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: 14-1329	Period: From 07/01/2016 To 06/30/2017	Worksheet S Parts I-III Date/Time Prepared: 11/21/2017 11:35 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 11/21/2017 Time: 11:35 am
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by MORRISON COMMUNITY HOSPITAL (14-1329) for the cost reporting period beginning 07/01/2016 and ending 06/30/2017 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

_____
Title

_____
Date

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	1,919	-62,255	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	-39,565	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
10.00	RURAL HEALTH CLINIC I	0		-5,864		0	10.00
200.00	Total	0	-37,646	-68,119	0	0	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1329 | Period: From 07/01/2016 To 06/30/2017 | Worksheet S-2 Part I | Date/Time Prepared: 11/20/2017 2:41 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 303 JACKSON	PO Box:			1.00
2.00	City: MORRISON	State: IL	Zip Code: 61270	County: WHITESIDE	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	MORRISON COMMUNITY HOSPITAL	141329	99914	1	08/01/2003	N	O	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	MORRISON SWING BED	14Z329	99914		08/01/2003	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	MORRISON COMMUNITY HOSPITAL CLINIC	143981	99914		07/01/1996	N	O	O	15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	07/01/2016	06/30/2017	20.00
21.00	Type of Control (see instructions)	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.	2	N	23.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1329 | Period: From 07/01/2016 To 06/30/2017 | Worksheet S-2 Part I Date/Time Prepared: 11/20/2017 2:41 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.	N			58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59.00
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: 14-1329 | Period: From 07/01/2016 To 06/30/2017 | Worksheet S-2 Part I | Date/Time Prepared: 11/20/2017 2:41 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: 14-1329 | Period: From 07/01/2016 To 06/30/2017 | Worksheet S-2 Part I | Date/Time Prepared: 11/20/2017 2:41 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)	N		0	71.00
	Inpatient Rehabilitation Facility PPS				
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	N			75.00
76.00	If line 75 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0	76.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1329 | Period: From 07/01/2016 To 06/30/2017 | Worksheet S-2 Part I | Date/Time Prepared: 11/20/2017 2:41 pm

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

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

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

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

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	367,779	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: 14-1329 | Period: From 07/01/2016 To 06/30/2017 | Worksheet S-2 Part I | Date/Time Prepared: 11/20/2017 2:41 pm

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

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

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

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

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

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

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

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

		1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act		
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.	Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)	0	168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)		168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	0.00	169.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 14-1329	Period: From 07/01/2016 To 06/30/2017	Worksheet S-2 Part I Date/Time Prepared: 11/20/2017 2:41 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)	10/01/2016	12/29/2016	170.00
		1.00	2.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)	N	0	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 14-1329 | Period: From 07/01/2016 To 06/30/2017 | Worksheet S-2 Part II | Date/Time Prepared: 11/20/2017 2:41 pm

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

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

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

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

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

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	N		N		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	10/03/2017	Y	10/03/2017	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 14-1329 | Period: From 07/01/2016 To 06/30/2017 | Worksheet S-2 Part II Date/Time Prepared: 11/20/2017 2:41 pm

		Description		Y/N	Y/N	
		0		1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
	Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions				N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				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.				Y	35.00
				Y/N	Date	
				1.00	2.00	
	Home Office Costs					
36.00	Were home office costs claimed on the cost report?			N		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			N		37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.			N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			N		40.00
		1.00		2.00		
	Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	DAN		LINHART		41.00
42.00	Enter the employer/company name of the cost report preparer.	RSM US LLP				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	563-888-4404		DAN.LINHART@RSMUS.COM		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 14-1329	Period: From 07/01/2016 To 06/30/2017	Worksheet S-2 Part II Date/Time Prepared: 11/20/2017 2:41 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.	MANAGER		41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 14-1329 | Period: From 07/01/2016 To 06/30/2017 | Worksheet S-3 Part I Date/Time Prepared: 11/20/2017 2:41 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	5,064.00	0	1.00
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		25	9,125	5,064.00	0	7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)		25	9,125	5,064.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						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: 14-1329 | Period: From 07/01/2016 To 06/30/2017 | Worksheet S-3 Part I | Date/Time Prepared: 11/20/2017 2:41 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)	131	24	211			1.00
2.00	HMO and other (see instructions)	10	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	2,008	0	2,298			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	584			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	2,139	24	3,093			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)	2,139	24	3,093	0.00	110.30	14.00
15.00	CAH visits	2,115	1,152	5,822			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	2,533	5,793	17,753	0.00	17.96	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	128.26	27.00
28.00	Observation Bed Days		15	94			28.00
29.00	Ambulance Trips	230					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: 14-1329 | Period: From 07/01/2016 To 06/30/2017 | Worksheet S-3 Part I | Date/Time Prepared: 11/20/2017 2:41 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	49	11	84	1.00
2.00	HMO and other (see instructions)			5	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	49	11	84	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: 14-1329 | Component CCN: 14-3981 | Period: From 07/01/2016 To 06/30/2017 | Worksheet S-8 | Date/Time Prepared: 11/20/2017 2:41 pm

RHC I | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			300 NORTH JACKSON STREET		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	MORRISON		IL	61270	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	20:00	08:00	20:00	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		WHITESIDE				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	20:00	08:00	20:00	08:00	20:00	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-1329
Component CCN: 14-3981

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

Worksheet S-8

Date/Time Prepared:
11/20/2017 2:41 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	20:00	08:00	20:00		11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 14-1329 | Period: From 07/01/2016 To 06/30/2017 | Worksheet S-10 | Date/Time Prepared: 11/20/2017 2:41 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)			0.722479	1.00
	Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid			1,196,529	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			3,269,935	6.00
7.00	Medicaid cost (line 1 times line 6)			2,362,459	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)			1,165,930	8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)				
9.00	Net revenue from stand-alone CHIP			0	9.00
10.00	Stand-alone CHIP charges			0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)			0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)			0	12.00
	Other state or local government indigent care program (see instructions for each line)				
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)			0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)			0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)			0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)			0	16.00
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)				
17.00	Private grants, donations, or endowment income restricted to funding charity care			0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations			0	18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)			1,165,930	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
	Uncompensated Care (see instructions for each line)				
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	18,506	38,481	56,987	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	13,370	38,481	51,851	21.00
22.00	Payments received from patients for amounts previously written off as charity care	999	8,189	9,188	22.00
23.00	Cost of charity care (line 21 minus line 22)	12,371	30,292	42,663	23.00

				1.00	
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?			N	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit			0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)			926,343	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)			32,425	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)			49,884	27.01
28.00	Non-Medicare bad debt expense (line 26 minus line 27.01)			876,459	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)			650,682	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)			693,345	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)			1,859,275	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-1329 | Period: From 07/01/2016 To 06/30/2017 | Worksheet A | Date/Time Prepared: 11/20/2017 2:41 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		677,567	677,567	-191,834	485,733	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		119,162	119,162	364,589	483,751	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	1,592,430	1,592,430	-150,617	1,441,813	4.00
5.01	00560	PURCHASING RECEIVING AND STORES	35,088	13,299	48,387	0	48,387	5.01
5.02	00591	PERSONNEL	94,562	10,892	105,454	0	105,454	5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	299,265	90,606	389,871	0	389,871	5.03
5.05	00590	ADMINISTRATIVE & GENERAL	427,901	446,842	874,743	269,270	1,144,013	5.05
7.00	00700	OPERATION OF PLANT	173,995	371,866	545,861	0	545,861	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	27,697	27,697	0	27,697	8.00
9.00	00900	HOUSEKEEPING	161,505	24,585	186,090	0	186,090	9.00
10.00	01000	DIETARY	192,317	91,394	283,711	0	283,711	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	110,192	2,306	112,498	0	112,498	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	23,107	34,904	58,011	0	58,011	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	208,597	38,379	246,976	0	246,976	16.00
17.00	01700	SOCIAL SERVICE	70,333	403	70,736	0	70,736	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,422,541	181,471	1,604,012	-7,918	1,596,094	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	183,529	161,881	345,410	3,970	349,380	50.00
53.00	05300	ANESTHESIOLOGY	0	104,476	104,476	0	104,476	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	313,920	130,846	444,766	2,034	446,800	54.00
60.00	06000	LABORATORY	356,785	375,805	732,590	0	732,590	60.00
64.00	06400	INTRAVENOUS THERAPY	0	37,908	37,908	26,639	64,547	64.00
65.00	06500	RESPIRATORY THERAPY	783	37,931	38,714	-33,736	4,978	65.00
66.00	06600	PHYSICAL THERAPY	273,411	6,429	279,840	0	279,840	66.00
67.00	06700	OCCUPATIONAL THERAPY	191,683	644	192,327	0	192,327	67.00
68.00	06800	SPEECH PATHOLOGY	3,922	1,625	5,547	0	5,547	68.00
69.00	06900	ELECTROCARDIOLOGY	3,862	5,914	9,776	0	9,776	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	2,585	2,585	44,392	46,977	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	230,511	230,511	0	230,511	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	140,955	228,054	369,009	0	369,009	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,796,523	628,847	2,425,370	59,700	2,485,070	88.00
91.00	09100	EMERGENCY	397,101	1,497,196	1,894,297	-264,615	1,629,682	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04950	WOUND CARE	55,041	9,152	64,193	0	64,193	93.00
93.01	04951	DIABETIC EDUCATION	0	0	0	0	0	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	48,127	34,630	82,757	-10,964	71,793	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		110,910	110,910	-110,910	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	6,985,045	7,329,147	14,314,192	0	14,314,192	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	OPTH CLINIC	0	0	0	0	0	194.00
194.01	07951	RENTAL SPACE	0	0	0	0	0	194.01
194.02	07952	OTHER NON-REIMBURSABLE COST CENTERS	0	0	0	0	0	194.02
200.00		TOTAL (SUM OF LINES 118-199)	6,985,045	7,329,147	14,314,192	0	14,314,192	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-1329 | Period: From 07/01/2016 To 06/30/2017 | Worksheet A | Date/Time Prepared: 11/20/2017 2:41 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	-954	484,779		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-182,792	300,959		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-3,776	1,438,037		4.00
5.01	00560	PURCHASING RECEIVING AND STORES	0	48,387		5.01
5.02	00591	PERSONNEL	0	105,454		5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	-13,384	376,487		5.03
5.05	00590	ADMINISTRATIVE & GENERAL	-10,848	1,133,165		5.05
7.00	00700	OPERATION OF PLANT	0	545,861		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	27,697		8.00
9.00	00900	HOUSEKEEPING	0	186,090		9.00
10.00	01000	DIETARY	-62,876	220,835		10.00
11.00	01100	CAFETERIA	0	0		11.00
13.00	01300	NURSING ADMINISTRATION	0	112,498		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	58,011		14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-5,181	241,795		16.00
17.00	01700	SOCIAL SERVICE	0	70,736		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	1,596,094		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-82,151	267,229		50.00
53.00	05300	ANESTHESIOLOGY	-4,192	100,284		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-23,352	423,448		54.00
60.00	06000	LABORATORY	-35,847	696,743		60.00
64.00	06400	INTRAVENOUS THERAPY	-864	63,683		64.00
65.00	06500	RESPIRATORY THERAPY	-42	4,936		65.00
66.00	06600	PHYSICAL THERAPY	-11,386	268,454		66.00
67.00	06700	OCCUPATIONAL THERAPY	-2,477	189,850		67.00
68.00	06800	SPEECH PATHOLOGY	0	5,547		68.00
69.00	06900	ELECTROCARDIOLOGY	-5,813	3,963		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	-236	46,741		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	230,511		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-3,641	365,368		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	-91,993	2,393,077		88.00
91.00	09100	EMERGENCY	-190,924	1,438,758		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
93.00	04950	WOUND CARE	-811	63,382		93.00
93.01	04951	DIABETIC EDUCATION	0	0		93.01
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	-476	71,317		95.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-734,016	13,580,176		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
194.00	07950	OPTH CLINIC	0	0		194.00
194.01	07951	RENTAL SPACE	0	0		194.01
194.02	07952	OTHER NON-REIMBURSABLE COST CENTERS	0	0		194.02
200.00		TOTAL (SUM OF LINES 118-199)	-734,016	13,580,176		200.00

