

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: 14-1324	Period: From 04/01/2016 To 03/31/2017	Worksheet S Parts I-III Date/Time Prepared: 7/26/2017 12:29 pm
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PART I - COST REPORT STATUS

Provider use only 1. Electronically filed cost report Date: 7/26/2017 Time: 12:29 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. 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 FERRELL HOSPITAL (14-1324) for the cost reporting period beginning 04/01/2016 and ending 03/31/2017 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

 Title

 Date

Cost Center Description	Title V 1.00	Title XVIII		HIT 4.00	Title XIX 5.00	
		Part A 2.00	Part B 3.00			
PART III - SETTLEMENT SUMMARY						
1.00 Hospital	0	308,810	542,447	0	0	1.00
2.00 Subprovider - IPF	0	0	0		0	2.00
3.00 Subprovider - IRF	0	0	0		0	3.00
5.00 Swing bed - SNF	0	212,365	0		0	5.00
6.00 Swing bed - NF	0				0	6.00
10.00 RURAL HEALTH CLINIC I	0		439,128		0	10.00
200.00 Total	0	521,175	981,575	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: 14-1324		Period: From 04/01/2016 To 03/31/2017		Worksheet S-2 Part I Date/Time Prepared: 7/26/2017 12:26 pm			
1.00		2.00		3.00		4.00					
Hospital and Hospital Health Care Complex Address:											
1.00	Street: 1201 PINE STREET			PO Box:						1.00	
2.00	City: EL DORADO			State: IL		Zip Code: 62930		County: SALINE		2.00	
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)			
		1.00		2.00	3.00	4.00	5.00	6.00	7.00	8.00	
				V	XVIII	XIX					
Hospital and Hospital-Based Component Identification:											
3.00	Hospital		FERRELL HOSPITAL	141324	99914	1	02/01/2003	N	O	N	3.00
4.00	Subprovider - IPF										4.00
5.00	Subprovider - IRF										5.00
6.00	Subprovider - (Other)										6.00
7.00	Swing Beds - SNF		FERRELL SWINGBED SNF	14Z324	99914		02/01/2003	N	O	N	7.00
8.00	Swing Beds - NF										8.00
9.00	Hospital-Based SNF										9.00
10.00	Hospital-Based NF										10.00
11.00	Hospital-Based OLTC										11.00
12.00	Hospital-Based HHA										12.00
13.00	Separately Certified ASC										13.00
14.00	Hospital-Based Hospice										14.00
15.00	Hospital-Based Health Clinic - RHC		FERRELL HOSPITAL CLINIC	148506	99914		04/01/2009	N	O	N	15.00
16.00	Hospital-Based Health Clinic - FQHC										16.00
17.00	Hospital-Based (CMHC) I										17.00
18.00	Renal Dialysis										18.00
19.00	Other										19.00
							From:	To:			
							1.00	2.00			
20.00	Cost Reporting Period (mm/dd/yyyy)						04/01/2016	03/31/2017		20.00	
21.00	Type of Control (see instructions)						2			21.00	
Inpatient PPS Information											
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2) (Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.						N			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.						1	N		23.00	
				In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days		
				1.00	2.00	3.00	4.00	5.00	6.00		
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.			0	0	0	0	0	0	0	24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.			0	0	0	0	0	0	0	25.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1324	Period: From 04/01/2016 To 03/31/2017	Worksheet S-2 Part I Date/Time Prepared: 7/26/2017 12:26 pm		
		Urban/Rural	S	Date of Geogr		
		1.00	2.00			
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.		2			26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.		2			27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.		0			35.00
		Beginning:	Ending:			
		1.00	2.00			
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.		0			36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.		0			37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)		N			37.01
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.					38.00
		Y/N	Y/N			
		1.00	2.00			
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)		N		N	39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)		N		N	40.00
		V	XVII	XIX		
		1.00	2.00	3.00		
Prospective Payment System (PPS)-Capital						
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section 412.320? (see instructions)		N		N	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	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	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.		N		N	48.00
Teaching Hospitals						
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.		N			56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.					57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.					58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.		N			59.00
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under 413.85? Enter "Y" for yes or "N" for no. (see instructions)		N			60.00
		Y/N	IME	Direct GME	IME	Direct GME
		1.00	2.00	3.00	4.00	5.00
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00	0.00		61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)		0.00	0.00		61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)		0.00	0.00		61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).		0.00	0.00		61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)		0.00	0.00		61.05

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1324		Period: From 04/01/2016 To 03/31/2017		Worksheet S-2 Part I Date/Time Prepared: 7/26/2017 12:26 pm				
	Y/N	IME	Direct GME	IME	Direct GME					
	1.00	2.00	3.00	4.00	5.00					
61.06	Enter the amount of ACA \$5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)							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				
62.00	ACA Provisions Affecting the Health Resources and Services Administration (HRSA) 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					
64.00	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. Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)						0.00	0.00	0.000000	64.00
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))				
		1.00	2.00	3.00	4.00	5.00				
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code, enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)						0.00	0.00	0.000000	65.00

