

**Pinckneyville Community Hospital  
District**  
Pinckneyville, Illinois

**Hospital Medicare Cost Report**  
April 30, 2017



## Accountant's Compilation Report

Board of Directors  
Pinckneyville Community Hospital District  
Pinckneyville, IL 62274

Management is responsible for the accompanying Medicare Cost Report of Pinckneyville Community Hospital District, included in the accompanying prescribed form as of and for the year ended April 30, 2017. We have performed a compilation engagement in accordance with *Statements on Standards for Accounting and Review Services* promulgated by the Accounting and Review Services Committee of the AICPA. We did not audit or review the Medicare Cost Report included in the accompanying prescribed form nor were we required to perform any procedures to verify the accuracy or completeness of the information provided by management. Accordingly, we do not express an opinion, a conclusion, nor provide any form of assurance on this Medicare Cost Report.

### Other Matter

The Medicare Cost Report included in the accompanying prescribed form is intended to comply with the requirements of the Centers for Medicare and Medicaid Services and is not intended to be a presentation in accordance with accounting principles generally accepted in the United States.

### Restriction on Use

Our report and the prescribed form are intended solely for the information and use of Pinckneyville Community Hospital District and the Centers for Medicare and Medicaid Services and is not intended to be, and should not be, used by anyone other than these specified parties.

A handwritten signature in cursive script that reads "Wipfli LLP".

Wipfli LLP

September 26, 2017  
Eau Claire, Wisconsin

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: 14-1307	Period: From 05/01/2016 To 04/30/2017	Worksheet S Parts I-III Date/Time Prepared: 9/27/2017 2:37 pm
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**PART I - COST REPORT STATUS**

Provider use only

1.  Electronically filed cost report  
 2.  Manually submitted cost report  
 3.  If this is an amended report enter the number of times the provider resubmitted this cost report  
 4.  Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

5.  Cost Report Status  
 (1) As Submitted  
 (2) Settled without Audit  
 (3) Settled with Audit  
 (4) Reopened  
 (5) Amended

6. Date Received:  
7. Contractor No. 06101  
8.  Initial Report for this Provider CCN  
9.  Final Report for this Provider CCN

10. NPR Date:  
11. Contractor's Vendor Code: 4  
12.  If line 5, column 1 is 4: Enter number of times reopened = 0-9.

Date: 9/27/2017 Time: 2:37 pm

**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 PINCKNEYVILLE COMMUNITY HOSPITAL ( 14-1307 ) for the cost reporting period beginning 05/01/2016 and ending 04/30/2017 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

**Encryption Information**

ECR: Date: 9/27/2017 Time: 2:37 pm  
 3uIIPcf3zmkd.MysJduovkXJX1hio0  
 rIexd05Aftaki3ztkz2e0za1g4b5kd  
 0g7H0So0qIOdy8EO  
 PI: Date: 9/27/2017 Time: 2:37 pm  
 :S5xelEfdRMsefFs4v3271g1wuk.a0  
 h8lRb0.6i:X4rHEhicdwwBZw:B9Yjv  
 E0ur0Dmi1002hVnr

(Signed)

Officer or Administrator of Provider(s)

Title

Date

	Title V 1.00	Title XVIII		HIT 4.00	Title XIX 5.00	
		Part A 2.00	Part B 3.00			
<b>PART III - SETTLEMENT SUMMARY</b>						
1.00 Hospital	0	11,746	-110,114	0	0	1.00
2.00 Subprovider - IPF	0	0	0		0	2.00
3.00 Subprovider - IRF	0	0	0		0	3.00
4.00 SUBPROVIDER I						4.00
5.00 Swing bed - SNF	0	12,563	0		0	5.00
6.00 Swing bed - NF	0				0	6.00
10.00 RURAL HEALTH CLINIC I	0		175,658		0	10.00
11.00 FEDERALLY QUALIFIED HEALTH CENTER I	0		0		0	11.00
200.00 Total	0	24,309	65,544	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.

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: 14-1307	Period: From 05/01/2016 To 04/30/2017	Worksheet S Parts I-III Date/Time Prepared: 9/27/2017 2:37 pm
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**PART I - COST REPORT STATUS**

Provider use only 1.  Electronically filed cost report Date: 9/27/2017 Time: 2:37 pm  
 2.  Manually submitted cost report  
 3.  If this is an amended report enter the number of times the provider resubmitted this cost report  
 4.  Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only 5.  Cost Report Status 6. Date Received: 10. NPR Date:  
 (1) As Submitted 7. Contractor No. 06101 11. Contractor's Vendor Code: 4  
 (2) Settled without Audit 8.  Initial Report for this Provider CCN 12.  If line 5, column 1 is 4: Enter  
 (3) Settled with Audit 9.  Final Report for this Provider CCN number of times reopened = 0-9.  
 (4) Reopened  
 (5) Amended

**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 PINCKNEYVILLE COMMUNITY HOSPITAL ( 14-1307 ) for the cost reporting period beginning 05/01/2016 and ending 04/30/2017 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

(Signed) \_\_\_\_\_  
 Officer or Administrator of Provider(s)

\_\_\_\_\_  
 Title

\_\_\_\_\_  
 Date

Cost Center Description	Title V 1.00	Title XVIII		HIT 4.00	Title XIX 5.00	
		Part A 2.00	Part B 3.00			
<b>PART III - SETTLEMENT SUMMARY</b>						
1.00 Hospital	0	11,746	-110,114	0	0	1.00
2.00 Subprovider - IPF	0	0	0		0	2.00
3.00 Subprovider - IRF	0	0	0		0	3.00
4.00 SUBPROVIDER I						4.00
5.00 Swing bed - SNF	0	12,563	0		0	5.00
6.00 Swing bed - NF	0				0	6.00
10.00 RURAL HEALTH CLINIC I	0		175,658		0	10.00
11.00 FEDERALLY QUALIFIED HEALTH CENTER I	0		0		0	11.00
200.00 Total	0	24,309	65,544	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: 14-1307	Period: From 05/01/2016 To 04/30/2017	Worksheet S-2 Part I Date/Time Prepared: 9/27/2017 2:32 pm
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1.00	2.00	3.00	4.00	1.00
Hospital and Hospital Health Care Complex Address:				
1.00	Street: 5383 STATE ROUTE 154	PO Box:	Zip Code: 62274-1034	County: PERRY
2.00	City: PINCKNEYVILLE	State: IL		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	PINCKNEYVILLE COMMUNITY HOSPITAL	141307	99914	1	11/30/2000	N	0	0	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	PINCKNEYVILLE CRITICAL ACC SWING BED	14Z307	99914		02/06/2001	N	0	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	PINCKNEYVILLE HOSPITAL RHC	143412	99914		03/27/1995	N	0	N	15.00
16.00	Hospital-Based Health Clinic - FOHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
17.10	Hospital-Based (CORF) I									17.10
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	05/01/2016	04/30/2017	20.00
21.00	Type of Control (see instructions)	11		21.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1307		Period: From 05/01/2016 To 04/30/2017		Worksheet S-2 Part I Date/Time Prepared: 9/27/2017 2:32 pm			
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of- State Medicaid paid days	Out-of- State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days		
		1.00	2.00	3.00	4.00	5.00	6.00		
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0		25.00	
		Urban/Rural		S		Date of Geogr			
		1.00		2.00					
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.					2		26.00	
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.					2		27.00	
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.					0		35.00	
		Beginning:		Ending:					
		1.00		2.00					
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.							36.00	
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.					0		37.00	
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPSS 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		XVII		XIX			
		1.00		2.00		3.00			
<b>Prospective Payment System (PPS)-Capital</b>									
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
<b>Teaching Hospitals</b>									
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			
		1.00		2.00		3.00		4.00	
								5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)						0.00	0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00		0.00				61.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-1307

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

Worksheet S-2  
Part I  
Date/Time Prepared:  
9/27/2017 2:32 pm

		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)		0.00	0.00			61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)		0.00	0.00			61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).		0.00	0.00			61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)		0.00	0.00			61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)		0.00	0.00			61.06
		Program Name		Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1.00	2.00	3.00	4.00		
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count 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	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1307		Period: From 05/01/2016 To 04/30/2017		Worksheet S-2 Part I Date/Time Prepared: 9/27/2017 2:32 pm	
	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3 / (col. 3 + col. 4))		
	1.00	2.00	3.00	4.00	5.00		
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code, enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000		65.00
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1 / (col. 1 + col. 2))		
			1.00	2.00	3.00		
Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010							
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000		66.00
	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3 / (col. 3 + col. 4))		
	1.00	2.00	3.00	4.00	5.00		
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000		67.00
					1.00	2.00	3.00
70.00	Inpatient Psychiatric Facility PPS Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.			N			70.00
71.00	If line 70 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)					0	71.00
Inpatient Rehabilitation Facility PPS							
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.			N			75.00
76.00	If line 75 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)					0	76.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1307	Period: From 05/01/2016 To 04/30/2017	Worksheet S-2 Part I Date/Time Prepared: 9/27/2017 2:32 pm		
			1.00			
<b>Long Term Care Hospital PPS</b>						
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	
<b>TEFRA Providers</b>						
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.			N	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		
<b>Title V and XIX Services</b>						
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.			N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.			N	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.				N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.			N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.			N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00		0.00	95.00	
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.			N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00		0.00	97.00	
<b>Rural Providers</b>						
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. 1, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. 11.			N		107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.			Y		108.00
		Physical	Occupational	Speech	Respiratory	
		1.00	2.00	3.00	4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	Y	N	Y	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	
<b>Miscellaneous Cost Reporting Information</b>						
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:	47,994	0	0		118.01



HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1307			Period: From 05/01/2016 To 04/30/2017		Worksheet S-2 Part I Date/Time Prepared: 9/27/2017 2:32 pm		
							1.00		
<b>Multi campus</b>									
165.00	Is this hospital part of a Multi campus 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		
<b>Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act</b>									
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)								168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)								168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)							0.00	169.00
							Beginning	Ending	
							1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)						10/01/2015	09/30/2016	170.00
							1.00	2.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. 1, 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		171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-1307		Period: From 05/01/2016 To 04/30/2017		Worksheet S-2 Part II Date/Time Prepared: 9/27/2017 2:32 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				
		1.00	2.00				
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				
		1.00	2.00				
Financial Data and Reports							
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A				4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	Y					5.00
		Y/N	Legal Oper.				
		1.00	2.00				
Approved Educational Activities							
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N					6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N					7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N					8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N					9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N					10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N					11.00
				Y/N			
				1.00			
Bad Debts							
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.				Y		12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.				N		13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.				N		14.00
Bed Complement							
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.				N		15.00
		Part A		Part B			
		Y/N	Date	Y/N	Date		
		1.00	2.00	3.00	4.00		
PS&R Data							
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	N		N			16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	09/08/2017	Y	07/06/2017		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: 14-1307	Period: From 05/01/2016 To 04/30/2017	Worksheet S-2 Part II Date/Time Prepared: 9/27/2017 2:32 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	
<b>COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)</b>					
<b>Capital Related Cost</b>					
22.00	Have assets been relieved for Medicare purposes? If yes, see instructions		N		22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.		N		23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions		N		24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.		N		25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.		N		26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.		N		27.00
<b>Interest Expense</b>					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.		N		28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions		Y		29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.		N		30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.		N		31.00
<b>Purchased Services</b>					
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
<b>Provider-Based Physicians</b>					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.		Y		34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.		N		35.00
			Y/N	Date	
			1.00	2.00	
<b>Home Office Costs</b>					
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
<b>Cost Report Preparer Contact Information</b>					
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.	PAUL	TRACZEK		41.00
42.00	Enter the employer/company name of the cost report preparer.	WI PFLI			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	715-858-6619	PTRACZEK@WI PFLI . COM		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-1307	Period: From 05/01/2016 To 04/30/2017	Worksheet S-2 Part II Date/Time Prepared: 9/27/2017 2:32 pm
		3.00		
<b>Cost Report Preparer Contact Information</b>				
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.	PARTNER		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

HFS Supplemental Information		Provider CCN: 14-1307	Period: From 05/01/2016 To 04/30/2017	Worksheet S-2 Part IX Date/Time Prepared: 9/27/2017 2:32 pm
		Title V 1.00	Title XIX 2.00	
<b>TITLES V AND/OR XIX FOLLOWING MEDICARE</b>				
1.00	Do Title V or XIX follow Medicare (Title XVIII) for the Interns and Residence post stepdown adjustments on W/S B, Part I, column 25? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	Y	Y	1.00
2.00	Do Title V or XIX follow Medicare (Title XVIII) for the reporting of charges on W/S C, Part I (e.g. net of Physician's component)? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	Y	Y	2.00
3.00	Do Title V or XIX follow Medicare (Title XVIII) for the calculation of Observation Bed Cost on W/S D-1, Part IV, line 89? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	Y	Y	3.00
3.01	Do Title V or XIX use W/S D-1 for reimbursement?	N	N	3.01
		Inpatient 1.00	Outpatient 2.00	
<b>CRITICAL ACCESS HOSPITALS</b>				
4.00	Does Title V follow Medicare (Title XVIII) for Critical Access Hospitals (CAH) being reimbursed 101% of cost? Enter Y or N in column 1 for inpatient and Y or N in column 2 for outpatient.	N	N	4.00
5.00	Does Title XIX follow Medicare (Title XVIII) for Critical Access Hospitals (CAH) being reimbursed 101% of cost? Enter Y or N in column 1 for inpatient and Y or N in column 2 for outpatient.	N	N	5.00
		Title V 1.00	Title XIX 2.00	
<b>RCE DISALLOWANCE</b>				
6.00	Do Title V or XIX follow Medicare and add back the RCE Disallowance on W/S C, Part I column 4? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	Y	Y	6.00
<b>PASS THROUGH COST</b>				
7.00	Do Title V or XIX follow Medicare when cost reimbursed (payment system is "0") for worksheets D, parts I through IV? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	Y	Y	7.00
<b>RHC</b>				
8.00	Do Title V & XIX impute 20% coinsurance (M-3 Line 16.04)? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	N	N	8.00
<b>FOHC</b>				
9.00	For fiscal year beginning on/after 10/01/2014, use M-series for Title V and/or Title XIX? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	N	N	9.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-1307

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

Worksheet S-3  
Part I  
Date/Time Prepared:  
9/27/2017 2:32 pm

Component	Worksheet A	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P	
	Line Number				Trips	Trips
	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	17	6,205	26,952.00	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)		17	6,205	26,952.00	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)		17	6,205	26,952.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF	41.00	0	0		0	17.00
18.00 SUBPROVIDER	42.00	0	0		0	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
25.10 CMHC - CORF	99.10				0	25.10
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)		17				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: 14-1307

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

Worksheet S-3  
Part I  
Date/Time Prepared:  
9/27/2017 2:32 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)	835	73	1,125			1.00
2.00 HMO and other (see instructions)	101	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	1,209	0	1,365			5.00
6.00 Hospital Adults & Peds. Swing Bed NF		0	285			6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	2,044	73	2,775			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)	2,044	73	2,775	0.00	157.28	14.00
15.00 CAH visits	0	0	0			15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF	0	0	0	0.00	0.00	17.00
18.00 SUBPROVIDER		0	0	0.00	0.00	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
25.10 CMHC - CORF	0	0	0	0.00	0.00	25.10
26.00 RURAL HEALTH CLINIC	6,146	4,009	19,565	0.00	30.54	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	187.82	27.00
28.00 Observation Bed Days		23	157			28.00
29.00 Ambulance Trips	0					29.00
30.00 Employee discount days (see instruction)			0			30.00
31.00 Employee discount days - IRF			0			31.00
32.00 Labor & delivery days (see instructions)	0	0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00 LTCH non-covered days	0					33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-1307

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

Worksheet S-3  
Part I  
Date/Time Prepared:  
9/27/2017 2:32 pm

Component	Full Time Equivalents	Discharges			Total All Patients		
		Nonpaid Workers	Title V	Title XVIII			Title XIX
		11.00	12.00	13.00			14.00
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	217	22	316	1.00
2.00 HMO and other (see instructions)				20	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		217	22	316	14.00
15.00 CAH visits							15.00
16.00 SUBPROVIDER - IPF							16.00
17.00 SUBPROVIDER - IRF	0.00	0		0	0	0	17.00
18.00 SUBPROVIDER	0.00	0			0	0	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
25.10 CMHC - CORF	0.00						25.10
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: 14-1307 Component CCN: 14-3412		Period: From 05/01/2016 To 04/30/2017		Worksheet S-8 Date/Time Prepared: 9/27/2017 2:32 pm	
		RHC I		Cost			
				1.00			
1.00	1.00	Clinic Address and Identification Street		5383 STATE ROUTE 154		1.00	
		City		State		ZIP Code	
		1.00		2.00		3.00	
2.00	2.00	City, State, ZIP Code, County		PI NCKNEYVILLE IL 62274		2.00	
				1.00			
3.00	3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban		Grant Award		Date	
				1.00		2.00	
4.00	4.00	Source of Federal Funds Community Health Center (Section 330(d), PHS Act)				4.00	
5.00	5.00	Migrant Health Center (Section 329(d), PHS Act)				5.00	
6.00	6.00	Health Services for the Homeless (Section 340(d), PHS Act)				6.00	
7.00	7.00	Appalachian Regional Commission				7.00	
8.00	8.00	Look-Alikes				8.00	
9.00	9.00	OTHER (SPECIFY)				9.00	
				1.00		2.00	
10.00	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	
		Sunday		Monday		Tuesday	
		from to		from to		from	
		1.00 2.00		3.00 4.00		5.00	
11.00	11.00	Facility hours of operations (1) Clinic		08:30 19:00		08:30	
				1.00		2.00	
12.00	12.00	Have you received an approval for an exception to the productivity standard?		N		0	
13.00	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	
				Provider name		CCN number	
				1.00		2.00	
14.00	14.00	RHC/FQHC name, CCN number		Y/N V		Total Visits	
				1.00 2.00		3.00 4.00	
				XVIII		XIX	
				3.00		4.00	
15.00	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)					
				County			
				4.00			
2.00	2.00	City, State, ZIP Code, County		PERRY			
				Tuesday		Wednesday	
				Thursday			
				to from to		from to	
				6.00 7.00 8.00		9.00 10.00	
11.00	11.00	Facility hours of operations (1) Clinic		19:00 08:30		19:00 08:30	

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provider CCN: 14-1307 Component CCN: 14-3412		Period: From 05/01/2016 To 04/30/2017		Worksheet S-8 Date/Time Prepared: 9/27/2017 2:32 pm	
				RHC I		Cost	
		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
11.00	Facility hours of operations (1) Clinic	08:30	17:00	09:00	12:00		11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 14-1307	Period: From 05/01/2016 To 04/30/2017	Worksheet S-10 Date/Time Prepared: 9/27/2017 2:32 pm
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				1.00	
<b>Uncompensated and indigent care cost computation</b>					
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)		0.559856		1.00
<b>Medicaid (see instructions for each line)</b>					
2.00	Net revenue from Medicaid		1,573,028		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?		N		4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid		167,012		5.00
6.00	Medicaid charges		4,817,970		6.00
7.00	Medicaid cost (line 1 times line 6)		2,697,369		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)		957,329		8.00
<b>Children's Health Insurance Program (CHIP) (see instructions for each line)</b>					
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
<b>Other state or local government indigent care program (see instructions for each line)</b>					
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
<b>Uncompensated care (see instructions for each line)</b>					
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		282,793		18.00
19.00	Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		957,329		19.00
		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
20.00	Charity care charges for the entire facility (see instructions)	322,896	211,843	534,739	20.00
21.00	Cost of patients approved for charity care (line 1 times line 20)	180,775	118,602	299,377	21.00
22.00	Partial payment by patients approved for charity care	0	7,466	7,466	22.00
23.00	Cost of charity care (line 21 minus line 22)	180,775	111,136	291,911	23.00
				1.00	
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?		N		24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit		0		25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)		1,167,673		26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)		217,781		27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)		949,892		28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)		531,803		29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		823,714		30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		1,781,043		31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1307

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

Worksheet A

Date/Time Prepared:  
9/27/2017 2:32 pm

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassified (See A-6)	Reclassified Trial Balance (col. 3 +/- col. 4)	
		1.00	2.00	3.00	4.00	5.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100		1,745,546	1,745,546	770,660	2,516,206	1.00
1.01	00101			0	0	0	1.01
1.02	00102			0	1,545	1,545	1.02
1.03	00103			0	16,729	16,729	1.03
1.04	00104			0	39,355	39,355	1.04
2.00	00200		616,044	616,044	0	616,044	2.00
2.01	00201			0	0	0	2.01
3.00	00300			0	0	0	3.00
4.00	00400	81,772	2,652,373	2,734,145	3,404	2,737,549	4.00
5.00	00500	1,397,187	1,351,726	2,748,913	-37,598	2,711,315	5.00
6.00	00600	262,722	510,903	773,625	-16,686	756,939	6.00
8.00	00800	31,623	98,082	129,705	0	129,705	8.00
9.00	00900	315,926	37,616	353,542	0	353,542	9.00
10.00	01000	312,255	136,138	448,393	0	448,393	10.00
11.00	01100	0	0	0	0	0	11.00
13.00	01300	340,944	20,951	361,895	0	361,895	13.00
14.00	01400	26,473	2,475	28,948	0	28,948	14.00
15.00	01500	304,495	1,611,833	1,916,328	0	1,916,328	15.00
16.00	01600	320,067	24,324	344,391	0	344,391	16.00
17.00	01700	30,845	4,707	35,552	0	35,552	17.00
19.00	01900	0	291,196	291,196	0	291,196	19.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	1,464,306	179,789	1,644,095	115,774	1,759,869	30.00
41.00	04100	0	0	0	0	0	41.00
42.00	04200	0	0	0	0	0	42.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	112,759	234,092	346,851	-71,958	274,893	50.00
53.00	05300	0	10,267	10,267	0	10,267	53.00
54.00	05400	470,825	141,097	611,922	565	612,487	54.00
54.01	05401	206,495	289,662	496,157	-3,477	492,680	54.01
56.00	05600	68,903	93,161	162,064	0	162,064	56.00
57.00	05700	58,682	33,627	92,309	0	92,309	57.00
58.00	05800	0	193,731	193,731	0	193,731	58.00
59.00	05900	0	0	0	0	0	59.00
60.00	06000	476,575	499,589	976,164	8,423	984,587	60.00
60.01	06001	0	0	0	0	0	60.01
65.00	06500	236,362	110,950	347,312	-493	346,819	65.00
66.00	06600	355,807	9,616	365,423	0	365,423	66.00
67.00	06700	126,030	5,547	131,577	0	131,577	67.00
68.00	06800	82,049	6,046	88,095	0	88,095	68.00
69.00	06900	4,533	19,699	24,232	0	24,232	69.00
70.00	07000	653	2,135	2,788	0	2,788	70.00
71.00	07100	0	0	0	86,531	86,531	71.00
72.00	07200	0	0	0	35,760	35,760	72.00
73.00	07300	0	0	0	0	0	73.00
76.00	03950	161,303	100,813	262,116	0	262,116	76.00
76.97	07697	36,941	14,135	51,076	0	51,076	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	1,953,973	230,790	2,184,763	-140,851	2,043,912	88.00
89.00	08900	0	0	0	0	0	89.00
90.00	09000	6,684	41,886	48,570	-204	48,366	90.00
90.01	09001	26,440	1,601	28,041	0	28,041	90.01
90.02	04050	1,724	2,499	4,223	0	4,223	90.02
91.00	09100	464,308	1,641,831	2,106,139	-18,404	2,087,735	91.00
92.00	09200						92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
99.10	09910	0	0	0	0	0	99.10
<b>SPECIAL PURPOSE COST CENTERS</b>							
109.00	10900	0	0	0	0	0	109.00
110.00	11000	0	0	0	0	0	110.00
111.00	11100	0	0	0	0	0	111.00
113.00	11300		802,357	802,357	-802,357	0	113.00
118.00		9,739,661	13,768,834	23,508,495	-13,282	23,495,213	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	0	0	0	0	0	192.00
192.01	19201	52,658	1,622	54,280	-3,404	50,876	192.01
192.02	19202	0	0	0	0	0	192.02
192.03	19203	0	0	0	0	0	192.03
192.04	19204	212	12,972	13,184	16,686	29,870	192.04
192.05	19205	0	0	0	0	0	192.05



RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1307

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

Worksheet A  
Date/Time Prepared:  
9/27/2017 2:32 pm

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
<b>GENERAL SERVICE COST CENTERS</b>					
1.00	00100	CAP REL COSTS-BLDG & FIXT	-46,637	2,469,569	1.00
1.01	00101	NEW CAP REL COSTS-NEW BLDG	0	0	1.01
1.02	00102	NEW CAP REL COSTS-PT BLDG	0	1,545	1.02
1.03	00103	NEW CAP REL COSTS-RHC BLDG	0	16,729	1.03
1.04	00104	CAP REL COSTS-15 N MAIN BLDG	0	39,355	1.04
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-210,131	405,913	2.00
2.01	00201	CAP REL COSTS-MVBLE EQUIP NEW BLDG	0	0	2.01
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-47	2,737,502	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-128,628	2,582,687	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	756,939	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	129,705	8.00
9.00	00900	HOUSEKEEPING	0	353,542	9.00
10.00	01000	DIETARY	-60,380	388,013	10.00
11.00	01100	CAFETERIA	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	361,895	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	-524	28,424	14.00
15.00	01500	PHARMACY	-37,695	1,878,633	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-492	343,899	16.00
17.00	01700	SOCIAL SERVICE	0	35,552	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	291,196	19.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS	-137,251	1,622,618	30.00
41.00	04100	SUBPROVIDER - IRF	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	42.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	-2,996	271,897	50.00
53.00	05300	ANESTHESIOLOGY	0	10,267	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-4,716	607,771	54.00
54.01	05401	ONCOLOGY	-268,000	224,680	54.01
56.00	05600	RADIOISOTOPE	0	162,064	56.00
57.00	05700	CT SCAN	0	92,309	57.00
58.00	05800	MRI	0	193,731	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000	LABORATORY	-12,721	971,866	60.00
60.01	06001	BLOOD LABORATORY	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	-29,249	317,570	65.00
66.00	06600	PHYSICAL THERAPY	-3,199	362,224	66.00
67.00	06700	OCCUPATIONAL THERAPY	-15,099	116,478	67.00
68.00	06800	SPEECH PATHOLOGY	-22,334	65,761	68.00
69.00	06900	ELECTROCARDIOLOGY	-12,222	12,010	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	2,788	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	86,531	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	35,760	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
76.00	03950	SENIOR LIFE SOLUTIONS	0	262,116	76.00
76.97	07697	CARDIAC REHABILITATION	0	51,076	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00	08800	RURAL HEALTH CLINIC	-1,011	2,042,901	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	89.00
90.00	09000	CLINIC	0	48,366	90.00
90.01	09001	COUMADIN CLINIC	0	28,041	90.01
90.02	04050	TELEMEDICINE	0	4,223	90.02
91.00	09100	EMERGENCY	-679,090	1,408,645	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
99.10	09910	CORF	0	0	99.10
<b>SPECIAL PURPOSE COST CENTERS</b>					
109.00	10900	PANCREAS ACQUISITION	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	111.00
113.00	11300	INTEREST EXPENSE	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-1,672,422	21,822,791	118.00
<b>NONREIMBURSABLE COST CENTERS</b>					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	192.00
192.01	19201	FITNESS CENTER	0	50,876	192.01
192.02	19202	RETAIL PHARMACY	0	0	192.02
192.03	19203	LEASED SPACE	0	0	192.03
192.04	19204	VACANT SPACE	0	29,870	192.04
192.05	19205	MEALS ON WHEELS	0	0	192.05
192.06	19206	15 N MAIN BUILDING	0	0	192.06
200.00		TOTAL (SUM OF LINES 118-199)	-1,672,422	21,903,537	200.00

COST CENTERS USED IN COST REPORT		Provider CCN: 14-1307	Period: From 05/01/2016 To 04/30/2017	Worksheet Non-CMS W Date/Time Prepared: 9/27/2017 2:32 pm
Cost Center Description		CMS Code	Standard Label For Non-Standard Codes	
		1.00	2.00	
<b>GENERAL SERVICE COST CENTERS</b>				
1.00	CAP REL COSTS-BLDG & FIXT	00100		1.00
1.01	NEW CAP REL COSTS-NEW BLDG	00101		1.01
1.02	NEW CAP REL COSTS-PT BLDG	00102		1.02
1.03	NEW CAP REL COSTS-RHC BLDG	00103		1.03
1.04	CAP REL COSTS-15 N MAIN BLDG	00104		1.04
2.00	CAP REL COSTS-MVBLE EQUIP	00200		2.00
2.01	CAP REL COSTS-MVBLE EQUIP NEW BLDG	00201		2.01
3.00	OTHER CAP REL COSTS	00300		3.00
4.00	EMPLOYEE BENEFITS DEPARTMENT	00400		4.00
5.00	ADMINISTRATIVE & GENERAL	00500		5.00
6.00	MAINTENANCE & REPAIRS	00600		6.00
8.00	LAUNDRY & LINEN SERVICE	00800		8.00
9.00	HOUSEKEEPING	00900		9.00
10.00	DIETARY	01000		10.00
11.00	CAFETERIA	01100		11.00
13.00	NURSING ADMINISTRATION	01300		13.00
14.00	CENTRAL SERVICES & SUPPLY	01400		14.00
15.00	PHARMACY	01500		15.00
16.00	MEDICAL RECORDS & LIBRARY	01600		16.00
17.00	SOCIAL SERVICE	01700		17.00
19.00	NONPHYSICIAN ANESTHETISTS	01900		19.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00	ADULTS & PEDIATRICS	03000		30.00
41.00	SUBPROVIDER - IRF	04100		41.00
42.00	SUBPROVIDER	04200		42.00
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	OPERATING ROOM	05000		50.00
53.00	ANESTHESIOLOGY	05300		53.00
54.00	RADIOLOGY-DIAGNOSTIC	05400		54.00
54.01	ONCOLOGY	05401		54.01
56.00	RADIOISOTOPE	05600		56.00
57.00	CT SCAN	05700		57.00
58.00	MRI	05800		58.00
59.00	CARDIAC CATHETERIZATION	05900		59.00
60.00	LABORATORY	06000		60.00
60.01	BLOOD LABORATORY	06001		60.01
65.00	RESPIRATORY THERAPY	06500		65.00
66.00	PHYSICAL THERAPY	06600		66.00
67.00	OCCUPATIONAL THERAPY	06700		67.00
68.00	SPEECH PATHOLOGY	06800		68.00
69.00	ELECTROCARDIOLOGY	06900		69.00
70.00	ELECTROENCEPHALOGRAPHY	07000		70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENT	07100		71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	07200		72.00
73.00	DRUGS CHARGED TO PATIENTS	07300		73.00
76.00	SENIOR LIFE SOLUTIONS	03950		76.00
76.97	CARDIAC REHABILITATION	07697	CARDIAC REHABILITATION	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>				
88.00	RURAL HEALTH CLINIC	08800		88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	08900		89.00
90.00	CLINIC	09000		90.00
90.01	COUMADIN CLINIC	09001		90.01
90.02	TELEMEDICINE	04050	TELEMEDICINE	90.02
91.00	EMERGENCY	09100		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART	09200		92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>				
99.10	CORF	09910		99.10
<b>SPECIAL PURPOSE COST CENTERS</b>				
109.00	PANCREAS ACQUISITION	10900		109.00
110.00	INTESTINAL ACQUISITION	11000		110.00
111.00	ISLET ACQUISITION	11100		111.00
113.00	INTEREST EXPENSE	11300		113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)			118.00
<b>NONREIMBURSABLE COST CENTERS</b>				
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	19000		190.00
192.00	PHYSICIANS' PRIVATE OFFICES	19200		192.00
192.01	FI TNES CENTER	19201		192.01
192.02	RETAIL PHARMACY	19202		192.02
192.03	LEASED SPACE	19203		192.03
192.04	VACANT SPACE	19204		192.04
192.05	MEALS ON WHEELS	19205		192.05

COST CENTERS USED IN COST REPORT		Provider CCN: 14-1307	Period: From 05/01/2016 To 04/30/2017	Worksheet Non-CMS W Date/Time Prepared: 9/27/2017 2:32 pm
Cost Center Description		CMS Code	Standard Label For Non-Standard Codes	
192.06	15 N MAIN BUILDING	1.00	2.00	
200.00	TOTAL (SUM OF LINES 118-199)	19206		
				192.06 200.00

RECLASSIFICATIONS

Provider CCN: 14-1307

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

Worksheet A-6

Date/Time Prepared:  
9/27/2017 2:32 pm

		Increases			
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
<b>A - INTEREST</b>					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	790,691	1.00
2.00	LABORATORY	60.00	0	2,383	2.00
3.00	RADIOLOGY-DIAGNOSTIC	54.00	0	9,283	3.00
TOTALS			0	802,357	
<b>C - RHC PHYSICIAN</b>					
1.00	ADULTS & PEDIATRICS	30.00	130,897	3,914	1.00
TOTALS			130,897	3,914	
<b>D - DEPRECIATION</b>					
1.00	NEW CAP REL COSTS-PT BLDG	1.02	0	52	1.00
2.00	NEW CAP REL COSTS-RHC BLDG	1.03	0	14,829	2.00
3.00	CAP REL COSTS-15 N MAIN BLDG	1.04	0	39,109	3.00
TOTALS			0	53,990	
<b>E - RHC LAB</b>					
1.00	LABORATORY	60.00	2,080	3,960	1.00
TOTALS			2,080	3,960	
<b>F - PROPERTY INSURANCE</b>					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	33,959	1.00
2.00	NEW CAP REL COSTS-PT BLDG	1.02	0	1,493	2.00
3.00	NEW CAP REL COSTS-RHC BLDG	1.03	0	1,900	3.00
4.00	CAP REL COSTS-15 N MAIN BLDG	1.04	0	246	4.00
TOTALS			0	37,598	
<b>G - IMPLANTABLE DEVICES</b>					
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	35,760	1.00
TOTALS			0	35,760	
<b>H - MEDICAL SUPPLIES RECLASS</b>					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	86,531	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
TOTALS			0	86,531	
<b>I - FITNESS CENTER RECLASS</b>					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	3,404	1.00
TOTALS			0	3,404	
<b>J - VACANT SPACE RECLASS</b>					
1.00	VACANT SPACE	192.04	0	16,686	1.00
TOTALS			0	16,686	
500.00	Grand Total: Increases		132,977	1,044,200	500.00

RECLASSIFICATIONS

Provider CCN: 14-1307

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

Worksheet A-6

Date/Time Prepared:  
9/27/2017 2:32 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
<b>A - INTEREST</b>							
1.00	INTEREST EXPENSE	113.00	0	802,357	11		1.00
2.00		0.00	0	0	11		2.00
3.00		0.00	0	0	11		3.00
	TOTALS		0	802,357			
<b>C - RHC PHYSICIAN</b>							
1.00	RURAL HEALTH CLINIC	88.00	130,897	3,914	0		1.00
	TOTALS		130,897	3,914			
<b>D - DEPRECIATION</b>							
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	53,990	9		1.00
2.00		0.00	0	0	9		2.00
3.00		0.00	0	0	9		3.00
	TOTALS		0	53,990			
<b>E - RHC LAB</b>							
1.00	RURAL HEALTH CLINIC	88.00	2,080	3,960	0		1.00
	TOTALS		2,080	3,960			
<b>F - PROPERTY INSURANCE</b>							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	37,598	12		1.00
2.00		0.00	0	0	12		2.00
3.00		0.00	0	0	12		3.00
4.00		0.00	0	0	12		4.00
	TOTALS		0	37,598			
<b>G - IMPLANTABLE DEVICES</b>							
1.00	OPERATING ROOM	50.00	0	35,760	0		1.00
	TOTALS		0	35,760			
<b>H - MEDICAL SUPPLIES RECLASS</b>							
1.00	ADULTS & PEDIATRICS	30.00	0	19,037	0		1.00
2.00	OPERATING ROOM	50.00	0	36,198	0		2.00
3.00	RADIOLOGY-DIAGNOSTIC	54.00	0	8,718	0		3.00
4.00	ONCOLOGY	54.01	0	3,477	0		4.00
5.00	RESPIRATORY THERAPY	65.00	0	493	0		5.00
6.00	CLINIC	90.00	0	204	0		6.00
7.00	EMERGENCY	91.00	0	18,404	0		7.00
	TOTALS		0	86,531			
<b>I - FITNESS CENTER RECLASS</b>							
1.00	FITNESS CENTER	192.01	0	3,404	0		1.00
	TOTALS		0	3,404			
<b>J - VACANT SPACE RECLASS</b>							
1.00	MAINTENANCE & REPAIRS	6.00	0	16,686	0		1.00
	TOTALS		0	16,686			
500.00	Grand Total: Decreases		132,977	1,044,200			500.00

		Increases			Decreases				
Cost Center		Line #	Salary	Other	Cost Center	Line #	Salary	Other	
2.00		3.00	4.00	5.00	6.00	7.00	8.00	9.00	
<b>A - INTEREST</b>									
1.00	CAP REL COSTS-BLDG & FI XT	1.00	0	790,691	INTEREST EXPENSE	113.00	0	802,357	1.00
2.00	LABORATORY	60.00	0	2,383		0.00	0	0	2.00
3.00	RADIOLOGY-DIAGNOSTIC	54.00	0	9,283		0.00	0	0	3.00
	TOTALS		0	802,357	TOTALS		0	802,357	
<b>C - RHC PHYSICIAN</b>									
1.00	ADULTS & PEDIATRICS	30.00	130,897	3,914	RURAL HEALTH CLINIC	88.00	130,897	3,914	1.00
	TOTALS		130,897	3,914	TOTALS		130,897	3,914	
<b>D - DEPRECIATION</b>									
1.00	NEW CAP REL COSTS-PT BLDG	1.02	0	52	CAP REL COSTS-BLDG & FI XT	1.00	0	53,990	1.00
2.00	NEW CAP REL COSTS-RHC BLDG	1.03	0	14,829		0.00	0	0	2.00
3.00	CAP REL COSTS-15 N MAIN BLDG	1.04	0	39,109		0.00	0	0	3.00
	TOTALS		0	53,990	TOTALS		0	53,990	
<b>E - RHC LAB</b>									
1.00	LABORATORY	60.00	2,080	3,960	RURAL HEALTH CLINIC	88.00	2,080	3,960	1.00
	TOTALS		2,080	3,960	TOTALS		2,080	3,960	
<b>F - PROPERTY INSURANCE</b>									
1.00	CAP REL COSTS-BLDG & FI XT	1.00	0	33,959	ADMINISTRATIVE & GENERAL	5.00	0	37,598	1.00
2.00	NEW CAP REL COSTS-PT BLDG	1.02	0	1,493		0.00	0	0	2.00
3.00	NEW CAP REL COSTS-RHC BLDG	1.03	0	1,900		0.00	0	0	3.00
4.00	CAP REL COSTS-15 N MAIN BLDG	1.04	0	246		0.00	0	0	4.00
	TOTALS		0	37,598	TOTALS		0	37,598	
<b>G - IMPLANTABLE DEVICES</b>									
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	35,760	OPERATING ROOM	50.00	0	35,760	1.00
	TOTALS		0	35,760	TOTALS		0	35,760	
<b>H - MEDICAL SUPPLIES RECLASS</b>									
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	86,531	ADULTS & PEDIATRICS	30.00	0	19,037	1.00
2.00		0.00	0	0	OPERATING ROOM	50.00	0	36,198	2.00
3.00		0.00	0	0	RADIOLOGY-DIAGNOSTIC	54.00	0	8,718	3.00
4.00		0.00	0	0	ONCOLOGY	54.01	0	3,477	4.00
5.00		0.00	0	0	RESPIRATORY THERAPY	65.00	0	493	5.00
6.00		0.00	0	0	CLINIC	90.00	0	204	6.00
7.00		0.00	0	0	EMERGENCY	91.00	0	18,404	7.00
	TOTALS		0	86,531	TOTALS		0	86,531	
<b>I - FITNESS CENTER RECLASS</b>									
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	3,404	FITNESS CENTER	192.01	0	3,404	1.00
	TOTALS		0	3,404	TOTALS		0	3,404	
<b>J - VACANT SPACE RECLASS</b>									
1.00	VACANT SPACE	192.04	0	16,686	MAINTENANCE & REPAIRS	6.00	0	16,686	1.00
	TOTALS		0	16,686	TOTALS		0	16,686	
500.00	Grand Total: Increases		132,977	1,044,200	Grand Total: Decreases		132,977	1,044,200	500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1307

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

Worksheet A-7  
Part I  
Date/Time Prepared:  
9/27/2017 2:32 pm

	Beginning Balances	Acquisitions			Disposals and Retirements	
		Purchases	Donation	Total		
	1.00	2.00	3.00	4.00	5.00	
<b>PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES</b>						
1.00	Land	658,227	0	0	0	1.00
2.00	Land Improvements	2,819,384	0	0	0	2.00
3.00	Buildings and Fixtures	29,077,452	154,167	0	154,167	3.00
4.00	Building Improvements	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	5.00
6.00	Movable Equipment	5,001,669	318,996	0	318,996	6.00
7.00	HIT designated Assets	1,682,322	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	39,239,054	473,163	0	473,163	8.00
9.00	Reconciling Items	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	39,239,054	473,163	0	473,163	10.00
	Ending Balance		Fully Depreciated Assets			
	6.00		7.00			
<b>PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES</b>						
1.00	Land	658,227	0			1.00
2.00	Land Improvements	2,819,384	0			2.00
3.00	Buildings and Fixtures	29,231,619	0			3.00
4.00	Building Improvements	0	0			4.00
5.00	Fixed Equipment	0	0			5.00
6.00	Movable Equipment	5,274,588	0			6.00
7.00	HIT designated Assets	1,682,322	0			7.00
8.00	Subtotal (sum of lines 1-7)	39,666,140	0			8.00
9.00	Reconciling Items	0	0			9.00
10.00	Total (line 8 minus line 9)	39,666,140	0			10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1307

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

Worksheet A-7  
Part II  
Date/Time Prepared:  
9/27/2017 2:32 pm

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	1,745,546	0	0	0	0	1.00
1.01	NEW CAP REL COSTS-NEW BLDG	0	0	0	0	0	1.01
1.02	NEW CAP REL COSTS-PT BLDG	0	0	0	0	0	1.02
1.03	NEW CAP REL COSTS-RHC BLDG	0	0	0	0	0	1.03
1.04	CAP REL COSTS-15 N MAIN BLDG	0	0	0	0	0	1.04
2.00	CAP REL COSTS-MVBLE EQUIP	616,044	0	0	0	0	2.00
2.01	CAP REL COSTS-MVBLE EQUIP NEW BLDG	0	0	0	0	0	2.01
3.00	Total (sum of lines 1-2)	2,361,590	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	0	1,745,546				1.00
1.01	NEW CAP REL COSTS-NEW BLDG	0	0				1.01
1.02	NEW CAP REL COSTS-PT BLDG	0	0				1.02
1.03	NEW CAP REL COSTS-RHC BLDG	0	0				1.03
1.04	CAP REL COSTS-15 N MAIN BLDG	0	0				1.04
2.00	CAP REL COSTS-MVBLE EQUIP	0	616,044				2.00
2.01	CAP REL COSTS-MVBLE EQUIP NEW BLDG	0	0				2.01
3.00	Total (sum of lines 1-2)	0	2,361,590				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1307

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

Worksheet A-7  
Part III  
Date/Time Prepared:  
9/27/2017 2:32 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	29,231,619	0	29,231,619	0.807759	0	1.00
1.01	NEW CAP REL COSTS-NEW BLDG	0	0	0	0.000000	0	1.01
1.02	NEW CAP REL COSTS-PT BLDG	0	0	0	0.000000	0	1.02
1.03	NEW CAP REL COSTS-RHC BLDG	0	0	0	0.000000	0	1.03
1.04	CAP REL COSTS-15 N MAIN BLDG	0	0	0	0.000000	0	1.04
2.00	CAP REL COSTS-MVBLE EQUIP	6,956,911	0	6,956,911	0.192241	0	2.00
2.01	CAP REL COSTS-MVBLE EQUIP NEW BLDG	0	0	0	0.000000	0	2.01
3.00	Total (sum of lines 1-2)	36,188,530	0	36,188,530	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	1,691,556	0	1.00
1.01	NEW CAP REL COSTS-NEW BLDG	0	0	0	0	0	1.01
1.02	NEW CAP REL COSTS-PT BLDG	0	0	0	52	0	1.02
1.03	NEW CAP REL COSTS-RHC BLDG	0	0	0	14,829	0	1.03
1.04	CAP REL COSTS-15 N MAIN BLDG	0	0	0	39,109	0	1.04
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	405,913	0	2.00
2.01	CAP REL COSTS-MVBLE EQUIP NEW BLDG	0	0	0	0	0	2.01
3.00	Total (sum of lines 1-2)	0	0	0	2,151,459	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	744,054	33,959	0	0	2,469,569	1.00
1.01	NEW CAP REL COSTS-NEW BLDG	0	0	0	0	0	1.01
1.02	NEW CAP REL COSTS-PT BLDG	0	1,493	0	0	1,545	1.02
1.03	NEW CAP REL COSTS-RHC BLDG	0	1,900	0	0	16,729	1.03
1.04	CAP REL COSTS-15 N MAIN BLDG	0	246	0	0	39,355	1.04
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	405,913	2.00
2.01	CAP REL COSTS-MVBLE EQUIP NEW BLDG	0	0	0	0	0	2.01
3.00	Total (sum of lines 1-2)	744,054	37,598	0	0	2,933,111	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1307