RECLASSIFICATIONS | Provider CCN: 14-1329 | Period: From 07/01/2016 To 06/30/2017 | Worksheet A-6 | Date/Time Prepared: 11/20/2017 2:41 pm

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - INTEREST EXPENSE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	96,274		1.00
2.00	ADMINISTRATIVE & GENERAL	5.05	0	9,478		2.00
3.00	OPERATING ROOM	50.00	0	3,124		3.00
5.00	RADIOLOGY-DIAGNOSTIC	54.00	0	2,034		5.00
	TOTALS		0	110,910		
	B - INSURANCE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	59,282		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	17,199		2.00
3.00	ADMINISTRATIVE & GENERAL	5.05	0	259,792		3.00
	TOTALS		0	336,273		
	C - DEPRECIATION					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	347,390		1.00
	TOTALS		0	347,390		
	E - MEDICAL SUPPLIES RECLASS					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	44,392		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
	TOTALS		0	44,392		
	H - IV THERAPY SALARIES					
1.00	INTRAVENOUS THERAPY	64.00	26,639	0		1.00
	TOTALS		26,639	0		
	I - PHYSICIAN BENEFITS					
1.00	RURAL HEALTH CLINIC	88.00	0	149,771		1.00
2.00	OPERATING ROOM	50.00	0	846		2.00
	TOTALS		0	150,617		
500.00	Grand Total: Increases		26,639	989,582		500.00

RECLASSIFICATIONS | Provider CCN: 14-1329 | Period: From 07/01/2016 To 06/30/2017 | Worksheet A-6 | Date/Time Prepared: 11/20/2017 2:41 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - INTEREST EXPENSE						
1.00	INTEREST EXPENSE	113.00	0	110,910	11		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
5.00		0.00	0	0	0		5.00
	TOTALS		0	110,910			
	B - INSURANCE						
1.00	EMERGENCY	91.00	0	235,238	12		1.00
2.00	RURAL HEALTH CLINIC	88.00	0	90,071	12		2.00
3.00	AMBULANCE SERVICES	95.00	0	10,964	0		3.00
	TOTALS		0	336,273			
	C - DEPRECIATION						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	347,390	9		1.00
	TOTALS		0	347,390			
	E - MEDICAL SUPPLIES RECLASS						
1.00	ADULTS & PEDIATRICS	30.00	0	7,918	0		1.00
2.00	RESPIRATORY THERAPY	65.00	0	33,736	0		2.00
3.00	EMERGENCY	91.00	0	2,738	0		3.00
	TOTALS		0	44,392			
	H - IV THERAPY SALARIES						
1.00	EMERGENCY	91.00	26,639	0	0		1.00
	TOTALS		26,639	0			
	I - PHYSICIAN BENEFITS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	150,617	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		0	150,617			
500.00	Grand Total: Decreases		26,639	989,582			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1329 | Period: From 07/01/2016 To 06/30/2017 | Worksheet A-7 Part I | Date/Time Prepared: 11/20/2017 2:41 pm

			Acquisitions				
		Beginning Balances	Purchases	Donation	Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	21,657	0	0	0	0	1.00
2.00	Land Improvements	374,171	57,159	0	57,159	0	2.00
3.00	Buildings and Fixtures	4,889,121	14,098	0	14,098	0	3.00
4.00	Building Improvements	4,472,634	66,809	0	66,809	0	4.00
5.00	Fixed Equipment	353,576	484	0	484	0	5.00
6.00	Movable Equipment	4,941,683	476,706	0	476,706	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	15,052,842	615,256	0	615,256	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	15,052,842	615,256	0	615,256	0	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	21,657	0	1.00
2.00	Land Improvements	431,330	0	2.00
3.00	Buildings and Fixtures	4,903,219	0	3.00
4.00	Building Improvements	4,539,443	0	4.00
5.00	Fixed Equipment	354,060	0	5.00
6.00	Movable Equipment	5,418,389	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	15,668,098	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	15,668,098	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1329 | Period: From 07/01/2016 To 06/30/2017 | Worksheet A-7 Part II | Date/Time Prepared: 11/20/2017 2:41 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	677,567	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	119,162	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	796,729	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	677,567	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	119,162	2.00
3.00	Total (sum of lines 1-2)	0	796,729	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1329 | Period: From 07/01/2016 To 06/30/2017 | Worksheet A-7 Part III Date/Time Prepared: 11/20/2017 2:41 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	10,249,709	0	10,249,709	0.654177	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	5,418,389	0	5,418,389	0.345823	0	2.00
3.00	Total (sum of lines 1-2)	15,668,098	0	15,668,098	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	330,177	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	283,760	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	613,937	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	95,320	59,282	0	0	484,779	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	17,199	0	0	300,959	2.00
3.00	Total (sum of lines 1-2)	95,320	76,481	0	0	785,738	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-1329 | Period: From 07/01/2016 To 06/30/2017 | Worksheet A-8 | Date/Time Prepared: 11/20/2017 2:41 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	-954	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		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	-1,705	ADMINISTRATIVE & GENERAL	5.05	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	-281,251			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	0			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-52,682	DIETARY	10.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-5,181	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-1329 | Period: From 07/01/2016 To 06/30/2017 | Worksheet A-8 | Date/Time Prepared: 11/20/2017 2:41 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	
32.00	CAH HIT Adjustment for Depreciation and Interest	A	-182,792	CAP REL COSTS-MVBLE EQUIP	2.00	9	32.00
33.00	CATERING REVENUE	B	-9,744	DIETARY	10.00	0	33.00
33.01	LAB OTHER REVENUE	B	-18,171	LABORATORY	60.00	0	33.01
33.02	REHAB MISC REV	B	-10,336	PHYSICAL THERAPY	66.00	0	33.02
33.03	INVESTMENT INCOME-OTHER	B	-94	ADMINISTRATIVE & GENERAL	5.05	0	33.03
33.04	INVESTMENT INCOME-OTHER	B	-31	OPERATING ROOM	50.00	0	33.04
33.05	INVESTMENT INCOME-OTHER	B	-20	RADIOLOGY-DIAGNOSTIC	54.00	0	33.05
33.06	OTHER REV -A&G	B	-940	ADMINISTRATIVE & GENERAL	5.05	0	33.06
33.07	OTHER REV - DIETARY	B	-450	DIETARY	10.00	0	33.07
33.08	OTHER REV - IT	B	-70	ADMINISTRATIVE & GENERAL	5.05	0	33.08
33.09	NONALLOWABLE DUES	B	-4,644	ADMINISTRATIVE & GENERAL	5.05	0	33.09
33.10	PATIENT TELEPHONE - SALARIES	A	-3,295	ADMINISTRATIVE & GENERAL	5.05	0	33.10
33.11	PATIENT TELEPHONE - BENEFITS	A	-725	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.11
33.12	PHYSICIAN BILLING SALARIES	A	-13,384	CASHIERING/ACCOUNTS RECEIVABLE	5.03	0	33.12
33.13	PHYSICIAN BILLING EMPLOYEE BENEFITS	A	-3,051	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.13
33.14	PHARMACY DRUG RETAIL 340B	A	-1,580	DRUGS CHARGED TO PATIENTS	73.00	0	33.14
33.15	OTHER REV- EDUCATION	A	-100	ADMINISTRATIVE & GENERAL	5.05	0	33.15
33.16	SELF INSURANCE EXPENSE	A	-35,619	OPERATING ROOM	50.00	0	33.16
33.17	SELF INSURANCE EXPENSE	A	-4,192	ANESTHESIOLOGY	53.00	0	33.17
33.18	SELF INSURANCE EXPENSE	A	-16,082	RADIOLOGY-DIAGNOSTIC	54.00	0	33.18
33.19	SELF INSURANCE EXPENSE	A	-17,676	LABORATORY	60.00	0	33.19
33.20	SELF INSURANCE EXPENSE	A	-864	INTRAVENOUS THERAPY	64.00	0	33.20
33.21	SELF INSURANCE EXPENSE	A	-42	RESPIRATORY THERAPY	65.00	0	33.21
33.22	SELF INSURANCE EXPENSE	A	-1,050	PHYSICAL THERAPY	66.00	0	33.22
33.23	SELF INSURANCE EXPENSE	A	-2,477	OCCUPATIONAL THERAPY	67.00	0	33.23
33.24	SELF INSURANCE EXPENSE	A	-97	ELECTROCARDIOLOGY	69.00	0	33.24
33.25	SELF INSURANCE EXPENSE	A	-236	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	33.25
33.26	SELF INSURANCE EXPENSE	A	-2,061	DRUGS CHARGED TO PATIENTS	73.00	0	33.26
33.27	SELF INSURANCE EXPENSE	A	-9,969	EMERGENCY	91.00	0	33.27
33.28	SELF INSURANCE EXPENSE	A	-51,164	RURAL HEALTH CLINIC	88.00	0	33.28
33.29	SELF INSURANCE EXPENSE	A	-811	WOUND CARE	93.00	0	33.29
33.30	SELF INSURANCE EXPENSE	A	-476	AMBULANCE SERVICES	95.00	0	33.30
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-734,016				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: 14-1329 | Period: From 07/01/2016 To 06/30/2017 | Worksheet A-8-2 | Date/Time Prepared: 11/20/2017 2:41 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	91.00	EMERGENCY	1,186,883	180,955	1,005,928	0	0	1.00
2.00	91.00	EMERGENCY	9,450	0	9,450	0	0	2.00
3.00	50.00	OPERATING ROOM	22,401	22,401	0	0	0	3.00
4.00	50.00	OPERATING ROOM	24,100	24,100	0	0	0	4.00
5.00	54.00	RADIOLOGY-DIAGNOSTIC	7,250	7,250	0	0	0	5.00
6.00	69.00	ELECTROCARDIOLOGY	5,716	5,716	0	0	0	6.00
7.00	88.00	RURAL HEALTH CLINIC	40,829	40,829	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			1,296,629	281,251	1,015,378		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	91.00	EMERGENCY	0	0	0	0	0	1.00
2.00	91.00	EMERGENCY	0	0	0	0	0	2.00
3.00	50.00	OPERATING ROOM	0	0	0	0	0	3.00
4.00	50.00	OPERATING ROOM	0	0	0	0	0	4.00
5.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	5.00
6.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	6.00
7.00	88.00	RURAL HEALTH CLINIC	0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	91.00	EMERGENCY	0	0	0	180,955		1.00
2.00	91.00	EMERGENCY	0	0	0	0		2.00
3.00	50.00	OPERATING ROOM	0	0	0	22,401		3.00
4.00	50.00	OPERATING ROOM	0	0	0	24,100		4.00
5.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	7,250		5.00
6.00	69.00	ELECTROCARDIOLOGY	0	0	0	5,716		6.00
7.00	88.00	RURAL HEALTH CLINIC	0	0	0	40,829		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	281,251		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1329 | Period: From 07/01/2016 To 06/30/2017 | Worksheet B Part I | Date/Time Prepared: 11/20/2017 2:41 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	PURCHASING RECEIVING AND STORES	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	4.00	5.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	484,779	484,779				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	300,959		300,959			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,438,037	0	0	1,438,037		4.00
5.01	00560	PURCHASING RECEIVING AND STORES	48,387	14,424	0	9,085	71,896	5.01
5.02	00591	PERSONNEL	105,454	2,950	0	24,485	0	5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	376,487	8,721	0	74,023	1,109	5.03
5.05	00590	ADMINISTRATIVE & GENERAL	1,133,165	26,189	71,044	109,942	5,138	5.05
7.00	00700	OPERATION OF PLANT	545,861	89,171	3,115	45,052	2,698	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	27,697	11,355	0	0	111	8.00
9.00	00900	HOUSEKEEPING	186,090	4,740	0	41,818	74	9.00
10.00	01000	DIETARY	220,835	13,128	232	49,796	739	10.00
11.00	01100	CAFETERIA	0	5,055	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	112,498	5,243	0	28,532	111	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	58,011	4,433	0	5,983	15,858	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	241,795	11,287	583	54,012	887	16.00
17.00	01700	SOCIAL SERVICE	70,736	1,304	0	18,211	407	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,596,094	79,648	26,952	368,335	4,621	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	267,229	20,034	60,052	41,500	8,169	50.00
53.00	05300	ANESTHESIOLOGY	100,284	0	0	0	333	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	423,448	13,717	122,296	81,283	2,403	54.00
60.00	06000	LABORATORY	696,743	12,983	5,705	92,382	2,070	60.00
64.00	06400	INTRAVENOUS THERAPY	63,683	0	0	6,898	0	64.00
65.00	06500	RESPIRATORY THERAPY	4,936	0	735	203	0	65.00
66.00	06600	PHYSICAL THERAPY	268,454	22,250	0	70,794	1,109	66.00
67.00	06700	OCCUPATIONAL THERAPY	189,850	4,220	0	49,632	0	67.00
68.00	06800	SPEECH PATHOLOGY	5,547	1,040	0	1,016	0	68.00
69.00	06900	ELECTROCARDIOLOGY	3,963	0	1,697	1,000	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	46,741	0	0	0	2,772	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	230,511	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	365,368	4,126	0	36,497	370	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	2,393,077	89,854	5,576	104,922	7,873	88.00
91.00	09100	EMERGENCY	1,438,758	11,253	2,972	95,923	6,136	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04950	WOUND CARE	63,382	2,617	0	14,252	5,249	93.00
93.01	04951	DIABETIC EDUCATION	0	0	0	0	0	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	71,317	24,040	0	12,461	3,659	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	13,580,176	483,782	300,959	1,438,037	71,896	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	OPTH CLINIC	0	0	0	0	0	194.00
194.01	07951	RENTAL SPACE	0	997	0	0	0	194.01
194.02	07952	OTHER NON-REIMBURSABLE COST CENTERS	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	13,580,176	484,779	300,959	1,438,037	71,896	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1329 | Period: From 07/01/2016 To 06/30/2017 | Worksheet B Part I | Date/Time Prepared: 11/20/2017 2:41 pm