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		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
				1.00	2.00	3.00
Inpatient Psychiatric Facility PPS						
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.			N		70.00
71.00	If line 70 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)				0	71.00
Inpatient Rehabilitation Facility PPS						
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.			N		75.00
76.00	If line 75 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)				0	76.00
				1.00		
Long Term Care Hospital PPS						
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.			N		80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.			N		81.00
TEFRA Providers						
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.			N		85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.			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	
Title V and XIX Services						
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.			N	N	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	N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.			N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.			N	N	94.00

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		V 1.00	XIX 2.00			
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	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	N	96.00	
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	0.00	97.00	
Rural Providers						
105.00	Does this hospital qualify as a critical access hospital (CAH)?	Y			105.00	
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	Y			106.00	
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. 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 1.00	Occupational 2.00	Speech 3.00	Respiratory 4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	Y	Y	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	
Miscellaneous Cost Reporting Information						
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N			0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N				116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	N				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 1.00	Losses 2.00	Insurance 3.00		
118.01	List amounts of malpractice premiums and paid losses:	126,856	0		0	118.01
					1.00	
					2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N				118.02
119.00	DO NOT USE THIS LINE					119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N		N		120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	N				121.00
122.00	Does the cost report contain state health or similar taxes? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N				122.00
Transplant Center Information						
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N				125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					132.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1324		Period: From 04/01/2016 To 03/31/2017		Worksheet S-2 Part I Date/Time Prepared: 7/26/2017 12:26 pm	
		1.00		2.00			
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					133.00	
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.					134.00	
All Providers							
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y		HB0778		140.00	
		1.00		2.00		3.00	
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.							
141.00	Name: DEACONESS HEALTH SYSTEM	Contractor's Name: NGS		Contractor's Number: 06101		141.00	
142.00	Street: 600 MARY STREET	PO Box:				142.00	
143.00	City: EVANSVILLE	State: IL		Zip Code: 47710		143.00	
						1.00	
144.00	Are provider based physicians' costs included in Worksheet A?			Y		144.00	
		1.00		2.00			
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.	N		N		145.00	
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N				146.00	
						1.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.			N		147.00	
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.			N		148.00	
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.			N		149.00	
		Part A		Part B		Title V	
		1.00		2.00		3.00	
						Title XIX	
						4.00	
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)							
155.00	Hospital	N		N		155.00	
156.00	Subprovider - IPF	N		N		156.00	
157.00	Subprovider - IRF	N		N		157.00	
158.00	SUBPROVIDER					158.00	
159.00	SNF	N		N		159.00	
160.00	HOME HEALTH AGENCY	N		N		160.00	
161.00	CMHC			N		161.00	
						1.00	
165.00	Multi campus 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	
		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	
						1.00	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act							
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.			Y		167.00	
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)					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)					9.99	
						169.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1324	Period: From 04/01/2016 To 03/31/2017	Worksheet S-2 Part I Date/Time Prepared: 7/26/2017 12:26 pm	
			Beginning	Ending	
			1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)		10/01/2015	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		0171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-1324		Period: From 04/01/2016 To 03/31/2017		Worksheet S-2 Part II Date/Time Prepared: 7/26/2017 12:26 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)	Y					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.	N					5.00
		Y/N	Legal Oper.				
		1.00	2.00				
Approved Educational Activities							
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N					6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N					7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N					8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N					9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N					10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N					11.00
		Y/N					
		1.00					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	06/02/2017	Y	06/02/2017		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: 14-1324	Period: From 04/01/2016 To 03/31/2017	Worksheet S-2 Part II Date/Time Prepared: 7/26/2017 12:26 pm	
		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.		N	N	21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been 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
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.		Y		28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions		Y		29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.		N		30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.		N		31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.		N		32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.		N		33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.		Y		34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.		N		35.00
			Y/N	Date	
			1.00	2.00	
Home Office Costs					
36.00	Were home office costs claimed on the cost report?		Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.		Y		37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.		Y	09/30/2016	38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.		N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.		N		40.00
			1.00	2.00	
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	KEVIN	WELLEN		41.00
42.00	Enter the employer/company name of the cost report preparer.	CLIFTONLARSONALLEN LLP			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	314-925-4446	KEVIN.WELLEN@CLACONNECT.COM		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-1324	Period: From 04/01/2016 To 03/31/2017	Worksheet S-2 Part II Date/Time Prepared: 7/26/2017 12:26 pm
		3.00		
Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	DI RECTOR, REI MBURSEMENT		41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-1324

