0	1,520,798	2.00
3.00	Total (sum of lines 1-2)	0	2,636,995	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1323 | Period: From 04/01/2016 To 03/31/2017 | Worksheet A-7 Part III Date/Time Prepared: 8/31/2017 1:24 pm

	Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	18,053,752	-53,822	18,107,574	0.711529	0	1.00
1.01	NEW CAP REL COSTS-BLDG AMBULANCE	0	0	0	0.000000	0	1.01
1.02	NEW CAP REL COSTS-BLDG EKG	0	0	0	0.000000	0	1.02
2.00	CAP REL COSTS-MVBLE EQUIP	7,471,752	130,503	7,341,249	0.288471	0	2.00
3.00	Total (sum of lines 1-2)	25,525,504	76,681	25,448,823	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	1,110,180	0	1.00
1.01	NEW CAP REL COSTS-BLDG AMBULANCE	0	0	0	0	0	1.01
1.02	NEW CAP REL COSTS-BLDG EKG	0	0	0	0	0	1.02
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	540,098	115,707	2.00
3.00	Total (sum of lines 1-2)	0	0	0	1,650,278	115,707	3.00

	Cost Center Description	SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	249,091	34,706	0	0	1,393,977	1.00
1.01	NEW CAP REL COSTS-BLDG AMBULANCE	0	0	0	0	0	1.01
1.02	NEW CAP REL COSTS-BLDG EKG	0	0	0	0	0	1.02
2.00	CAP REL COSTS-MVBLE EQUIP	14,756	0	0	0	670,561	2.00
3.00	Total (sum of lines 1-2)	263,847	34,706	0	0	2,064,538	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-1323 | Period: From 04/01/2016 To 03/31/2017 | Worksheet A-8 | Date/Time Prepared: 8/31/2017 1:24 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-92,953	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
1.01	Investment income - NEW CAP REL COSTS-BLDG AMBULANCE (chapter 2)		0	NEW CAP REL COSTS-BLDG AMBULANCE	1.01	0	1.01
1.02	Investment income - NEW CAP REL COSTS-BLDG EKG (chapter 2)		0	NEW CAP REL COSTS-BLDG EKG	1.02	0	1.02
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)	B	-5,507	CAP REL COSTS-MVBLE EQUIP	2.00	11	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-7,351	ADMINISTRATIVE & GENERAL	5.00	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	-293,228			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	0			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests		0		0.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients	A	-1,470	MEDICAL RECORDS & LIBRARY	16.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts		0		0.00	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
26.01	Depreciation - NEW CAP REL COSTS-BLDG AMBULANCE		0	NEW CAP REL COSTS-BLDG AMBULANCE	1.01	0	26.01
26.02	Depreciation - NEW CAP REL COSTS-BLDG EKG		0	NEW CAP REL COSTS-BLDG EKG	1.02	0	26.02
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

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-1323 | Period: From 04/01/2016 To 03/31/2017 | Worksheet A-8 | Date/Time Prepared: 8/31/2017 1:24 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
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	PHYSICIAN RECRUITMENT	A	-44,651	ADMINISTRATIVE & GENERAL	5.00	0	33.00
34.00	OTHER OPERATING REVENUE	B	-1,946	DIETARY	10.00	0	34.00
35.00	PHARMACY REBATES	B	-24,337	DRUGS CHARGED TO PATIENTS	73.00	0	35.00
36.00	OTHER REVENUE	B	-1,504	ADMINISTRATIVE & GENERAL	5.00	0	36.00
37.00	ACCOUNTS PAYABLE DISCOUNT	B	-1,243	ADMINISTRATIVE & GENERAL	5.00	0	37.00
38.00	PURCHASING REBATES	B	-1,223	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	38.00
39.00	BILLING REC	B	-148	ADMINISTRATIVE & GENERAL	5.00	0	39.00
42.00	LOBBYING EXPENSE	A	-2,364	ADMINISTRATIVE & GENERAL	5.00	0	42.00
43.00	CRNA EXPENSES	A	-243,743	ANESTHESIOLOGY	53.00	0	43.00
44.00	RHC MISC INCOME	B	-260	RURAL HEALTH CLINIC	88.00	0	44.00
45.00	COMMUNITY OUTREACH	A	-844	GERIATRIC PSYCH	76.00	0	45.00
45.01	PATIENT TV DEPRECIATION	A	-1,861	CAP REL COSTS-MVBLE EQUIP	2.00	9	45.01
45.02	PATIENT PHONE SALARY	A	-896	ADMINISTRATIVE & GENERAL	5.00	0	45.02
45.03	PATIENT PHONE BENEFITS	A	-243	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	45.03
45.04	PATIENT PHONE DEPRECIATION	A	-1,934	CAP REL COSTS-MVBLE EQUIP	2.00	9	45.04
45.05	MARKETING EXPENSE	A	-15,692	ADMINISTRATIVE & GENERAL	5.00	0	45.05
45.06	HITECH DEPRECIATION	A	-976,905	CAP REL COSTS-MVBLE EQUIP	2.00	9	45.06
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-1,720,303				50.00

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 14-1323 | Period: From 04/01/2016 To 03/31/2017 | Worksheet A-8-2 | Date/Time Prepared: 8/31/2017 1:24 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	ADULTS & PEDIATRICS	153,970	153,970	0	0	0	1.00
2.00	91.00	EMERGENCY	649,804	0	649,804	0	0	2.00
3.00	69.00	ELECTROCARDIOLOGY	139,258	139,258	0	0	0	3.00
4.00	0.00		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			943,032	293,228	649,804		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	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	91.00	EMERGENCY	0	0	0	0	0	2.00
3.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	3.00
4.00	0.00		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	30.00	ADULTS & PEDIATRICS	0	0	0	153,970		1.00
2.00	91.00	EMERGENCY	0	0	0	0		2.00
3.00	69.00	ELECTROCARDIOLOGY	0	0	0	139,258		3.00
4.00	0.00		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	293,228		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1323 | Period: From 04/01/2016 To 03/31/2017 | Worksheet B Part I | Date/Time Prepared: 8/31/2017 1:24 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS				
				BLDG & FIXT	NEW BLDG AMBULANCE	NEW BLDG EKG	MVBLE EQUIP	
			0	1.00	1.01	1.02	2.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	1,393,977	1,393,977				1.00
1.01	00101	NEW CAP REL COSTS-BLDG AMBULANCE	0	0	0			1.01
1.02	00102	NEW CAP REL COSTS-BLDG EKG	0	0	0	0		1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP	670,561				670,561	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4,605,501	6,448	0	0	2,904	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,714,589	346,572	0	0	156,087	5.00
7.00	00700	OPERATION OF PLANT	995,408	123,884	0	0	55,794	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	116,956	25,793	0	0	11,617	8.00
9.00	00900	HOUSEKEEPING	329,465	9,498	0	0	4,278	9.00
10.00	01000	DIETARY	266,106	31,050	0	0	13,984	10.00
11.00	01100	CAFETERIA	205,119	12,992	0	0	5,851	11.00
13.00	01300	NURSING ADMINISTRATION	152,791	5,400	0	0	2,432	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	248,175	24,443	0	0	12,382	16.00
17.00	01700	SOCIAL SERVICE	164,698	2,875	0	0	1,295	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,561,917	233,664	0	0	105,237	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	472,840	143,403	0	0	64,585	50.00
53.00	05300	ANESTHESIOLOGY	88,337	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	976,029	77,777	0	0	35,029	54.00
60.00	06000	LABORATORY	1,239,660	18,916	0	0	8,519	60.00
65.00	06500	RESPIRATORY THERAPY	452,851	26,159	0	0	11,781	65.00
66.00	06600	PHYSICAL THERAPY	415,667	55,065	0	0	24,800	66.00
69.00	06900	ELECTROCARDIOLOGY	173,470	48,473	0	0	22,046	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	44,192	21,950	0	0	9,886	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	30,374	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	782,691	9,053	0	0	4,077	73.00
76.00	03020	GERIATRIC PSYCH	380,177	22,918	0	0	10,322	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,066,386	29,573	0	0	41,932	88.00
90.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	90.00
90.01	04951	WOUND CARE	59,300	22,236	0	0	0	90.01
91.00	09100	EMERGENCY	1,444,225	93,167	0	0	41,960	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04040	OTHER OUTPATIENT SERVICES	17,903	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	671,009	0	0	0	22,561	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	21,740,374	1,391,309	0	0	669,359	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	2,668	0	0	1,202	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	7,880	0	0	0	0	192.00
192.01	19201	PROMOTION	0	0	0	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	21,748,254	1,393,977	0	0	670,561	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1323 | Period: From 04/01/2016 To 03/31/2017 | Worksheet B Part I | Date/Time Prepared: 8/31/2017 1:24 pm