		Cost Center Description	PERSONNEL	CASHIERING/ACCOUNTS RECEIVABLE	Subtotal	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	
			5.02	5.03	5A.03	5.05	7.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00560	PURCHASING RECEIVING AND STORES						5.01
5.02	00591	PERSONNEL	132,889					5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	5,801	466,141				5.03
5.05	00590	ADMINISTRATIVE & GENERAL	8,295	0	1,353,773	1,353,773		5.05
7.00	00700	OPERATION OF PLANT	3,373	0	689,270	76,319	765,589	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	39,163	4,336	25,321	8.00
9.00	00900	HOUSEKEEPING	3,131	0	235,853	26,115	10,570	9.00
10.00	01000	DIETARY	3,728	0	288,458	31,940	29,275	10.00
11.00	01100	CAFETERIA	0	0	5,055	560	11,273	11.00
13.00	01300	NURSING ADMINISTRATION	2,136	0	148,520	16,445	11,691	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	448	0	84,733	9,382	9,885	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,044	0	312,608	34,614	25,169	16.00
17.00	01700	SOCIAL SERVICE	1,363	0	92,021	10,189	2,909	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	27,576	41,458	2,144,684	237,470	177,610	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,558	34,754	435,296	48,198	44,673	50.00
53.00	05300	ANESTHESIOLOGY	0	7,425	108,042	11,963	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,085	65,486	714,718	79,137	30,587	54.00
60.00	06000	LABORATORY	6,916	64,976	881,775	97,635	28,952	60.00
64.00	06400	INTRAVENOUS THERAPY	516	22,251	93,348	10,336	0	64.00
65.00	06500	RESPIRATORY THERAPY	15	4,862	10,751	1,190	0	65.00
66.00	06600	PHYSICAL THERAPY	5,300	28,675	396,582	43,912	49,616	66.00
67.00	06700	OCCUPATIONAL THERAPY	3,716	13,939	261,357	28,939	9,410	67.00
68.00	06800	SPEECH PATHOLOGY	76	538	8,217	910	2,319	68.00
69.00	06900	ELECTROCARDIOLOGY	75	2,759	9,494	1,051	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	5,005	54,518	6,037	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	12,316	242,827	26,887	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,732	42,248	451,341	49,975	9,201	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	34,824	72,757	2,708,883	299,944	200,367	88.00
91.00	09100	EMERGENCY	7,181	30,859	1,593,082	176,394	25,093	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			0			92.00
93.00	04950	WOUND CARE	1,067	1,918	88,485	9,798	5,836	93.00
93.01	04951	DIABETIC EDUCATION	0	0	0	0	0	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	933	13,915	126,325	13,987	53,608	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	132,889	466,141	13,579,179	1,353,663	763,365	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	OPTH CLINIC	0	0	0	0	0	194.00
194.01	07951	RENTAL SPACE	0	0	997	110	2,224	194.01
194.02	07952	OTHER NON-REIMBURSABLE COST CENTERS	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments			0			200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	132,889	466,141	13,580,176	1,353,773	765,589	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1329 | Period: From 07/01/2016 To 06/30/2017 | Worksheet B Part I | Date/Time Prepared: 11/20/2017 2:41 pm

		Cost Center Description	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
			8.00	9.00	10.00	11.00	13.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00560	PURCHASING RECEIVING AND STORES						5.01
5.02	00591	PERSONNEL						5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.03
5.05	00590	ADMINISTRATIVE & GENERAL						5.05
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE	68,820					8.00
9.00	00900	HOUSEKEEPING	0	272,538				9.00
10.00	01000	DIETARY	0	1,522	351,195			10.00
11.00	01100	CAFETERIA	0	0	222,040	238,928		11.00
13.00	01300	NURSING ADMINISTRATION	0	1,727	0	4,011	182,394	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	4,827	0	2,019	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	6,098	0	17,531	0	16.00
17.00	01700	SOCIAL SERVICE	0	1,420	0	2,762	3,845	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	38,617	85,231	127,348	74,189	103,430	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,101	15,204	0	7,039	9,817	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,399	13,459	0	14,397	0	54.00
60.00	06000	LABORATORY	0	14,137	0	18,115	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	292	395	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	53	62	65.00
66.00	06600	PHYSICAL THERAPY	2,829	24,245	0	9,961	13,876	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	4,595	0	5,552	7,754	67.00
68.00	06800	SPEECH PATHOLOGY	0	1,132	0	106	142	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	106	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	3,769	0	4,994	6,948	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	6,541	80,292	0	47,706	0	88.00
91.00	09100	EMERGENCY	12,096	12,262	0	23,428	32,652	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04950	WOUND CARE	0	1,532	0	2,497	3,473	93.00
93.01	04951	DIABETIC EDUCATION	0	0	0	0	0	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1,237	0	0	4,170	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	68,820	271,452	349,388	238,928	182,394	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	OPTH CLINIC	0	0	0	0	0	194.00
194.01	07951	RENTAL SPACE	0	1,086	0	0	0	194.01
194.02	07952	OTHER NON-REIMBURSABLE COST CENTERS	0	0	1,807	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	68,820	272,538	351,195	238,928	182,394	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1329 | Period: From 07/01/2016 To 06/30/2017 | Worksheet B Part I Date/Time Prepared: 11/20/2017 2:41 pm