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

Worksheet S-3
Part I
Date/Time Prepared:
7/26/2017 12:26 pm

Component	Worksheet A Line Number	No. of Beds	Bed Days Avai lable	CAH Hours	I/P Days / O/P Vi si ts / Tri ps	
					Title V	
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	25	9,125	50,856.00	0	1.00
2.00 HMO and other (see instructions)						2.00
3.00 HMO IPF Subprovider						3.00
4.00 HMO IRF Subprovider						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00 Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)		25	9,125	50,856.00	0	7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)		25	9,125	50,856.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RHC (CONSOLIDATED)	88.00				0	26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		25				27.00
28.00 Observation Bed Days					0	28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)		0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-1324

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

Worksheet S-3
Part I
Date/Time Prepared:
7/26/2017 12:26 pm

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents			
	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll		
	6.00	7.00	8.00	9.00	10.00		
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	1,476	307	2,119			1.00
2.00	HMO and other (see instructions)	0	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	565	0	623			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	36			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	2,041	307	2,778			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)	2,041	307	2,778	0.00	140.53	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	0	0	0			24.10
25.00	CMHC - CMHC						25.00
26.00	RHC (CONSOLIDATED)	8,340	0	27,376	0.00	26.01	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	166.54	27.00
28.00	Observation Bed Days		0	436			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: 14-1324

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

Worksheet S-3
Part I
Date/Time Prepared:
7/26/2017 12:26 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	408	105	625	1.00
2.00 HMO and other (see instructions)				0	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	408	105	625		14.00
15.00 CAH visits							15.00
16.00 SUBPROVIDER - IPF							16.00
17.00 SUBPROVIDER - IRF							17.00
18.00 SUBPROVIDER							18.00
19.00 SKILLED NURSING FACILITY							19.00
20.00 NURSING FACILITY							20.00
21.00 OTHER LONG TERM CARE							21.00
22.00 HOME HEALTH AGENCY							22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)							23.00
24.00 HOSPICE							24.00
24.10 HOSPICE (non-distinct part)							24.10
25.00 CMHC - CMHC							25.00
26.00 RHC (CONSOLIDATED)	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: 14-1324 Component CCN: 14-8506		Period: From 04/01/2016 To 03/31/2017		Worksheet S-8 Date/Time Prepared: 7/26/2017 12:26 pm	
		RHC I		Cost			
				1.00			
1.00	1.00	Clinic Address and Identification Street		1201 PINE STREET		1.00	
		City		State		ZIP Code	
		1.00		2.00		3.00	
2.00	2.00	City, State, ZIP Code, County		EL DORADO IL 62930		2.00	
				1.00			
3.00	3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban		0		3.00	
				Grant Award		Date	
				1.00		2.00	
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	
				1.00		2.00	
				3.00		4.00	
				5.00			
11.00	11.00	Facility hours of operations (1) Clinic		13:00 17:00		07:00 19:00	
				1.00		2.00	
12.00	12.00	Have you received an approval for an exception to the productivity standard?		N		12.00	
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.		Y		2	
				Provider name		CCN number	
				1.00		2.00	
14.00	14.00	RHC/FQHC name, CCN number		FERRELL HOSPITAL CLINIC		148506	
14.01	14.01			EL DORADO		148507	
				XVIII		XIX	
				Total Visits			
				1.00		2.00	
				3.00		4.00	
				5.00			
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		SALINE		2.00	
				Tuesday		Wednesday	
				Thursday			
				to		to	
				6.00		7.00	
				8.00		9.00	
				10.00			
11.00	11.00	Facility hours of operations (1) Clinic		19:00 07:00		19:00 07:00	

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provider CCN: 14-1324 Component CCN: 14-8506		Period: From 04/01/2016 To 03/31/2017		Worksheet S-8 Date/Time Prepared: 7/26/2017 12:26 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	07:00	19:00	09:00	17:00		11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 14-1324	Period: From 04/01/2016 To 03/31/2017	Worksheet S-10 Date/Time Prepared: 7/26/2017 12:26 pm
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			1.00	
Uncompensated and indigent care cost computation				
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)		0.441774	1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid		433,694	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		2,384,190	5.00
6.00	Medicaid charges		10,940,591	6.00
7.00	Medicaid cost (line 1 times line 6)		4,833,269	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)		2,015,385	8.00
Children's Health Insurance Program (CHIP) (see instructions for each line)				
9.00	Net revenue from stand-alone CHIP		0	9.00
10.00	Stand-alone CHIP charges		0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)		0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)		0	12.00
Other state or local government indigent care program (see instructions for each line)				
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)		0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)		0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)		0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)		0	16.00
Uncompensated care (see instructions for each line)				
17.00	Private grants, donations, or endowment income restricted to funding charity care		0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations		0	18.00
19.00	Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		2,015,385	19.00
			1.00	
			2.00	
			3.00	
20.00	Charity care charges for the entire facility (see instructions)	0	105,797	20.00
21.00	Cost of patients approved for charity care (line 1 times line 20)	0	46,738	21.00
22.00	Partial payment by patients approved for charity care	0	388	22.00
23.00	Cost of charity care (line 21 minus line 22)	0	46,350	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)		1,132,845	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)		375,548	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)		757,297	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)		334,554	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		380,904	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		2,396,289	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1324