		Cost Center Description	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
			4.00	4A	5.00	7.00	8.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-BLDG AMBULANCE						1.01
1.02	00102	NEW CAP REL COSTS-BLDG EKG						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4,614,853					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	751,655	3,968,903	3,968,903			5.00
7.00	00700	OPERATION OF PLANT	101,683	1,276,769	285,014	1,561,783		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	4,202	158,568	35,397	43,926	237,891	8.00
9.00	00900	HOUSEKEEPING	140,910	484,151	108,078	16,175	0	9.00
10.00	01000	DIETARY	83,083	394,223	88,003	52,879	1,585	10.00
11.00	01100	CAFETERIA	63,402	287,364	64,149	22,125	0	11.00
13.00	01300	NURSING ADMINISTRATION	74,122	234,745	52,402	9,196	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	116,680	401,680	89,667	41,627	0	16.00
17.00	01700	SOCIAL SERVICE	81,199	250,067	55,823	4,896	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	711,998	2,612,816	583,263	397,933	106,218	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	168,824	849,652	189,669	244,217	18,037	50.00
53.00	05300	ANESTHESIOLOGY	0	88,337	19,720	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	291,700	1,380,535	308,178	132,454	23,094	54.00
60.00	06000	LABORATORY	241,232	1,508,327	336,705	32,214	0	60.00
65.00	06500	RESPIRATORY THERAPY	174,042	664,833	148,411	44,548	0	65.00
66.00	06600	PHYSICAL THERAPY	199,286	694,818	155,105	93,776	17,886	66.00
69.00	06900	ELECTROCARDIOLOGY	42,018	286,007	63,846	82,551	4,259	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	22,580	98,608	22,012	37,380	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	30,374	6,780	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	154,957	950,778	212,243	15,417	0	73.00
76.00	03020	GERIATRIC PSYCH	108,620	522,037	116,535	39,030	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	417,945	1,555,836	347,311	50,364	323	88.00
90.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	90.00
90.01	04951	WOUND CARE	0	81,536	18,201	37,867	0	90.01
91.00	09100	EMERGENCY	351,011	1,930,363	430,917	158,664	65,314	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0				92.00
93.00	04040	OTHER OUTPATIENT SERVICES	9,146	27,049	6,038	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	304,558	998,128	222,813	0	442	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	4,614,853	21,736,504	3,966,280	1,557,239	237,158	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	3,870	864	4,544	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	7,880	1,759	0	733	192.00
192.01	19201	PROMOTION	0	0	0	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments		0				200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	4,614,853	21,748,254	3,968,903	1,561,783	237,891	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1323 | Period: From 04/01/2016 To 03/31/2017 | Worksheet B Part I | Date/Time Prepared: 8/31/2017 1:24 pm

		Cost Center Description	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	
			9.00	10.00	11.00	13.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-BLDG AMBULANCE						1.01
1.02	00102	NEW CAP REL COSTS-BLDG EKG						1.02
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
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING	608,404					9.00
10.00	01000	DIETARY	30,388	567,078				10.00
11.00	01100	CAFETERIA	0	200,338	573,976			11.00
13.00	01300	NURSING ADMINISTRATION	0	0	14,370	310,713		13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	7,162	0	39,056	0	579,192	16.00
17.00	01700	SOCIAL SERVICE	0	0	12,641	14,329	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	242,889	295,599	143,822	161,744	336,524	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,446	0	29,396	33,322	25,951	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	44,392	0	58,316	0	98,017	54.00
60.00	06000	LABORATORY	22,860	0	64,159	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	24,999	0	42,813	0	0	65.00
66.00	06600	PHYSICAL THERAPY	18,832	0	40,249	0	4,683	66.00
69.00	06900	ELECTROCARDIOLOGY	961	0	9,958	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	10,435	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,879	0	18,783	0	0	73.00
76.00	03020	GERIATRIC PSYCH	0	26,034	23,851	27,036	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	57,916	0	0	0	0	88.00
90.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	90.00
90.01	04951	WOUND CARE	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	100,489	0	65,531	74,282	114,017	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	560,213	521,971	573,380	310,713	579,192	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	48,191	45,107	596	0	0	192.00
192.01	19201	PROMOTION	0	0	0	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	608,404	567,078	573,976	310,713	579,192	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1323 | Period: From 04/01/2016 To 03/31/2017 | Worksheet B Part I | Date/Time Prepared: 8/31/2017 1:24 pm