		Cost Center Description	CENTRAL SERVICES & SUPPLY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			14.00	16.00	17.00	24.00	25.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00560	PURCHASING RECEIVING AND STORES						5.01
5.02	00591	PERSONNEL						5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.03
5.05	00590	ADMINISTRATIVE & GENERAL						5.05
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
14.00	01400	CENTRAL SERVICES & SUPPLY	110,846					14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	396,020				16.00
17.00	01700	SOCIAL SERVICE	0	0	113,146			17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	33,648	113,146	3,135,373	-29,692	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	67,623	32,172	0	664,123	0	50.00
53.00	05300	ANESTHESIOLOGY	0	6,026	0	126,031	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	53,330	0	909,027	0	54.00
60.00	06000	LABORATORY	0	52,735	0	1,093,349	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	18,059	0	122,430	29,692	64.00
65.00	06500	RESPIRATORY THERAPY	0	3,946	0	16,002	0	65.00
66.00	06600	PHYSICAL THERAPY	0	23,273	0	564,294	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	11,313	0	328,920	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	437	0	13,263	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	2,905	0	13,556	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	4,062	0	64,617	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	9,996	0	279,710	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	34,289	0	560,517	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	41,054	62,442	0	3,447,229	0	88.00
91.00	09100	EMERGENCY	2,169	34,537	0	1,911,713	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
93.00	04950	WOUND CARE	0	1,557	0	113,178	0	93.00
93.01	04951	DIABETIC EDUCATION	0	0	0	0	0	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	11,293	0	210,620	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	110,846	396,020	113,146	13,573,952	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	OPTH CLINIC	0	0	0	0	0	194.00
194.01	07951	RENTAL SPACE	0	0	0	4,417	0	194.01
194.02	07952	OTHER NON-REIMBURSABLE COST CENTERS	0	0	0	1,807	0	194.02
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	110,846	396,020	113,146	13,580,176	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1329 | Period: From 07/01/2016 To 06/30/2017 | Worksheet B Part I | Date/Time Prepared: 11/20/2017 2:41 pm

		Cost Center Description	Total		
			26.00		
		GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.01	00560	PURCHASING RECEIVING AND STORES			5.01
5.02	00591	PERSONNEL			5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE			5.03
5.05	00590	ADMINISTRATIVE & GENERAL			5.05
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
14.00	01400	CENTRAL SERVICES & SUPPLY			14.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
17.00	01700	SOCIAL SERVICE			17.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	3,105,681		30.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	664,123		50.00
53.00	05300	ANESTHESIOLOGY	126,031		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	909,027		54.00
60.00	06000	LABORATORY	1,093,349		60.00
64.00	06400	INTRAVENOUS THERAPY	152,122		64.00
65.00	06500	RESPIRATORY THERAPY	16,002		65.00
66.00	06600	PHYSICAL THERAPY	564,294		66.00
67.00	06700	OCCUPATIONAL THERAPY	328,920		67.00
68.00	06800	SPEECH PATHOLOGY	13,263		68.00
69.00	06900	ELECTROCARDIOLOGY	13,556		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	64,617		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	279,710		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	560,517		73.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	3,447,229		88.00
91.00	09100	EMERGENCY	1,911,713		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
93.00	04950	WOUND CARE	113,178		93.00
93.01	04951	DIABETIC EDUCATION	0		93.01
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	210,620		95.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	13,573,952		118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		190.00
194.00	07950	OPTH CLINIC	0		194.00
194.01	07951	RENTAL SPACE	4,417		194.01
194.02	07952	OTHER NON-REIMBURSABLE COST CENTERS	1,807		194.02
200.00		Cross Foot Adjustments	0		200.00
201.00		Negative Cost Centers	0		201.00
202.00		TOTAL (sum lines 118-201)	13,580,176		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1329 | Period: From 07/01/2016 To 06/30/2017 | Worksheet B Part II | Date/Time Prepared: 11/20/2017 2:41 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	4.00
5.01	00560	PURCHASING RECEIVING AND STORES	0	14,424	0	14,424	0	5.01
5.02	00591	PERSONNEL	0	2,950	0	2,950	0	5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	8,721	0	8,721	0	5.03
5.05	00590	ADMINISTRATIVE & GENERAL	0	26,189	71,044	97,233	0	5.05
7.00	00700	OPERATION OF PLANT	0	89,171	3,115	92,286	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	11,355	0	11,355	0	8.00
9.00	00900	HOUSEKEEPING	0	4,740	0	4,740	0	9.00
10.00	01000	DIETARY	0	13,128	232	13,360	0	10.00
11.00	01100	CAFETERIA	0	5,055	0	5,055	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	5,243	0	5,243	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	4,433	0	4,433	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	11,287	583	11,870	0	16.00
17.00	01700	SOCIAL SERVICE	0	1,304	0	1,304	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	79,648	26,952	106,600	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	20,034	60,052	80,086	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	13,717	122,296	136,013	0	54.00
60.00	06000	LABORATORY	0	12,983	5,705	18,688	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	735	735	0	65.00
66.00	06600	PHYSICAL THERAPY	0	22,250	0	22,250	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	4,220	0	4,220	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	1,040	0	1,040	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	1,697	1,697	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	4,126	0	4,126	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	89,854	5,576	95,430	0	88.00
91.00	09100	EMERGENCY	0	11,253	2,972	14,225	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
93.00	04950	WOUND CARE	0	2,617	0	2,617	0	93.00
93.01	04951	DIABETIC EDUCATION	0	0	0	0	0	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	24,040	0	24,040	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	483,782	300,959	784,741	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	OPTH CLINIC	0	0	0	0	0	194.00
194.01	07951	RENTAL SPACE	0	997	0	997	0	194.01
194.02	07952	OTHER NON-REIMBURSABLE COST CENTERS	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	0	484,779	300,959	785,738	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1329 | Period: From 07/01/2016 To 06/30/2017 | Worksheet B Part II | Date/Time Prepared: 11/20/2017 2:41 pm

		Cost Center Description	PURCHASING RECEIVING AND STORES	PERSONNEL	CASHIERING/ACCOUNTS RECEIVABLE	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	
			5.01	5.02	5.03	5.05	7.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00560	PURCHASING RECEIVING AND STORES	14,424					5.01
5.02	00591	PERSONNEL	0	2,950				5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	222	129	9,072			5.03
5.05	00590	ADMINISTRATIVE & GENERAL	1,031	184	0	98,448		5.05
7.00	00700	OPERATION OF PLANT	541	75	0	5,550	98,452	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	22	0	0	315	3,256	8.00
9.00	00900	HOUSEKEEPING	15	69	0	1,899	1,359	9.00
10.00	01000	DIETARY	148	83	0	2,323	3,765	10.00
11.00	01100	CAFETERIA	0	0	0	41	1,450	11.00
13.00	01300	NURSING ADMINISTRATION	22	47	0	1,196	1,503	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3,183	10	0	682	1,271	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	178	90	0	2,517	3,237	16.00
17.00	01700	SOCIAL SERVICE	82	30	0	741	374	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	927	612	807	17,269	22,840	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,639	79	677	3,505	5,745	50.00
53.00	05300	ANESTHESIOLOGY	67	0	145	870	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	482	135	1,275	5,755	3,933	54.00
60.00	06000	LABORATORY	415	153	1,265	7,100	3,723	60.00
64.00	06400	INTRAVENOUS THERAPY	0	11	433	752	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	95	87	0	65.00
66.00	06600	PHYSICAL THERAPY	222	118	558	3,193	6,380	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	82	271	2,104	1,210	67.00
68.00	06800	SPEECH PATHOLOGY	0	2	10	66	298	68.00
69.00	06900	ELECTROCARDIOLOGY	0	2	54	76	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	556	0	97	439	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	240	1,955	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	74	61	823	3,634	1,183	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,580	774	1,413	21,815	25,768	88.00
91.00	09100	EMERGENCY	1,231	159	601	12,827	3,227	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04950	WOUND CARE	1,053	24	37	712	750	93.00
93.01	04951	DIABETIC EDUCATION	0	0	0	0	0	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	734	21	271	1,017	6,894	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	14,424	2,950	9,072	98,440	98,166	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	OPTH CLINIC	0	0	0	0	0	194.00
194.01	07951	RENTAL SPACE	0	0	0	8	286	194.01
194.02	07952	OTHER NON-REIMBURSABLE COST CENTERS	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	14,424	2,950	9,072	98,448	98,452	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1329 | Period: From 07/01/2016 To 06/30/2017 | Worksheet B Part II | Date/Time Prepared: 11/20/2017 2:41 pm

		Cost Center Description	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
			8.00	9.00	10.00	11.00	13.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00560	PURCHASING RECEIVING AND STORES						5.01
5.02	00591	PERSONNEL						5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.03
5.05	00590	ADMINISTRATIVE & GENERAL						5.05
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE	14,948					8.00
9.00	00900	HOUSEKEEPING	0	8,082				9.00
10.00	01000	DIETARY	0	45	19,724			10.00
11.00	01100	CAFETERIA	0	0	12,471	19,017		11.00
13.00	01300	NURSING ADMINISTRATION	0	51	0	319	8,381	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	143	0	161	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	181	0	1,395	0	16.00
17.00	01700	SOCIAL SERVICE	0	42	0	220	177	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	8,387	2,528	7,152	5,906	4,752	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	891	451	0	560	451	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	738	399	0	1,146	0	54.00
60.00	06000	LABORATORY	0	419	0	1,442	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	23	18	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	4	3	65.00
66.00	06600	PHYSICAL THERAPY	615	719	0	793	638	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	136	0	442	356	67.00
68.00	06800	SPEECH PATHOLOGY	0	34	0	8	7	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	8	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	112	0	397	319	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,421	2,381	0	3,797	0	88.00
91.00	09100	EMERGENCY	2,627	364	0	1,865	1,500	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04950	WOUND CARE	0	45	0	199	160	93.00
93.01	04951	DIABETIC EDUCATION	0	0	0	0	0	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	269	0	0	332	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	14,948	8,050	19,623	19,017	8,381	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	OPTH CLINIC	0	0	0	0	0	194.00
194.01	07951	RENTAL SPACE	0	32	0	0	0	194.01
194.02	07952	OTHER NON-REIMBURSABLE COST CENTERS	0	0	101	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	14,948	8,082	19,724	19,017	8,381	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1329 | Period: From 07/01/2016 To 06/30/2017 | Worksheet B Part II | Date/Time Prepared: 11/20/2017 2:41 pm