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

Worksheet A-8

Date/Time Prepared:  
9/27/2017 2:32 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
1.00 Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-46,637	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
1.01 Investment income - NEW CAP REL COSTS-NEW BLDG (chapter 2)			ONEW CAP REL COSTS-NEW BLDG	1.01	0	1.01
1.02 Investment income - NEW CAP REL COSTS-PT BLDG (chapter 2)			ONEW CAP REL COSTS-PT BLDG	1.02	0	1.02
1.03 Investment income - NEW CAP REL COSTS-RHC BLDG (chapter 2)			ONEW CAP REL COSTS-RHC BLDG	1.03	0	1.03
1.04 Investment income - CAP REL COSTS-15 N MAIN BLDG (chapter 2)			OCAP REL COSTS-15 N MAIN BLDG	1.04	0	1.04
2.00 Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			OCAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
2.01 Investment income - CAP REL COSTS-MVBLE EQUIP NEW BLDG (chapter 2)			OCAP REL COSTS-MVBLE EQUIP NEW BLDG	2.01	0	2.01
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)	B	-32,096	PHARMACY	15.00	0	5.00
6.00 Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00 Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00 Television and radio service (chapter 21)	A	-2,658	ADMINISTRATIVE & GENERAL	5.00	0	8.00
9.00 Parking lot (chapter 21)		0		0.00	0	9.00
10.00 Provider-based physician adjustment	A-8-2	-1,102,508			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	-56,394	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	-483	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	B	-317	ADMINISTRATIVE & GENERAL	5.00	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		ORESPIRATORY THERAPY	65.00		23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		OPHYSICAL 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			OCAP REL COSTS-BLDG & FIXT	1.00	0	26.00
26.01 Depreciation - NEW CAP REL COSTS-NEW BLDG			ONEW CAP REL COSTS-NEW BLDG	1.01	0	26.01
26.02 Depreciation - NEW CAP REL COSTS-PT BLDG			ONEW CAP REL COSTS-PT BLDG	1.02	0	26.02

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1307

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

Worksheet A-8

Date/Time Prepared:  
9/27/2017 2:32 pm

Line #	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	Ref.	
				Cost Center	Line #			
				3.00	4.00			
1.00	2.00	3.00	4.00	5.00				
26.03	Depreciation - NEW CAP REL COSTS-RHC BLDG			0	NEW CAP REL COSTS-RHC BLDG	1.03	0	26.03
26.04	Depreciation - CAP REL COSTS-15 N MAIN BLDG			0	CAP REL COSTS-15 N MAIN BLDG	1.04	0	26.04
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP			0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
27.01	Depreciation - CAP REL COSTS-MVBLE EQUIP NEW BLDG			0	CAP REL COSTS-MVBLE EQUIP NEW BLDG	2.01	0	27.01
28.00	Non-physician Anesthetist			0	NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00	Physicians' assistant			0	0	0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)			0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	A	-210,131		CAP REL COSTS-MVBLE EQUIP	2.00	9	32.00
33.00	NONPATIENT CARE RELATED PROPERTY INS	A	-8,714		ADMINISTRATIVE & GENERAL	5.00	0	33.00
34.00	MISCELLANEOUS INCOME	B	-856		ADMINISTRATIVE & GENERAL	5.00	0	34.00
34.01	REBATE - LAB	B	-3,026		LABORATORY	60.00	0	34.01
34.02	REBATE - CENTRAL SUPPLY	B	-524		CENTRAL SERVICES & SUPPLY	14.00	0	34.02
34.03	REBATE - DIETARY	B	-534		DIETARY	10.00	0	34.03
34.04	REBATE - COMMUNICATIONS	B	-368		ADMINISTRATIVE & GENERAL	5.00	0	34.04
35.00	RENT - SPECIALTY CLINIC	B	-26,044		RESPIRATORY THERAPY	65.00	0	35.00
36.00	MOBILE PET SCAN RENTAL	B	-4,675		RADIOLOGY-DIAGNOSTIC	54.00	0	36.00
37.00	NON-ALLOWABLE LOBBYING	A	-8,615		ADMINISTRATIVE & GENERAL	5.00	0	37.00
37.01	NON-ALLOWABLE LOBBYING	A	-2		DIETARY	10.00	0	37.01
37.02	NON-ALLOWABLE LOBBYING	A	-9		MEDICAL RECORDS & LIBRARY	16.00	0	37.02
37.03	NON-ALLOWABLE LOBBYING	A	-11		OPERATING ROOM	50.00	0	37.03
37.04	NON-ALLOWABLE LOBBYING	A	-41		RADIOLOGY-DIAGNOSTIC	54.00	0	37.04
37.05	NON-ALLOWABLE LOBBYING	A	-1,011		RURAL HEALTH CLINIC	88.00	0	37.05
37.06	NON-ALLOWABLE LOBBYING	A	-6		EMPLOYEE BENEFITS DEPARTMENT	4.00	0	37.06
37.07	NON-ALLOWABLE LOBBYING	A	-20		RESPIRATORY THERAPY	65.00	0	37.07
38.00	NON-ALLOWABLE LOBBYING	A	-87		PHYSICAL THERAPY	66.00	0	38.00
39.00	NON-ALLOWABLE ADVERTISING	A	-87,634		ADMINISTRATIVE & GENERAL	5.00	0	39.00
40.00	GIFTS & DONATIONS	A	-1,084		ADMINISTRATIVE & GENERAL	5.00	0	40.00
41.00	OTHER ENTERTAINMENT	A	-2,882		ADMINISTRATIVE & GENERAL	5.00	0	41.00
42.00	COMMUNITY EDUCATION	A	-15,500		ADMINISTRATIVE & GENERAL	5.00	0	42.00
43.00	OUTSIDE SERVICES - PHYSICAL THERAPY	B	-3,112		PHYSICAL THERAPY	66.00	0	43.00
43.01	OUTSIDE SERVICES - OCCUP THERAPY	B	-15,099		OCCUPATIONAL THERAPY	67.00	0	43.01
43.02	OUTSIDE SERVICES - SPEECH PATHOLOGY	B	-22,334		SPEECH PATHOLOGY	68.00	0	43.02
43.03			0			0.00	0	43.03
43.04	OUTSIDE SERVICES - LAB	B	-9,695		LABORATORY	60.00	0	43.04
44.00	PHYSICIAN RECRUITMENT	A	-41		EMPLOYEE BENEFITS DEPARTMENT	4.00	0	44.00
45.00	SPECIALTY CLINIC SUPPORT	A	-225		RESPIRATORY THERAPY	65.00	0	45.00
46.00	DIETICIAN'S CONSULTS	B	-3,450		DIETARY	10.00	0	46.00
47.00	NON-HOSP RX	B	-5,599		PHARMACY	15.00	0	47.00
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-1,672,422					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: 14-1307

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

Worksheet A-8-2

Date/Time Prepared:  
9/27/2017 2:32 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	DR. F	64,576	64,576	0	0	0	1.00
2.00	30.00	DR. R	38,408	38,408	0	0	0	2.00
3.00	30.00	DR. B	8,822	8,822	0	0	0	3.00
4.00	30.00	DR. F	23,005	23,005	0	0	0	4.00
5.00	30.00	AGGREGATE-ADULTS & PEDIATRICS	2,440	2,440	0	0	0	5.00
6.00	50.00	AGGREGATE-OPERATING ROOM	2,985	2,985	0	0	0	6.00
7.00	54.01	AGGREGATE-ONCOLOGY	268,000	268,000	0	0	0	7.00
8.00	60.00	AGGREGATE-LABORATORY	20,475	0	20,475	0	0	8.00
9.00	65.00	AGGREGATE-RESPIRATORY THERAPY	2,960	2,960	0	0	0	9.00
10.00	69.00	AGGREGATE-ELECTROCARDIOLOGY	12,222	12,222	0	0	0	10.00
11.00	76.00	AGGREGATE-SENIOR LIFE SOLUTIONS	29,375	0	29,375	0	0	11.00
12.00	91.00	AGGREGATE-EMERGENCY	1,543,386	679,090	864,296	0	0	12.00
200.00			2,016,654	1,102,508	914,146	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	DR. F	0	0	0	0	0	1.00
2.00	30.00	DR. R	0	0	0	0	0	2.00
3.00	30.00	DR. B	0	0	0	0	0	3.00
4.00	30.00	DR. F	0	0	0	0	0	4.00
5.00	30.00	AGGREGATE-ADULTS & PEDIATRICS	0	0	0	0	0	5.00
6.00	50.00	AGGREGATE-OPERATING ROOM	0	0	0	0	0	6.00
7.00	54.01	AGGREGATE-ONCOLOGY	0	0	0	0	0	7.00
8.00	60.00	AGGREGATE-LABORATORY	0	0	0	0	0	8.00
9.00	65.00	AGGREGATE-RESPIRATORY THERAPY	0	0	0	0	0	9.00
10.00	69.00	AGGREGATE-ELECTROCARDIOLOGY	0	0	0	0	0	10.00
11.00	76.00	AGGREGATE-SENIOR LIFE SOLUTIONS	0	0	0	0	0	11.00
12.00	91.00	AGGREGATE-EMERGENCY	0	0	0	0	0	12.00
200.00			0	0	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	30.00	DR. F	0	0	0	64,576		1.00
2.00	30.00	DR. R	0	0	0	38,408		2.00
3.00	30.00	DR. B	0	0	0	8,822		3.00
4.00	30.00	DR. F	0	0	0	23,005		4.00
5.00	30.00	AGGREGATE-ADULTS & PEDIATRICS	0	0	0	2,440		5.00
6.00	50.00	AGGREGATE-OPERATING ROOM	0	0	0	2,985		6.00
7.00	54.01	AGGREGATE-ONCOLOGY	0	0	0	268,000		7.00
8.00	60.00	AGGREGATE-LABORATORY	0	0	0	0		8.00
9.00	65.00	AGGREGATE-RESPIRATORY THERAPY	0	0	0	2,960		9.00
10.00	69.00	AGGREGATE-ELECTROCARDIOLOGY	0	0	0	12,222		10.00
11.00	76.00	AGGREGATE-SENIOR LIFE SOLUTIONS	0	0	0	0		11.00
12.00	91.00	AGGREGATE-EMERGENCY	0	0	0	679,090		12.00
200.00			0	0	0	1,102,508		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 14-1307		Period: From 05/01/2016 To 04/30/2017		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 9/27/2017 2:32 pm	
		Physical Therapy		Cost			
						1.00	
<b>PART I - GENERAL INFORMATION</b>							
1.00	Total number of weeks worked (excluding aides) (see instructions)					9	1.00
2.00	Line 1 multiplied by 15 hours per week					135	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					9	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00
7.00	Standard travel expense rate					5.38	7.00
8.00	Optional travel expense rate per mile					0.00	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	44.75	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	79.55	0.00	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	39.78	39.78	0.00			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01
						1.00	
<b>Part II - SALARY EQUIVALENCY COMPUTATION</b>							
14.00	Supervisors (column 1, line 9 times column 1, line 10)					0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					3,560	15.00
16.00	Assistants (column 3, line 9 times column 3, line 10)					0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					3,560	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)					0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)					0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)					3,560	20.00
If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.							
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)					79.55	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					10,739	22.00
23.00	Total salary equivalency (see instructions)					10,739	23.00
<b>PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE</b>							
<b>Standard Travel Allowance</b>							
24.00	Therapists (line 3 times column 2, line 11)					358	24.00
25.00	Assistants (line 4 times column 3, line 11)					0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					358	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					48	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					406	28.00
<b>Optional Travel Allowance and Optional Travel Expense</b>							
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)					0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)					0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)					0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)					406	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					48	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
<b>Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE</b>							
<b>Standard Travel Expense</b>							
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00
<b>Optional Travel Allowance and Optional Travel Expense</b>							
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.							
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 14-1307				Period: From 05/01/2016 To 04/30/2017		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 9/27/2017 2:32 pm	
								Physical Therapy	Cost
								1.00	
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)							0	46.00
		Therapists	Assistants	Aides	Trainees	Total			
		1.00	2.00	3.00	4.00	5.00			
<b>PART V - OVERTIME COMPUTATION</b>									
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00		47.00	
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00	0.00		48.00	
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00	0.00		49.00	
<b>CALCULATION OF LIMIT</b>									
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00		50.00	
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50 (see instructions)	0.00	0.00	0.00	0.00	0.00		51.00	
<b>DETERMINATION OF OVERTIME ALLOWANCE</b>									
52.00	Adjusted hourly salary equivalency amount (see instructions)	79.55	0.00	0.00	0.00			52.00	
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0			53.00	
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0			54.00	
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0			55.00	
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0		56.00	
								1.00	
<b>Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT</b>									
57.00	Salary equivalency amount (from line 23)							10,739	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35)							406	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)							0	59.00
60.00	Overtime allowance (from column 5, line 56)							0	60.00
61.00	Equipment cost (see instructions)							0	61.00
62.00	Supplies (see instructions)							0	62.00
63.00	Total allowance (sum of lines 57-62)							11,145	63.00
64.00	Total cost of outside supplier services (from your records)							2,695	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)							0	65.00
<b>LINE 33 CALCULATION</b>									
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others							358	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others							48	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27							406	100.02
<b>LINE 34 CALCULATION</b>									
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others							48	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others							0	101.01
101.02	Line 34 = sum of lines 27 and 31							48	101.02
<b>LINE 35 CALCULATION</b>									
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others							0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others							0	102.01
102.02	Line 35 = sum of lines 31 and 32							0	102.02

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 14-1307		Period: From 05/01/2016 To 04/30/2017		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 9/27/2017 2:32 pm	
		Speech Pathology		Cost			
						1.00	
<b>PART I - GENERAL INFORMATION</b>							
1.00	Total number of weeks worked (excluding aides) (see instructions)					4	1.00
2.00	Line 1 multiplied by 15 hours per week					60	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					4	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00
7.00	Standard travel expense rate					5.38	7.00
8.00	Optional travel expense rate per mile					0.00	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	14.50	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	72.46	0.00	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	36.23	36.23	0.00			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01
						1.00	
<b>Part II - SALARY EQUIVALENCY COMPUTATION</b>							
14.00	Supervisors (column 1, line 9 times column 1, line 10)					0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					1,051	15.00
16.00	Assistants (column 3, line 9 times column 3, line 10)					0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					1,051	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)					0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)					0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)					1,051	20.00
If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.							
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)					72.48	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					4,349	22.00
23.00	Total salary equivalency (see instructions)					4,349	23.00
<b>PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE</b>							
<b>Standard Travel Allowance</b>							
24.00	Therapists (line 3 times column 2, line 11)					145	24.00
25.00	Assistants (line 4 times column 3, line 11)					0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					145	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					22	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					167	28.00
<b>Optional Travel Allowance and Optional Travel Expense</b>							
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)					0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)					0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)					0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)					167	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					22	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
<b>Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE</b>							
<b>Standard Travel Expense</b>							
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00
<b>Optional Travel Allowance and Optional Travel Expense</b>							
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.							
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 14-1307				Period: From 05/01/2016 To 04/30/2017	Worksheet A-8-3 Parts I-VI Date/Time Prepared: 9/27/2017 2:32 pm
						Speech Pathology	Cost
						1.00	
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)						0 46.00
		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
<b>PART V - OVERTIME COMPUTATION</b>							
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00	0.00	48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00	0.00	49.00
<b>CALCULATION OF LIMIT</b>							
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50 (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
<b>DETERMINATION OF OVERTIME ALLOWANCE</b>							
52.00	Adjusted hourly salary equivalency amount (see instructions)	72.46	0.00	0.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00
						1.00	
<b>Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT</b>							
57.00	Salary equivalency amount (from line 23)					4,349	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))					167	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)					0	59.00
60.00	Overtime allowance (from column 5, line 56)					0	60.00
61.00	Equipment cost (see instructions)					0	61.00
62.00	Supplies (see instructions)					0	62.00
63.00	Total allowance (sum of lines 57-62)					4,516	63.00
64.00	Total cost of outside supplier services (from your records)					689	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)					0	65.00
<b>LINE 33 CALCULATION</b>							
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others					145	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others					22	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27					167	100.02
<b>LINE 34 CALCULATION</b>							
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others					22	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others					0	101.01
101.02	Line 34 = sum of lines 27 and 31					22	101.02
<b>LINE 35 CALCULATION</b>							
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others					0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others					0	102.01
102.02	Line 35 = sum of lines 31 and 32					0	102.02

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1307

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

Worksheet B  
Part I  
Date/Time Prepared:  
9/27/2017 2:32 pm

Cost Center Description		Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS				
			BLDG & FIXT	NEW NEW BLDG	NEW PT BLDG	NEW RHC BLDG	
		0	1.00	1.01	1.02	1.03	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100	CAP REL COSTS-BLDG & FIXT	2,469,569	2,469,569			1.00
1.01	00101	NEW CAP REL COSTS-NEW BLDG	0	0	0		1.01
1.02	00102	NEW CAP REL COSTS-PT BLDG	1,545	0	0	1,545	1.02
1.03	00103	NEW CAP REL COSTS-RHC BLDG	16,729	0	0		1.03
1.04	00104	CAP REL COSTS-15 N MAIN BLDG	39,355	0	0		1.04
2.00	00200	CAP REL COSTS-MVBLE EQUIP	405,913				2.00
2.01	00201	CAP REL COSTS-MVBLE EQUIP NEW BLDG	0				2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,737,502	0	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,582,687	577,787	0	24	5.00
6.00	00600	MAINTENANCE & REPAIRS	756,939	180,672	0	0	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	129,705	11,803	0	0	8.00
9.00	00900	HOUSEKEEPING	353,542	23,606	0	0	9.00
10.00	01000	DIETARY	388,013	111,047	0	0	10.00
11.00	01100	CAFETERIA	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	361,895	10,999	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	28,424	37,958	0	0	14.00
15.00	01500	PHARMACY	1,878,633	37,403	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	343,899	37,653	0	0	16.00
17.00	01700	SOCIAL SERVICE	35,552	2,632	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	291,196	0	0	0	19.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	1,622,618	261,353	0	0	30.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	42.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	271,897	256,975	0	0	50.00
53.00	05300	ANESTHESIOLOGY	10,267	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	607,771	153,631	0	0	54.00
54.01	05401	ONCOLOGY	224,680	76,469	0	0	54.01
56.00	05600	RADIOISOTOPE	162,064	8,201	0	0	56.00
57.00	05700	CT SCAN	92,309	25,240	0	0	57.00
58.00	05800	MRI	193,731	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	971,866	75,029	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	317,570	97,581	0	0	65.00
66.00	06600	PHYSICAL THERAPY	362,224	0	0	1,072	66.00
67.00	06700	OCCUPATIONAL THERAPY	116,478	0	0	145	67.00
68.00	06800	SPEECH PATHOLOGY	65,761	0	0	27	68.00
69.00	06900	ELECTROCARDIOLOGY	12,010	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	2,788	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	86,531	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	35,760	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
76.00	03950	SENIOR LIFE SOLUTIONS	262,116	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	51,076	6,151	0	0	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	RURAL HEALTH CLINIC	2,042,901	280,498	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00
90.00	09000	CLINIC	48,366	3,602	0	0	90.00
90.01	09001	COUMADIN CLINIC	28,041	0	0	0	90.01
90.02	04050	TELEMEDICINE	4,223	18,674	0	0	90.02
91.00	09100	EMERGENCY	1,408,645	162,996	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
99.10	09910	CORF	0	0	0	0	99.10
<b>SPECIAL PURPOSE COST CENTERS</b>							
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	21,822,791	2,457,960	0	1,268	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	11,609	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
192.01	19201	FITNESS CENTER	50,876	0	0	9	192.01
192.02	19202	RETAIL PHARMACY	0	0	0	0	192.02
192.03	19203	LEASED SPACE	0	0	0	0	192.03

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1307

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

Worksheet B  
Part I  
Date/Time Prepared:  
9/27/2017 2:32 pm

Cost Center Description		Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS					
			BLDG & FIXT	NEW NEW BLDG	NEW PT BLDG	NEW RHC BLDG		
		0	1.00	1.01	1.02	1.03		
192.04	19204	VACANT SPACE	29,870	0	0	268	13,964	192.04
192.05	19205	MEALS ON WHEELS	0	0	0	0	0	192.05
192.06	19206	15 N MAIN BUILDING	0	0	0	0	0	192.06
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	21,903,537	2,469,569	0	1,545	16,729	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1307

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

Worksheet B  
Part I  
Date/Time Prepared:  
9/27/2017 2:32 pm

Cost Center Description			CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			15 N MAIN BLDG	MVBLE EQUIP	MVBLE EQUIP NEW BLDG			
			1.04	2.00	2.01			
<b>GENERAL SERVICE COST CENTERS</b>								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-NEW BLDG						1.01
1.02	00102	NEW CAP REL COSTS-PT BLDG						1.02
1.03	00103	NEW CAP REL COSTS-RHC BLDG						1.03
1.04	00104	CAP REL COSTS-15 N MAIN BLDG	39,355					1.04
2.00	00200	CAP REL COSTS-MVBLE EQUIP		405,913				2.00
2.01	00201	CAP REL COSTS-MVBLE EQUIP NEW BLDG		0	0			2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	2,737,502		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	98,293	0	393,873	3,655,429	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	26,450	0	74,062	1,038,123	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	1,728	0	8,915	152,151	8.00
9.00	00900	HOUSEKEEPING	0	3,456	0	89,061	469,665	9.00
10.00	01000	DIETARY	0	16,257	0	88,026	603,343	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	1,610	0	96,113	470,617	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	5,557	0	7,463	79,402	14.00
15.00	01500	PHARMACY	0	5,476	0	85,838	2,007,350	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	5,512	0	90,228	477,292	16.00
17.00	01700	SOCIAL SERVICE	0	385	0	8,695	47,264	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	291,196	19.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	0	38,261	0	449,694	2,371,926	30.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	0	37,621	0	31,787	598,280	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	10,267	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	22,491	0	132,727	916,620	54.00
54.01	05401	ONCOLOGY	0	11,195	0	58,212	370,556	54.01
56.00	05600	RADIOISOTOPE	0	1,201	0	19,424	190,890	56.00
57.00	05700	CT SCAN	0	3,695	0	16,543	137,787	57.00
58.00	05800	MRI	0	0	0	0	193,731	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	10,984	0	134,935	1,192,814	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	14,286	0	66,631	496,068	65.00
66.00	06600	PHYSICAL THERAPY	0	22,029	0	100,303	485,628	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	2,973	0	35,528	155,124	67.00
68.00	06800	SPEECH PATHOLOGY	0	552	0	23,130	89,470	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	1,278	13,288	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	184	2,972	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	86,531	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	35,760	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950	SENIOR LIFE SOLUTIONS	19,677	6,814	0	45,472	334,079	76.00
76.97	07697	CARDIAC REHABILITATION	0	900	0	10,414	68,541	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>								
88.00	08800	RURAL HEALTH CLINIC	0	41,064	0	513,347	2,877,810	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	527	0	1,884	54,379	90.00
90.01	09001	COUMADIN CLINIC	0	0	0	7,454	35,495	90.01
90.02	04050	TELEMEDICINE	0	2,734	0	486	26,117	90.02
91.00	09100	EMERGENCY	0	23,862	0	130,890	1,726,393	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
99.10	09910	CORF	0	0	0	0	0	99.10
<b>SPECIAL PURPOSE COST CENTERS</b>								
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	19,677	405,913	0	2,722,597	21,762,358	118.00
<b>NONREIMBURSABLE COST CENTERS</b>								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	11,609	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	FITNESS CENTER	0	0	0	14,845	65,730	192.01
192.02	19202	RETAIL PHARMACY	0	0	0	0	0	192.02
192.03	19203	LEASED SPACE	0	0	0	0	0	192.03
192.04	19204	VACANT SPACE	19,678	0	0	60	63,840	192.04
192.05	19205	MEALS ON WHEELS	0	0	0	0	0	192.05