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

Worksheet A
Date/Time Prepared:
7/26/2017 12:26 pm

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassified ons (See A-6)	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	00100		593,901	593,901	-350,977	242,924	1.00
1.01	00101				43,847	43,847	1.01
2.00	00200				533,869	533,869	2.00
3.00	00300				0	0	3.00
4.00	00400	82,413	1,734,667	1,817,080	0	1,817,080	4.00
5.01	00580	872,303	343,632	1,215,935	51,556	1,267,491	5.01
5.02	00591	424,779	2,039,847	2,464,626	-12,429	2,452,197	5.02
6.00	00600	234,227	74,601	308,828	0	308,828	6.00
7.00	00700	0	221,406	221,406	0	221,406	7.00
8.00	00800	51,732	14,953	66,685	0	66,685	8.00
9.00	00900	163,565	22,148	185,713	0	185,713	9.00
10.00	01000	185,326	133,362	318,688	-166,210	152,478	10.00
11.00	01100	0	0	0	166,210	166,210	11.00
13.00	01300	98,186	5,332	103,518	0	103,518	13.00
16.00	01600	263,056	11,118	274,174	0	274,174	16.00
19.00	01900	0	238,411	238,411	0	238,411	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	1,238,555	47,319	1,285,874	0	1,285,874	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	398,489	357,496	755,985	0	755,985	50.00
53.00	05300	0	6,308	6,308	0	6,308	53.00
54.00	05400	495,218	530,623	1,025,841	11,308	1,037,149	54.00
60.00	06000	416,698	440,622	857,320	7,319	864,639	60.00
64.00	06400	0	0	0	0	0	64.00
65.00	06500	316,221	42,851	359,072	-6,134	352,938	65.00
66.00	06600	0	538,545	538,545	-51,556	486,989	66.00
71.00	07100	0	136,709	136,709	6,134	142,843	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	194,682	576,506	771,188	17,241	788,429	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	2,863,215	237,466	3,100,681	-18,100	3,082,581	88.00
90.00	09000	0	0	0	0	0	90.00
91.00	09100	485,494	1,129,525	1,615,019	6,000	1,621,019	91.00
92.00	09200						92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300		193,646	193,646	-183,665	9,981	113.00
118.00		8,784,159	9,670,994	18,455,153	54,413	18,509,566	118.00
NONREIMBURSABLE COST CENTERS							
192.00	19200	0	14,769	14,769	-4,362	10,407	192.00
194.00	07950	0	40,093	40,093	-32,810	7,283	194.00
194.01	07951	0	181,605	181,605	-17,241	164,364	194.01
200.00		8,784,159	9,907,461	18,691,620	0	18,691,620	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1324

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

Worksheet A
Date/Time Prepared:
7/26/2017 12:26 pm

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	-3,463	239,461	1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - EFM BLDG	-152	43,695	1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-12,118	521,751	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	513,223	2,330,303	4.00
5.01	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	1,267,491	5.01
5.02	00591	OTHER ADMIN AND GENERAL	1,151,249	3,603,446	5.02
6.00	00600	MAINTENANCE & REPAIRS	-27	308,801	6.00
7.00	00700	OPERATION OF PLANT	56,770	278,176	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	66,685	8.00
9.00	00900	HOUSEKEEPING	0	185,713	9.00
10.00	01000	DIETARY	0	152,478	10.00
11.00	01100	CAFETERIA	-31,684	134,526	11.00
13.00	01300	NURSING ADMINISTRATION	56,128	159,646	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	25,434	299,608	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	238,411	19.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	0	1,285,874	30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	755,985	50.00
53.00	05300	ANESTHESIOLOGY	0	6,308	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-299	1,036,850	54.00
60.00	06000	LABORATORY	-194	864,445	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	352,938	65.00
66.00	06600	PHYSICAL THERAPY	0	486,989	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	142,843	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	211,893	1,000,322	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	-364,547	2,718,034	88.00
90.00	09000	CLINIC	0	0	90.00
91.00	09100	EMERGENCY	-99,060	1,521,959	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	-9,981	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,493,172	20,002,738	118.00
NONREIMBURSABLE COST CENTERS					
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	10,407	192.00
194.00	07950	MARKETING	0	7,283	194.00
194.01	07951	340B	0	164,364	194.01
200.00		TOTAL (SUM OF LINES 118-199)	1,493,172	20,184,792	200.00