		Cost Center Description	CENTRAL SERVICES & SUPPLY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			14.00	16.00	17.00	24.00	25.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00560	PURCHASING RECEIVING AND STORES						5.01
5.02	00591	PERSONNEL						5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.03
5.05	00590	ADMINISTRATIVE & GENERAL						5.05
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
14.00	01400	CENTRAL SERVICES & SUPPLY	9,883					14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	19,468				16.00
17.00	01700	SOCIAL SERVICE	0	0	2,970			17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	1,653	2,970	182,403	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,030	1,581	0	101,695	0	50.00
53.00	05300	ANESTHESIOLOGY	0	296	0	1,378	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,621	0	152,497	0	54.00
60.00	06000	LABORATORY	0	2,591	0	35,796	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	887	0	2,124	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	194	0	1,118	0	65.00
66.00	06600	PHYSICAL THERAPY	0	1,144	0	36,630	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	556	0	9,377	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	21	0	1,486	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	143	0	1,980	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	200	0	1,292	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	491	0	2,686	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,685	0	12,414	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	3,660	3,077	0	161,116	0	88.00
91.00	09100	EMERGENCY	193	1,697	0	40,516	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
93.00	04950	WOUND CARE	0	76	0	5,673	0	93.00
93.01	04951	DIABETIC EDUCATION	0	0	0	0	0	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	555	0	34,133	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	9,883	19,468	2,970	784,314	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	OPTH CLINIC	0	0	0	0	0	194.00
194.01	07951	RENTAL SPACE	0	0	0	1,323	0	194.01
194.02	07952	OTHER NON-REIMBURSABLE COST CENTERS	0	0	0	101	0	194.02
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	9,883	19,468	2,970	785,738	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1329 | Period: From 07/01/2016 To 06/30/2017 | Worksheet B Part II | Date/Time Prepared: 11/20/2017 2:41 pm

		Cost Center Description	Total		
			26.00		
		GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.01	00560	PURCHASING RECEIVING AND STORES			5.01
5.02	00591	PERSONNEL			5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE			5.03
5.05	00590	ADMINISTRATIVE & GENERAL			5.05
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
14.00	01400	CENTRAL SERVICES & SUPPLY			14.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
17.00	01700	SOCIAL SERVICE			17.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	182,403		30.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	101,695		50.00
53.00	05300	ANESTHESIOLOGY	1,378		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	152,497		54.00
60.00	06000	LABORATORY	35,796		60.00
64.00	06400	INTRAVENOUS THERAPY	2,124		64.00
65.00	06500	RESPIRATORY THERAPY	1,118		65.00
66.00	06600	PHYSICAL THERAPY	36,630		66.00
67.00	06700	OCCUPATIONAL THERAPY	9,377		67.00
68.00	06800	SPEECH PATHOLOGY	1,486		68.00
69.00	06900	ELECTROCARDIOLOGY	1,980		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,292		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,686		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	12,414		73.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	161,116		88.00
91.00	09100	EMERGENCY	40,516		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
93.00	04950	WOUND CARE	5,673		93.00
93.01	04951	DIABETIC EDUCATION	0		93.01
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	34,133		95.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	784,314		118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		190.00
194.00	07950	OPTH CLINIC	0		194.00
194.01	07951	RENTAL SPACE	1,323		194.01
194.02	07952	OTHER NON-REIMBURSABLE COST CENTERS	101		194.02
200.00		Cross Foot Adjustments	0		200.00
201.00		Negative Cost Centers	0		201.00
202.00		TOTAL (sum lines 118-201)	785,738		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1329 | Period: From 07/01/2016 To 06/30/2017 | Worksheet B-1 | Date/Time Prepared: 11/20/2017 2:41 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	PURCHASING RECEIVING AND STORES (PURCHASE ORDERS)	PERSONNEL (GROSS SALARIES)	
			1.00	2.00	4.00	5.01	5.02	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	56,866					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		283,726				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	5,553,806			4.00
5.01	00560	PURCHASING RECEIVING AND STORES	1,692	0	35,088	1,945		5.01
5.02	00591	PERSONNEL	346	0	94,562	0	6,855,395	5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	1,023	0	285,881	30	299,265	5.03
5.05	00590	ADMINISTRATIVE & GENERAL	3,072	66,976	424,606	139	427,901	5.05
7.00	00700	OPERATION OF PLANT	10,460	2,937	173,995	73	173,995	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,332	0	0	3	0	8.00
9.00	00900	HOUSEKEEPING	556	0	161,505	2	161,505	9.00
10.00	01000	DIETARY	1,540	219	192,317	20	192,317	10.00
11.00	01100	CAFETERIA	593	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	615	0	110,192	3	110,192	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	520	0	23,107	429	23,107	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,324	550	208,597	24	208,597	16.00
17.00	01700	SOCIAL SERVICE	153	0	70,333	11	70,333	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	9,343	25,409	1,422,541	125	1,422,541	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,350	56,613	160,275	221	183,529	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	9	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,609	115,292	313,920	65	313,920	54.00
60.00	06000	LABORATORY	1,523	5,378	356,785	56	356,785	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	26,639	0	26,639	64.00
65.00	06500	RESPIRATORY THERAPY	0	693	783	0	783	65.00
66.00	06600	PHYSICAL THERAPY	2,610	0	273,411	30	273,411	66.00
67.00	06700	OCCUPATIONAL THERAPY	495	0	191,683	0	191,683	67.00
68.00	06800	SPEECH PATHOLOGY	122	0	3,922	0	3,922	68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,600	3,862	0	3,862	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	75	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	484	0	140,955	10	140,955	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	10,540	5,257	405,217	213	1,796,523	88.00
91.00	09100	EMERGENCY	1,320	2,802	370,462	166	370,462	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04950	WOUND CARE	307	0	55,041	142	55,041	93.00
93.01	04951	DIABETIC EDUCATION	0	0	0	0	0	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	2,820	0	48,127	99	48,127	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	56,749	283,726	5,553,806	1,945	6,855,395	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	OPTH CLINIC	0	0	0	0	0	194.00
194.01	07951	RENTAL SPACE	117	0	0	0	0	194.01
194.02	07952	OTHER NON-REIMBURSABLE COST CENTERS	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	484,779	300,959	1,438,037	71,896	132,889	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	8.524936	1.060738	0.258928	36.964524	0.019385	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			0	14,424	2,950	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000000	7.415938	0.000430	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1329 | Period: From 07/01/2016 To 06/30/2017 | Worksheet B-1 | Date/Time Prepared: 11/20/2017 2:41 pm

		Cost Center Description	CASHIERING/ACCOUNTS RECEIVABLE (NON-NURSING HOME CH)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	
			5.03	5A.05	5.05	7.00	8.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00560	PURCHASING RECEIVING AND STORES						5.01
5.02	00591	PERSONNEL						5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	19,028,123					5.03
5.05	00590	ADMINISTRATIVE & GENERAL	0	-1,353,773	12,226,403			5.05
7.00	00700	OPERATION OF PLANT	0	0	689,270	40,273		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	39,163	1,332	9,900	8.00
9.00	00900	HOUSEKEEPING	0	0	235,853	556	0	9.00
10.00	01000	DIETARY	0	0	288,458	1,540	0	10.00
11.00	01100	CAFETERIA	0	0	5,055	593	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	148,520	615	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	84,733	520	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	312,608	1,324	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	92,021	153	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,692,385	0	2,144,684	9,343	5,555	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,418,719	0	435,296	2,350	590	50.00
53.00	05300	ANESTHESIOLOGY	303,109	0	108,042	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,673,211	0	714,718	1,609	489	54.00
60.00	06000	LABORATORY	2,652,419	0	881,775	1,523	0	60.00
64.00	06400	INTRAVENOUS THERAPY	908,326	0	93,348	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	198,483	0	10,751	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,170,562	0	396,582	2,610	407	66.00
67.00	06700	OCCUPATIONAL THERAPY	569,001	0	261,357	495	0	67.00
68.00	06800	SPEECH PATHOLOGY	21,960	0	8,217	122	0	68.00
69.00	06900	ELECTROCARDIOLOGY	112,634	0	9,494	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	204,309	0	54,518	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	502,753	0	242,827	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,724,622	0	451,341	484	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	2,969,632	0	2,708,883	10,540	941	88.00
91.00	09100	EMERGENCY	1,259,687	0	1,593,082	1,320	1,740	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04950	WOUND CARE	78,294	0	88,485	307	0	93.00
93.01	04951	DIABETIC EDUCATION	0	0	0	0	0	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	568,017	0	126,325	2,820	178	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	19,028,123	-1,353,773	12,225,406	40,156	9,900	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	OPTH CLINIC	0	0	0	0	0	194.00
194.01	07951	RENTAL SPACE	0	0	997	117	0	194.01
194.02	07952	OTHER NON-REIMBURSABLE COST CENTERS	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	466,141		1,353,773	765,589	68,820	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.024497		0.110725	19.009982	6.951515	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	9,072		98,448	98,452	14,948	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000477		0.008052	2.444615	1.509899	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1329 | Period: From 07/01/2016 To 06/30/2017 | Worksheet B-1 | Date/Time Prepared: 11/20/2017 2:41 pm

		Cost Center Description	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	NURSING ADMINISTRATION (HOURS OF SERVICE)	CENTRAL SERVICES & SUPPLY (# OF LOADS)	
			9.00	10.00	11.00	13.00	14.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00560	PURCHASING RECEIVING AND STORES						5.01
5.02	00591	PERSONNEL						5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.03
5.05	00590	ADMINISTRATIVE & GENERAL						5.05
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING	29,361					9.00
10.00	01000	DIETARY	164	25,661				10.00
11.00	01100	CAFETERIA	0	16,224	8,995			11.00
13.00	01300	NURSING ADMINISTRATION	186	0	151	102,464		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	520	0	76	0	1,431	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	657	0	660	0	0	16.00
17.00	01700	SOCIAL SERVICE	153	0	104	2,160	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	9,182	9,305	2,793	58,104	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,638	0	265	5,515	873	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,450	0	542	0	0	54.00
60.00	06000	LABORATORY	1,523	0	682	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	11	222	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	2	35	0	65.00
66.00	06600	PHYSICAL THERAPY	2,612	0	375	7,795	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	495	0	209	4,356	0	67.00
68.00	06800	SPEECH PATHOLOGY	122	0	4	80	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	4	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	406	0	188	3,903	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	8,650	0	1,796	0	530	88.00
91.00	09100	EMERGENCY	1,321	0	882	18,343	28	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04950	WOUND CARE	165	0	94	1,951	0	93.00
93.01	04951	DIABETIC EDUCATION	0	0	0	0	0	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	157	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	29,244	25,529	8,995	102,464	1,431	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	OPTH CLINIC	0	0	0	0	0	194.00
194.01	07951	RENTAL SPACE	117	0	0	0	0	194.01
194.02	07952	OTHER NON-REIMBURSABLE COST CENTERS	0	132	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	272,538	351,195	238,928	182,394	110,846	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	9.282313	13.685944	26.562312	1.780079	77.460517	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	8,082	19,724	19,017	8,381	9,883	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.275263	0.768637	2.114175	0.081795	6.906359	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1329 | Period: From 07/01/2016 To 06/30/2017 | Worksheet B-1 | Date/Time Prepared: 11/20/2017 2:41 pm