COST ALLOCATION - GENERAL SERVICE COSTS

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Worksheet B  
Part I  
Date/Time Prepared:  
9/27/2017 2:32 pm

Cost Center Description		CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
		15 N MAIN BLDG	MVBLE EQUIP	MVBLE EQUIP NEW BLDG			
		1.04	2.00	2.01			
192.06	19206	15 N MAIN BUILDING	0	0	0	0	192.06
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)	39,355	405,913	0	2,737,502	21,903,537 202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1307

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

Worksheet B  
Part I  
Date/Time Prepared:  
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Cost Center Description			ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	6.00	8.00	9.00	10.00	
<b>GENERAL SERVICE COST CENTERS</b>								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-NEW BLDG						1.01
1.02	00102	NEW CAP REL COSTS-PT BLDG						1.02
1.03	00103	NEW CAP REL COSTS-RHC BLDG						1.03
1.04	00104	CAP REL COSTS-15 N MAIN BLDG						1.04
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	CAP REL COSTS-MVBLE EQUIP NEW BLDG						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	3,655,429					5.00
6.00	00600	MAINTENANCE & REPAIRS	207,955	1,246,078				6.00
8.00	00800	LAUNDRY & LINEN SERVICE	30,479	7,607	190,237			8.00
9.00	00900	HOUSEKEEPING	94,082	15,213	0	578,960		9.00
10.00	01000	DIETARY	120,860	71,568	0	34,104	829,875	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	94,273	7,089	0	3,378	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	15,906	24,463	0	11,657	0	14.00
15.00	01500	PHARMACY	402,108	24,106	0	11,487	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	95,610	24,267	0	11,564	0	16.00
17.00	01700	SOCIAL SERVICE	9,468	1,696	0	808	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	58,332	0	0	0	0	19.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	475,139	168,438	190,237	80,264	829,875	30.00
41.00	04100	SUBPROVIDER - I RF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	119,846	165,616	0	78,920	0	50.00
53.00	05300	ANESTHESIOLOGY	2,057	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	183,615	99,013	0	47,182	0	54.00
54.01	05401	ONCOLOGY	74,229	49,283	0	23,484	0	54.01
56.00	05600	RADIOISOTOPE	38,239	5,285	0	2,519	0	56.00
57.00	05700	CT SCAN	27,601	16,267	0	7,752	0	57.00
58.00	05800	MRI	38,808	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	238,942	48,355	0	23,042	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	99,371	62,890	0	29,968	0	65.00
66.00	06600	PHYSICAL THERAPY	97,280	96,977	0	46,212	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	31,074	13,089	0	6,237	0	67.00
68.00	06800	SPEECH PATHOLOGY	17,922	2,428	0	1,157	0	68.00
69.00	06900	ELECTROCARDIOLOGY	2,662	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	595	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	17,334	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	7,163	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950	SENIOR LIFE SOLUTIONS	66,922	29,998	0	14,295	0	76.00
76.97	07697	CARDIAC REHABILITATION	13,730	3,964	0	1,889	0	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>								
88.00	08800	RURAL HEALTH CLINIC	576,484	180,776	0	86,142	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	10,893	2,321	0	1,106	0	90.00
90.01	09001	COUMADIN CLINIC	7,110	0	0	0	0	90.01
90.02	04050	TELEMEDICINE	5,232	12,035	0	5,735	0	90.02
91.00	09100	EMERGENCY	345,828	105,048	0	50,058	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
99.10	09910	CORF	0	0	0	0	0	99.10
<b>SPECIAL PURPOSE COST CENTERS</b>								
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	3,627,149	1,237,792	190,237	578,960	829,875	118.00
<b>NONREIMBURSABLE COST CENTERS</b>								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,325	7,482	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	FITNESS CENTER	13,167	804	0	0	0	192.01
192.02	19202	RETAIL PHARMACY	0	0	0	0	0	192.02
192.03	19203	LEASED SPACE	0	0	0	0	0	192.03
192.04	19204	VACANT SPACE	12,788	0	0	0	0	192.04
192.05	19205	MEALS ON WHEELS	0	0	0	0	0	192.05
192.06	19206	15 N MAIN BUILDING	0	0	0	0	0	192.06
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1307

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

Worksheet B  
Part I  
Date/Time Prepared:  
9/27/2017 2:32 pm

Cost Center Description	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
	5.00	6.00	8.00	9.00	10.00	
202.00   TOTAL (sum lines 118-201)	3,655,429	1,246,078	190,237	578,960	829,875	202.00

COST ALLOCATION - GENERAL SERVICE COSTS			Provider CCN: 14-1307		Period: From 05/01/2016 To 04/30/2017		Worksheet B Part I Date/Time Prepared: 9/27/2017 2:32 pm	
Cost Center Description			CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
<b>GENERAL SERVICE COST CENTERS</b>								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-NEW BLDG						1.01
1.02	00102	NEW CAP REL COSTS-PT BLDG						1.02
1.03	00103	NEW CAP REL COSTS-RHC BLDG						1.03
1.04	00104	CAP REL COSTS-15 N MAIN BLDG						1.04
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	CAP REL COSTS-MVBLE EQUIP NEW BLDG						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	0					11.00
13.00	01300	NURSING ADMINISTRATION	0	575,357				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	131,428			14.00
15.00	01500	PHARMACY	0	0	796	2,445,847		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	635	0	609,368	16.00
17.00	01700	SOCIAL SERVICE	0	0	29	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	0	359,526	9,903	0	27,306	30.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	0	31,023	6,585	0	11,527	50.00
53.00	05300	ANESTHESIOLOGY	0	0	454	0	8,235	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	6,944	0	49,931	54.00
54.01	05401	ONCOLOGY	0	56,813	0	0	7,407	54.01
56.00	05600	RADIOISOTOPE	0	0	62	0	11,163	56.00
57.00	05700	CT SCAN	0	0	1,565	0	90,058	57.00
58.00	05800	MRI	0	0	5	0	22,044	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	38,432	0	117,608	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	0	2,261	0	14,869	65.00
66.00	06600	PHYSICAL THERAPY	0	0	364	0	35,038	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	97	0	9,119	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	1,956	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	91	0	5,253	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	172	0	76	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	38,660	0	3,298	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	5,330	0	1,232	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	2,445,847	89,878	73.00
76.00	03950	SENIOR LIFE SOLUTIONS	0	0	311	0	15,299	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	8	0	3,081	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>								
88.00	08800	RURAL HEALTH CLINIC	0	0	9,120	0	43,847	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	251	15	0	1,016	90.00
90.01	09001	COUMADIN CLINIC	0	0	239	0	2,541	90.01
90.02	04050	TELEMEDICINE	0	0	0	0	21	90.02
91.00	09100	EMERGENCY	0	127,744	9,253	0	37,565	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
99.10	09910	CORF	0	0	0	0	0	99.10
<b>SPECIAL PURPOSE COST CENTERS</b>								
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	575,357	131,331	2,445,847	609,368	118.00
<b>NONREIMBURSABLE COST CENTERS</b>								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	FITNESS CENTER	0	0	97	0	0	192.01
192.02	19202	RETAIL PHARMACY	0	0	0	0	0	192.02
192.03	19203	LEASED SPACE	0	0	0	0	0	192.03
192.04	19204	VACANT SPACE	0	0	0	0	0	192.04
192.05	19205	MEALS ON WHEELS	0	0	0	0	0	192.05
192.06	19206	15 N MAIN BUILDING	0	0	0	0	0	192.06
200.00		Cross Foot Adjustments						200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1307

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

Worksheet B  
Part I  
Date/Time Prepared:  
9/27/2017 2:32 pm

Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		11.00	13.00	14.00	15.00	16.00	
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	0	575,357	131,428	2,445,847	609,368	202.00

COST ALLOCATION - GENERAL SERVICE COSTS			Provider CCN: 14-1307	Period: From 05/01/2016 To 04/30/2017	Worksheet B Part I Date/Time Prepared: 9/27/2017 2:32 pm	
Cost Center Description	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
	17.00	19.00	24.00	25.00	26.00	
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	CAP REL COSTS-BLDG & FIXT					1.00
1.01 00101	NEW CAP REL COSTS-NEW BLDG					1.01
1.02 00102	NEW CAP REL COSTS-PT BLDG					1.02
1.03 00103	NEW CAP REL COSTS-RHC BLDG					1.03
1.04 00104	CAP REL COSTS-15 N MAIN BLDG					1.04
2.00 00200	CAP REL COSTS-MVBLE EQUIP					2.00
2.01 00201	CAP REL COSTS-MVBLE EQUIP NEW BLDG					2.01
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00 00500	ADMINISTRATIVE & GENERAL					5.00
6.00 00600	MAINTENANCE & REPAIRS					6.00
8.00 00800	LAUNDRY & LINEN SERVICE					8.00
9.00 00900	HOUSEKEEPING					9.00
10.00 01000	DIETARY					10.00
11.00 01100	CAFETERIA					11.00
13.00 01300	NURSING ADMINISTRATION					13.00
14.00 01400	CENTRAL SERVICES & SUPPLY					14.00
15.00 01500	PHARMACY					15.00
16.00 01600	MEDICAL RECORDS & LIBRARY					16.00
17.00 01700	SOCIAL SERVICE	59,265				17.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	349,528			19.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	59,265	0	4,571,879	0	30.00
41.00 04100	SUBPROVIDER - IRF	0	0	0	0	41.00
42.00 04200	SUBPROVIDER	0	0	0	0	42.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000	OPERATING ROOM	0	0	1,011,797	0	50.00
53.00 05300	ANESTHESIOLOGY	0	349,528	370,541	0	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	0	1,303,305	0	54.00
54.01 05401	ONCOLOGY	0	0	581,772	0	54.01
56.00 05600	RADIOISOTOPE	0	0	248,158	0	56.00
57.00 05700	CT SCAN	0	0	281,030	0	57.00
58.00 05800	MRI	0	0	254,588	0	58.00
59.00 05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00 06000	LABORATORY	0	0	1,659,193	0	60.00
60.01 06001	BLOOD LABORATORY	0	0	0	0	60.01
65.00 06500	RESPIRATORY THERAPY	0	0	705,427	0	65.00
66.00 06600	PHYSICAL THERAPY	0	0	761,499	0	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	0	214,740	0	67.00
68.00 06800	SPEECH PATHOLOGY	0	0	112,933	0	68.00
69.00 06900	ELECTROCARDIOLOGY	0	0	21,294	0	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0	0	3,815	0	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	145,823	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	49,485	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	2,535,725	0	73.00
76.00 03950	SENIOR LIFE SOLUTIONS	0	0	460,904	0	76.00
76.97 07697	CARDIAC REHABILITATION	0	0	91,213	0	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00 08800	RURAL HEALTH CLINIC	0	0	3,774,179	0	88.00
89.00 08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00
90.00 09000	CLINIC	0	0	69,981	0	90.00
90.01 09001	COUMADIN CLINIC	0	0	45,385	0	90.01
90.02 04050	TELEMEDICINE	0	0	49,140	0	90.02
91.00 09100	EMERGENCY	0	0	2,401,889	0	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
99.10 09910	CORF	0	0	0	0	99.10
<b>SPECIAL PURPOSE COST CENTERS</b>						
109.00 10900	PANCREAS ACQUISITION	0	0	0	0	109.00
110.00 11000	INTESTINAL ACQUISITION	0	0	0	0	110.00
111.00 11100	ISLET ACQUISITION	0	0	0	0	111.00
113.00 11300	INTEREST EXPENSE	0	0	0	0	113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	59,265	349,528	21,725,695	0	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	21,416	0	190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
192.01 19201	FITNESS CENTER	0	0	79,798	0	192.01
192.02 19202	RETAIL PHARMACY	0	0	0	0	192.02
192.03 19203	LEASED SPACE	0	0	0	0	192.03
192.04 19204	VACANT SPACE	0	0	76,628	0	192.04
192.05 19205	MEALS ON WHEELS	0	0	0	0	192.05

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1307

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

Worksheet B  
Part I  
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Cost Center Description			SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			17.00	19.00	24.00	25.00	26.00	
192.06	19206	15 N MAIN BUILDING	0	0	0	0	0	192.06
200.00		Cross Foot Adjustments	0	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	59,265	349,528	21,903,537	0	21,903,537	202.00

COST ALLOCATION STATISTICS

Provider CCN: 14-1307

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

Worksheet Non-CMS W  
Date/Time Prepared:  
9/27/2017 2:32 pm

Cost Center Description		Statistics Code	Statistics Description	
		1.00	2.00	
GENERAL SERVICE COST CENTERS				
1.00	CAP REL COSTS-BLDG & FIXT	1	SQUARE FEET	1.00
1.01	NEW CAP REL COSTS-NEW BLDG	2	SQUARE FEET	1.01
1.02	NEW CAP REL COSTS-PT BLDG	3	SQUARE FEET	1.02
1.03	NEW CAP REL COSTS-RHC BLDG	4	SQUARE FEET	1.03
1.04	CAP REL COSTS-15 N MAIN BLDG	22	SQUARE FEET	1.04
2.00	CAP REL COSTS-MVBLE EQUIP	25	SQUARE FEET	2.00
2.01	CAP REL COSTS-MVBLE EQUIP NEW BLDG	25	SQUARE FEET	2.01
4.00	EMPLOYEE BENEFITS DEPARTMENT	6	GROSS SALARIE	4.00
5.00	ADMINISTRATIVE & GENERAL	-5	ACCUM. COST	5.00
6.00	MAINTENANCE & REPAIRS	11	SQUARE FEET	6.00
8.00	LAUNDRY & LINEN SERVICE	12	PATIENT DAYS	8.00
9.00	HOUSEKEEPING	25	SQUARE FEET	9.00
10.00	DIETARY	12	PATIENT DAYS	10.00
11.00	CAFETERIA	15	SALARIES	11.00
13.00	NURSING ADMINISTRATION	16	NURSING SALARIES	13.00
14.00	CENTRAL SERVICES & SUPPLY	17	COSTED REQUIS.	14.00
15.00	PHARMACY	18	COSTED REQUIS.	15.00
16.00	MEDICAL RECORDS & LIBRARY	19	GROSS PATIENT REVENUE	16.00
17.00	SOCIAL SERVICE	12	PATIENT DAYS	17.00
19.00	NONPHYSICIAN ANESTHETISTS	21	ASSIGNED TIME	19.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1307

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

Worksheet B  
Part II  
Date/Time Prepared:  
9/27/2017 2:32 pm

Cost Center Description		Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS				
			BLDG & FIXT	NEW NEW BLDG	NEW PT BLDG	NEW RHC BLDG	
			0	1.00	1.01	1.02	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	NEW CAP REL COSTS-NEW BLDG					1.01
1.02	00102	NEW CAP REL COSTS-PT BLDG					1.02
1.03	00103	NEW CAP REL COSTS-RHC BLDG					1.03
1.04	00104	CAP REL COSTS-15 N MAIN BLDG					1.04
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
2.01	00201	CAP REL COSTS-MVBLE EQUIP NEW BLDG					2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	577,787	0	24	2,765
6.00	00600	MAINTENANCE & REPAIRS	0	180,672	0	0	0
8.00	00800	LAUNDRY & LINEN SERVICE	0	11,803	0	0	0
9.00	00900	HOUSEKEEPING	0	23,606	0	0	0
10.00	01000	DIETARY	0	111,047	0	0	0
11.00	01100	CAFETERIA	0	0	0	0	0
13.00	01300	NURSING ADMINISTRATION	0	10,999	0	0	0
14.00	01400	CENTRAL SERVICES & SUPPLY	0	37,958	0	0	0
15.00	01500	PHARMACY	0	37,403	0	0	0
16.00	01600	MEDICAL RECORDS & LIBRARY	0	37,653	0	0	0
17.00	01700	SOCIAL SERVICE	0	2,632	0	0	0
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	0	261,353	0	0	0
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0
42.00	04200	SUBPROVIDER	0	0	0	0	0
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	0	256,975	0	0	0
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	153,631	0	0	0
54.01	05401	ONCOLOGY	0	76,469	0	0	0
56.00	05600	RADIOISOTOPE	0	8,201	0	0	0
57.00	05700	CT SCAN	0	25,240	0	0	0
58.00	05800	MRI	0	0	0	0	0
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0
60.00	06000	LABORATORY	0	75,029	0	0	0
60.01	06001	BLOOD LABORATORY	0	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	0	97,581	0	0	0
66.00	06600	PHYSICAL THERAPY	0	0	0	1,072	0
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	145	0
68.00	06800	SPEECH PATHOLOGY	0	0	0	27	0
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
76.00	03950	SENIOR LIFE SOLUTIONS	0	0	0	0	0
76.97	07697	CARDIAC REHABILITATION	0	6,151	0	0	0
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	RURAL HEALTH CLINIC	0	280,498	0	0	0
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0
90.00	09000	CLINIC	0	3,602	0	0	0
90.01	09001	COUMADIN CLINIC	0	0	0	0	0
90.02	04050	TELEMEDICINE	0	18,674	0	0	0
91.00	09100	EMERGENCY	0	162,996	0	0	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					
<b>OTHER REIMBURSABLE COST CENTERS</b>							
99.10	09910	CORF	0	0	0	0	0
<b>SPECIAL PURPOSE COST CENTERS</b>							
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0
111.00	11100	ISLET ACQUISITION	0	0	0	0	0
113.00	11300	INTEREST EXPENSE					
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	2,457,960	0	1,268	2,765
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	11,609	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0
192.01	19201	FITNESS CENTER	0	0	0	9	0
192.02	19202	RETAIL PHARMACY	0	0	0	0	0
192.03	19203	LEASED SPACE	0	0	0	0	0
192.04	19204	VACANT SPACE	0	0	0	268	13,964

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1307

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

Worksheet B  
Part II  
Date/Time Prepared:  
9/27/2017 2:32 pm

Cost Center Description		Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS					
			BLDG & FIXT	NEW NEW BLDG	NEW PT BLDG	NEW RHC BLDG		
			1.00	1.01	1.02	1.03		
192.05	19205	MEALS ON WHEELS	0	0	0	0	0	192.05
192.06	19206	15 N MAIN BUILDING	0	0	0	0	0	192.06
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	0	2,469,569	0	1,545	16,729	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1307

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

Worksheet B  
Part II  
Date/Time Prepared:  
9/27/2017 2:32 pm

Cost Center Description		CAPITAL RELATED COSTS			Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		15 N MAIN BLDG	MVBLE EQUIP	MVBLE EQUIP NEW BLDG			
		1.04	2.00	2.01			
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	NEW CAP REL COSTS-NEW BLDG					1.01
1.02	00102	NEW CAP REL COSTS-PT BLDG					1.02
1.03	00103	NEW CAP REL COSTS-RHC BLDG					1.03
1.04	00104	CAP REL COSTS-15 N MAIN BLDG					1.04
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
2.01	00201	CAP REL COSTS-MVBLE EQUIP NEW BLDG					2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	98,293	0	678,869	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	26,450	0	207,122	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	1,728	0	13,531	8.00
9.00	00900	HOUSEKEEPING	0	3,456	0	27,062	9.00
10.00	01000	DIETARY	0	16,257	0	127,304	10.00
11.00	01100	CAFETERIA	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	1,610	0	12,609	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	5,557	0	43,515	14.00
15.00	01500	PHARMACY	0	5,476	0	42,879	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	5,512	0	43,165	16.00
17.00	01700	SOCIAL SERVICE	0	385	0	3,017	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	0	38,261	0	299,614	30.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	42.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	0	37,621	0	294,596	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	22,491	0	176,122	54.00
54.01	05401	ONCOLOGY	0	11,195	0	87,664	54.01
56.00	05600	RADIOISOTOPE	0	1,201	0	9,402	56.00
57.00	05700	CT SCAN	0	3,695	0	28,935	57.00
58.00	05800	MRI	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	0	10,984	0	86,013	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	14,286	0	111,867	65.00
66.00	06600	PHYSICAL THERAPY	0	22,029	0	23,101	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	2,973	0	3,118	67.00
68.00	06800	SPEECH PATHOLOGY	0	552	0	579	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
76.00	03950	SENIOR LIFE SOLUTIONS	19,677	6,814	0	26,491	76.00
76.97	07697	CARDIAC REHABILITATION	0	900	0	7,051	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	RURAL HEALTH CLINIC	0	41,064	0	321,562	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00
90.00	09000	CLINIC	0	527	0	4,129	90.00
90.01	09001	COUMADIN CLINIC	0	0	0	0	90.01
90.02	04050	TELEMEDICINE	0	2,734	0	21,408	90.02
91.00	09100	EMERGENCY	0	23,862	0	186,858	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
99.10	09910	CORF	0	0	0	0	99.10
<b>SPECIAL PURPOSE COST CENTERS</b>							
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	19,677	405,913	0	2,887,583	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	11,609	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
192.01	19201	FITNESS CENTER	0	0	0	9	192.01
192.02	19202	RETAIL PHARMACY	0	0	0	0	192.02
192.03	19203	LEASED SPACE	0	0	0	0	192.03
192.04	19204	VACANT SPACE	19,678	0	0	33,910	192.04
192.05	19205	MEALS ON WHEELS	0	0	0	0	192.05