		Increases				
Cost Center		Line #	Salary	Other		
2.00		3.00	4.00	5.00		
A - CAFETERIA COSTS						
1.00	CAFETERIA	11.00	96,656	69,554	1.00	
	O		96,656	69,554		
B - INTEREST EXPENSE						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	130,911	1.00	
2.00	CAP REL COSTS-BLDG & FIXT - EFM BLDG	1.01	0	5,747	2.00	
3.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	703	3.00	
4.00	OTHER ADMIN AND GENERAL	5.02	0	27,677	4.00	
5.00	RADIOLOGY-DIAGNOSTIC	54.00	0	11,308	5.00	
6.00	LABORATORY	60.00	0	7,319	6.00	
	O		0	183,665		
C - PROPERTY INSURANCE						
1.00	OTHER CAP REL COSTS	3.00	0	39,039	1.00	
	O		0	39,039		
D - PROPERTY TAXES						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	7,877	1.00	
	O		0	7,877		
E - MARKETING & ADVERTISING						
1.00	OTHER ADMIN AND GENERAL	5.02	0	32,810	1.00	
	O		0	32,810		
F - MME DEPRECIATION						
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	510,926	1.00	
	O		0	510,926		
G - ADMIN RECRUITING						
1.00	EMERGENCY	91.00	0	6,000	1.00	
2.00	RURAL HEALTH CLINIC	88.00	0	20,000	2.00	
	O		0	26,000		
H - EFM BUILDING RENT						
1.00	CAP REL COSTS-BLDG & FIXT - EFM BLDG	1.01	0	38,100	1.00	
2.00	CAP REL COSTS-BLDG & FIXT	1.00	0	4,362	2.00	
	O		0	42,462		
J - BILLABLE OXYGEN COSTS						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	6,134	1.00	
	O		0	6,134		
K - PT BILLING COSTS						
1.00	CASHIERING/ACCOUNTS RECEIVABLE	5.01	0	51,556	1.00	
	O		0	51,556		
L - 340B ADMIN COSTS						
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	17,241	1.00	
	O		0	17,241		
500.00	Grand Total: Increases		96,656	987,264	500.00	

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
A - CAFETERIA COSTS							
1.00	DIETARY	10.00	96,656	69,554	0		1.00
	O		96,656	69,554			
B - INTEREST EXPENSE							
1.00	INTEREST EXPENSE	113.00	0	183,665	11		1.00
2.00		0.00	0	0	11		2.00
3.00		0.00	0	0	11		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
	O		0	183,665			
C - PROPERTY INSURANCE							
1.00	OTHER ADMIN AND GENERAL	5.02	0	39,039	12		1.00
	O		0	39,039			
D - PROPERTY TAXES							
1.00	OTHER ADMIN AND GENERAL	5.02	0	7,877	13		1.00
	O		0	7,877			
E - MARKETING & ADVERTISING							
1.00	MARKETING	194.00	0	32,810	0		1.00
	O		0	32,810			
F - MME DEPRECIATION							
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	510,926	9		1.00
	O		0	510,926			
G - ADMIN RECRUITING							
1.00	OTHER ADMIN AND GENERAL	5.02	0	26,000	0		1.00
2.00		0.00	0	0	0		2.00
	O		0	26,000			
H - EFM BUILDING RENT							
1.00	RURAL HEALTH CLINIC	88.00	0	38,100	10		1.00
2.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	4,362	10		2.00
	O		0	42,462			
J - BILLABLE OXYGEN COSTS							
1.00	RESPIRATORY THERAPY	65.00	0	6,134	0		1.00
	O		0	6,134			
K - PT BILLING COSTS							
1.00	PHYSICAL THERAPY	66.00	0	51,556	0		1.00
	O		0	51,556			
L - 340B ADMIN COSTS							
1.00	340B	194.01	0	17,241	0		1.00
	O		0	17,241			
500.00	Grand Total: Decreases		96,656	987,264			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1324

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

Worksheet A-7
Part I
Date/Time Prepared:
7/26/2017 12:26 pm

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
			1.00	2.00	3.00		
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	180,412	3,000	0	3,000	0	1.00
2.00	Land Improvements	44,285	0	0	0	393	2.00
3.00	Buildings and Fixtures	2,992,816	360,427	0	360,427	63,740	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	642,006	13,121	0	13,121	34,787	5.00
6.00	Movable Equipment	2,858,646	70,942	0	70,942	418,134	6.00
7.00	HIT designated Assets	1,724,929	0	0	0	200,821	7.00
8.00	Subtotal (sum of lines 1-7)	8,443,094	447,490	0	447,490	717,875	8.00
9.00	Reconciling Items	-92,217	-1,618,707	0	-1,618,707	-348,937	9.00
10.00	Total (line 8 minus line 9)	8,535,311	2,066,197	0	2,066,197	1,066,812	10.00
		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	183,412	0				1.00
2.00	Land Improvements	43,892	0				2.00
3.00	Buildings and Fixtures	3,289,503	0				3.00
4.00	Building Improvements	0	0				4.00
5.00	Fixed Equipment	620,340	0				5.00
6.00	Movable Equipment	2,511,454	0				6.00
7.00	HIT designated Assets	1,524,108	0				7.00
8.00	Subtotal (sum of lines 1-7)	8,172,709	0				8.00
9.00	Reconciling Items	-1,361,987	0				9.00
10.00	Total (line 8 minus line 9)	9,534,696	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1324