		Cost Center Description	MEDICAL RECORDS & LIBRARY (NON-NURSIN G HOME CH)	SOCIAL SERVICE (TIME SPENT)		
			16.00	17.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.01	00560	PURCHASING RECEIVING AND STORES				5.01
5.02	00591	PERSONNEL				5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE				5.03
5.05	00590	ADMINISTRATIVE & GENERAL				5.05
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
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	19,918,960			16.00
17.00	01700	SOCIAL SERVICE	0	100		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	1,692,385	100		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	1,618,136	0		50.00
53.00	05300	ANESTHESIOLOGY	303,109	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,682,346	0		54.00
60.00	06000	LABORATORY	2,652,419	0		60.00
64.00	06400	INTRAVENOUS THERAPY	908,326	0		64.00
65.00	06500	RESPIRATORY THERAPY	198,483	0		65.00
66.00	06600	PHYSICAL THERAPY	1,170,562	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	569,001	0		67.00
68.00	06800	SPEECH PATHOLOGY	21,960	0		68.00
69.00	06900	ELECTROCARDIOLOGY	146,134	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	204,309	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	502,753	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,724,622	0		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	3,141,002	0		88.00
91.00	09100	EMERGENCY	1,737,102	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
93.00	04950	WOUND CARE	78,294	0		93.00
93.01	04951	DIABETIC EDUCATION	0	0		93.01
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	568,017	0		95.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE				113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	19,918,960	100		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
194.00	07950	OPTH CLINIC	0	0		194.00
194.01	07951	RENTAL SPACE	0	0		194.01
194.02	07952	OTHER NON-REIMBURSABLE COST CENTERS	0	0		194.02
200.00		Cross Foot Adjustments				200.00
201.00		Negative Cost Centers				201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	396,020	113,146		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.019882	1,131.460000		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	19,468	2,970		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000977	29.700000		205.00

POST STEPDOWN ADJUSTMENTS | Provider CCN: 14-1329 | Period: From 07/01/2016 To 06/30/2017 | Worksheet B-2 | Date/Time Prepared: 11/20/2017 2:41 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
7.00		IV THERAPY	1	30.00	-29,692	7.00
8.00		IV THERAPY	1	64.00	29,692	8.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1329 | Period: From 07/01/2016 To 06/30/2017 | Worksheet C Part I Date/Time Prepared: 11/20/2017 2:41 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	3,105,681		3,105,681	0	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	664,123		664,123	0	0	50.00
53.00	05300	ANESTHESIOLOGY	126,031		126,031	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	909,027		909,027	0	0	54.00
60.00	06000	LABORATORY	1,093,349		1,093,349	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	152,122		152,122	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	16,002	0	16,002	0	0	65.00
66.00	06600	PHYSICAL THERAPY	564,294	0	564,294	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	328,920	0	328,920	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	13,263	0	13,263	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	13,556		13,556	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	64,617		64,617	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	279,710		279,710	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	560,517		560,517	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	3,447,229		3,447,229	0	0	88.00
91.00	09100	EMERGENCY	1,911,713		1,911,713	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	109,045		109,045		0	92.00
93.00	04950	WOUND CARE	113,178		113,178	0	0	93.00
93.01	04951	DIABETIC EDUCATION	0		0	0	0	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	210,620		210,620	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	13,682,997	0	13,682,997	0	0	200.00
201.00		Less Observation Beds	109,045		109,045		0	201.00
202.00		Total (see instructions)	13,573,952	0	13,573,952	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1329 | Period: From 07/01/2016 To 06/30/2017 | Worksheet C Part I Date/Time Prepared: 11/20/2017 2:41 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	1,462,195		1,462,195			30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,000	1,345,210	1,348,210	0.492596	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	2,000	290,841	292,841	0.430373	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	84,668	2,542,001	2,626,669	0.346076	0.000000	54.00
60.00	06000	LABORATORY	204,811	2,405,392	2,610,203	0.418875	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	263,700	641,817	905,517	0.167995	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	158,056	40,262	198,318	0.080689	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	730,055	438,331	1,168,386	0.482969	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	461,441	103,302	564,743	0.582424	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	19,422	2,538	21,960	0.603962	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	9,567	102,271	111,838	0.121211	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	159,780	43,785	203,565	0.317427	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	502,753	502,753	0.556357	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,164,678	552,174	1,716,852	0.326480	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	2,926,278	2,926,278			88.00
91.00	09100	EMERGENCY	0	1,253,032	1,253,032	1.525670	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	230,190	230,190	0.473717	0.000000	92.00
93.00	04950	WOUND CARE	12,157	65,581	77,738	1.455890	0.000000	93.00
93.01	04951	DIABETIC EDUCATION	0	0	0	0.000000	0.000000	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	566,737	566,737	0.371636	0.000000	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	4,735,530	14,052,495	18,788,025			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	4,735,530	14,052,495	18,788,025			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1329 | Period: From 07/01/2016 To 06/30/2017 | Worksheet C Part I Date/Time Prepared: 11/20/2017 2:41 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
64.00	06400	INTRAVENOUS THERAPY	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	68.00
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
		OUTPATIENT SERVICE COST CENTERS		
88.00	08800	RURAL HEALTH CLINIC		88.00
91.00	09100	EMERGENCY	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	92.00
93.00	04950	WOUND CARE	0.000000	93.00
93.01	04951	DIABETIC EDUCATION	0.000000	93.01
		OTHER REIMBURSABLE COST CENTERS		
95.00	09500	AMBULANCE SERVICES	0.000000	95.00
		SPECIAL PURPOSE COST CENTERS		
113.00	11300	INTEREST EXPENSE		113.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1329 | Period: From 07/01/2016 To 06/30/2017 | Worksheet C Part I Date/Time Prepared: 11/20/2017 2:41 pm

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,105,681		3,105,681	0	3,105,681	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	664,123		664,123	0	664,123	50.00
53.00	05300	ANESTHESIOLOGY	126,031		126,031	0	126,031	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	909,027		909,027	0	909,027	54.00
60.00	06000	LABORATORY	1,093,349		1,093,349	0	1,093,349	60.00
64.00	06400	INTRAVENOUS THERAPY	152,122		152,122	0	152,122	64.00
65.00	06500	RESPIRATORY THERAPY	16,002	0	16,002	0	16,002	65.00
66.00	06600	PHYSICAL THERAPY	564,294	0	564,294	0	564,294	66.00
67.00	06700	OCCUPATIONAL THERAPY	328,920	0	328,920	0	328,920	67.00
68.00	06800	SPEECH PATHOLOGY	13,263	0	13,263	0	13,263	68.00
69.00	06900	ELECTROCARDIOLOGY	13,556		13,556	0	13,556	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	64,617		64,617	0	64,617	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	279,710		279,710	0	279,710	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	560,517		560,517	0	560,517	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	3,447,229		3,447,229	0	3,447,229	88.00
91.00	09100	EMERGENCY	1,911,713		1,911,713	0	1,911,713	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	109,045		109,045		109,045	92.00
93.00	04950	WOUND CARE	113,178		113,178	0	113,178	93.00
93.01	04951	DIABETIC EDUCATION	0		0	0	0	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	210,620		210,620	0	210,620	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	13,682,997	0	13,682,997	0	13,682,997	200.00
201.00		Less Observation Beds	109,045		109,045		109,045	201.00
202.00		Total (see instructions)	13,573,952	0	13,573,952	0	13,573,952	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1329 | Period: From 07/01/2016 To 06/30/2017 | Worksheet C Part I Date/Time Prepared: 11/20/2017 2:41 pm

Title XIX | Hospital | Cost

		Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
			Inpatient	Outpatient	Total (col. 6 + col. 7)			
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,462,195		1,462,195			30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,000	1,345,210	1,348,210	0.492596	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	2,000	290,841	292,841	0.430373	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	84,668	2,542,001	2,626,669	0.346076	0.000000	54.00
60.00	06000	LABORATORY	204,811	2,405,392	2,610,203	0.418875	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	263,700	641,817	905,517	0.167995	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	158,056	40,262	198,318	0.080689	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	730,055	438,331	1,168,386	0.482969	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	461,441	103,302	564,743	0.582424	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	19,422	2,538	21,960	0.603962	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	9,567	102,271	111,838	0.121211	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	159,780	43,785	203,565	0.317427	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	502,753	502,753	0.556357	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,164,678	552,174	1,716,852	0.326480	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	2,926,278	2,926,278	1.178025	0.000000	88.00
91.00	09100	EMERGENCY	0	1,253,032	1,253,032	1.525670	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	230,190	230,190	0.473717	0.000000	92.00
93.00	04950	WOUND CARE	12,157	65,581	77,738	1.455890	0.000000	93.00
93.01	04951	DIABETIC EDUCATION	0	0	0	0.000000	0.000000	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	566,737	566,737	0.371636	0.000000	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	4,735,530	14,052,495	18,788,025			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	4,735,530	14,052,495	18,788,025			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1329 | Period: From 07/01/2016 To 06/30/2017 | Worksheet C Part I Date/Time Prepared: 11/20/2017 2:41 pm