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1307

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

Worksheet B  
Part II  
Date/Time Prepared:  
9/27/2017 2:32 pm

Cost Center Description		CAPITAL RELATED COSTS			Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		15 N MAIN BLDG	MVBLE EQUIP	MVBLE EQUIP NEW BLDG			
		1.04	2.00	2.01			
192.06	19206	15 N MAIN BUILDING	0	0	0	0	192.06
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)	39,355	405,913	0	2,933,111	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 14-1307	Period: From 05/01/2016 To 04/30/2017	Worksheet B Part II Date/Time Prepared: 9/27/2017 2:32 pm			
Cost Center Description		ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.00	6.00	8.00	9.00	10.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	NEW CAP REL COSTS-NEW BLDG					1.01
1.02	00102	NEW CAP REL COSTS-PT BLDG					1.02
1.03	00103	NEW CAP REL COSTS-RHC BLDG					1.03
1.04	00104	CAP REL COSTS-15 N MAIN BLDG					1.04
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
2.01	00201	CAP REL COSTS-MVBLE EQUIP NEW BLDG					2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	678,869				5.00
6.00	00600	MAINTENANCE & REPAIRS	38,620	245,742			6.00
8.00	00800	LAUNDRY & LINEN SERVICE	5,660	1,500	20,691		8.00
9.00	00900	HOUSEKEEPING	17,472	3,000	0	47,534	9.00
10.00	01000	DIETARY	22,446	14,114	0	2,800	166,664
11.00	01100	CAFETERIA	0	0	0	0	0
13.00	01300	NURSING ADMINISTRATION	17,508	1,398	0	277	0
14.00	01400	CENTRAL SERVICES & SUPPLY	2,954	4,824	0	957	0
15.00	01500	PHARMACY	74,677	4,754	0	943	0
16.00	01600	MEDICAL RECORDS & LIBRARY	17,756	4,786	0	949	0
17.00	01700	SOCIAL SERVICE	1,758	335	0	66	0
19.00	01900	NONPHYSICIAN ANESTHETISTS	10,833	0	0	0	0
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	88,240	33,218	20,691	6,590	166,664
41.00	04100	SUBPROVIDER - I RF	0	0	0	0	0
42.00	04200	SUBPROVIDER	0	0	0	0	0
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	22,257	32,662	0	6,479	0
53.00	05300	ANESTHESIOLOGY	382	0	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	34,100	19,527	0	3,874	0
54.01	05401	ONCOLOGY	13,785	9,719	0	1,928	0
56.00	05600	RADIOISOTOPE	7,101	1,042	0	207	0
57.00	05700	CT SCAN	5,126	3,208	0	636	0
58.00	05800	MRI	7,207	0	0	0	0
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0
60.00	06000	LABORATORY	44,375	9,536	0	1,892	0
60.01	06001	BLOOD LABORATORY	0	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	18,455	12,403	0	2,460	0
66.00	06600	PHYSICAL THERAPY	18,066	19,125	0	3,794	0
67.00	06700	OCCUPATIONAL THERAPY	5,771	2,581	0	512	0
68.00	06800	SPEECH PATHOLOGY	3,328	479	0	95	0
69.00	06900	ELECTROCARDIOLOGY	494	0	0	0	0
70.00	07000	ELECTROENCEPHALOGRAPHY	111	0	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,219	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,330	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
76.00	03950	SENIOR LIFE SOLUTIONS	12,428	5,916	0	1,174	0
76.97	07697	CARDIAC REHABILITATION	2,550	782	0	155	0
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	RURAL HEALTH CLINIC	107,068	35,652	0	7,074	0
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0
90.00	09000	CLINIC	2,023	458	0	91	0
90.01	09001	COUMADIN CLINIC	1,320	0	0	0	0
90.02	04050	TELEMEDICINE	972	2,373	0	471	0
91.00	09100	EMERGENCY	64,225	20,717	0	4,110	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					
<b>OTHER REIMBURSABLE COST CENTERS</b>							
99.10	09910	CORF	0	0	0	0	0
<b>SPECIAL PURPOSE COST CENTERS</b>							
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0
111.00	11100	ISLET ACQUISITION	0	0	0	0	0
113.00	11300	INTEREST EXPENSE					
118.00		SUBTOTALS (SUM OF LINES 1-117)	673,617	244,109	20,691	47,534	166,664
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	432	1,475	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0
192.01	19201	FITNESS CENTER	2,445	158	0	0	0
192.02	19202	RETAIL PHARMACY	0	0	0	0	0
192.03	19203	LEASED SPACE	0	0	0	0	0
192.04	19204	VACANT SPACE	2,375	0	0	0	0
192.05	19205	MEALS ON WHEELS	0	0	0	0	0
192.06	19206	15 N MAIN BUILDING	0	0	0	0	0
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers	0	0	0	0	0

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 14-1307			Period: From 05/01/2016 To 04/30/2017		Worksheet B Part II Date/Time Prepared: 9/27/2017 2:32 pm	
Cost Center Description		ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY		
202.00	TOTAL (sum lines 118-201)	5.00 678,869	6.00 245,742	8.00 20,691	9.00 47,534	10.00 166,664	202.00	

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 14-1307		Period: From 05/01/2016 To 04/30/2017		Worksheet B Part II Date/Time Prepared: 9/27/2017 2:32 pm	
Cost Center Description			CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
<b>GENERAL SERVICE COST CENTERS</b>								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-NEW BLDG						1.01
1.02	00102	NEW CAP REL COSTS-PT BLDG						1.02
1.03	00103	NEW CAP REL COSTS-RHC BLDG						1.03
1.04	00104	CAP REL COSTS-15 N MAIN BLDG						1.04
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	CAP REL COSTS-MVBLE EQUIP NEW BLDG						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	0					11.00
13.00	01300	NURSING ADMINISTRATION	0	31,792				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	52,250			14.00
15.00	01500	PHARMACY	0	0	317	123,570		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	253	0	66,909	16.00
17.00	01700	SOCIAL SERVICE	0	0	11	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	0	19,867	3,937	0	2,998	30.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	0	1,714	2,618	0	1,266	50.00
53.00	05300	ANESTHESIOLOGY	0	0	181	0	904	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	2,761	0	5,482	54.00
54.01	05401	ONCOLOGY	0	3,139	0	0	813	54.01
56.00	05600	RADIOISOTOPE	0	0	25	0	1,226	56.00
57.00	05700	CT SCAN	0	0	622	0	9,887	57.00
58.00	05800	MRI	0	0	2	0	2,420	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	15,279	0	12,920	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	0	899	0	1,632	65.00
66.00	06600	PHYSICAL THERAPY	0	0	145	0	3,847	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	39	0	1,001	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	215	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	36	0	577	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	68	0	8	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	15,366	0	362	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	2,119	0	135	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	123,570	9,867	73.00
76.00	03950	SENIOR LIFE SOLUTIONS	0	0	124	0	1,680	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	3	0	338	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>								
88.00	08800	RURAL HEALTH CLINIC	0	0	3,626	0	4,814	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	14	6	0	112	90.00
90.01	09001	COUMADIN CLINIC	0	0	95	0	279	90.01
90.02	04050	TELEMEDICINE	0	0	0	0	2	90.02
91.00	09100	EMERGENCY	0	7,058	3,679	0	4,124	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
99.10	09910	CORF	0	0	0	0	0	99.10
<b>SPECIAL PURPOSE COST CENTERS</b>								
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	31,792	52,211	123,570	66,909	118.00
<b>NONREIMBURSABLE COST CENTERS</b>								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	FITNESS CENTER	0	0	39	0	0	192.01
192.02	19202	RETAIL PHARMACY	0	0	0	0	0	192.02
192.03	19203	LEASED SPACE	0	0	0	0	0	192.03
192.04	19204	VACANT SPACE	0	0	0	0	0	192.04
192.05	19205	MEALS ON WHEELS	0	0	0	0	0	192.05
192.06	19206	15 N MAIN BUILDING	0	0	0	0	0	192.06
200.00		Cross Foot Adjustments						200.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1307

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

Worksheet B  
Part II  
Date/Time Prepared:  
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Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		11.00	13.00	14.00	15.00	16.00	
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	0	31,792	52,250	123,570	66,909	202.00

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 14-1307	Period: From 05/01/2016 To 04/30/2017	Worksheet B Part II Date/Time Prepared: 9/27/2017 2:32 pm			
Cost Center	Description	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
		17.00	19.00	24.00	25.00	26.00		
<b>GENERAL SERVICE COST CENTERS</b>								
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00	
1.01	00101	NEW CAP REL COSTS-NEW BLDG					1.01	
1.02	00102	NEW CAP REL COSTS-PT BLDG					1.02	
1.03	00103	NEW CAP REL COSTS-RHC BLDG					1.03	
1.04	00104	CAP REL COSTS-15 N MAIN BLDG					1.04	
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00	
2.01	00201	CAP REL COSTS-MVBLE EQUIP NEW BLDG					2.01	
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00	
5.00	00500	ADMINISTRATIVE & GENERAL					5.00	
6.00	00600	MAINTENANCE & REPAIRS					6.00	
8.00	00800	LAUNDRY & LINEN SERVICE					8.00	
9.00	00900	HOUSEKEEPING					9.00	
10.00	01000	DIETARY					10.00	
11.00	01100	CAFETERIA					11.00	
13.00	01300	NURSING ADMINISTRATION					13.00	
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00	
15.00	01500	PHARMACY					15.00	
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00	
17.00	01700	SOCIAL SERVICE	5,187				17.00	
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	10,833			19.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	5,187	647,006	0	647,006	30.00	
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	41.00	
42.00	04200	SUBPROVIDER	0	0	0	0	42.00	
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	0	361,592	0	361,592	50.00	
53.00	05300	ANESTHESIOLOGY	0	1,467	0	1,467	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	241,866	0	241,866	54.00	
54.01	05401	ONCOLOGY	0	117,048	0	117,048	54.01	
56.00	05600	RADIOISOTOPE	0	19,003	0	19,003	56.00	
57.00	05700	CT SCAN	0	48,414	0	48,414	57.00	
58.00	05800	MRI	0	9,629	0	9,629	58.00	
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00	
60.00	06000	LABORATORY	0	170,015	0	170,015	60.00	
60.01	06001	BLOOD LABORATORY	0	0	0	0	60.01	
65.00	06500	RESPIRATORY THERAPY	0	147,716	0	147,716	65.00	
66.00	06600	PHYSICAL THERAPY	0	68,078	0	68,078	66.00	
67.00	06700	OCCUPATIONAL THERAPY	0	13,022	0	13,022	67.00	
68.00	06800	SPEECH PATHOLOGY	0	4,696	0	4,696	68.00	
69.00	06900	ELECTROCARDIOLOGY	0	1,107	0	1,107	69.00	
70.00	07000	ELECTROENCEPHALOGRAPHY	0	187	0	187	70.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	18,947	0	18,947	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	3,584	0	3,584	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0	133,437	0	133,437	73.00	
76.00	03950	SENIOR LIFE SOLUTIONS	0	47,813	0	47,813	76.00	
76.97	07697	CARDIAC REHABILITATION	0	10,879	0	10,879	76.97	
<b>OUTPATIENT SERVICE COST CENTERS</b>								
88.00	08800	RURAL HEALTH CLINIC	0	479,796	0	479,796	88.00	
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00	
90.00	09000	CLINIC	0	6,833	0	6,833	90.00	
90.01	09001	COUMADIN CLINIC	0	1,694	0	1,694	90.01	
90.02	04050	TELEMEDICINE	0	25,226	0	25,226	90.02	
91.00	09100	EMERGENCY	0	290,771	0	290,771	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	92.00	
<b>OTHER REIMBURSABLE COST CENTERS</b>								
99.10	09910	CORF	0	0	0	0	99.10	
<b>SPECIAL PURPOSE COST CENTERS</b>								
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	109.00	
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	110.00	
111.00	11100	ISLET ACQUISITION	0	0	0	0	111.00	
113.00	11300	INTEREST EXPENSE	0	0	0	0	113.00	
118.00		SUBTOTALS (SUM OF LINES 1-117)	5,187	0	2,869,826	0	2,869,826	118.00
<b>NONREIMBURSABLE COST CENTERS</b>								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	13,516	0	13,516	190.00	
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00	
192.01	19201	FITNESS CENTER	0	2,651	0	2,651	192.01	
192.02	19202	RETAIL PHARMACY	0	0	0	0	192.02	
192.03	19203	LEASED SPACE	0	0	0	0	192.03	
192.04	19204	VACANT SPACE	0	36,285	0	36,285	192.04	
192.05	19205	MEALS ON WHEELS	0	0	0	0	192.05	

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1307

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

Worksheet B  
Part II  
Date/Time Prepared:  
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Cost Center Description		SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		17.00	19.00	24.00	25.00	26.00	
192.06	19206 15 N MAIN BUILDING	0	0	0	0	0	192.06
200.00	Cross Foot Adjustments		10,833	10,833	0	10,833	200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	5,187	10,833	2,933,111	0	2,933,111	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1307

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

Worksheet B-1

Date/Time Prepared:  
9/27/2017 2:32 pm

Cost Center Description		CAPITAL RELATED COSTS					15 N MAIN BLDG (SQUARE FEET)	
		BLDG & FIXT (SQUARE FEET)	NEW NEW BLDG (SQUARE FEET)	NEW PT BLDG (SQUARE FEET)	NEW RHC BLDG (SQUARE FEET)			
		1.00	1.01	1.02	1.03	1.04		
<b>GENERAL SERVICE COST CENTERS</b>								
1.00	00100	CAP REL COSTS-BLDG & FIXT	89,134					1.00
1.01	00101	NEW CAP REL COSTS-NEW BLDG	0	0				1.01
1.02	00102	NEW CAP REL COSTS-PT BLDG	0		7,828			1.02
1.03	00103	NEW CAP REL COSTS-RHC BLDG	0	0	0	19,702		1.03
1.04	00104	CAP REL COSTS-15 N MAIN BLDG	0	0	0	0	3,360	1.04
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	CAP REL COSTS-MVBLE EQUIP NEW BLDG						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	20,854	0	123	3,256	0	5.00
6.00	00600	MAINTENANCE & REPAIRS	6,521	0	0	0	0	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	426	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	852	0	0	0	0	9.00
10.00	01000	DIETARY	4,008	0	0	0	0	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	397	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,370	0	0	0	0	14.00
15.00	01500	PHARMACY	1,350	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,359	0	0	1,359	0	16.00
17.00	01700	SOCIAL SERVICE	95	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	9,433	0	0	0	0	30.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	9,275	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,545	0	0	0	0	54.00
54.01	05401	ONCOLOGY	2,760	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	296	0	0	0	0	56.00
57.00	05700	CT SCAN	911	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	2,708	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	3,522	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	5,431	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	733	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	136	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950	SENIOR LIFE SOLUTIONS	0	0	0	0	1,680	76.00
76.97	07697	CARDIAC REHABILITATION	222	0	0	0	0	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>								
88.00	08800	RURAL HEALTH CLINIC	10,124	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	130	0	0	0	0	90.00
90.01	09001	COUMADIN CLINIC	0	0	0	0	0	90.01
90.02	04050	TELEMEDICINE	674	0	0	0	0	90.02
91.00	09100	EMERGENCY	5,883	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
99.10	09910	CORF	0	0	0	0	0	99.10
<b>SPECIAL PURPOSE COST CENTERS</b>								
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	88,715	0	6,423	3,256	1,680	118.00
<b>NONREIMBURSABLE COST CENTERS</b>								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	419	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	FITNESS CENTER	0	0	45	0	0	192.01
192.02	19202	RETAIL PHARMACY	0	0	0	0	0	192.02
192.03	19203	LEASED SPACE	0	0	0	0	0	192.03
192.04	19204	VACANT SPACE	0	0	1,360	16,446	1,680	192.04
192.05	19205	MEALS ON WHEELS	0	0	0	0	0	192.05

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1307

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

Worksheet B-1

Date/Time Prepared:  
9/27/2017 2:32 pm

Cost Center Description			CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	NEW NEW BLDG (SQUARE FEET)	NEW PT BLDG (SQUARE FEET)	NEW RHC BLDG (SQUARE FEET)	15 N MAIN BLDG (SQUARE FEET)	
			1.00	1.01	1.02	1.03	1.04	
192.06	19206	15 N MAIN BUILDING	0	0	0	0	0	192.06
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	2,469,569	0	1,545	16,729	39,355	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	27.706251	0.000000	0.197368	0.849102	11.712798	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)						204.00
205.00		Unit cost multiplier (Wkst. B, Part II)						205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1307

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

Worksheet B-1  
Date/Time Prepared:  
9/27/2017 2:32 pm

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIE)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	MVBLE EQUIP (SQUARE FEET)	MVBLE EQUIP NEW BLDG (SQUARE FEET)				
	2.00	2.01				
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	CAP REL COSTS-BLDG & FIXT					1.00
1.01 00101	NEW CAP REL COSTS-NEW BLDG					1.01
1.02 00102	NEW CAP REL COSTS-PT BLDG					1.02
1.03 00103	NEW CAP REL COSTS-RHC BLDG					1.03
1.04 00104	CAP REL COSTS-15 N MAIN BLDG					1.04
2.00 00200	CAP REL COSTS-MVBLE EQUIP	100,074				2.00
2.01 00201	CAP REL COSTS-MVBLE EQUIP NEW BLDG	0	100,074			2.01
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	9,710,759		4.00
5.00 00500	ADMINISTRATIVE & GENERAL	24,233	24,233	1,397,187	-3,655,429	18,248,108 5.00
6.00 00600	MAINTENANCE & REPAIRS	6,521	6,521	262,722	0	1,038,123 6.00
8.00 00800	LAUNDRY & LINEN SERVICE	426	426	31,623	0	152,151 8.00
9.00 00900	HOUSEKEEPING	852	852	315,926	852	469,665 9.00
10.00 01000	DIETARY	4,008	4,008	312,255	0	603,343 10.00
11.00 01100	CAFETERIA	0	0	0	0	0 11.00
13.00 01300	NURSING ADMINISTRATION	397	397	340,944	0	470,617 13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	1,370	1,370	26,473	0	79,402 14.00
15.00 01500	PHARMACY	1,350	1,350	304,495	0	2,007,350 15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	1,359	1,359	320,067	0	477,292 16.00
17.00 01700	SOCIAL SERVICE	95	95	30,845	0	47,264 17.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	291,196 19.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	9,433	9,433	1,595,203	0	2,371,926 30.00
41.00 04100	SUBPROVIDER - I RF	0	0	0	0	0 41.00
42.00 04200	SUBPROVIDER	0	0	0	0	0 42.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000	OPERATING ROOM	9,275	9,275	112,759	0	598,280 50.00
53.00 05300	ANESTHESIOLOGY	0	0	0	0	10,267 53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	5,545	5,545	470,825	0	916,620 54.00
54.01 05401	ONCOLOGY	2,760	2,760	206,495	0	370,556 54.01
56.00 05600	RADIOISOTOPE	296	296	68,903	0	190,890 56.00
57.00 05700	CT SCAN	911	911	58,682	0	137,787 57.00
58.00 05800	MRI	0	0	0	0	193,731 58.00
59.00 05900	CARDIAC CATHETERIZATION	0	0	0	0	0 59.00
60.00 06000	LABORATORY	2,708	2,708	478,655	0	1,192,814 60.00
60.01 06001	BLOOD LABORATORY	0	0	0	0	0 60.01
65.00 06500	RESPIRATORY THERAPY	3,522	3,522	236,362	0	496,068 65.00
66.00 06600	PHYSICAL THERAPY	5,431	5,431	355,807	0	485,628 66.00
67.00 06700	OCCUPATIONAL THERAPY	733	733	126,030	0	155,124 67.00
68.00 06800	SPEECH PATHOLOGY	136	136	82,049	0	89,470 68.00
69.00 06900	ELECTROCARDIOLOGY	0	0	4,533	0	13,288 69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0	0	653	0	2,972 70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	86,531 71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	35,760 72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0 73.00
76.00 03950	SENIOR LIFE SOLUTIONS	1,680	1,680	161,303	0	334,079 76.00
76.97 07697	CARDIAC REHABILITATION	222	222	36,941	0	68,541 76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00 08800	RURAL HEALTH CLINIC	10,124	10,124	1,820,996	0	2,877,810 88.00
89.00 08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0 89.00
90.00 09000	CLINIC	130	130	6,684	0	54,379 90.00
90.01 09001	COUMADIN CLINIC	0	0	26,440	0	35,495 90.01
90.02 04050	TELEMEDICINE	674	674	1,724	0	26,117 90.02
91.00 09100	EMERGENCY	5,883	5,883	464,308	0	1,726,393 91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					
<b>OTHER REIMBURSABLE COST CENTERS</b>						
99.10 09910	CORF	0	0	0	0	0 99.10
<b>SPECIAL PURPOSE COST CENTERS</b>						
109.00 10900	PANCREAS ACQUISITION	0	0	0	0	0 109.00
110.00 11000	INTESTINAL ACQUISITION	0	0	0	0	0 110.00
111.00 11100	ISLET ACQUISITION	0	0	0	0	0 111.00
113.00 11300	INTEREST EXPENSE					
118.00	SUBTOTALS (SUM OF LINES 1-117)	100,074	100,074	9,657,889	-3,655,429	18,106,929 118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	11,609 190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0 192.00
192.01 19201	FITNESS CENTER	0	0	52,658	0	65,730 192.01
192.02 19202	RETAIL PHARMACY	0	0	0	0	0 192.02
192.03 19203	LEASED SPACE	0	0	0	0	0 192.03

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1307

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

Worksheet B-1

Date/Time Prepared:  
9/27/2017 2:32 pm

Cost Center Description		CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIE)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)		
		MVBLE EQUIP (SQUARE FEET)	MVBLE EQUIP NEW BLDG (SQUARE FEET)					
		2.00	2.01	4.00	5A	5.00		
192.04	19204	VACANT SPACE	0	0	212	0	63,840	192.04
192.05	19205	MEALS ON WHEELS	0	0	0	0	0	192.05
192.06	19206	15 N MAIN BUILDING	0	0	0	0	0	192.06
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)	405,913	0	2,737,502		3,655,429	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	4.056128	0.000000	0.281904		0.200318	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			0		678,869	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000000		0.037202	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1307