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

Worksheet A-7
Part II
Date/Time Prepared:
7/26/2017 12:26 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	593,901	0	0	0	0	1.00
1.01	CAP REL COSTS-BLDG & FIXT - EFM BLDG	0	0	0	0	0	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	593,901	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	593,901				1.00
1.01	CAP REL COSTS-BLDG & FIXT - EFM BLDG	0	0				1.01
2.00	CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00	Total (sum of lines 1-2)	0	593,901				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1324

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

Worksheet A-7
Part III
Date/Time Prepared:
7/26/2017 12:26 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	3,516,807	0	3,516,807	0.430311	16,799	1.00
1.01	CAP REL COSTS-BLDG & FIXT - EFM BLDG	0	0	0	0.000000	0	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	4,655,902	0	4,655,902	0.569689	22,240	2.00
3.00	Total (sum of lines 1-2)	8,172,709	0	8,172,709	1.000000	39,039	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of col. 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	16,799	82,975	4,362	1.00
1.01	CAP REL COSTS-BLDG & FIXT - EFM BLDG	0	0	0	0	38,100	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	22,240	498,827	0	2.00
3.00	Total (sum of lines 1-2)	0	0	39,039	581,802	42,462	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 col. 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	127,448	16,799	7,877	0	239,461	1.00
1.01	CAP REL COSTS-BLDG & FIXT - EFM BLDG	5,595	0	0	0	43,695	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	684	22,240	0	0	521,751	2.00
3.00	Total (sum of lines 1-2)	133,727	39,039	7,877	0	804,907	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1324

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

Worksheet A-8

Date/Time Prepared:
7/26/2017 12:26 pm

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted				
			Cost Center	Line #	Wkst. A-7	Ref.	
			1.00	2.00	3.00	4.00	5.00
1.00 Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-3,463	CAP REL COSTS-BLDG & FIXT	1.00		11	1.00
1.01 Investment income - CAP REL COSTS-BLDG & FIXT - EFM BLDG (chapter 2)	B	-152	CAP REL COSTS-BLDG & FIXT - EFM BLDG	1.01		11	1.01
2.00 Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)	B	-19	CAP REL COSTS-MVBLE EQUIP	2.00		11	2.00
3.00 Investment income - other (chapter 2)		0		0.00		0	3.00
4.00 Trade, quantity, and time discounts (chapter 8)		0		0.00		0	4.00
5.00 Refunds and rebates of expenses (chapter 8)	B	-6,405	OTHER ADMIN AND GENERAL	5.02		0	5.00
6.00 Rental of provider space by suppliers (chapter 8)		0		0.00		0	6.00
7.00 Telephone services (pay stations excluded) (chapter 21)	A	-1,474	OTHER ADMIN AND GENERAL	5.02		0	7.00
8.00 Television and radio service (chapter 21)	A	-9,590	OTHER ADMIN AND GENERAL	5.02		0	8.00
9.00 Parking lot (chapter 21)		0		0.00		0	9.00
10.00 Provider-based physician adjustment	A-8-2	-99,060				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	2,587,022				0	12.00
13.00 Laundry and linen service		0		0.00		0	13.00
14.00 Cafeteria-employees and guests	B	-31,684	CAFETERIA	11.00		0	14.00
15.00 Rental of quarters to employee and others	B	-4,575	RURAL HEALTH CLINIC	88.00		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	-20,278	MEDICAL RECORDS & LIBRARY	16.00		0	18.00
19.00 Nursing school (tuition, fees, books, etc.)		0		0.00		0	19.00
20.00 Vending machines		0		0.00		0	20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00		0	21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments	A	-9,981	INTEREST EXPENSE	113.00		0	22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00			23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00			24.00
25.00 Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00			25.00
26.00 Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00		0	26.00
26.01 Depreciation - CAP REL COSTS-BLDG & FIXT - EFM BLDG		0	CAP REL COSTS-BLDG & FIXT - EFM BLDG	1.01		0	26.01
27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00		0	27.00
28.00 Non-physician Anesthetist		0	NONPHYSICIAN ANESTHETISTS	19.00			28.00
29.00 Physicians' assistant		0		0.00		0	29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	67.00			30.00
30.99 Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00			30.99