		Cost Center Description	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			17.00	19.00	24.00	25.00	26.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-BLDG AMBULANCE						1.01
1.02	00102	NEW CAP REL COSTS-BLDG EKG						1.02
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
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	337,756					17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0				19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	337,756	0	5,218,564	0	5,218,564	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	1,395,690	0	1,395,690	50.00
53.00	05300	ANESTHESIOLOGY	0	0	108,057	0	108,057	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	2,044,986	0	2,044,986	54.00
60.00	06000	LABORATORY	0	0	1,964,265	0	1,964,265	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	925,604	0	925,604	65.00
66.00	06600	PHYSICAL THERAPY	0	0	1,025,349	0	1,025,349	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	447,582	0	447,582	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	168,435	0	168,435	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	37,154	0	37,154	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	1,201,100	0	1,201,100	73.00
76.00	03020	GERIATRIC PSYCH	0	0	754,523	0	754,523	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	2,011,750	0	2,011,750	88.00
90.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	90.00
90.01	04951	WOUND CARE	0	0	137,604	0	137,604	90.01
91.00	09100	EMERGENCY	0	0	2,939,577	0	2,939,577	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0	0	33,087	0	33,087	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	1,221,383	0	1,221,383	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	337,756	0	21,634,710	0	21,634,710	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	9,278	0	9,278	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	104,266	0	104,266	192.00
192.01	19201	PROMOTION	0	0	0	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments		0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	337,756	0	21,748,254	0	21,748,254	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1323 | Period: From 04/01/2016 To 03/31/2017 | Worksheet B Part II | Date/Time Prepared: 8/31/2017 1:24 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	NEW BLDG AMBULANCE	NEW BLDG EKG	MVBLE EQUIP	
			0	1.00	1.01	1.02	2.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-BLDG AMBULANCE						1.01
1.02	00102	NEW CAP REL COSTS-BLDG EKG						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	6,448	0	0	2,904	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	346,572	0	0	156,087	5.00
7.00	00700	OPERATION OF PLANT	0	123,884	0	0	55,794	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	25,793	0	0	11,617	8.00
9.00	00900	HOUSEKEEPING	0	9,498	0	0	4,278	9.00
10.00	01000	DIETARY	0	31,050	0	0	13,984	10.00
11.00	01100	CAFETERIA	0	12,992	0	0	5,851	11.00
13.00	01300	NURSING ADMINISTRATION	0	5,400	0	0	2,432	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	24,443	0	0	12,382	16.00
17.00	01700	SOCIAL SERVICE	0	2,875	0	0	1,295	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	233,664	0	0	105,237	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	143,403	0	0	64,585	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	77,777	0	0	35,029	54.00
60.00	06000	LABORATORY	0	18,916	0	0	8,519	60.00
65.00	06500	RESPIRATORY THERAPY	0	26,159	0	0	11,781	65.00
66.00	06600	PHYSICAL THERAPY	0	55,065	0	0	24,800	66.00
69.00	06900	ELECTROCARDIOLOGY	0	48,473	0	0	22,046	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	21,950	0	0	9,886	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	9,053	0	0	4,077	73.00
76.00	03020	GERIATRIC PSYCH	0	22,918	0	0	10,322	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	29,573	0	0	41,932	88.00
90.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	90.00
90.01	04951	WOUND CARE	0	22,236	0	0	0	90.01
91.00	09100	EMERGENCY	0	93,167	0	0	41,960	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	22,561	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	1,391,309	0	0	669,359	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	2,668	0	0	1,202	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	PROMOTION	0	0	0	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	0	1,393,977	0	0	670,561	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1323 | Period: From 04/01/2016 To 03/31/2017 | Worksheet B Part II | Date/Time Prepared: 8/31/2017 1:24 pm

		Cost Center Description	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
			2A	4.00	5.00	7.00	8.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-BLDG AMBULANCE						1.01
1.02	00102	NEW CAP REL COSTS-BLDG EKG						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	9,352	9,352				4.00
5.00	00500	ADMINISTRATIVE & GENERAL	502,659	1,524	504,183			5.00
7.00	00700	OPERATION OF PLANT	179,678	206	36,207	216,091		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	37,410	9	4,497	6,078	47,994	8.00
9.00	00900	HOUSEKEEPING	13,776	285	13,730	2,238	0	9.00
10.00	01000	DIETARY	45,034	168	11,179	7,316	320	10.00
11.00	01100	CAFETERIA	18,843	128	8,149	3,061	0	11.00
13.00	01300	NURSING ADMINISTRATION	7,832	150	6,657	1,272	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	36,825	236	11,391	5,760	0	16.00
17.00	01700	SOCIAL SERVICE	4,170	165	7,091	677	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	338,901	1,443	74,092	55,060	21,429	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	207,988	342	24,094	33,790	3,639	50.00
53.00	05300	ANESTHESIOLOGY	0	0	2,505	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	112,806	591	39,149	18,327	4,659	54.00
60.00	06000	LABORATORY	27,435	489	42,773	4,457	0	60.00
65.00	06500	RESPIRATORY THERAPY	37,940	353	18,853	6,164	0	65.00
66.00	06600	PHYSICAL THERAPY	79,865	404	19,704	12,975	3,609	66.00
69.00	06900	ELECTROCARDIOLOGY	70,519	85	8,111	11,422	859	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	31,836	46	2,796	5,172	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	861	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	13,130	314	26,962	2,133	0	73.00
76.00	03020	GERIATRIC PSYCH	33,240	220	14,804	5,400	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	71,505	847	44,120	6,968	65	88.00
90.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	90.00
90.01	04951	WOUND CARE	22,236	0	2,312	5,239	0	90.01
91.00	09100	EMERGENCY	135,127	711	54,741	21,953	13,177	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0					92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0	19	767	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	22,561	617	28,305	0	89	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	2,060,668	9,352	503,850	215,462	47,846	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	3,870	0	110	629	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	223	0	148	192.00
192.01	19201	PROMOTION	0	0	0	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments	0					200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	2,064,538	9,352	504,183	216,091	47,994	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1323 | Period: From 04/01/2016 To 03/31/2017 | Worksheet B Part II | Date/Time Prepared: 8/31/2017 1:24 pm

		Cost Center Description	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	
			9.00	10.00	11.00	13.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-BLDG AMBULANCE						1.01
1.02	00102	NEW CAP REL COSTS-BLDG EKG						1.02
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
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING	30,029					9.00
10.00	01000	DIETARY	1,500	65,517				10.00
11.00	01100	CAFETERIA	0	23,146	53,327			11.00
13.00	01300	NURSING ADMINISTRATION	0	0	1,335	17,246		13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	354	0	3,629	0	58,195	16.00
17.00	01700	SOCIAL SERVICE	0	0	1,174	795	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	11,987	34,152	13,364	8,977	33,812	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	269	0	2,731	1,850	2,608	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,191	0	5,418	0	9,848	54.00
60.00	06000	LABORATORY	1,128	0	5,961	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	1,234	0	3,978	0	0	65.00
66.00	06600	PHYSICAL THERAPY	930	0	3,739	0	471	66.00
69.00	06900	ELECTROCARDIOLOGY	47	0	925	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	969	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	191	0	1,745	0	0	73.00
76.00	03020	GERIATRIC PSYCH	0	3,008	2,216	1,501	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	2,859	0	0	0	0	88.00
90.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	90.00
90.01	04951	WOUND CARE	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	4,960	0	6,088	4,123	11,456	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	27,650	60,306	53,272	17,246	58,195	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	2,379	5,211	55	0	0	192.00
192.01	19201	PROMOTION	0	0	0	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	30,029	65,517	53,327	17,246	58,195	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1323 | Period: From 04/01/2016 To 03/31/2017 | Worksheet B Part II | Date/Time Prepared: 8/31/2017 1:24 pm