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
		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
64.00	06400	INTRAVENOUS THERAPY	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	68.00
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
		OUTPATIENT SERVICE COST CENTERS		
88.00	08800	RURAL HEALTH CLINIC	0.000000	88.00
91.00	09100	EMERGENCY	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	92.00
93.00	04950	WOUND CARE	0.000000	93.00
93.01	04951	DIABETIC EDUCATION	0.000000	93.01
		OTHER REIMBURSABLE COST CENTERS		
95.00	09500	AMBULANCE SERVICES	0.000000	95.00
		SPECIAL PURPOSE COST CENTERS		
113.00	11300	INTEREST EXPENSE		113.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 14-1329 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D Part II Date/Time Prepared: 11/20/2017 2:41 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	101,695	1,348,210	0.075430	2,392	180	50.00
53.00	05300	ANESTHESIOLOGY	1,378	292,841	0.004706	1,094	5	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	152,497	2,626,669	0.058057	19,376	1,125	54.00
60.00	06000	LABORATORY	35,796	2,610,203	0.013714	38,031	522	60.00
64.00	06400	INTRAVENOUS THERAPY	2,124	905,517	0.002346	25,492	60	64.00
65.00	06500	RESPIRATORY THERAPY	1,118	198,318	0.005637	23,502	132	65.00
66.00	06600	PHYSICAL THERAPY	36,630	1,168,386	0.031351	11,093	348	66.00
67.00	06700	OCCUPATIONAL THERAPY	9,377	564,743	0.016604	5,814	97	67.00
68.00	06800	SPEECH PATHOLOGY	1,486	21,960	0.067668	1,379	93	68.00
69.00	06900	ELECTROCARDIOLOGY	1,980	111,838	0.017704	4,351	77	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,292	203,565	0.006347	33,829	215	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,686	502,753	0.005343	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	12,414	1,716,852	0.007231	63,798	461	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	161,116	2,926,278	0.055058	0	0	88.00
91.00	09100	EMERGENCY	40,516	1,253,032	0.032334	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	6,404	230,190	0.027820	0	0	92.00
93.00	04950	WOUND CARE	5,673	77,738	0.072976	0	0	93.00
93.01	04951	DIABETIC EDUCATION	0	0	0.000000	0	0	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	574,182	16,759,093		230,151	3,315	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1329 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D Part IV | Date/Time Prepared: 11/20/2017 2:41 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
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
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
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
93.00	04950	WOUND CARE	0	0	0	0	0	93.00
93.01	04951	DIABETIC EDUCATION	0	0	0	0	0	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 14-1329 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D Part IV Date/Time Prepared: 11/20/2017 2:41 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	1,348,210	0.000000	0.000000	2,392	50.00
53.00	05300	ANESTHESIOLOGY	0	292,841	0.000000	0.000000	1,094	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,626,669	0.000000	0.000000	19,376	54.00
60.00	06000	LABORATORY	0	2,610,203	0.000000	0.000000	38,031	60.00
64.00	06400	INTRAVENOUS THERAPY	0	905,517	0.000000	0.000000	25,492	64.00
65.00	06500	RESPIRATORY THERAPY	0	198,318	0.000000	0.000000	23,502	65.00
66.00	06600	PHYSICAL THERAPY	0	1,168,386	0.000000	0.000000	11,093	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	564,743	0.000000	0.000000	5,814	67.00
68.00	06800	SPEECH PATHOLOGY	0	21,960	0.000000	0.000000	1,379	68.00
69.00	06900	ELECTROCARDIOLOGY	0	111,838	0.000000	0.000000	4,351	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	203,565	0.000000	0.000000	33,829	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	502,753	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,716,852	0.000000	0.000000	63,798	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	2,926,278	0.000000	0.000000	0	88.00
91.00	09100	EMERGENCY	0	1,253,032	0.000000	0.000000	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	230,190	0.000000	0.000000	0	92.00
93.00	04950	WOUND CARE	0	77,738	0.000000	0.000000	0	93.00
93.01	04951	DIABETIC EDUCATION	0	0	0.000000	0.000000	0	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	16,759,093			230,151	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1329 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D Part IV | Date/Time Prepared: 11/20/2017 2:41 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
64.00	06400	INTRAVENOUS THERAPY	0	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
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
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	0		88.00
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0		92.00
93.00	04950	WOUND CARE	0	0	0		93.00
93.01	04951	DIABETIC EDUCATION	0	0	0		93.01
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES					95.00
200.00		Total (lines 50-199)	0	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-1329 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D Part V Date/Time Prepared: 11/20/2017 2:41 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	0.492596	0	643,454	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.430373	0	81,933	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.346076	0	709,890	0	0	54.00
60.00	06000	LABORATORY	0.418875	0	647,340	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.167995	0	244,817	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.080689	0	20,350	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.482969	0	186,025	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.582424	0	43,041	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.603962	0	2,538	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.121211	0	61,679	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.317427	0	21,955	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.556357	0	386,018	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.326480	0	211,124	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
91.00	09100	EMERGENCY	1.525670	0	364,188	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.473717	0	114,970	0	0	92.00
93.00	04950	WOUND CARE	1.455890	0	51,563	0	0	93.00
93.01	04951	DIABETIC EDUCATION	0.000000	0	0	0	0	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.371636		0			95.00
200.00		Subtotal (see instructions)		0	3,790,885	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	3,790,885	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-1329 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D Part V Date/Time Prepared: 11/20/2017 2:41 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	316,963	0	50.00
53.00	05300	ANESTHESIOLOGY	35,262	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	245,676	0	54.00
60.00	06000	LABORATORY	271,155	0	60.00
64.00	06400	INTRAVENOUS THERAPY	41,128	0	64.00
65.00	06500	RESPIRATORY THERAPY	1,642	0	65.00
66.00	06600	PHYSICAL THERAPY	89,844	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	25,068	0	67.00
68.00	06800	SPEECH PATHOLOGY	1,533	0	68.00
69.00	06900	ELECTROCARDIOLOGY	7,476	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	6,969	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	214,764	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	68,928	0	73.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	0	0	88.00
91.00	09100	EMERGENCY	555,631	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	54,463	0	92.00
93.00	04950	WOUND CARE	75,070	0	93.00
93.01	04951	DIABETIC EDUCATION	0	0	93.01
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0		95.00
200.00		Subtotal (see instructions)	2,011,572	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 +/- line 201)	2,011,572	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1329 | Component CCN: 14-Z329 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D Part V Date/Time Prepared: 11/20/2017 2:41 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	0.492596	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.430373	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.346076	0	0	0	0	54.00
60.00	06000	LABORATORY	0.418875	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.167995	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.080689	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.482969	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.582424	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.603962	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.121211	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.317427	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.556357	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.326480	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
91.00	09100	EMERGENCY	1.525670	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.473717	0	0	0	0	92.00
93.00	04950	WOUND CARE	1.455890	0	0	0	0	93.00
93.01	04951	DIABETIC EDUCATION	0.000000	0	0	0	0	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.371636		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: 14-1329 | Component CCN: 14-Z329 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D Part V Date/Time Prepared: 11/20/2017 2:41 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
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
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
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
93.00	04950	WOUND CARE	0	0		93.00
93.01	04951	DIABETIC EDUCATION	0	0		93.01
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	0	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	0	0		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1329 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D-1 | Date/Time Prepared: 11/20/2017 2:41 pm

Title XVIII | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	3,187	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	305	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)	211	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	1,149	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)	1,149	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	292	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)	292	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	131	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)	1,004	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)	1,004	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	147.50	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	147.50	20.00
21.00	Total general inpatient routine service cost (see instructions)	3,105,681	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)	43,070	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)	43,070	25.00
26.00	Total swing-bed cost (see instructions)	2,751,866	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	353,815	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)	353,815	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)	1,160.02	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	151,963	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)	151,963	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1329 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D-1 | Date/Time Prepared: 11/20/2017 2:41 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)	72,135	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	224,098	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)	1,164,660	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	1,164,660	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	2,329,320	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)	94	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,160.05	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	109,045	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1329 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D-1 | Date/Time Prepared: 11/20/2017 2:41 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	182,403	3,105,681	0.058732	109,045	6,404	90.00
91.00	Nursing School cost	0	3,105,681	0.000000	109,045	0	91.00
92.00	Allied health cost	0	3,105,681	0.000000	109,045	0	92.00
93.00	All other Medical Education	0	3,105,681	0.000000	109,045	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 14-1329 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D-3 | Date/Time Prepared: 11/20/2017 2:41 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		125,340		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.492596	2,392	1,178	50.00
53.00	05300	ANESTHESIOLOGY	0.430373	1,094	471	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.346076	19,376	6,706	54.00
60.00	06000	LABORATORY	0.418875	38,031	15,930	60.00
64.00	06400	INTRAVENOUS THERAPY	0.167995	25,492	4,283	64.00
65.00	06500	RESPIRATORY THERAPY	0.080689	23,502	1,896	65.00
66.00	06600	PHYSICAL THERAPY	0.482969	11,093	5,358	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.582424	5,814	3,386	67.00
68.00	06800	SPEECH PATHOLOGY	0.603962	1,379	833	68.00
69.00	06900	ELECTROCARDIOLOGY	0.121211	4,351	527	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.317427	33,829	10,738	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.556357	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.326480	63,798	20,829	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
91.00	09100	EMERGENCY	1.525670	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.473717	0	0	92.00
93.00	04950	WOUND CARE	1.455890	0	0	93.00
93.01	04951	DIABETIC EDUCATION	0.000000	0	0	93.01
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		230,151	72,135	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)		230,151		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 14-1329 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D-3

Component CCN: 14-Z329 | Date/Time Prepared: 11/20/2017 2:41 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		410		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.492596	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.430373	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.346076	41,309	14,296	54.00
60.00	06000	LABORATORY	0.418875	114,153	47,816	60.00
64.00	06400	INTRAVENOUS THERAPY	0.167995	168,588	28,322	64.00
65.00	06500	RESPIRATORY THERAPY	0.080689	100,970	8,147	65.00
66.00	06600	PHYSICAL THERAPY	0.482969	525,678	253,886	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.582424	342,006	199,193	67.00
68.00	06800	SPEECH PATHOLOGY	0.603962	17,099	10,327	68.00
69.00	06900	ELECTROCARDIOLOGY	0.121211	3,841	466	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.317427	125,345	39,788	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.556357	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.326480	810,586	264,640	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
91.00	09100	EMERGENCY	1.525670	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.473717	0	0	92.00
93.00	04950	WOUND CARE	1.455890	265	386	93.00
93.01	04951	DIABETIC EDUCATION	0.000000	0	0	93.01
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		2,249,840	867,267	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)		2,249,840		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-1329	Period: From 07/01/2016 To 06/30/2017	Worksheet E Part B Date/Time Prepared: 11/20/2017 2:41 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	2,011,572	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)	2,011,572	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)	2,031,688	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)	10,009	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	630,849	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)	1,390,830	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)	1,390,830	30.00
31.00	Primary payer payments	190	31.00
32.00	Subtotal (line 30 minus line 31)	1,390,640	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)	31,131	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	20,235	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	24,021	36.00
37.00	Subtotal (see instructions)	1,410,875	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)	1,410,875	40.00
40.01	Sequestration adjustment (see instructions)	28,218	40.01
41.00	Interim payments	1,444,912	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	-62,255	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: 14-1329 | Period: From 07/01/2016 To 06/30/2017 | Worksheet E-1 Part I | Date/Time Prepared: 11/20/2017 2:41 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		183,230		1,514,881	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0	12/15/2016	7,084	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	06/29/2017	5,591	06/29/2017	77,053	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)		-5,591		-69,969	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)		177,639		1,444,912	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		1,919		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		62,255	6.02
7.00	Total Medicare program liability (see instructions)		179,558		1,382,657	7.00

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-1329 | Component CCN: 14-Z329 | Period: From 07/01/2016 To 06/30/2017 | Worksheet E-1 Part I | Date/Time Prepared: 11/20/2017 2:41 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		3,152,604		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER	12/15/2016	43,812		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	06/29/2017	67,402		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)		-23,590		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)		3,129,014		0	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		39,565		0	6.02
7.00	Total Medicare program liability (see instructions)		3,089,449		0	7.00