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

Worksheet B-1

Date/Time Prepared:  
9/27/2017 2:32 pm

Cost Center Description		MAINTENANCE & REPAIRS (SQUARE FEET)	LAUNDRY & LINEN SERVICE (PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (PATIENT DAYS)	CAFETERIA (SALARIES)	
		6.00	8.00	9.00	10.00	11.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
1.01	00101						1.01
1.02	00102						1.02
1.03	00103						1.03
1.04	00104						1.04
2.00	00200						2.00
2.01	00201						2.01
4.00	00400						4.00
5.00	00500						5.00
6.00	00600	69,784					6.00
8.00	00800	426	2,775				8.00
9.00	00900	852	0	68,042			9.00
10.00	01000	4,008	0	4,008	2,775		10.00
11.00	01100	0	0	0	0	0	11.00
13.00	01300	397	0	397	0	0	13.00
14.00	01400	1,370	0	1,370	0	0	14.00
15.00	01500	1,350	0	1,350	0	0	15.00
16.00	01600	1,359	0	1,359	0	0	16.00
17.00	01700	95	0	95	0	0	17.00
19.00	01900	0	0	0	0	0	19.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	9,433	2,775	9,433	2,775	0	30.00
41.00	04100	0	0	0	0	0	41.00
42.00	04200	0	0	0	0	0	42.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	9,275	0	9,275	0	0	50.00
53.00	05300	0	0	0	0	0	53.00
54.00	05400	5,545	0	5,545	0	0	54.00
54.01	05401	2,760	0	2,760	0	0	54.01
56.00	05600	296	0	296	0	0	56.00
57.00	05700	911	0	911	0	0	57.00
58.00	05800	0	0	0	0	0	58.00
59.00	05900	0	0	0	0	0	59.00
60.00	06000	2,708	0	2,708	0	0	60.00
60.01	06001	0	0	0	0	0	60.01
65.00	06500	3,522	0	3,522	0	0	65.00
66.00	06600	5,431	0	5,431	0	0	66.00
67.00	06700	733	0	733	0	0	67.00
68.00	06800	136	0	136	0	0	68.00
69.00	06900	0	0	0	0	0	69.00
70.00	07000	0	0	0	0	0	70.00
71.00	07100	0	0	0	0	0	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	0	0	0	0	73.00
76.00	03950	1,680	0	1,680	0	0	76.00
76.97	07697	222	0	222	0	0	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	10,124	0	10,124	0	0	88.00
89.00	08900	0	0	0	0	0	89.00
90.00	09000	130	0	130	0	0	90.00
90.01	09001	0	0	0	0	0	90.01
90.02	04050	674	0	674	0	0	90.02
91.00	09100	5,883	0	5,883	0	0	91.00
92.00	09200						92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
99.10	09910	0	0	0	0	0	99.10
<b>SPECIAL PURPOSE COST CENTERS</b>							
109.00	10900	0	0	0	0	0	109.00
110.00	11000	0	0	0	0	0	110.00
111.00	11100	0	0	0	0	0	111.00
113.00	11300						113.00
118.00		69,320	2,775	68,042	2,775	0	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	419	0	0	0	0	190.00
192.00	19200	0	0	0	0	0	192.00
192.01	19201	45	0	0	0	0	192.01
192.02	19202	0	0	0	0	0	192.02
192.03	19203	0	0	0	0	0	192.03
192.04	19204	0	0	0	0	0	192.04
192.05	19205	0	0	0	0	0	192.05
192.06	19206	0	0	0	0	0	192.06
200.00							200.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1307

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

Worksheet B-1

Date/Time Prepared:  
9/27/2017 2:32 pm

Cost Center Description		MAINTENANCE & REPAIRS (SQUARE FEET) 6.00	LAUNDRY & LINEN SERVICE (PATIENT DAYS) 8.00	HOUSEKEEPING (SQUARE FEET) 9.00	DIETARY (PATIENT DAYS) 10.00	CAFETERIA (SALARIES) 11.00	
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	1,246,078	190,237	578,960	829,875	0	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	17.856213	68.553874	8.508862	299.054054	0.000000	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	245,742	20,691	47,534	166,664	0	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	3.521466	7.456216	0.698598	60.059099	0.000000	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1307

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

Worksheet B-1

Date/Time Prepared:  
9/27/2017 2:32 pm

Cost Center Description			NURSING ADMINISTRATION  (NURSING SALARIES)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS PATIENT REVENUE)	SOCIAL SERVICE  (PATIENT DAYS)	
			13.00	14.00	15.00	16.00	17.00	
<b>GENERAL SERVICE COST CENTERS</b>								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-NEW BLDG						1.01
1.02	00102	NEW CAP REL COSTS-PT BLDG						1.02
1.03	00103	NEW CAP REL COSTS-RHC BLDG						1.03
1.04	00104	CAP REL COSTS-15 N MAIN BLDG						1.04
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	CAP REL COSTS-MVBLE EQUIP NEW BLDG						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	2,091,237					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	881,820				14.00
15.00	01500	PHARMACY	0	5,343	1,544,641			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	4,262	0	38,805,853		16.00
17.00	01700	SOCIAL SERVICE	0	193	0	0	2,775	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	1,306,761	66,447	0	1,738,883	2,775	30.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	112,759	44,181	0	734,056	0	50.00
53.00	05300	ANESTHESIOLOGY	0	3,048	0	524,416	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	46,594	0	3,179,731	0	54.00
54.01	05401	ONCOLOGY	206,495	0	0	471,671	0	54.01
56.00	05600	RADIOISOTOPE	0	415	0	710,866	0	56.00
57.00	05700	CT SCAN	0	10,499	0	5,735,052	0	57.00
58.00	05800	MRI	0	31	0	1,403,784	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	257,858	0	7,489,620	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	15,167	0	946,865	0	65.00
66.00	06600	PHYSICAL THERAPY	0	2,441	0	2,231,317	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	650	0	580,712	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	2	0	124,548	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	613	0	334,524	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	1,155	0	4,864	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	259,391	0	209,994	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	35,760	0	78,455	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	1,544,641	5,723,607	0	73.00
76.00	03950	SENIOR LIFE SOLUTIONS	0	2,088	0	974,293	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	54	0	196,206	0	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>								
88.00	08800	RURAL HEALTH CLINIC	0	61,189	0	2,792,262	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	914	102	0	64,699	0	90.00
90.01	09001	COUMADIN CLINIC	0	1,601	0	161,846	0	90.01
90.02	04050	TELEMEDICINE	0	0	0	1,347	0	90.02
91.00	09100	EMERGENCY	464,308	62,085	0	2,392,235	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
99.10	09910	CORF	0	0	0	0	0	99.10
<b>SPECIAL PURPOSE COST CENTERS</b>								
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	2,091,237	881,169	1,544,641	38,805,853	2,775	118.00
<b>NONREIMBURSABLE COST CENTERS</b>								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	FITNESS CENTER	0	651	0	0	0	192.01
192.02	19202	RETAIL PHARMACY	0	0	0	0	0	192.02
192.03	19203	LEASED SPACE	0	0	0	0	0	192.03
192.04	19204	VACANT SPACE	0	0	0	0	0	192.04
192.05	19205	MEALS ON WHEELS	0	0	0	0	0	192.05

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1307

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

Worksheet B-1

Date/Time Prepared:  
9/27/2017 2:32 pm

Cost Center Description			NURSING ADMINISTRATION  (NURSING SALARIES)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS PATIENT REVENUE)	SOCIAL SERVICE  (PATIENT DAYS)	
			13.00	14.00	15.00	16.00	17.00	
192.06	19206	15 N MAIN BUILDING	0	0	0	0	0	192.06
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)	575,357	131,428	2,445,847	609,368	59,265	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.275128	0.149042	1.583440	0.015703	21.356757	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	31,792	52,250	123,570	66,909	5,187	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.015202	0.059252	0.079999	0.001724	1.869189	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1307

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

Worksheet B-1  
Date/Time Prepared:  
9/27/2017 2:32 pm

Cost Center Description		NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	
		19.00	
<b>GENERAL SERVICE COST CENTERS</b>			
1.00	00100	CAP REL COSTS-BLDG & FIXT	1.00
1.01	00101	NEW CAP REL COSTS-NEW BLDG	1.01
1.02	00102	NEW CAP REL COSTS-PT BLDG	1.02
1.03	00103	NEW CAP REL COSTS-RHC BLDG	1.03
1.04	00104	CAP REL COSTS-15 N MAIN BLDG	1.04
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2.00
2.01	00201	CAP REL COSTS-MVBLE EQUIP NEW BLDG	2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5.00
6.00	00600	MAINTENANCE & REPAIRS	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	8.00
9.00	00900	HOUSEKEEPING	9.00
10.00	01000	DIETARY	10.00
11.00	01100	CAFETERIA	11.00
13.00	01300	NURSING ADMINISTRATION	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	14.00
15.00	01500	PHARMACY	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
17.00	01700	SOCIAL SERVICE	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	19.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>			
30.00	03000	ADULTS & PEDIATRICS	30.00
41.00	04100	SUBPROVIDER - IRF	41.00
42.00	04200	SUBPROVIDER	42.00
<b>ANCILLARY SERVICE COST CENTERS</b>			
50.00	05000	OPERATING ROOM	50.00
53.00	05300	ANESTHESIOLOGY	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
54.01	05401	ONCOLOGY	54.01
56.00	05600	RADIOISOTOPE	56.00
57.00	05700	CT SCAN	57.00
58.00	05800	MRI	58.00
59.00	05900	CARDIAC CATHETERIZATION	59.00
60.00	06000	LABORATORY	60.00
60.01	06001	BLOOD LABORATORY	60.01
65.00	06500	RESPIRATORY THERAPY	65.00
66.00	06600	PHYSICAL THERAPY	66.00
67.00	06700	OCCUPATIONAL THERAPY	67.00
68.00	06800	SPEECH PATHOLOGY	68.00
69.00	06900	ELECTROCARDIOLOGY	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
76.00	03950	SENIOR LIFE SOLUTIONS	76.00
76.97	07697	CARDIAC REHABILITATION	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>			
88.00	08800	RURAL HEALTH CLINIC	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	89.00
90.00	09000	CLINIC	90.00
90.01	09001	COUMADIN CLINIC	90.01
90.02	04050	TELEMEDICINE	90.02
91.00	09100	EMERGENCY	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>			
99.10	09910	CORF	99.10
<b>SPECIAL PURPOSE COST CENTERS</b>			
109.00	10900	PANCREAS ACQUISITION	109.00
110.00	11000	INTESTINAL ACQUISITION	110.00
111.00	11100	ISLET ACQUISITION	111.00
113.00	11300	INTEREST EXPENSE	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	118.00
<b>NONREIMBURSABLE COST CENTERS</b>			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	192.00
192.01	19201	FITNESS CENTER	192.01
192.02	19202	RETAIL PHARMACY	192.02
192.03	19203	LEASED SPACE	192.03
192.04	19204	VACANT SPACE	192.04
192.05	19205	MEALS ON WHEELS	192.05
192.06	19206	15 N MAIN BUILDING	192.06

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1307

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

Worksheet B-1  
Date/Time Prepared:  
9/27/2017 2:32 pm

Cost Center Description		NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	
		19.00	
200.00	Cross Foot Adjustments		200.00
201.00	Negative Cost Centers		201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	349,528	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	3,495.280000	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	10,833	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	108.330000	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1307

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

Worksheet C  
Part I  
Date/Time Prepared:  
9/27/2017 2:32 pm

Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs				
				Total Costs	Hospital			
					RCE Disallowance	Total Costs		
		1.00	2.00	3.00	4.00	5.00		
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	4,571,879		4,571,879	0	0	30.00
41.00	04100	SUBPROVIDER - IRF	0		0	0	0	41.00
42.00	04200	SUBPROVIDER	0		0	0	0	42.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	1,011,797		1,011,797	0	0	50.00
53.00	05300	ANESTHESIOLOGY	370,541		370,541	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,303,305		1,303,305	0	0	54.00
54.01	05401	ONCOLOGY	581,772		581,772	0	0	54.01
56.00	05600	RADIOISOTOPE	248,158		248,158	0	0	56.00
57.00	05700	CT SCAN	281,030		281,030	0	0	57.00
58.00	05800	MRI	254,588		254,588	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0		0	0	0	59.00
60.00	06000	LABORATORY	1,659,193		1,659,193	0	0	60.00
60.01	06001	BLOOD LABORATORY	0		0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	705,427	0	705,427	0	0	65.00
66.00	06600	PHYSICAL THERAPY	761,499	0	761,499	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	214,740	0	214,740	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	112,933	0	112,933	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	21,294		21,294	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	3,815		3,815	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	145,823		145,823	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	49,485		49,485	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,535,725		2,535,725	0	0	73.00
76.00	03950	SENIOR LIFE SOLUTIONS	460,904		460,904	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	91,213		91,213	0	0	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>								
88.00	08800	RURAL HEALTH CLINIC	3,774,179		3,774,179	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0	89.00
90.00	09000	CLINIC	69,981		69,981	0	0	90.00
90.01	09001	COUMADIN CLINIC	45,385		45,385	0	0	90.01
90.02	04050	TELEMEDICINE	49,140		49,140	0	0	90.02
91.00	09100	EMERGENCY	2,401,889		2,401,889	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	268,906		268,906	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
99.10	09910	CORF	0		0	0	0	99.10
<b>SPECIAL PURPOSE COST CENTERS</b>								
109.00	10900	PANCREAS ACQUISITION	0		0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0		0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0		0	0	0	111.00
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	21,994,601	0	21,994,601	0	0	200.00
201.00		Less Observation Beds	268,906		268,906			201.00
202.00		Total (see instructions)	21,725,695	0	21,725,695	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1307

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

Worksheet C  
Part I  
Date/Time Prepared:  
9/27/2017 2:32 pm

		Title XVIII			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	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	1,561,638		1,561,638		30.00
41.00	04100	SUBPROVIDER - I RF	0		0		41.00
42.00	04200	SUBPROVIDER	0		0		42.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	5,079	728,977	734,056	1.378365	50.00
53.00	05300	ANESTHESIOLOGY	3,297	521,119	524,416	0.706578	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	236,954	2,942,777	3,179,731	0.409879	54.00
54.01	05401	ONCOLOGY	13,998	457,673	471,671	1.233428	54.01
56.00	05600	RADIOISOTOPE	27,999	682,867	710,866	0.349093	56.00
57.00	05700	CT SCAN	332,982	5,402,070	5,735,052	0.049002	57.00
58.00	05800	MRI	27,833	1,375,951	1,403,784	0.181358	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	59.00
60.00	06000	LABORATORY	691,343	6,798,277	7,489,620	0.221532	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	60.01
65.00	06500	RESPIRATORY THERAPY	212,249	734,616	946,865	0.745013	65.00
66.00	06600	PHYSICAL THERAPY	502,450	1,728,867	2,231,317	0.341278	66.00
67.00	06700	OCCUPATIONAL THERAPY	260,282	320,430	580,712	0.369787	67.00
68.00	06800	SPEECH PATHOLOGY	29,058	95,490	124,548	0.906743	68.00
69.00	06900	ELECTROCARDIOLOGY	15,346	319,178	334,524	0.063655	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	973	3,891	4,864	0.784334	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	105,874	104,120	209,994	0.694415	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	78,455	78,455	0.630744	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	764,727	4,958,880	5,723,607	0.443029	73.00
76.00	03950	SENIOR LIFE SOLUTIONS	0	974,293	974,293	0.473065	76.00
76.97	07697	CARDIAC REHABILITATION	0	196,206	196,206	0.464884	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	RURAL HEALTH CLINIC	0	2,792,262	2,792,262		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		89.00
90.00	09000	CLINIC	0	64,699	64,699	1.081640	90.00
90.01	09001	COUMADIN CLINIC	0	161,846	161,846	0.280421	90.01
90.02	04050	TELEMEDICINE	0	1,347	1,347	36.481069	90.02
91.00	09100	EMERGENCY	73,788	2,318,447	2,392,235	1.004036	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	177,245	177,245	1.517143	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
99.10	09910	CORF	0	0	0		99.10
<b>SPECIAL PURPOSE COST CENTERS</b>							
109.00	10900	PANCREAS ACQUISITION	0	0	0		109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0		110.00
111.00	11100	ISLET ACQUISITION	0	0	0		111.00
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (see instructions)	4,865,870	33,939,983	38,805,853		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	4,865,870	33,939,983	38,805,853		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 14-1307	Period: From 05/01/2016 To 04/30/2017	Worksheet C Part I Date/Time Prepared: 9/27/2017 2:32 pm
Cost Center Description			PPS Inpatient Ratio	Title XVIII	Hospital Cost
			11.00		
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS			30.00
41.00	04100	SUBPROVIDER - IRF			41.00
42.00	04200	SUBPROVIDER			42.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	0.000000		50.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
54.01	05401	ONCOLOGY	0.000000		54.01
56.00	05600	RADIOISOTOPE	0.000000		56.00
57.00	05700	CT SCAN	0.000000		57.00
58.00	05800	MRI	0.000000		58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000		59.00
60.00	06000	LABORATORY	0.000000		60.00
60.01	06001	BLOOD LABORATORY	0.000000		60.01
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
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
76.00	03950	SENIOR LIFE SOLUTIONS	0.000000		76.00
76.97	07697	CARDIAC REHABILITATION	0.000000		76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00	08800	RURAL HEALTH CLINIC			88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER			89.00
90.00	09000	CLINIC	0.000000		90.00
90.01	09001	COUMADIN CLINIC	0.000000		90.01
90.02	04050	TELEMEDICINE	0.000000		90.02
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
99.10	09910	CORF			99.10
<b>SPECIAL PURPOSE COST CENTERS</b>					
109.00	10900	PANCREAS ACQUISITION			109.00
110.00	11000	INTESTINAL ACQUISITION			110.00
111.00	11100	ISLET ACQUISITION			111.00
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: 14-1307