		Cost Center Description	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			17.00	19.00	24.00	25.00	26.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-BLDG AMBULANCE						1.01
1.02	00102	NEW CAP REL COSTS-BLDG EKG						1.02
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
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	14,072					17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0				19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	14,072		607,289	0	607,289	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0		277,311	0	277,311	50.00
53.00	05300	ANESTHESIOLOGY	0		2,505	0	2,505	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0		192,989	0	192,989	54.00
60.00	06000	LABORATORY	0		82,243	0	82,243	60.00
65.00	06500	RESPIRATORY THERAPY	0		68,522	0	68,522	65.00
66.00	06600	PHYSICAL THERAPY	0		121,697	0	121,697	66.00
69.00	06900	ELECTROCARDIOLOGY	0		91,968	0	91,968	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0		40,819	0	40,819	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0		861	0	861	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0		44,475	0	44,475	73.00
76.00	03020	GERIATRIC PSYCH	0		60,389	0	60,389	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0		126,364	0	126,364	88.00
90.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0		0	0	0	90.00
90.01	04951	WOUND CARE	0		29,787	0	29,787	90.01
91.00	09100	EMERGENCY	0		252,336	0	252,336	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0		786	0	786	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0		51,572	0	51,572	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	14,072	0	2,051,913	0	2,051,913	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		4,609	0	4,609	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0		8,016	0	8,016	192.00
192.01	19201	PROMOTION	0		0	0	0	192.01
193.00	19300	NONPAID WORKERS	0		0	0	0	193.00
200.00		Cross Foot Adjustments		0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	14,072	0	2,064,538	0	2,064,538	202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1323 | Period: From 04/01/2016 To 03/31/2017 | Worksheet B-1 | Date/Time Prepared: 8/31/2017 1:24 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	NEW BLDG AMBULANCE (SQUARE FEET)	NEW BLDG EKG (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	
			1.00	1.01	1.02	2.00	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	87,768					1.00
1.01	00101	NEW CAP REL COSTS-BLDG AMBULANCE	0	0				1.01
1.02	00102	NEW CAP REL COSTS-BLDG EKG	0	0	0			1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP				93,744		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	406	0	0	406	9,033,487	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	21,821	0	0	21,821	1,471,353	5.00
7.00	00700	OPERATION OF PLANT	7,800	0	0	7,800	199,043	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,624	0	0	1,624	8,226	8.00
9.00	00900	HOUSEKEEPING	598	0	0	598	275,829	9.00
10.00	01000	DIETARY	1,955	0	0	1,955	162,633	10.00
11.00	01100	CAFETERIA	818	0	0	818	124,109	11.00
13.00	01300	NURSING ADMINISTRATION	340	0	0	340	145,092	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,539	0	0	1,731	228,399	16.00
17.00	01700	SOCIAL SERVICE	181	0	0	181	158,946	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	14,712	0	0	14,712	1,393,721	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	9,029	0	0	9,029	330,470	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,897	0	0	4,897	570,996	54.00
60.00	06000	LABORATORY	1,191	0	0	1,191	472,206	60.00
65.00	06500	RESPIRATORY THERAPY	1,647	0	0	1,647	340,683	65.00
66.00	06600	PHYSICAL THERAPY	3,467	0	0	3,467	390,099	66.00
69.00	06900	ELECTROCARDIOLOGY	3,052	0	0	3,082	82,250	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,382	0	0	1,382	44,199	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	570	0	0	570	303,326	73.00
76.00	03020	GERIATRIC PSYCH	1,443	0	0	1,443	212,622	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,862	0	0	5,862	818,119	88.00
90.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	90.00
90.01	04951	WOUND CARE	1,400	0	0	0	0	90.01
91.00	09100	EMERGENCY	5,866	0	0	5,866	687,097	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0	0	0	0	17,903	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	3,154	596,166	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	87,600	0	0	93,576	9,033,487	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	168	0	0	168	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	PROMOTION	0	0	0	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,393,977	0	0	670,561	4,614,853	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	15.882520	0.000000	0.000000	7.153108	0.510861	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)					9,352	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)					0.001035	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1323 | Period: From 04/01/2016 To 03/31/2017 | Worksheet B-1 | Date/Time Prepared: 8/31/2017 1:24 pm

		Cost Center Description	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (TIME SPENT)	
			5A	5.00	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-BLDG AMBULANCE						1.01
1.02	00102	NEW CAP REL COSTS-BLDG EKG						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-3,968,903	17,779,351				5.00
7.00	00700	OPERATION OF PLANT	0	1,276,769	57,741			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	158,568	1,624	22,065		8.00
9.00	00900	HOUSEKEEPING	0	484,151	598	0	265,880	9.00
10.00	01000	DIETARY	0	394,223	1,955	147	13,280	10.00
11.00	01100	CAFETERIA	0	287,364	818	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	234,745	340	0	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	401,680	1,539	0	3,130	16.00
17.00	01700	SOCIAL SERVICE	0	250,067	181	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	2,612,816	14,712	9,852	106,145	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	849,652	9,029	1,673	2,380	50.00
53.00	05300	ANESTHESIOLOGY	0	88,337	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,380,535	4,897	2,142	19,400	54.00
60.00	06000	LABORATORY	0	1,508,327	1,191	0	9,990	60.00
65.00	06500	RESPIRATORY THERAPY	0	664,833	1,647	0	10,925	65.00
66.00	06600	PHYSICAL THERAPY	0	694,818	3,467	1,659	8,230	66.00
69.00	06900	ELECTROCARDIOLOGY	0	286,007	3,052	395	420	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	98,608	1,382	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	30,374	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	950,778	570	0	1,695	73.00
76.00	03020	GERIATRIC PSYCH	0	522,037	1,443	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	1,555,836	1,862	30	25,310	88.00
90.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	90.00
90.01	04951	WOUND CARE	0	81,536	1,400	0	0	90.01
91.00	09100	EMERGENCY	0	1,930,363	5,866	6,058	43,915	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0	27,049	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	998,128	0	41	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-3,968,903	17,767,601	57,573	21,997	244,820	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	3,870	168	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	7,880	0	68	21,060	192.00
192.01	19201	PROMOTION	0	0	0	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)		3,968,903	1,561,783	237,891	608,404	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)		0.223231	27.048077	10.781373	2.288265	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)		504,183	216,091	47,994	30,029	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)		0.028358	3.742419	2.175119	0.112942	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1323 | Period: From 04/01/2016 To 03/31/2017 | Worksheet B-1 | Date/Time Prepared: 8/31/2017 1:24 pm

		Cost Center Description	DIETARY (MEALS SERVED)	CAFETERIA (FTE)	NURSING ADMINISTRATION (NURSING FTES)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (ASSIGNEDTIMES)	
			10.00	11.00	13.00	16.00	17.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-BLDG AMBULANCE						1.01
1.02	00102	NEW CAP REL COSTS-BLDG EKG						1.02
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
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	32,586					10.00
11.00	01100	CAFETERIA	11,512	9,626				11.00
13.00	01300	NURSING ADMINISTRATION	0	241	4,597			13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	655	0	222,625		16.00
17.00	01700	SOCIAL SERVICE	0	212	212	0	100	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	16,986	2,412	2,393	129,350	100	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	493	493	9,975	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	978	0	37,675	0	54.00
60.00	06000	LABORATORY	0	1,076	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	718	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	675	0	1,800	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	167	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	175	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	315	0	0	0	73.00
76.00	03020	GERIATRIC PSYCH	1,496	400	400	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	90.00
90.01	04951	WOUND CARE	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	1,099	1,099	43,825	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	29,994	9,616	4,597	222,625	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	2,592	10	0	0	0	192.00
192.01	19201	PROMOTION	0	0	0	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	567,078	573,976	310,713	579,192	337,756	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	17.402504	59.627675	67.590385	2.601649	3,377.560000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	65,517	53,327	17,246	58,195	14,072	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	2.010587	5.539892	3.751577	0.261404	140.720000	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1323 | Period: From 04/01/2016 To 03/31/2017 | Worksheet B-1 | Date/Time Prepared: 8/31/2017 1:24 pm