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted					
			Cost Center		Line #	Wkst. A-7 Ref.		
			1.00	2.00	3.00	4.00	5.00	
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***		68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	A	-10,291	CAP REL COSTS-MVBLE EQUIP		2.00	9	32.00
33.00	ROTARY DUES	A	-967	OTHER ADMIN AND GENERAL		5.02	0	33.00
34.00	ROOM RENTAL INCOME	B	-210	OPERATION OF PLANT		7.00	0	34.00
35.00	INTEREST INCOME OFFSET	B	-732	OTHER ADMIN AND GENERAL		5.02	0	35.00
35.01	INTEREST INCOME OFFSET	B	-299	RADIOLOGY-DIAGNOSTIC		54.00	0	35.01
35.02	INTEREST INCOME OFFSET	B	-194	LABORATORY		60.00	0	35.02
36.00	PROVIDER TAX	A	-419,260	OTHER ADMIN AND GENERAL		5.02	0	36.00
37.00	ADVERTISING COSTS	A	-28,519	OTHER ADMIN AND GENERAL		5.02	0	37.00
38.00	TELEPHONE - DEPRECIATION	A	-1,808	CAP REL COSTS-MVBLE EQUIP		2.00	9	38.00
38.01	TELEPHONE - OPERATOR WAGES	A	-486	OTHER ADMIN AND GENERAL		5.02	0	38.01
38.02	TELEPHONE - OPERATOR BENEFITS	A	-101	EMPLOYEE BENEFITS DEPARTMENT		4.00	0	38.02
39.00	LOBBYING PORTION OF DUES	A	-5,921	OTHER ADMIN AND GENERAL		5.02	0	39.00
40.00	NON-RHC PROVIDER SALARIES	A	-359,972	RURAL HEALTH CLINIC		88.00	0	40.00
40.01	NON-RHC PROVIDER BENEFITS	A	-71,086	EMPLOYEE BENEFITS DEPARTMENT		4.00	0	40.01
41.00	RENTAL INCOME	B	-6,000	OPERATION OF PLANT		7.00	0	41.00
42.00	RECYCLING INCOME	B	-27	MAINTENANCE & REPAIRS		6.00	0	42.00
44.00	OTHER MISC. RECEIPTS	B	-1,409	OTHER ADMIN AND GENERAL		5.02	0	44.00
45.00	MOBILE HOME TEMP HOUSING RENTAL INCO	B	113	OPERATION OF PLANT		7.00	0	45.00
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		1,493,172					50.00

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS
 Provider CCN: 14-1324
 Period: From 04/01/2016 To 03/31/2017
 Worksheet A-8-1
 Date/Time Prepared: 7/26/2017 12:26 pm

Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5		
1.00	2.00	3.00	4.00	5.00		
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:						
1.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	DHS - HR/EMPLOYEE BENEFITS	584,410	0	1.00
2.00	5.02	OTHER ADMIN AND GENERAL	DHS - A&G	1,667,734	120,000	2.00
3.00	7.00	OPERATION OF PLANT	DHS - OPERATION PLANT	62,867	0	3.00
4.00	13.00	NURSING ADMINISTRATION	DHS - NURSING ADMIN	56,128	0	4.00
4.01	73.00	DRUGS CHARGED TO PATIENTS	DHS - PHARMACY	211,893	0	4.01
4.02	16.00	MEDICAL RECORDS & LIBRARY	DHS - MEDICAL RECORDS	45,712	0	4.02
4.03	5.02	OTHER ADMIN AND GENERAL	DHS - CASE MANAGEMENT	78,278	0	4.03
4.04	5.01	CASHIERING/ACCOUNTS RECEIVABLE	DEACONESS HOSPITAL - EPIC US	44,860	44,860	4.04
4.05	5.02	OTHER ADMIN AND GENERAL	DEACONESS HOSPITAL - SUPPLIE	3,270	3,270	4.05
4.06	16.00	MEDICAL RECORDS & LIBRARY	DEACONESS HOSPITAL - SUPPLIE	90	90	4.06
4.07	30.00	ADULTS & PEDIATRICS	DEACONESS HOSPITAL - SUPPLIE	2,127	2,127	4.07
4.08	50.00	OPERATING ROOM	DEACONESS HOSPITAL - SUPPLIE	635	635	4.08
4.09	54.00	RADIOLOGY-DIAGNOSTIC	DEACONESS HOSPITAL - SUPPLIE	45	45	4.09
4.10	88.00	RURAL HEALTH CLINIC	DEACONESS HOSPITAL - SUPPLIE	745	745	4.10
4.11	194.00	MARKETING	DEACONESS HOSPITAL - SUPPLIE	3,251	3,251	4.11
4.12	50.00	OPERATING ROOM	DRHS IL - PAIN MGT COVERAGE	97,618	97,618	4.12
4.13	91.00	EMERGENCY	DRHS IL - ER COVERAGE	749,250	749,250	4.13
4.14	5.02	OTHER ADMIN AND GENERAL	DRHS IL - C SUITE SALARY/BEN	393,410	393,410	4.14
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			4,002,323	1,415,301	5.00

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

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

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

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

6.00	B	0.00	DEACONESS HLTH	0.00	6.00
7.00	B	0.00	DEACONESS HOSP	0.00	7.00
8.00	B	0.00	DRHS IL	0.00	8.00
9.00		0.00		0.00	9.00
10.00		0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:				100.00