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

Worksheet C  
Part I  
Date/Time Prepared:  
9/27/2017 2:32 pm

Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Title XIX Hospital Cost			
				Total Costs	Costs		
					RCE Disallowance	Total Costs	
		1.00	2.00	3.00	4.00	5.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000 ADULTS & PEDIATRICS	4,571,879		4,571,879	0	4,571,879	30.00
41.00	04100 SUBPROVIDER - IRF	0		0	0	0	41.00
42.00	04200 SUBPROVIDER	0		0	0	0	42.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	1,011,797		1,011,797	0	1,011,797	50.00
53.00	05300 ANESTHESIOLOGY	370,541		370,541	0	370,541	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	1,303,305		1,303,305	0	1,303,305	54.00
54.01	05401 ONCOLOGY	581,772		581,772	0	581,772	54.01
56.00	05600 RADIOISOTOPE	248,158		248,158	0	248,158	56.00
57.00	05700 CT SCAN	281,030		281,030	0	281,030	57.00
58.00	05800 MRI	254,588		254,588	0	254,588	58.00
59.00	05900 CARDIAC CATHETERIZATION	0		0	0	0	59.00
60.00	06000 LABORATORY	1,659,193		1,659,193	0	1,659,193	60.00
60.01	06001 BLOOD LABORATORY	0		0	0	0	60.01
65.00	06500 RESPIRATORY THERAPY	705,427	0	705,427	0	705,427	65.00
66.00	06600 PHYSICAL THERAPY	761,499	0	761,499	0	761,499	66.00
67.00	06700 OCCUPATIONAL THERAPY	214,740	0	214,740	0	214,740	67.00
68.00	06800 SPEECH PATHOLOGY	112,933	0	112,933	0	112,933	68.00
69.00	06900 ELECTROCARDIOLOGY	21,294		21,294	0	21,294	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	3,815		3,815	0	3,815	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	145,823		145,823	0	145,823	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	49,485		49,485	0	49,485	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	2,535,725		2,535,725	0	2,535,725	73.00
76.00	03950 SENIOR LIFE SOLUTIONS	460,904		460,904	0	460,904	76.00
76.97	07697 CARDIAC REHABILITATION	91,213		91,213	0	91,213	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800 RURAL HEALTH CLINIC	3,774,179		3,774,179	0	3,774,179	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0	89.00
90.00	09000 CLINIC	69,981		69,981	0	69,981	90.00
90.01	09001 COUMADIN CLINIC	45,385		45,385	0	45,385	90.01
90.02	04050 TELEMEDICINE	49,140		49,140	0	49,140	90.02
91.00	09100 EMERGENCY	2,401,889		2,401,889	0	2,401,889	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	268,906		268,906	0	268,906	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
99.10	09910 CORF	0		0	0	0	99.10
<b>SPECIAL PURPOSE COST CENTERS</b>							
109.00	10900 PANCREAS ACQUISITION	0		0	0	0	109.00
110.00	11000 INTESTINAL ACQUISITION	0		0	0	0	110.00
111.00	11100 ISLET ACQUISITION	0		0	0	0	111.00
113.00	11300 INTEREST EXPENSE	0		0	0	0	113.00
200.00	Subtotal (see instructions)	21,994,601	0	21,994,601	0	21,994,601	200.00
201.00	Less Observation Beds	268,906		268,906	0	268,906	201.00
202.00	Total (see instructions)	21,725,695	0	21,725,695	0	21,725,695	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 14-1307		Period: From 05/01/2016 To 04/30/2017		Worksheet C Part I Date/Time Prepared: 9/27/2017 2:32 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							
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	1,561,638		1,561,638			30.00
41.00	04100	SUBPROVIDER - I RF	0		0			41.00
42.00	04200	SUBPROVIDER	0		0			42.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	5,079	728,977	734,056	1.378365	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	3,297	521,119	524,416	0.706578	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	236,954	2,942,777	3,179,731	0.409879	0.000000	54.00
54.01	05401	ONCOLOGY	13,998	457,673	471,671	1.233428	0.000000	54.01
56.00	05600	RADIOISOTOPE	27,999	682,867	710,866	0.349093	0.000000	56.00
57.00	05700	CT SCAN	332,982	5,402,070	5,735,052	0.049002	0.000000	57.00
58.00	05800	MRI	27,833	1,375,951	1,403,784	0.181358	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	0.000000	59.00
60.00	06000	LABORATORY	691,343	6,798,277	7,489,620	0.221532	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	0.000000	60.01
65.00	06500	RESPIRATORY THERAPY	212,249	734,616	946,865	0.745013	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	502,450	1,728,867	2,231,317	0.341278	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	260,282	320,430	580,712	0.369787	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	29,058	95,490	124,548	0.906743	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	15,346	319,178	334,524	0.063655	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	973	3,891	4,864	0.784334	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	105,874	104,120	209,994	0.694415	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	78,455	78,455	0.630744	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	764,727	4,958,880	5,723,607	0.443029	0.000000	73.00
76.00	03950	SENIOR LIFE SOLUTIONS	0	974,293	974,293	0.473065	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0	196,206	196,206	0.464884	0.000000	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>								
88.00	08800	RURAL HEALTH CLINIC	0	2,792,262	2,792,262	1.351656	0.000000	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.000000	0.000000	89.00
90.00	09000	CLINIC	0	64,699	64,699	1.081640	0.000000	90.00
90.01	09001	COUMADIN CLINIC	0	161,846	161,846	0.280421	0.000000	90.01
90.02	04050	TELEMEDICINE	0	1,347	1,347	36.481069	0.000000	90.02
91.00	09100	EMERGENCY	73,788	2,318,447	2,392,235	1.004036	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	177,245	177,245	1.517143	0.000000	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
99.10	09910	CORF	0	0	0			99.10
<b>SPECIAL PURPOSE COST CENTERS</b>								
109.00	10900	PANCREAS ACQUISITION	0	0	0			109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0			110.00
111.00	11100	ISLET ACQUISITION	0	0	0			111.00
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	4,865,870	33,939,983	38,805,853			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	4,865,870	33,939,983	38,805,853			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 14-1307	Period: From 05/01/2016 To 04/30/2017	Worksheet C Part I Date/Time Prepared: 9/27/2017 2:32 pm
Cost Center Description			PPS Inpatient Ratio 11.00	Title XIX	Hospital Cost
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS			30.00
41.00	04100	SUBPROVIDER - IRF			41.00
42.00	04200	SUBPROVIDER			42.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	0.000000		50.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
54.01	05401	ONCOLOGY	0.000000		54.01
56.00	05600	RADIOISOTOPE	0.000000		56.00
57.00	05700	CT SCAN	0.000000		57.00
58.00	05800	MRI	0.000000		58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000		59.00
60.00	06000	LABORATORY	0.000000		60.00
60.01	06001	BLOOD LABORATORY	0.000000		60.01
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
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
76.00	03950	SENIOR LIFE SOLUTIONS	0.000000		76.00
76.97	07697	CARDIAC REHABILITATION	0.000000		76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00	08800	RURAL HEALTH CLINIC	0.000000		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		89.00
90.00	09000	CLINIC	0.000000		90.00
90.01	09001	COUMADIN CLINIC	0.000000		90.01
90.02	04050	TELEMEDICINE	0.000000		90.02
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
99.10	09910	CORF			99.10
<b>SPECIAL PURPOSE COST CENTERS</b>					
109.00	10900	PANCREAS ACQUISITION			109.00
110.00	11000	INTESTINAL ACQUISITION			110.00
111.00	11100	ISLET ACQUISITION			111.00
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: 14-1307	Period: From 05/01/2016 To 04/30/2017	Worksheet D Part II Date/Time Prepared: 9/27/2017 2:32 pm
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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	361,592	734,056	0.492595	0	50.00
53.00	05300	ANESTHESIOLOGY	1,467	524,416	0.002797	1,267	4 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	241,866	3,179,731	0.076065	126,912	9,654 54.00
54.01	05401	ONCOLOGY	117,048	471,671	0.248156	0	0 54.01
56.00	05600	RADIOISOTOPE	19,003	710,866	0.026732	9,865	264 56.00
57.00	05700	CT SCAN	48,414	5,735,052	0.008442	173,063	1,461 57.00
58.00	05800	MRI	9,629	1,403,784	0.006859	9,988	69 58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0	0 59.00
60.00	06000	LABORATORY	170,015	7,489,620	0.022700	322,839	7,328 60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0	0 60.01
65.00	06500	RESPIRATORY THERAPY	147,716	946,865	0.156005	104,392	16,286 65.00
66.00	06600	PHYSICAL THERAPY	68,078	2,231,317	0.030510	59,235	1,807 66.00
67.00	06700	OCCUPATIONAL THERAPY	13,022	580,712	0.022424	28,736	644 67.00
68.00	06800	SPEECH PATHOLOGY	4,696	124,548	0.037704	6,449	243 68.00
69.00	06900	ELECTROCARDIOLOGY	1,107	334,524	0.003309	9,324	31 69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	187	4,864	0.038446	648	25 70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	18,947	209,994	0.090226	47,666	4,301 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,584	78,455	0.045682	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	133,437	5,723,607	0.023313	242,458	5,652 73.00
76.00	03950	SENIOR LIFE SOLUTIONS	47,813	974,293	0.049075	0	0 76.00
76.97	07697	CARDIAC REHABILITATION	10,879	196,206	0.055447	0	0 76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	479,796	2,792,262	0.171831	0	0 88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0 89.00
90.00	09000	CLINIC	6,833	64,699	0.105612	0	0 90.00
90.01	09001	COUMADIN CLINIC	1,694	161,846	0.010467	0	0 90.01
90.02	04050	TELEMEDICINE	25,226	1,347	18.727543	0	0 90.02
91.00	09100	EMERGENCY	290,771	2,392,235	0.121548	152	18 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	38,055	177,245	0.214703	0	0 92.00
200.00		Total (lines 50-199)	2,260,875	37,244,215		1,142,994	47,787 200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-1307	Period: From 05/01/2016 To 04/30/2017	Worksheet D Part IV Date/Time Prepared: 9/27/2017 2:32 pm
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Cost Center Description		Title XVIII				Hospital	
		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	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	0	0	0	0	0 50.00
53.00	05300	ANESTHESIOLOGY	349,528	0	0	0	349,528 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0 54.00
54.01	05401	ONCOLOGY	0	0	0	0	0 54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0 56.00
57.00	05700	CT SCAN	0	0	0	0	0 57.00
58.00	05800	MRI	0	0	0	0	0 58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0 59.00
60.00	06000	LABORATORY	0	0	0	0	0 60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0 60.01
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
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0 70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0 73.00
76.00	03950	SENIOR LIFE SOLUTIONS	0	0	0	0	0 76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0 76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0 88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0 89.00
90.00	09000	CLINIC	0	0	0	0	0 90.00
90.01	09001	COUMADIN CLINIC	0	0	0	0	0 90.01
90.02	04050	TELEMEDICINE	0	0	0	0	0 90.02
91.00	09100	EMERGENCY	0	0	0	0	0 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0 92.00
200.00		Total (lines 50-199)	349,528	0	0	0	349,528 200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-1307	Period: From 05/01/2016 To 04/30/2017	Worksheet D Part IV Date/Time Prepared: 9/27/2017 2:32 pm
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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	Cost
		6.00	7.00	8.00	9.00	10.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	0	734,056	0.000000	0.000000	0	50.00
53.00	05300 ANESTHESIOLOGY	0	524,416	0.666509	0.000000	1,267	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	3,179,731	0.000000	0.000000	126,912	54.00
54.01	05401 ONCOLOGY	0	471,671	0.000000	0.000000	0	54.01
56.00	05600 RADIOISOTOPE	0	710,866	0.000000	0.000000	9,865	56.00
57.00	05700 CT SCAN	0	5,735,052	0.000000	0.000000	173,063	57.00
58.00	05800 MRI	0	1,403,784	0.000000	0.000000	9,988	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0.000000	0.000000	0	59.00
60.00	06000 LABORATORY	0	7,489,620	0.000000	0.000000	322,839	60.00
60.01	06001 BLOOD LABORATORY	0	0	0.000000	0.000000	0	60.01
65.00	06500 RESPIRATORY THERAPY	0	946,865	0.000000	0.000000	104,392	65.00
66.00	06600 PHYSICAL THERAPY	0	2,231,317	0.000000	0.000000	59,235	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	580,712	0.000000	0.000000	28,736	67.00
68.00	06800 SPEECH PATHOLOGY	0	124,548	0.000000	0.000000	6,449	68.00
69.00	06900 ELECTROCARDIOLOGY	0	334,524	0.000000	0.000000	9,324	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	4,864	0.000000	0.000000	648	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	209,994	0.000000	0.000000	47,666	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	78,455	0.000000	0.000000	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	5,723,607	0.000000	0.000000	242,458	73.00
76.00	03950 SENIOR LIFE SOLUTIONS	0	974,293	0.000000	0.000000	0	76.00
76.97	07697 CARDIAC REHABILITATION	0	196,206	0.000000	0.000000	0	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800 RURAL HEALTH CLINIC	0	2,792,262	0.000000	0.000000	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0.000000	0	89.00
90.00	09000 CLINIC	0	64,699	0.000000	0.000000	0	90.00
90.01	09001 COUMADIN CLINIC	0	161,846	0.000000	0.000000	0	90.01
90.02	04050 TELEMEDICINE	0	1,347	0.000000	0.000000	0	90.02
91.00	09100 EMERGENCY	0	2,392,235	0.000000	0.000000	152	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	177,245	0.000000	0.000000	0	92.00
200.00	Total (lines 50-199)	0	37,244,215			1,142,994	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-1307	Period: From 05/01/2016 To 04/30/2017	Worksheet D Part IV Date/Time Prepared: 9/27/2017 2:32 pm
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Cost Center Description		Title XVIII			Hospital		Cost
		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School	
		11.00	12.00	13.00	21.00	22.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	0	0	0	0	0	50.00
53.00	05300 ANESTHESIOLOGY	844	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401 ONCOLOGY	0	0	0	0	0	54.01
56.00	05600 RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700 CT SCAN	0	0	0	0	0	57.00
58.00	05800 MRI	0	0	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000 LABORATORY	0	0	0	0	0	60.00
60.01	06001 BLOOD LABORATORY	0	0	0	0	0	60.01
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
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950 SENIOR LIFE SOLUTIONS	0	0	0	0	0	76.00
76.97	07697 CARDIAC REHABILITATION	0	0	0	0	0	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000 CLINIC	0	0	0	0	0	90.00
90.01	09001 COUMADIN CLINIC	0	0	0	0	0	90.01
90.02	04050 TELEMEDICINE	0	0	0	0	0	90.02
91.00	09100 EMERGENCY	0	0	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
200.00	Total (lines 50-199)	844	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-1307	Period: From 05/01/2016 To 04/30/2017	Worksheet D Part IV Date/Time Prepared: 9/27/2017 2:32 pm
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Cost Center Description		PSA Adj. Allied Health	PSA Adj. All Other Medical Education Cost	Cost
		23.00	24.00	
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	05000 OPERATING ROOM	0	0	50.00
53.00	05300 ANESTHESIOLOGY	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	54.00
54.01	05401 ONCOLOGY	0	0	54.01
56.00	05600 RADIOISOTOPE	0	0	56.00
57.00	05700 CT SCAN	0	0	57.00
58.00	05800 MRI	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000 LABORATORY	0	0	60.00
60.01	06001 BLOOD LABORATORY	0	0	60.01
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
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	73.00
76.00	03950 SENIOR LIFE SOLUTIONS	0	0	76.00
76.97	07697 CARDIAC REHABILITATION	0	0	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>				
88.00	08800 RURAL HEALTH CLINIC	0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	89.00
90.00	09000 CLINIC	0	0	90.00
90.01	09001 COUMADIN CLINIC	0	0	90.01
90.02	04050 TELEMEDICINE	0	0	90.02
91.00	09100 EMERGENCY	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	92.00
200.00	Total (Lines 50-199)	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 14-1307	Period: From 05/01/2016 To 04/30/2017	Worksheet D Part V Date/Time Prepared: 9/27/2017 2:32 pm
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		Title XVIII		Hospital		Cost	
Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs		PPS Services (see inst.)	
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)			
		1.00	2.00	3.00	4.00	5.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	1.378365	0	394,415	0	0	50.00
53.00	05300 ANESTHESIOLOGY	0.706578	0	261,217	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.409879	0	1,356,752	0	0	54.00
54.01	05401 ONCOLOGY	1.233428	0	339,712	0	0	54.01
56.00	05600 RADIOISOTOPE	0.349093	0	316,909	0	0	56.00
57.00	05700 CT SCAN	0.049002	0	2,474,627	0	0	57.00
58.00	05800 MRI	0.181358	0	500,951	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000 LABORATORY	0.221532	0	3,216,027	0	0	60.00
60.01	06001 BLOOD LABORATORY	0.000000	0	0	0	0	60.01
65.00	06500 RESPIRATORY THERAPY	0.745013	0	299,888	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.341278	0	640,721	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.369787	0	88,811	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.906743	0	8,771	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.063655	0	164,724	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.784334	0	648	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.694415	0	52,702	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.630744	0	54,485	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.443029	0	3,523,326	318	0	73.00
76.00	03950 SENIOR LIFE SOLUTIONS	0.473065	0	972,445	0	0	76.00
76.97	07697 CARDIAC REHABILITATION	0.464884	0	102,152	0	0	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800 RURAL HEALTH CLINIC	0.000000				0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0.000000				0	89.00
90.00	09000 CLINIC	1.081640	0	56,073	0	0	90.00
90.01	09001 COUMADIN CLINIC	0.280421	0	137,057	0	0	90.01
90.02	04050 TELEMEDICINE	36.481069	0	294	0	0	90.02
91.00	09100 EMERGENCY	1.004036	0	904,870	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	1.517143	0	97,400	0	0	92.00
200.00	Subtotal (see instructions)		0	15,964,977	318	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	15,964,977	318	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 14-1307	Period: From 05/01/2016 To 04/30/2017	Worksheet D Part V Date/Time Prepared: 9/27/2017 2:32 pm
	Title XVIII	Hospital	Cost

Cost Center Description	Costs		Hospital	Cost
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00 05000 OPERATING ROOM	543,648	0		50.00
53.00 05300 ANESTHESIOLOGY	184,570	0		53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	556,104	0		54.00
54.01 05401 ONCOLOGY	419,010	0		54.01
56.00 05600 RADIOISOTOPE	110,631	0		56.00
57.00 05700 CT SCAN	121,262	0		57.00
58.00 05800 MRI	90,851	0		58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0		59.00
60.00 06000 LABORATORY	712,453	0		60.00
60.01 06001 BLOOD LABORATORY	0	0		60.01
65.00 06500 RESPIRATORY THERAPY	223,420	0		65.00
66.00 06600 PHYSICAL THERAPY	218,664	0		66.00
67.00 06700 OCCUPATIONAL THERAPY	32,841	0		67.00
68.00 06800 SPEECH PATHOLOGY	7,953	0		68.00
69.00 06900 ELECTROCARDIOLOGY	10,486	0		69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	508	0		70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	36,597	0		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	34,366	0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	1,560,936	141		73.00
76.00 03950 SENIOR LIFE SOLUTIONS	460,030	0		76.00
76.97 07697 CARDIAC REHABILITATION	47,489	0		76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>				
88.00 08800 RURAL HEALTH CLINIC	0	0		88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		89.00
90.00 09000 CLINIC	60,651	0		90.00
90.01 09001 COUMADIN CLINIC	38,434	0		90.01
90.02 04050 TELEMEDICINE	10,725	0		90.02
91.00 09100 EMERGENCY	908,522	0		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	147,770	0		92.00
200.00 Subtotal (see instructions)	6,537,921	141		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00 Net Charges (line 200 +/- line 201)	6,537,921	141		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1307

Period: From 05/01/2016

Worksheet D

Component CCN: 14-Z307

To 04/30/2017

Part V  
Date/Time Prepared:  
9/27/2017 2:32 pm

Title XVIII

Swing Beds - SNF

Cost

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs	
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000 OPERATING ROOM	1.378365	0	0	0	0	50.00
53.00 05300 ANESTHESIOLOGY	0.706578	0	0	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.409879	0	0	0	0	54.00
54.01 05401 ONCOLOGY	1.233428	0	0	0	0	54.01
56.00 05600 RADIOISOTOPE	0.349093	0	0	0	0	56.00
57.00 05700 CT SCAN	0.049002	0	0	0	0	57.00
58.00 05800 MRI	0.181358	0	0	0	0	58.00
59.00 05900 CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00 06000 LABORATORY	0.221532	0	0	0	0	60.00
60.01 06001 BLOOD LABORATORY	0.000000	0	0	0	0	60.01
65.00 06500 RESPIRATORY THERAPY	0.745013	0	0	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0.341278	0	0	0	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	0.369787	0	0	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0.906743	0	0	0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	0.063655	0	0	0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0.784334	0	0	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.694415	0	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0.630744	0	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0.443029	0	0	0	0	73.00
76.00 03950 SENIOR LIFE SOLUTIONS	0.473065	0	0	0	0	76.00
76.97 07697 CARDIAC REHABILITATION	0.464884	0	0	0	0	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00 08800 RURAL HEALTH CLINIC	0.000000					88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0.000000					89.00
90.00 09000 CLINIC	1.081640	0	0	0	0	90.00
90.01 09001 COUMADIN CLINIC	0.280421	0	0	0	0	90.01
90.02 04050 TELEMEDICINE	36.481069	0	0	0	0	90.02
91.00 09100 EMERGENCY	1.004036	0	0	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	1.517143	0	0	0	0	92.00
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: 14-1307 Component CCN: 14-Z307	Period: From 05/01/2016 To 04/30/2017	Worksheet D Part V Date/Time Prepared: 9/27/2017 2:32 pm
Title XVIII			Swing Beds - SNF	Cost

Cost Center Description	Costs			Cost	
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)			
	6.00	7.00			
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
54.01	05401	ONCOLOGY	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	56.00
57.00	05700	CT SCAN	0	0	57.00
58.00	05800	MRI	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000	LABORATORY	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	60.01
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
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
76.00	03950	SENIOR LIFE SOLUTIONS	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00	08800	RURAL HEALTH CLINIC	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	89.00
90.00	09000	CLINIC	0	0	90.00
90.01	09001	COUMADIN CLINIC	0	0	90.01
90.02	04050	TELEMEDICINE	0	0	90.02
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	92.00
200.00		Subtotal (see instructions)	0	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