		Cost Center Description	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)		
			19.00		
		GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
1.01	00101	NEW CAP REL COSTS-BLDG AMBULANCE			1.01
1.02	00102	NEW CAP REL COSTS-BLDG EKG			1.02
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
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	0		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	0		30.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0		50.00
53.00	05300	ANESTHESIOLOGY	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0		54.00
60.00	06000	LABORATORY	0		60.00
65.00	06500	RESPIRATORY THERAPY	0		65.00
66.00	06600	PHYSICAL THERAPY	0		66.00
69.00	06900	ELECTROCARDIOLOGY	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0		73.00
76.00	03020	GERIATRIC PSYCH	0		76.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	0		88.00
90.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0		90.00
90.01	04951	WOUND CARE	0		90.01
91.00	09100	EMERGENCY	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0		93.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0		95.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0		118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0		192.00
192.01	19201	PROMOTION	0		192.01
193.00	19300	NONPAID WORKERS	0		193.00
200.00		Cross Foot Adjustments			200.00
201.00		Negative Cost Centers			201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	0		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	0		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000		205.00

POST STEPDOWN ADJUSTMENTS | Provider CCN: 14-1323 | Period: From 04/01/2016 To 03/31/2017 | Worksheet B-2 | Date/Time Prepared: 8/31/2017 1:24 pm

		Description	Worksheet Part	Worksheet Line No.	Amount	
		1.00	2.00	3.00	4.00	
1.00		ADJ FOR EPO COSTS IN RENAL DIALYSIS	1	74.00	0	1.00
2.00		ADJ FOR EPO COSTS IN HOME PROGRAM	1	94.00	0	2.00
3.00		ADJ FOR ARANESP COSTS IN RENAL DIALYSIS	1	74.00	0	3.00
4.00		ADJ FOR ARANESP COSTS IN HOME PROGRAM	1	94.00	0	4.00
5.00		ADJ FOR ESA COSTS IN RENAL DIALYSIS	1	74.00	0	5.00
6.00		ADJ FOR ESA COSTS IN HOME PROGRAM	1	94.00	0	6.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1323 | Period: From 04/01/2016 To 03/31/2017 | Worksheet C Part I Date/Time Prepared: 8/31/2017 1:24 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,218,564		5,218,564	0	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,395,690		1,395,690	0	0	50.00
53.00	05300	ANESTHESIOLOGY	108,057		108,057	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,044,986		2,044,986	0	0	54.00
60.00	06000	LABORATORY	1,964,265		1,964,265	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	925,604	0	925,604	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,025,349	0	1,025,349	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	447,582		447,582	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	168,435		168,435	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	37,154		37,154	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,201,100		1,201,100	0	0	73.00
76.00	03020	GERIATRIC PSYCH	754,523		754,523	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	2,011,750		2,011,750	0	0	88.00
90.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0		0	0	0	90.00
90.01	04951	WOUND CARE	137,604		137,604	0	0	90.01
91.00	09100	EMERGENCY	2,939,577		2,939,577	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	310,026		310,026		0	92.00
93.00	04040	OTHER OUTPATIENT SERVICES	33,087		33,087	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1,221,383		1,221,383	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	21,944,736	0	21,944,736	0	0	200.00
201.00		Less Observation Beds	310,026		310,026		0	201.00
202.00		Total (see instructions)	21,634,710	0	21,634,710	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1323 | Period: From 04/01/2016 To 03/31/2017 | Worksheet C Part I Date/Time Prepared: 8/31/2017 1:24 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,683,013		2,683,013			30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,165	2,065,266	2,069,431	0.674432	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	106,915	106,915	1.010681	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,888,660	18,153,694	21,042,354	0.097184	0.000000	54.00
60.00	06000	LABORATORY	1,768,361	4,895,528	6,663,889	0.294763	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	1,269,364	283,292	1,552,656	0.596142	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	176,934	1,114,240	1,291,174	0.794121	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	746,818	1,867,840	2,614,658	0.171182	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	11,731	31,105	42,836	3.932090	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	40,000	40,000	0.928850	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,298,173	957,965	2,256,138	0.532370	0.000000	73.00
76.00	03020	GERIATRIC PSYCH	1,012	606,177	607,189	1.242649	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	1,050,920	1,050,920			88.00
90.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0.000000	0.000000	90.00
90.01	04951	WOUND CARE	288	183,096	183,384	0.750360	0.000000	90.01
91.00	09100	EMERGENCY	620,736	4,712,034	5,332,770	0.551229	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	8,995	113,561	122,556	2.529668	0.000000	92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0	49,410	49,410	0.669642	0.000000	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	1,729,632	1,729,632	0.706152	0.000000	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	11,478,250	37,960,675	49,438,925			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	11,478,250	37,960,675	49,438,925			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1323 | Period: From 04/01/2016 To 03/31/2017 | Worksheet C Part I Date/Time Prepared: 8/31/2017 1:24 pm