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

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 14-1329	Period: From 07/01/2016 To 06/30/2017	Worksheet E-1 Part II Date/Time Prepared: 11/20/2017 2:41 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	84	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12	131	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2	10	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12	211	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200	18,788,025	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20	56,987	6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168	0	7.00
8.00	Calculation of the HIT incentive payment (see instructions)	0	8.00
9.00	Sequestration adjustment amount (see instructions)	0	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)	0	10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH		
30.00	Initial/interim HIT payment adjustment (see instructions)	0	30.00
31.00	Other Adjustment (specify)	0	31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)	0	32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

Provider CCN: 14-1329 | Component CCN: 14-Z329 | Period: From 07/01/2016 To 06/30/2017 | Worksheet E-2 | Date/Time Prepared: 11/20/2017 2:41 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)	2,352,613	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)	875,940	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	2,008	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)	3,228,553	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	3,228,553	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)	3,228,553	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	76,682	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)	3,151,871	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)	966	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	628	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	966	0	18.00
19.00	Total (see instructions)	3,152,499	0	19.00
19.01	Sequestration adjustment (see instructions)	63,050	0	19.01
20.00	Interim payments	3,129,014	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)	-39,565	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: 14-1329	Period: From 07/01/2016 To 06/30/2017	Worksheet E-3 Part V Date/Time Prepared: 11/20/2017 2:41 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	224,098	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)	224,098	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	226,339	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)	226,339	19.00
20.00	Deductibles (exclude professional component)	45,667	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	180,672	22.00
23.00	Coinsurance	0	23.00
24.00	Subtotal (line 22 minus line 23)	180,672	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	3,923	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	2,550	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	2,548	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	183,222	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)	183,222	30.00
30.01	Sequestration adjustment (see instructions)	3,664	30.01
31.00	Interim payments	177,639	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)	1,919	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: 14-1329 | Period: From 07/01/2016 To 06/30/2017 | Worksheet G | Date/Time Prepared: 11/20/2017 2:41 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	496,664	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	4,012,642	0	0	0	4.00
5.00	Other receivable	1,092,639	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	269,654	0	0	0	7.00
8.00	Prepaid expenses	75,181	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	5,946,780	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	34,453	0	0	0	12.00
13.00	Land improvements	431,331	0	0	0	13.00
14.00	Accumulated depreciation	-292,852	0	0	0	14.00
15.00	Buildings	9,442,661	0	0	0	15.00
16.00	Accumulated depreciation	-5,662,686	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	824,347	0	0	0	19.00
20.00	Accumulated depreciation	-359,841	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	4,948,182	0	0	0	23.00
24.00	Accumulated depreciation	-4,302,119	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)	5,063,476	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	548	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	548	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	11,010,804	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	573,532	0	0	0	37.00
38.00	Salaries, wages, and fees payable	389,073	0	0	0	38.00
39.00	Payroll taxes payable	219,045	0	0	0	39.00
40.00	Notes and loans payable (short term)	975,632	0	0	0	40.00
41.00	Deferred income	573,500	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	136,662	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	2,867,444	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	2,805,958	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)	2,805,958	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	5,673,402	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	5,337,402				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)	5,337,402	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	11,010,804	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 14-1329 | Period: From 07/01/2016 To 06/30/2017 | Worksheet G-1 | Date/Time Prepared: 11/20/2017 2:41 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		4,931,991		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		405,411				2.00
3.00	Total (sum of line 1 and line 2)		5,337,402		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)		5,337,402		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)		5,337,402		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: 14-1329 | Period: From 07/01/2016 To 06/30/2017 | Worksheet G-2 Parts I & II Date/Time Prepared: 11/20/2017 2:41 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	442,965		442,965	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	1,226,102		1,226,102	5.00
6.00	Swing bed - NF	39,726		39,726	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)	1,708,793		1,708,793	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	1,708,793		1,708,793	17.00
18.00	Ancillary services	3,237,248	9,448,503	12,685,751	18.00
19.00	Outpatient services	12,157	1,803,239	1,815,396	19.00
20.00	RURAL HEALTH CLINIC	122,732	3,018,270	3,141,002	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	568,017	568,017	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	NRCC	0	10,336	10,336	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	5,080,930	14,848,365	19,929,295	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		14,314,192		29.00
30.00	CHARITY CARE RHC SLIDING FEE	3,810			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)		3,810		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		14,318,002		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 14-1329 | Period: From 07/01/2016 To 06/30/2017 | Worksheet G-3 | Date/Time Prepared: 11/20/2017 2:41 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	19,929,295	1.00
2.00	Less contractual allowances and discounts on patients' accounts	6,519,977	2.00
3.00	Net patient revenues (line 1 minus line 2)	13,409,318	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	14,318,002	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-908,684	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	15,666	6.00
7.00	Income from investments	10,859	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER OPERATING REVENUE	138,384	24.00
24.01	COUNTY TAX REVENUE	1,092,220	24.01
24.02	STATE TAX REVENUE	95,347	24.02
24.03	ROUNDING	0	24.03
25.00	Total other income (sum of lines 6-24)	1,352,476	25.00
26.00	Total (line 5 plus line 25)	443,792	26.00
27.00		0	27.00
27.01	CHARITY CARE	38,381	27.01
28.00	Total other expenses (sum of line 27 and subscripts)	38,381	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	405,411	29.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1329 | Component CCN: 14-3981 | Period: From 07/01/2016 To 06/30/2017 | Worksheet M-1 | Date/Time Prepared: 11/20/2017 2:41 pm

RHC I | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	1,192,687	0	1,192,687	0	1,192,687	1.00
2.00	Physician Assistant	15,690	0	15,690	0	15,690	2.00
3.00	Nurse Practitioner	116,077	0	116,077	0	116,077	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	66,852	0	66,852	0	66,852	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	405,217	0	405,217	0	405,217	9.00
10.00	Subtotal (sum of lines 1 through 9)	1,796,523	0	1,796,523	0	1,796,523	10.00
11.00	Physician Services Under Agreement	0	425,198	425,198	0	425,198	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	425,198	425,198	0	425,198	14.00
15.00	Medical Supplies	0	22,705	22,705	0	22,705	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	90,072	90,072	-90,071	1	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	112,777	112,777	-90,071	22,706	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	1,796,523	537,975	2,334,498	-90,071	2,244,427	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	16,445	16,445	0	16,445	29.00
30.00	Administrative Costs	0	74,427	74,427	149,771	224,198	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	90,872	90,872	149,771	240,643	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	1,796,523	628,847	2,425,370	59,700	2,485,070	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1329 | Component CCN: 14-3981 | Period: From 07/01/2016 To 06/30/2017 | Worksheet M-1 | Date/Time Prepared: 11/20/2017 2:41 pm

RHC I | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	1,192,687		1.00
2.00	Physician Assistant	0	15,690		2.00
3.00	Nurse Practitioner	-40,829	75,248		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	66,852		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	405,217		9.00
10.00	Subtotal (sum of lines 1 through 9)	-40,829	1,755,694		10.00
11.00	Physician Services Under Agreement	0	425,198		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	0		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	425,198		14.00
15.00	Medical Supplies	0	22,705		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	1		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	22,706		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-40,829	2,203,598		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	16,445		29.00
30.00	Administrative Costs	-51,164	173,034		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-51,164	189,479		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-91,993	2,393,077		32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1329 | Component CCN: 14-3981 | Period: From 07/01/2016 To 06/30/2017 | Worksheet M-2 | Date/Time Prepared: 11/20/2017 2:41 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	4.40	14,463	4,200	18,480		1.00
2.00	Physician Assistant	0.15	350	2,100	315		2.00
3.00	Nurse Practitioner	0.47	1,606	2,100	987		3.00
4.00	Subtotal (sum of lines 1 through 3)	5.02	16,419		19,782	19,782	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	0.96	1,334			1,334	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	5.98	17,753			21,116	8.00
9.00	Physician Services Under Agreements		0			0	9.00
						1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)					2,203,598	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					2,203,598	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)					189,479	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					1,054,152	15.00
16.00	Total overhead (sum of lines 14 and 15)					1,243,631	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					1,243,631	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					1,243,631	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					3,447,229	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 14-1329 Component CCN: 14-3981	Period: From 07/01/2016 To 06/30/2017	Worksheet M-3 Date/Time Prepared: 11/20/2017 2:41 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)			3,447,229	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			25,469	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			3,421,760	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			21,116	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)			0	5.00
6.00	Total adjusted visits (line 4 plus line 5)			21,116	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			162.05	7.00
		Calculation of Limit (1)			
		Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)		
		1.00	2.00		
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	81.32	82.30		8.00
9.00	Rate for Program covered visits (see instructions)	162.05	162.05		9.00
	CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	0	2,377		10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	385,193		11.00
12.00	Program covered visits for mental health services (from contractor records)	0	156		12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	25,280		13.00
14.00	Limit adjustment for mental health services (see instructions)	0	25,280		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	410,473		16.00
16.01	Total program charges (see instructions)(from contractor's records)		461,741		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		4,246		16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		3,775		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.)		299,820		16.04
16.05	Total program cost (see instructions)	0	303,595		16.05
17.00	Primary payer amounts		196		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		31,923		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		85,114		19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		303,399		20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		4,665		21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		308,064		22.00
23.00	Allowable bad debts (see instructions)		13,864		23.00
23.01	Adjusted reimbursable bad debts (see instructions)		9,012		23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		12,510		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)		317,076		26.00
26.01	Sequestration adjustment (see instructions)		6,342		26.01
27.00	Interim payments		316,598		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)		-5,864		29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0		30.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA VACCINE COST	Provider CCN: 14-1329 Component CCN: 14-3981	Period: From 07/01/2016 To 06/30/2017	Worksheet M-4 Date/Time Prepared: 11/20/2017 2:41 pm
	Title XVIII	RHC I	Cost

		Pneumococcal	Influenza	
		1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	1,755,694	1,755,694	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000312	0.000803	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	548	1,410	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	10,255	4,068	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	10,803	5,478	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	2,203,598	2,203,598	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	1,243,631	1,243,631	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.004902	0.002486	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	6,096	3,092	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	16,899	8,570	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	70	180	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	241.41	47.61	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	14	27	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	3,380	1,285	14.00
15.00	Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2)		25,469	15.00
16.00	Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3, line 21)		4,665	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 14-1329 Component CCN: 14-3981	Period: From 07/01/2016 To 06/30/2017	Worksheet M-5 Date/Time Prepared: 11/20/2017 2:41 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		309,157	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		06/29/2017	19,153	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		12/15/2016	11,712	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		7,441	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		316,598	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		5,864	6.02
7.00	Total Medicare program liability (see instructions)		310,734	7.00

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