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 14-1307	Period: From 05/01/2016 To 04/30/2017	Worksheet D Part V Date/Time Prepared: 9/27/2017 2:32 pm
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		Title XIX		Hospital		Cost		
Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs		PPS Services (see inst.)		
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)			
		1.00	2.00	3.00	4.00	5.00		
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	1.378365	0	65,915	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.706578	0	28,754	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.409879	0	427,270	0	0	54.00
54.01	05401	ONCOLOGY	1.233428	0	36,584	0	0	54.01
56.00	05600	RADIOISOTOPE	0.349093	0	75,320	0	0	56.00
57.00	05700	CT SCAN	0.049002	0	935,928	0	0	57.00
58.00	05800	MRI	0.181358	0	281,292	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY	0.221532	0	918,218	0	0	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0.745013	0	118,167	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.341278	0	191,104	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.369787	0	40,397	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.906743	0	43,431	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.063655	0	40,050	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.784334	0	2,594	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.694415	0	9,388	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.630744	0	6,590	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.443029	0	326,992	0	0	73.00
76.00	03950	SENIOR LIFE SOLUTIONS	0.473065	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.464884	0	21,862	0	0	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>								
88.00	08800	RURAL HEALTH CLINIC	1.351656				0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000				0	89.00
90.00	09000	CLINIC	1.081640	0	3,164	0	0	90.00
90.01	09001	COUMADIN CLINIC	0.280421	0	2,460	0	0	90.01
90.02	04050	TELEMEDICINE	36.481069	0	197	0	0	90.02
91.00	09100	EMERGENCY	1.004036	0	611,426	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.517143	0	24,645	0	0	92.00
200.00		Subtotal (see instructions)		0	4,211,748	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	4,211,748	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 14-1307	Period: From 05/01/2016 To 04/30/2017	Worksheet D Part V Date/Time Prepared: 9/27/2017 2:32 pm
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		Title XIX		Hospital	Cost
Cost Center Description		Costs			
		Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
		6.00	7.00		
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	90,855	0	50.00
53.00	05300	ANESTHESIOLOGY	20,317	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	175,129	0	54.00
54.01	05401	ONCOLOGY	45,124	0	54.01
56.00	05600	RADIOISOTOPE	26,294	0	56.00
57.00	05700	CT SCAN	45,862	0	57.00
58.00	05800	MRI	51,015	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000	LABORATORY	203,415	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	88,036	0	65.00
66.00	06600	PHYSICAL THERAPY	65,220	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	14,938	0	67.00
68.00	06800	SPEECH PATHOLOGY	39,381	0	68.00
69.00	06900	ELECTROCARDIOLOGY	2,549	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	2,035	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	6,519	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	4,157	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	144,867	0	73.00
76.00	03950	SENIOR LIFE SOLUTIONS	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	10,163	0	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00	08800	RURAL HEALTH CLINIC	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	89.00
90.00	09000	CLINIC	3,422	0	90.00
90.01	09001	COUMADIN CLINIC	690	0	90.01
90.02	04050	TELEMEDICINE	7,187	0	90.02
91.00	09100	EMERGENCY	613,894	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	37,390	0	92.00
200.00		Subtotal (see instructions)	1,698,459	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 +/- line 201)	1,698,459	0	202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-1307	Period: From 05/01/2016 To 04/30/2017	Worksheet D-1 Date/Time Prepared: 9/27/2017 2:32 pm
Cost Center Description		Title XVIII	Hospital	Cost
				1.00
<b>PART I - ALL PROVIDER COMPONENTS</b>				
<b>INPATIENT DAYS</b>				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			2,932 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			1,282 2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.			0 3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)			1,125 4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period			948 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)			417 6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period			167 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)			118 8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)			835 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)			792 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)			417 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
<b>SWING BED ADJUSTMENT</b>				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period			131.13 19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period			137.69 20.00
21.00	Total general inpatient routine service cost (see instructions)			4,571,879 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)			21,899 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)			16,247 25.00
26.00	Total swing-bed cost (see instructions)			2,376,091 26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)			2,195,788 27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)			0 28.00
29.00	Private room charges (excluding swing-bed charges)			0 29.00
30.00	Semi-private room charges (excluding swing-bed charges)			0 30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)			0.000000 31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00 32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00 33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)			0.00 34.00
35.00	Average per diem private room cost differential (line 34 x line 31)			0.00 35.00
36.00	Private room cost differential adjustment (line 3 x line 35)			0 36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)			2,195,788 37.00
<b>PART II - HOSPITAL AND SUBPROVIDERS ONLY</b>				
<b>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS</b>				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)			1,712.78 38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			1,430,171 39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)			0 40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)			1,430,171 41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 14-1307	Period: From 05/01/2016 To 04/30/2017	Worksheet D-1 Date/Time Prepared: 9/27/2017 2:32 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)					394,402 48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					1,824,573 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)					1,356,522 64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					714,229 65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					2,070,751 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)					157 87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,712.78 88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					268,906 89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-1307		Period: From 05/01/2016 To 04/30/2017		Worksheet D-1 Date/Time Prepared: 9/27/2017 2:32 pm	
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	647,006	4,571,879	0.141519	268,906	38,055	90.00
91.00	Nursing School cost	0	4,571,879	0.000000	268,906	0	91.00
92.00	Allied health cost	0	4,571,879	0.000000	268,906	0	92.00
93.00	All other Medical Education	0	4,571,879	0.000000	268,906	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-1307	Period: From 05/01/2016 To 04/30/2017	Worksheet D-3 Date/Time Prepared: 9/27/2017 2:32 pm	
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	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000 ADULTS & PEDIATRICS		794,840		30.00
41.00	04100 SUBPROVIDER - I RF		0		41.00
42.00	04200 SUBPROVIDER		0		42.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000 OPERATING ROOM	1.378365	0	0	50.00
53.00	05300 ANESTHESIOLOGY	0.706578	1,267	895	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.409879	126,912	52,019	54.00
54.01	05401 ONCOLOGY	1.233428	0	0	54.01
56.00	05600 RADIOISOTOPE	0.349093	9,865	3,444	56.00
57.00	05700 CT SCAN	0.049002	173,063	8,480	57.00
58.00	05800 MRI	0.181358	9,988	1,811	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	06000 LABORATORY	0.221532	322,839	71,519	60.00
60.01	06001 BLOOD LABORATORY	0.000000	0	0	60.01
65.00	06500 RESPIRATORY THERAPY	0.745013	104,392	77,773	65.00
66.00	06600 PHYSICAL THERAPY	0.341278	59,235	20,216	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.369787	28,736	10,626	67.00
68.00	06800 SPEECH PATHOLOGY	0.906743	6,449	5,848	68.00
69.00	06900 ELECTROCARDIOLOGY	0.063655	9,324	594	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.784334	648	508	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.694415	47,666	33,100	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.630744	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.443029	242,458	107,416	73.00
76.00	03950 SENIOR LIFE SOLUTIONS	0.473065	0	0	76.00
76.97	07697 CARDIAC REHABILITATION	0.464884	0	0	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00	08800 RURAL HEALTH CLINIC	0.000000		0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0	89.00
90.00	09000 CLINIC	1.081640	0	0	90.00
90.01	09001 COUMADIN CLINIC	0.280421	0	0	90.01
90.02	04050 TELEMEDICINE	36.481069	0	0	90.02
91.00	09100 EMERGENCY	1.004036	152	153	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	1.517143	0	0	92.00
200.00	Total (sum of lines 50-94 and 96-98)		1,142,994	394,402	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net Charges (line 200 minus line 201)		1,142,994		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-1307 Component CCN: 14-Z307	Period: From 05/01/2016 To 04/30/2017	Worksheet D-3 Date/Time Prepared: 9/27/2017 2:32 pm	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	Cost
		1.00	2.00	3.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS		0	30.00
41.00	04100	SUBPROVIDER - I RF		0	41.00
42.00	04200	SUBPROVIDER		0	42.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	1.378365	2,040	50.00
53.00	05300	ANESTHESIOLOGY	0.706578	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.409879	28,798	54.00
54.01	05401	ONCOLOGY	1.233428	0	54.01
56.00	05600	RADIOISOTOPE	0.349093	8,028	56.00
57.00	05700	CT SCAN	0.049002	71,235	57.00
58.00	05800	MRI	0.181358	2,479	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	59.00
60.00	06000	LABORATORY	0.221532	186,111	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	60.01
65.00	06500	RESPIRATORY THERAPY	0.745013	58,214	65.00
66.00	06600	PHYSICAL THERAPY	0.341278	311,400	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.369787	157,211	67.00
68.00	06800	SPEECH PATHOLOGY	0.906743	12,334	68.00
69.00	06900	ELECTROCARDIOLOGY	0.063655	2,331	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.784334	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.694415	39,417	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.630744	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.443029	316,914	73.00
76.00	03950	SENIOR LIFE SOLUTIONS	0.473065	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.464884	0	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00	08800	RURAL HEALTH CLINIC	0.000000		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		89.00
90.00	09000	CLINIC	1.081640	0	90.00
90.01	09001	COUMADIN CLINIC	0.280421	0	90.01
90.02	04050	TELEMEDICINE	36.481069	0	90.02
91.00	09100	EMERGENCY	1.004036	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.517143	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		1,196,512	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	201.00
202.00		Net Charges (line 200 minus line 201)		1,196,512	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-1307	Period: From 05/01/2016 To 04/30/2017	Worksheet D-3 Date/Time Prepared: 9/27/2017 2:32 pm	
Cost Center Description		Title XIX	Hospital	Cost	
		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS		65,241	30.00
41.00	04100	SUBPROVIDER - I RF		0	41.00
42.00	04200	SUBPROVIDER		0	42.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	1.378365	3,039	50.00
53.00	05300	ANESTHESIOLOGY	0.706578	2,030	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.409879	5,590	54.00
54.01	05401	ONCOLOGY	1.233428	7,602	54.01
56.00	05600	RADIOISOTOPE	0.349093	1,130	56.00
57.00	05700	CT SCAN	0.049002	19,827	57.00
58.00	05800	MRI	0.181358	4,467	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	59.00
60.00	06000	LABORATORY	0.221532	23,675	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	60.01
65.00	06500	RESPIRATORY THERAPY	0.745013	7,331	65.00
66.00	06600	PHYSICAL THERAPY	0.341278	1,195	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.369787	309	67.00
68.00	06800	SPEECH PATHOLOGY	0.906743	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.063655	659	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.784334	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.694415	2,432	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.630744	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.443029	20,115	73.00
76.00	03950	SENIOR LIFE SOLUTIONS	0.473065	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.464884	0	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00	08800	RURAL HEALTH CLINIC	1.351656	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	89.00
90.00	09000	CLINIC	1.081640	0	90.00
90.01	09001	COUMADIN CLINIC	0.280421	0	90.01
90.02	04050	TELEMEDICINE	36.481069	0	90.02
91.00	09100	EMERGENCY	1.004036	21,892	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.517143	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		121,293	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)		121,293	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-1307	Period: From 05/01/2016 To 04/30/2017	Worksheet E Part B Date/Time Prepared: 9/27/2017 2:32 pm
		Title XVIII	Hospital	Cost
				1.00
<b>PART B - MEDICAL AND OTHER HEALTH SERVICES</b>				
1.00	Medical and other services (see instructions)			6,538,062 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)			6,538,062 11.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>				
<b>Reasonable charges</b>				
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
<b>Customary charges</b>				
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 charge basis 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)			6,603,443 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
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>				
25.00	Deductibles and coinsurance (for CAH, see instructions)			33,672 25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)			2,531,959 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)			4,037,812 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)			4,037,812 30.00
31.00	Primary payer payments			1,137 31.00
32.00	Subtotal (line 30 minus line 31)			4,036,675 32.00
<b>ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)</b>				
33.00	Composite rate ESRD (from Wkst. I-5, line 11)			0 33.00
34.00	Allowable bad debts (see instructions)			303,725 34.00
35.00	Adjusted reimbursable bad debts (see instructions)			197,421 35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			281,337 36.00
37.00	Subtotal (see instructions)			4,234,096 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)			4,234,096 40.00
40.01	Sequestration adjustment (see instructions)			84,682 40.01
41.00	Interim payments			4,259,528 41.00
42.00	Tentative settlement (for contractors use only)			0 42.00
43.00	Balance due provider/program (see instructions)			-110,114 43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			0 44.00
<b>TO BE COMPLETED BY CONTRACTOR</b>				
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
				Overrides
				1.00
<b>WORKSHEET OVERRIDE VALUES</b>				
112.00	Override of Ancillary service charges (line 12)			0 112.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-1307

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

Worksheet E-1  
Part I  
Date/Time Prepared:  
9/27/2017 2:32 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		1,488,600		4,796,684	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	12/06/2016	27,194		0	3.01	
3.02		04/06/2017	100,871		0	3.02	
3.03			0		0	3.03	
3.04			0		0	3.04	
3.05			0		0	3.05	
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM		0	12/06/2016	74,810	3.50	
3.51			0	04/06/2017	462,346	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)		128,065		-537,156	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,616,665		4,259,528	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		11,746		0	6.01	
6.02	SETTLEMENT TO PROGRAM		0		110,114	6.02	
7.00	Total Medicare program liability (see instructions)		1,628,411		4,149,414	7.00	
				Contractor Number	NPR Date (Mo/Day/Yr)		
		0		1.00	2.00		
8.00	Name of Contractor	National Government Services, Inc.		06101		8.00	

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-1307  
Component CCN: 14-Z307

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

Worksheet E-1  
Part I  
Date/Time Prepared:  
9/27/2017 2:32 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		2,281,651		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	04/06/2017	163,245		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	12/06/2016	13,613		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)		149,632		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)		2,431,283		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		12,563		0	6.01	
6.02	SETTLEMENT TO PROGRAM		0		0	6.02	
7.00	Total Medicare program liability (see instructions)		2,443,846		0	7.00	
				Contractor Number	NPR Date (Mo/Day/Yr)		
		0		1.00	2.00		
8.00	Name of Contractor	National Government Services, Inc.		06101		8.00	

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

Provider CCN: 14-1307

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

Worksheet E-1  
Part II  
Date/Time Prepared:  
9/27/2017 2:32 pm

		Title XVIII	Hospital	Cost	
				1.00	
<b>TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS</b>					
<b>HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION</b>					
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14			316	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12			835	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2			101	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12			1,125	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			38,805,853	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20			534,739	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
<b>INPATIENT HOSPITAL SERVICES UNDER THE IPPS &amp; CAH</b>					
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
				Overrides	
				1.00	
<b>CONTRACTOR OVERRIDES</b>					
108.00	Override of HIT payment				108.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

Provider CCN: 14-1307  
Component CCN: 14-Z307

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

Worksheet E-2  
Date/Time Prepared:  
9/27/2017 2:32 pm

		Title XVIII		Swing Beds - SNF	
		Part A	Part B	Cost	
		1.00	2.00		
<b>COMPUTATION OF NET COST OF COVERED SERVICES</b>					
1.00	Inpatient routine services - swing bed-SNF (see instructions)	2,091,459	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)	453,970	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	1,209	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)	2,545,429	0	8.00	
9.00	Primary payer payments (see instructions)	0	0	9.00	
10.00	Subtotal (line 8 minus line 9)	2,545,429	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)	2,545,429	0	12.00	
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	51,709	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)	2,493,720	0	15.00	
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00	
16.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	0	16.50	
16.55	410A RURAL DEMONSTRATION PROJECT	0		16.55	
17.00	Allowable bad debts (see instructions)	0	0	17.00	
17.01	Adjusted reimbursable bad debts (see instructions)	0	0	17.01	
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00	
19.00	Total (see instructions)	2,493,720	0	19.00	
19.01	Sequestration adjustment (see instructions)	49,874	0	19.01	
20.00	Interim payments	2,431,283	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)	12,563	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: 14-1307	Period: From 05/01/2016 To 04/30/2017	Worksheet E-3 Part V Date/Time Prepared: 9/27/2017 2:32 pm
		Title XVIII	Hospital	Cost
				1.00
<b>PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT</b>				
1.00	Inpatient services			1,824,573 1.00
2.00	Nursing and Allied Health Managed Care payment (see instructions)			0 2.00
3.00	Organ acquisition			0 3.00
4.00	Subtotal (sum of lines 1 through 3)			1,824,573 4.00
5.00	Primary payer payments			0 5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)			1,842,819 6.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>				
<b>Reasonable charges</b>				
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
<b>Customary charges</b>				
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
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>				
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)			0 18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)			1,842,819 19.00
20.00	Deductibles (exclude professional component)			197,328 20.00
21.00	Excess reasonable cost (from line 16)			0 21.00
22.00	Subtotal (line 19 minus line 20 and 21)			1,645,491 22.00
23.00	Coinsurance			4,207 23.00
24.00	Subtotal (line 22 minus line 23)			1,641,284 24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			31,323 25.00
26.00	Adjusted reimbursable bad debts (see instructions)			20,360 26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			26,541 27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)			1,661,644 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)			1,661,644 30.00
30.01	Sequestration adjustment (see instructions)			33,233 30.01
31.00	Interim payments			1,616,665 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)			11,746 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: 14-1307

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

Worksheet G

Date/Time Prepared:  
9/27/2017 2:32 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
<b>CURRENT ASSETS</b>						
1.00	Cash on hand in banks	6,956,667	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	3,682,174	0	0	0	4.00
5.00	Other receivable	357,140	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	235,427	0	0	0	7.00
8.00	Prepaid expenses	385,730	0	0	0	8.00
9.00	Other current assets	812,479	0	0	175,475	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	12,429,617	0	0	175,475	11.00
<b>FIXED ASSETS</b>						
12.00	Land	658,227	0	0	0	12.00
13.00	Land improvements	2,819,384	0	0	0	13.00
14.00	Accumulated depreciation	-356,810	0	0	0	14.00
15.00	Buildings	29,246,039	0	0	0	15.00
16.00	Accumulated depreciation	-3,699,084	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	5,274,588	0	0	0	23.00
24.00	Accumulated depreciation	-3,933,571	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	1,682,323	0	0	0	27.00
28.00	Accumulated depreciation	-1,360,522	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)	30,330,574	0	0	0	30.00
<b>OTHER ASSETS</b>						
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	7	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	7	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	42,760,198	0	0	175,475	36.00
<b>CURRENT LIABILITIES</b>						
37.00	Accounts payable	480,188	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,017,111	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	420,960	0	0	0	40.00
41.00	Deferred income	282,500	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	905,669	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	3,106,428	0	0	0	45.00
<b>LONG TERM LIABILITIES</b>						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	22,796,411	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)	22,796,411	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	25,902,839	0	0	0	51.00
<b>CAPITAL ACCOUNTS</b>						
52.00	General fund balance	16,857,359	0	0	0	52.00
53.00	Specific purpose fund	0	0	0	0	53.00
54.00	Donor created - endowment fund balance - restricted	0	0	0	0	54.00
55.00	Donor created - endowment fund balance - unrestricted	0	0	0	0	55.00
56.00	Governing body created - endowment fund balance	0	0	0	0	56.00
57.00	Plant fund balance - invested in plant	0	0	0	175,475	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion	0	0	0	0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	16,857,359	0	0	175,475	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	42,760,198	0	0	175,475	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-1307

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

Worksheet G-1

Date/Time Prepared:  
9/27/2017 2:32 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		15,380,694			0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		1,527,829				2.00
3.00	Total (sum of line 1 and line 2)		16,908,523			0	3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00	TRANSFER	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)		16,908,523			0	11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00	TRANSFER	51,164		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)		51,164			0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		16,857,359			0	19.00
		Endowment Fund		Plant Fund			
		6.00	7.00	8.00			
1.00	Fund balances at beginning of period	0		124,311			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		124,311			3.00
4.00	Additions (credit adjustments) (specify)		0				4.00
5.00	TRANSFER		51,164				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		51,164			10.00
11.00	Subtotal (line 3 plus line 10)	0		175,475			11.00
12.00	Deductions (debit adjustments) (specify)		0				12.00
13.00	TRANSFER		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		175,475			19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 14-1307

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

Worksheet G-2  
Parts I & II  
Date/Time Prepared:  
9/27/2017 2:32 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
<b>PART I - PATIENT REVENUES</b>					
General Inpatient Routine Services					
1.00	Hospital	1,081,373		1,081,373	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF	0		0	3.00
4.00	SUBPROVIDER	0		0	4.00
5.00	Swing bed - SNF	480,265		480,265	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	1,561,638		1,561,638	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)	1,561,638		1,561,638	17.00
18.00	Ancillary services	3,228,404	28,426,177	31,654,581	18.00
19.00	Outpatient services	73,788	2,723,584	2,797,372	19.00
20.00	RURAL HEALTH CLINIC	0	2,792,262	2,792,262	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
24.10	CORF	0	0	0	24.10
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PROFESSIONAL FEES	58,206	2,081,922	2,140,128	27.00
27.01	340 GROSS UP	0	-4,906	-4,906	27.01
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	4,922,036	36,019,039	40,941,075	28.00
<b>PART II - OPERATING EXPENSES</b>					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		23,575,959		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		23,575,959		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-1307

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

Worksheet G-3

Date/Time Prepared:  
9/27/2017 2:32 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	40,941,075	1.00
2.00	Less contractual allowances and discounts on patients' accounts	17,866,888	2.00
3.00	Net patient revenues (line 1 minus line 2)	23,074,187	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	23,575,959	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-501,772	5.00
<b>OTHER INCOME</b>			
6.00	Contributions, donations, bequests, etc	65,723	6.00
7.00	Income from investments	46,637	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	664,417	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	56,394	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	5,599	17.00
18.00	Revenue from sale of medical records and abstracts	483	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	317	21.00
22.00	Rental of hospital space	26,269	22.00
23.00	Governmental appropriations	311,712	23.00
24.00	<b>CONTRACT SERVICES</b>	62,593	24.00
24.01	MISC OPERATING REVENUE	66,574	24.01
24.02	MISC NON-OPERATING REVENUE	14,539	24.02
24.03	340B DISCOUNT	708,344	24.03
25.00	Total other income (sum of lines 6-24)	2,029,601	25.00
26.00	Total (line 5 plus line 25)	1,527,829	26.00
27.00	<b>OTHER EXPENSES (SPECIFY)</b>	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	1,527,829	29.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1307

Period: From 05/01/2016

Worksheet M-1

Component CCN: 14-3412

To 04/30/2017

Date/Time Prepared: 9/27/2017 2:32 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	
<b>FACILITY HEALTH CARE STAFF COSTS</b>							
1.00	Physician	902,037	1,189	903,226	-134,811	768,415	1.00
2.00	Physician Assistant	297,649	0	297,649	0	297,649	2.00
3.00	Nurse Practitioner	62,835	0	62,835	0	62,835	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	318,933	0	318,933	-2,080	316,853	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	18,756	18,756	-3,960	14,796	9.00
10.00	Subtotal (sum of lines 1 through 9)	1,581,454	19,945	1,601,399	-140,851	1,460,548	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	158,946	158,946	0	158,946	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	33,369	33,369	0	33,369	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	192,315	192,315	0	192,315	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	1,581,454	212,260	1,793,714	-140,851	1,652,863	22.00
<b>COSTS OTHER THAN RHC/FQHC SERVICES</b>							
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	0	0	0	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0	28.00
<b>FACILITY OVERHEAD</b>							
29.00	Facility Costs	0	0	0	0	0	29.00
30.00	Administrative Costs	372,519	18,530	391,049	0	391,049	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	372,519	18,530	391,049	0	391,049	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	1,953,973	230,790	2,184,763	-140,851	2,043,912	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1307

Period: From 05/01/2016

Worksheet M-1

Component CCN: 14-3412

To 04/30/2017

Date/Time Prepared: 9/27/2017 2:32 pm

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	RHC I	Cost
		6.00	7.00		
<b>FACILITY HEALTH CARE STAFF COSTS</b>					
1.00	Physician	0	768,415		1.00
2.00	Physician Assistant	0	297,649		2.00
3.00	Nurse Practitioner	0	62,835		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	316,853		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	14,796		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	1,460,548		10.00
11.00	Physician Services Under Agreement	0	0		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	0		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0		14.00
15.00	Medical Supplies	0	158,946		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	33,369		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	192,315		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	1,652,863		22.00
<b>COSTS OTHER THAN RHC/FQHC SERVICES</b>					
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
<b>FACILITY OVERHEAD</b>					
29.00	Facility Costs	0	0		29.00
30.00	Administrative Costs	-1,011	390,038		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-1,011	390,038		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-1,011	2,042,901		32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 14-1307 Component CCN: 14-3412	Period: From 05/01/2016 To 04/30/2017	Worksheet M-2 Date/Time Prepared: 9/27/2017 2:32 pm
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		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	
<b>VISITS AND PRODUCTIVITY</b>						
<b>Positions</b>						
1.00	Physician	2.01	11,787	4,200	8,442	1.00
2.00	Physician Assistant	1.77	6,079	2,100	3,717	2.00
3.00	Nurse Practitioner	0.57	1,699	2,100	1,197	3.00
4.00	Subtotal (sum of lines 1 through 3)	4.35	19,565		13,356	4.00
5.00	Visiting Nurse	0.00	0		0	5.00
6.00	Clinical Psychologist	0.00	0		0	6.00
7.00	Clinical Social Worker	0.00	0		0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0		0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0		0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	4.35	19,565		19,565	8.00
9.00	Physician Services Under Agreements		0		0	9.00
					1.00	
<b>DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES</b>						
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)				1,652,863	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)				0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)				1,652,863	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)				390,038	14.00
15.00	Parent provider overhead allocated to facility (see instructions)				1,731,278	15.00
16.00	Total overhead (sum of lines 14 and 15)				2,121,316	16.00
17.00	Allowable GME overhead (see instructions)				0	17.00
18.00	Enter the amount from line 16				2,121,316	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)				2,121,316	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)				3,774,179	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 14-1307 Component CCN: 14-3412	Period: From 05/01/2016 To 04/30/2017	Worksheet M-3 Date/Time Prepared: 9/27/2017 2:32 pm	
		Title XVIII	RHC I	Cost	
				1.00	
<b>DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES</b>					
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			3,774,179	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			148,298	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			3,625,881	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			19,565	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)			0	5.00
6.00	Total adjusted visits (line 4 plus line 5)			19,565	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			185.32	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)	185.32	185.32		9.00
<b>CALCULATION OF SETTLEMENT</b>					
10.00	Program covered visits excluding mental health services (from contractor records)	4,097	2,049		10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	759,256	379,721		11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0		12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0		13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0		14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)				15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *	0	1,138,977		16.00
16.01	Total program charges (see instructions)(from contractor's records)		823,600		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		14,167		16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		19,592		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.)		825,452		16.04
16.05	Total program cost (see instructions)	0	845,044		16.05
17.00	Primary payer amounts		94		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		87,570		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		144,373		19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		844,950		20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		74,494		21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		919,444		22.00
23.00	Allowable bad debts (see instructions)		0		23.00
23.01	Adjusted reimbursable bad debts (see instructions)		0		23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0		24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0		25.50
26.00	Net reimbursable amount (see instructions)		919,444		26.00
26.01	Sequestration adjustment (see instructions)		18,389		26.01
27.00	Interim payments		725,397		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)		175,658		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: 14-1307 Component CCN: 14-3412	Period: From 05/01/2016 To 04/30/2017	Worksheet M-4 Date/Time Prepared: 9/27/2017 2:32 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)		1,460,548	1,460,548	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time		0.001295	0.003297	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)		1,891	4,815	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)		44,432	13,807	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)		46,323	18,622	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)		1,652,863	1,652,863	6.00
7.00	Total overhead (from Wkst. M-2, line 19)		2,121,316	2,121,316	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)		0.028026	0.011267	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)		59,452	23,901	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)		105,775	42,523	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)		282	717	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)		375.09	59.31	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries		145	339	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)		54,388	20,106	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)			148,298	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)			74,494	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN: 14-1307 Component CCN: 14-3412	Period: From 05/01/2016 To 04/30/2017	Worksheet M-5 Date/Time Prepared: 9/27/2017 2:32 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		873,902	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00
Program to Provider				
3.01			0	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
Provider to Program				
3.50		12/06/2016	75,035	3.50
3.51		04/06/2017	73,470	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)		-148,505	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		725,397	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		175,658	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		901,055	7.00
		Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	
		1.00	2.00	
8.00	Name of Contractor	National Government Services, Inc.	06101	8.00