Title XVIII | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	06000	LABORATORY	0.000000		60.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
76.00	03020	GERIATRIC PSYCH	0.000000		76.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC			88.00
90.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0.000000		90.00
90.01	04951	WOUND CARE	0.000000		90.01
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0.000000		93.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0.000000		95.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 14-1323 | Period: From 04/01/2016 To 03/31/2017 | Worksheet D Part II Date/Time Prepared: 8/31/2017 1:24 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	277,311	2,069,431	0.134004	0	0	50.00
53.00	05300	ANESTHESIOLOGY	2,505	106,915	0.023430	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	192,989	21,042,354	0.009171	844,566	7,746	54.00
60.00	06000	LABORATORY	82,243	6,663,889	0.012342	782,839	9,662	60.00
65.00	06500	RESPIRATORY THERAPY	68,522	1,552,656	0.044132	630,618	27,830	65.00
66.00	06600	PHYSICAL THERAPY	121,697	1,291,174	0.094253	16,999	1,602	66.00
69.00	06900	ELECTROCARDIOLOGY	91,968	2,614,658	0.035174	336,112	11,822	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	40,819	42,836	0.952913	6,375	6,075	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	861	40,000	0.021525	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	44,475	2,256,138	0.019713	663,596	13,081	73.00
76.00	03020	GERIATRIC PSYCH	60,389	607,189	0.099457	1,012	101	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	126,364	1,050,920	0.120241	0	0	88.00
90.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0.000000	0	0	90.00
90.01	04951	WOUND CARE	29,787	183,384	0.162430	288	47	90.01
91.00	09100	EMERGENCY	252,336	5,332,770	0.047318	10,899	516	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	36,078	122,556	0.294380	609	179	92.00
93.00	04040	OTHER OUTPATIENT SERVICES	786	49,410	0.015908	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	1,429,130	45,026,280		3,293,913	78,661	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1323 | Period: From 04/01/2016 To 03/31/2017 | Worksheet D Part IV | Date/Time Prepared: 8/31/2017 1:24 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	GERIATRIC PSYCH	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	90.00
90.01	04951	WOUND CARE	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1323 | Period: From 04/01/2016 To 03/31/2017 | Worksheet D Part IV | Date/Time Prepared: 8/31/2017 1:24 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	2,069,431	0.000000	0.000000	0	50.00
53.00	05300	ANESTHESIOLOGY	0	106,915	0.000000	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	21,042,354	0.000000	0.000000	844,566	54.00
60.00	06000	LABORATORY	0	6,663,889	0.000000	0.000000	782,839	60.00
65.00	06500	RESPIRATORY THERAPY	0	1,552,656	0.000000	0.000000	630,618	65.00
66.00	06600	PHYSICAL THERAPY	0	1,291,174	0.000000	0.000000	16,999	66.00
69.00	06900	ELECTROCARDIOLOGY	0	2,614,658	0.000000	0.000000	336,112	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	42,836	0.000000	0.000000	6,375	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	40,000	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,256,138	0.000000	0.000000	663,596	73.00
76.00	03020	GERIATRIC PSYCH	0	607,189	0.000000	0.000000	1,012	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	1,050,920	0.000000	0.000000	0	88.00
90.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0.000000	0.000000	0	90.00
90.01	04951	WOUND CARE	0	183,384	0.000000	0.000000	288	90.01
91.00	09100	EMERGENCY	0	5,332,770	0.000000	0.000000	10,899	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	122,556	0.000000	0.000000	609	92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0	49,410	0.000000	0.000000	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	45,026,280			3,293,913	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1323 | Period: From 04/01/2016 To 03/31/2017 | Worksheet D Part IV | Date/Time Prepared: 8/31/2017 1:24 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
60.00	06000	LABORATORY	0	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
76.00	03020	GERIATRIC PSYCH	0	0	0		76.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	0		88.00
90.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0		90.00
90.01	04951	WOUND CARE	0	0	0		90.01
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0		92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0	0	0		93.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES					95.00
200.00		Total (lines 50-199)	0	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-1323 | Period: From 04/01/2016 To 03/31/2017 | Worksheet D Part V Date/Time Prepared: 8/31/2017 1:24 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.674432	0	869,483	0	0	50.00
53.00	05300	ANESTHESIOLOGY	1.010681	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.097184	0	6,446,537	0	0	54.00
60.00	06000	LABORATORY	0.294763	0	1,817,886	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.596142	0	73,478	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.794121	0	299,216	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.171182	0	710,559	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3.932090	0	23,547	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.928850	0	35,948	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.532370	0	635,592	0	0	73.00
76.00	03020	GERIATRIC PSYCH	1.242649	0	533,436	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
90.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	0	0	90.00
90.01	04951	WOUND CARE	0.750360	0	165,595	0	0	90.01
91.00	09100	EMERGENCY	0.551229	0	1,325,535	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2.529668	0	45,828	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0.669642	0	45,410	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.706152		2,049			95.00
200.00		Subtotal (see instructions)		0	13,030,099	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		0	13,030,099	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-1323 | Period: From 04/01/2016 To 03/31/2017 | Worksheet D Part V Date/Time Prepared: 8/31/2017 1:24 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
			6.00	7.00	
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	586,407	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	626,500	0	54.00
60.00	06000	LABORATORY	535,846	0	60.00
65.00	06500	RESPIRATORY THERAPY	43,803	0	65.00
66.00	06600	PHYSICAL THERAPY	237,614	0	66.00
69.00	06900	ELECTROCARDIOLOGY	121,635	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	92,589	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	33,390	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	338,370	0	73.00
76.00	03020	GERIATRIC PSYCH	662,874	0	76.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	0	0	88.00
90.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0	0	90.00
90.01	04951	WOUND CARE	124,256	0	90.01
91.00	09100	EMERGENCY	730,673	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	115,930	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICES	30,408	0	93.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	1,447		95.00
200.00		Subtotal (see instructions)	4,281,742	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 +/- line 201)	4,281,742	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1323 | Component CCN: 14-Z323 | Period: From 04/01/2016 To 03/31/2017 | Worksheet D Part V Date/Time Prepared: 8/31/2017 1:24 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.674432	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	1.010681	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.097184	0	0	0	0	54.00
60.00	06000	LABORATORY	0.294763	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.596142	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.794121	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.171182	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3.932090	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.928850	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.532370	0	0	0	0	73.00
76.00	03020	GERIATRIC PSYCH	1.242649	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
90.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	0	0	90.00
90.01	04951	WOUND CARE	0.750360	0	0	0	0	90.01
91.00	09100	EMERGENCY	0.551229	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2.529668	0	0	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0.669642	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.706152		0			95.00
200.00		Subtotal (see instructions)		0	0	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		0	0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1323 | Component CCN: 14-Z323 | Period: From 04/01/2016 To 03/31/2017 | Worksheet D Part V | Date/Time Prepared: 8/31/2017 1:24 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
60.00	06000	LABORATORY	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
76.00	03020	GERIATRIC PSYCH	0	0		76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
90.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0	0		90.00
90.01	04951	WOUND CARE	0	0		90.01
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0	0		93.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	0	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	0	0		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1323 | Period: From 04/01/2016 To 03/31/2017 | Worksheet D-1 | Date/Time Prepared: 8/31/2017 1:24 pm

Title XVIII | Hospital

	Cost Center Description	Cost	
		1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	3,536	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,811	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)	2,610	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	243	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)	315	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	85	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)	82	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	1,648	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)	243	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)	315	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	132.61	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	132.61	20.00
21.00	Total general inpatient routine service cost (see instructions)	5,218,564	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)	11,272	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)	10,874	25.00
26.00	Total swing-bed cost (see instructions)	882,816	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	4,335,748	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)	4,335,748	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)	1,542.42	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	2,541,908	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)	2,541,908	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1323 | Period: From 04/01/2016 To 03/31/2017 | Worksheet D-1 | Date/Time Prepared: 8/31/2017 1:24 pm

Title XVIII | Hospital | Cost

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	1,147,172	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	3,689,080	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)	374,808	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	485,862	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	860,670	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)	201	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,542.42	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	310,026	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1323 | Period: From 04/01/2016 To 03/31/2017 | Worksheet D-1 | Date/Time Prepared: 8/31/2017 1:24 pm

Title XVIII | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	607,289	5,218,564	0.116371	310,026	36,078	90.00
91.00	Nursing School cost	0	5,218,564	0.000000	310,026	0	91.00
92.00	Allied health cost	0	5,218,564	0.000000	310,026	0	92.00
93.00	All other Medical Education	0	5,218,564	0.000000	310,026	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 14-1323 | Period: From 04/01/2016 To 03/31/2017 | Worksheet D-3 | Date/Time Prepared: 8/31/2017 1:24 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		1,511,485		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.674432	0	0	50.00
53.00	05300	ANESTHESIOLOGY	1.010681	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.097184	844,566	82,078	54.00
60.00	06000	LABORATORY	0.294763	782,839	230,752	60.00
65.00	06500	RESPIRATORY THERAPY	0.596142	630,618	375,938	65.00
66.00	06600	PHYSICAL THERAPY	0.794121	16,999	13,499	66.00
69.00	06900	ELECTROCARDIOLOGY	0.171182	336,112	57,536	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3.932090	6,375	25,067	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.928850	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.532370	663,596	353,279	73.00
76.00	03020	GERIATRIC PSYCH	1.242649	1,012	1,258	76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	90.00
90.01	04951	WOUND CARE	0.750360	288	216	90.01
91.00	09100	EMERGENCY	0.551229	10,899	6,008	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2.529668	609	1,541	92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0.669642	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50-94 and 96-98)		3,293,913	1,147,172	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)		3,293,913		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 14-1323 | Component CCN: 14-Z323 | Period: From 04/01/2016 To 03/31/2017 | Worksheet D-3 | Date/Time Prepared: 8/31/2017 1:24 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		235,818		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.674432	0	0	50.00
53.00	05300	ANESTHESIOLOGY	1.010681	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.097184	38,423	3,734	54.00
60.00	06000	LABORATORY	0.294763	98,229	28,954	60.00
65.00	06500	RESPIRATORY THERAPY	0.596142	128,577	76,650	65.00
66.00	06600	PHYSICAL THERAPY	0.794121	107,318	85,223	66.00
69.00	06900	ELECTROCARDIOLOGY	0.171182	11,740	2,010	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3.932090	1,975	7,766	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.928850	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.532370	162,922	86,735	73.00
76.00	03020	GERIATRIC PSYCH	1.242649	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	90.00
90.01	04951	WOUND CARE	0.750360	0	0	90.01
91.00	09100	EMERGENCY	0.551229	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2.529668	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0.669642	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50-94 and 96-98)		549,184	291,072	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)		549,184		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 14-1323 | Period: From 04/01/2016 To 03/31/2017 | Worksheet E Part B Date/Time Prepared: 8/31/2017 1:24 pm

Title XVIII | Hospital | Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	4,281,742	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	PPS payments	0	3.00
4.00	Outlier payment (see instructions)	0	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	4,281,742	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	0	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)	4,324,559	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)	0	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	43,975	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	2,225,062	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	2,055,522	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	2,055,522	30.00
31.00	Primary payer payments	1,093	31.00
32.00	Subtotal (line 30 minus line 31)	2,054,429	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)	632,371	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	411,041	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	519,354	36.00
37.00	Subtotal (see instructions)	2,465,470	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	39.50
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	2,465,470	40.00
40.01	Sequestration adjustment (see instructions)	49,309	40.01
41.00	Interim payments	2,526,843	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	-110,682	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: 14-1323 | Period: From 04/01/2016 To 03/31/2017 | Worksheet E-1 Part I | Date/Time Prepared: 8/31/2017 1:24 pm

Title XVIII | Hospital | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		2,797,337		2,641,797	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	11/08/2016	27,234	11/08/2016	112,830	3.50
3.51		03/23/2017	8,903	03/23/2017	2,124	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)		-36,137		-114,954	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)		2,761,200		2,526,843	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		540,398		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		110,682	6.02
7.00	Total Medicare program liability (see instructions)		3,301,598		2,416,161	7.00

			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor	CGS	15101		8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-1323 | Component CCN: 14-Z323 | Period: From 04/01/2016 To 03/31/2017 | Worksheet E-1 Part I | Date/Time Prepared: 8/31/2017 1:24 pm

Title XVIII | Swing Beds - SNF | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		957,717		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER	11/08/2016	1,634		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)		1,634		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)		959,351		0	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		173,825		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,133,176		0	7.00

			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor	CGS	15101		8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 14-1323	Period: From 04/01/2016 To 03/31/2017	Worksheet E-1 Part II Date/Time Prepared: 8/31/2017 1:24 pm
	Title XVIII	Hospital	Cost

		1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS		
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION		
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14	722	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12	1,648	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2	143	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12	2,610	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200	49,438,925	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20	435,751	6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168	1	7.00
8.00	Calculation of the HIT incentive payment (see instructions)	1	8.00
9.00	Sequestration adjustment amount (see instructions)	0	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)	1	10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH		
30.00	Initial/interim HIT payment adjustment (see instructions)	0	30.00
31.00	Other Adjustment (specify)	0	31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)	1	32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

Provider CCN: 14-1323 | Component CCN: 14-Z323 | Period: From 04/01/2016 To 03/31/2017 | Worksheet E-2 | Date/Time Prepared: 8/31/2017 1:24 pm

Title XVIII | Swing Beds - SNF | Cost

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	869,277	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)	293,983	0	3.00
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)		0.00	4.00
5.00	Program days	558	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)		0	6.00
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	1,163,260	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	1,163,260	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0	0	11.00
12.00	Subtotal (line 10 minus line 11)	1,163,260	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	6,958	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)	1,156,302	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	0	16.50
16.55	410A RURAL DEMONSTRATION PROJECT	0		16.55
17.00	Allowable bad debts (see instructions)	0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (see instructions)	1,156,302	0	19.00
19.01	Sequestration adjustment (see instructions)	23,126	0	19.01
20.00	Interim payments	959,351	0	20.00
21.00	Tentative settlement (for contractor use only)	0	0	21.00
22.00	Balance due provider/program (line 19 minus lines 19.01, 20, and 21)	173,825	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	23.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-1323	Period: From 04/01/2016 To 03/31/2017	Worksheet E-3 Part V Date/Time Prepared: 8/31/2017 1:24 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	3,689,080	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)	3,689,080	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	3,725,971	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)	3,725,971	19.00
20.00	Deductibles (exclude professional component)	402,080	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	3,323,891	22.00
23.00	Coinsurance	0	23.00
24.00	Subtotal (line 22 minus line 23)	3,323,891	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	69,365	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	45,087	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	51,312	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	3,368,978	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	29.50
29.99	Recovery of Accelerated Depreciation	0	29.99
30.00	Subtotal (see instructions)	3,368,978	30.00
30.01	Sequestration adjustment (see instructions)	67,380	30.01
31.00	Interim payments	2,761,200	31.00
32.00	Tentative settlement (for contractor use only)	0	32.00
33.00	Balance due provider/program (line 30 minus lines 30.01, 31, and 32)	540,398	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	34.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only)

Provider CCN: 14-1323 | Period: From 04/01/2016 To 03/31/2017 | Worksheet G | Date/Time Prepared: 8/31/2017 1:24 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	12,642,931	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	19,795,172	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-13,237,568	0	0	0	6.00
7.00	Inventory	346,334	0	0	0	7.00
8.00	Prepaid expenses	357,806	0	0	0	8.00
9.00	Other current assets	33,863	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)	19,938,538	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	708,452	0	0	0	12.00
13.00	Land improvements	1,083,220	0	0	0	13.00
14.00	Accumulated depreciation	-720,508	0	0	0	14.00
15.00	Buildings	17,294,233	0	0	0	15.00
16.00	Accumulated depreciation	-7,570,983	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	8,004,965	0	0	0	23.00
24.00	Accumulated depreciation	-5,863,295	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)	12,936,084	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	1,863,968	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	90,832	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	1,954,800	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	34,829,422	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	1,524,397	0	0	0	37.00
38.00	Salaries, wages, and fees payable	0	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	718,843	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	3,543,729	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	5,786,969	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	9,633,512	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	9,633,512	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	15,420,481	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	19,408,941				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)	19,408,941	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	34,829,422	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 14-1323 | Period: From 04/01/2016 To 03/31/2017 | Worksheet G-1 | Date/Time Prepared: 8/31/2017 1:24 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		23,339,575		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-3,930,634				2.00
3.00	Total (sum of line 1 and line 2)		19,408,941		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)		19,408,941		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)		19,408,941		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: 14-1323 | Period: From 04/01/2016 To 03/31/2017 | Worksheet G-2 Parts I & II Date/Time Prepared: 8/31/2017 1:24 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	2,438,973		2,438,973	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	255,040		255,040	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	2,694,013		2,694,013	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	2,694,013		2,694,013	17.00
18.00	Ancillary services	8,794,949	35,180,410	43,975,359	18.00
19.00	Outpatient services	0	0	0	19.00
20.00	RURAL HEALTH CLINIC	0	1,050,920	1,050,920	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES	0	1,729,632	1,729,632	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	11,488,962	37,960,962	49,449,924	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		23,468,557		29.00
30.00	BAD DEBT EXPENSE	5,479,746			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)		5,479,746		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)		28,948,303		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 14-1323 | Period: From 04/01/2016 To 03/31/2017 | Worksheet G-3 | Date/Time Prepared: 8/31/2017 1:24 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	49,449,924	1.00
2.00	Less contractual allowances and discounts on patients' accounts	25,698,044	2.00
3.00	Net patient revenues (line 1 minus line 2)	23,751,880	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	28,948,303	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-5,196,423	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	97,592	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	17,767	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	71,878	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	1,497	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	112,334	22.00
23.00	Governmental appropriations	198,483	23.00
24.00	OTHER OPERATING REVENUE	925,488	24.00
25.00	Total other income (sum of lines 6-24)	1,425,039	25.00
26.00	Total (line 5 plus line 25)	-3,771,384	26.00
27.00	LOSS ON EQUITY INVESTMENT	159,250	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	159,250	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-3,930,634	29.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1323 | Component CCN: 14-3478 | Period: From 04/01/2016 To 03/31/2017 | Worksheet M-1 | Date/Time Prepared: 8/31/2017 1:24 pm

RHC I | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	293,099	0	293,099	0	293,099	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	179,848	0	179,848	0	179,848	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	0	0	0	0	0	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	472,947	0	472,947	0	472,947	10.00
11.00	Physician Services Under Agreement	361,308	0	361,308	0	361,308	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	59,474	59,474	0	59,474	13.00
14.00	Subtotal (sum of lines 11 through 13)	361,308	59,474	420,782	0	420,782	14.00
15.00	Medical Supplies	0	32,825	32,825	0	32,825	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	42,886	42,886	0	42,886	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	75,711	75,711	0	75,711	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	834,255	135,185	969,440	0	969,440	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	19,870	19,870	0	19,870	29.00
30.00	Administrative Costs	34,190	42,886	77,076	0	77,076	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	34,190	62,756	96,946	0	96,946	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	868,445	197,941	1,066,386	0	1,066,386	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1323 | Component CCN: 14-3478 | Period: From 04/01/2016 To 03/31/2017 | Worksheet M-1 | Date/Time Prepared: 8/31/2017 1:24 pm

RHC I | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	293,099		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	179,848		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	0		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	0		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	472,947		10.00
11.00	Physician Services Under Agreement	0	361,308		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	59,474		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	420,782		14.00
15.00	Medical Supplies	0	32,825		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	42,886		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	75,711		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	969,440		22.00
	COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
25.01	Telehealth	0	0		25.01
25.02	Chronic Care Management	0	0		25.02
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs				27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	19,870		29.00
30.00	Administrative Costs	0	77,076		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	96,946		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	1,066,386		32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1323 | Component CCN: 14-3478 | Period: From 04/01/2016 To 03/31/2017 | Worksheet M-2 | Date/Time Prepared: 8/31/2017 1:24 pm

RHC I | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	2.10	4,500	4,200	8,820		1.00
2.00	Physician Assistant	1.82	5,268	2,100	3,822		2.00
3.00	Nurse Practitioner	0.00	0	2,100	0		3.00
4.00	Subtotal (sum of lines 1 through 3)	3.92	9,768		12,642	12,642	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	3.92	9,768			12,642	8.00
9.00	Physician Services Under Agreements		2,432			2,432	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)					969,440	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)					969,440	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)					96,946	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					945,364	15.00
16.00	Total overhead (sum of lines 14 and 15)					1,042,310	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					1,042,310	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					1,042,310	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					2,011,750	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 14-1323 Component CCN: 14-3478	Period: From 04/01/2016 To 03/31/2017	Worksheet M-3 Date/Time Prepared: 8/31/2017 1:24 pm
	Title XVIII	RHC I	Cost

				1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES				
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			2,011,750	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			0	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			2,011,750	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			12,642	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)			2,432	5.00
6.00	Total adjusted visits (line 4 plus line 5)			15,074	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			133.46	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	0.00		8.00
9.00	Rate for Program covered visits (see instructions)	133.46	133.46		9.00
	CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	0	2,629		10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	350,866		11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0		12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0		13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0		14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)				15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *	0	350,866		16.00
16.01	Total program charges (see instructions)(from contractor's records)		187,368		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		1,378		16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		2,581		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.)		266,301		16.04
16.05	Total program cost (see instructions)	0	268,882		16.05
17.00	Primary payer amounts		0		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		15,409		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		34,392		19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		268,882		20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		0		21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		268,882		22.00
23.00	Allowable bad debts (see instructions)		17,711		23.00
23.01	Adjusted reimbursable bad debts (see instructions)		11,512		23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		14,542		24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0		25.50
26.00	Net reimbursable amount (see instructions)		280,394		26.00
26.01	Sequestration adjustment (see instructions)		5,608		26.01
27.00	Interim payments		318,890		27.00
28.00	Tentative settlement (for contractor use only)		0		28.00
29.00	Balance due component/program (line 26 minus lines 26.01, 27, and 28)		-44,104		29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0		30.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 14-1323 Component CCN: 14-3478	Period: From 04/01/2016 To 03/31/2017	Worksheet M-5 Date/Time Prepared: 8/31/2017 1:24 pm
		RHC I	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		339,312	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00
	Program to Provider			
3.01			0	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
	Provider to Program			
3.50		11/08/2016	9,867	3.50
3.51		03/23/2017	10,555	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)		-20,422	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		318,890	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		44,104	6.02
7.00	Total Medicare program liability (see instructions)		274,786	7.00

			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor	CGS	15101		8.00