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS

Provider CCN: 14-1324

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

Worksheet A-8-1

Date/Time Prepared:
7/26/2017 12:26 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00	584,410	0		1.00
2.00	1,547,734	0		2.00
3.00	62,867	0		3.00
4.00	56,128	0		4.00
4.01	211,893	0		4.01
4.02	45,712	0		4.02
4.03	78,278	0		4.03
4.04	0	0		4.04
4.05	0	0		4.05
4.06	0	0		4.06
4.07	0	0		4.07
4.08	0	0		4.08
4.09	0	0		4.09
4.10	0	0		4.10
4.11	0	0		4.11
4.12	0	0		4.12
4.13	0	0		4.13
4.14	0	0		4.14
5.00	2,587,022			5.00

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

Related Organization(s) and/or Home Office	Type of Business		
	6.00		

B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:

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

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

6.00	HOME OFFICE		6.00
7.00	HOSPITAL		7.00
8.00	PROF SVS CO		8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 14-1324

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

Worksheet A-8-2

Date/Time Prepared:
7/26/2017 12:26 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	91.00	EMERGENCY	988,741	0	988,741	0	0	1.00
2.00	91.00	EMERGENCY	99,060	99,060	0	0	0	2.00
3.00	0.00		0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			1,087,801	99,060	988,741			200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	91.00	EMERGENCY	0	0	0	0	0	1.00
2.00	91.00	EMERGENCY	0	0	0	0	0	2.00
3.00	0.00		0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	91.00	EMERGENCY	0	0	0	0		1.00
2.00	91.00	EMERGENCY	0	0	0	99,060		2.00
3.00	0.00		0	0	0	0		3.00
4.00	0.00		0	0	0	0		4.00
5.00	0.00		0	0	0	0		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	99,060		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 14-1324		Period: From 04/01/2016 To 03/31/2017		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 7/26/2017 12:26 pm	
		Physical Therapy		Cost			
				1.00			
PART I - GENERAL INFORMATION							
1.00	Total number of weeks worked (excluding aides) (see instructions)					52	1.00
2.00	Line 1 multiplied by 15 hours per week					780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					260	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)					127	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					5.39	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	2,377.48	2,067.51	467.64	0.00	0.00	9.00
10.00	AHSEA (see instructions)	80.20	80.20	60.15	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	40.10	40.10	30.08			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01
						1.00	
Part II - SALARY EQUIVALENCY COMPUTATION							
14.00	Supervisors (column 1, line 9 times column 1, line 10)					190,674	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					165,814	15.00
16.00	Assistants (column 3, line 9 times column 3, line 10)					28,129	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					384,617	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)					384,617	20.00
If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.							
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)					0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					0	22.00
23.00	Total salary equivalency (see instructions)					384,617	23.00
PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE							
Standard Travel Allowance							
24.00	Therapists (line 3 times column 2, line 11)					10,426	24.00
25.00	Assistants (line 4 times column 3, line 11)					3,820	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					14,246	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)					2,086	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					16,332	28.00
Optional Travel Allowance and Optional Travel Expense							
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)					0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)					0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)					0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)					16,332	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
PART IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE							
Standard Travel Expense							
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00
Optional Travel Allowance and Optional Travel Expense							
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.							
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 14-1324				Period: From 04/01/2016 To 03/31/2017		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 7/26/2017 12:26 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				
PART V - OVERTIME COMPUTATION										
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00			
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00	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			
CALCULATION OF LIMIT										
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00			
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50 (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00			
DETERMINATION OF OVERTIME ALLOWANCE										
52.00	Adjusted hourly salary equivalency amount (see instructions)	80.20	60.15	0.00	0.00		52.00			
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00			
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00			
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00			
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00			
							1.00			
Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT										
57.00	Salary equivalency amount (from line 23)						384,617	57.00		
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))						16,332	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)						400,949	63.00		
64.00	Total cost of outside supplier services (from your records)						254,923	64.00		
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)						0	65.00		
LINE 33 CALCULATION										
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others						14,246	100.00		
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others						2,086	100.01		
100.02	Line 33 = line 28 = sum of lines 26 and 27						16,332	100.02		
LINE 34 CALCULATION										
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others						2,086	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						2,086	101.02		
LINE 35 CALCULATION										
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others						0	102.00		
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others						0	102.01		
102.02	Line 35 = sum of lines 31 and 32						0	102.02		

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 14-1324		Period: From 04/01/2016 To 03/31/2017		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 7/26/2017 12:26 pm	
				Occupational Therapy		Cost	
						1.00	
PART I - GENERAL INFORMATION							
1.00	Total number of weeks worked (excluding aides) (see instructions)					52	1.00
2.00	Line 1 multiplied by 15 hours per week					780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					260	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)					12	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					5.39	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	91.01	1,563.86	19.59	0.00	0.00	9.00
10.00	AHSEA (see instructions)	76.01	76.01	57.00	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)	38.01	38.01	28.50			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01
						1.00	
Part II - SALARY EQUIVALENCY COMPUTATION							
14.00	Supervisors (column 1, line 9 times column 1, line 10)					6,918	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					118,869	15.00
16.00	Assistants (column 3, line 9 times column 3, line 10)					1,117	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					126,904	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)					126,904	20.00
If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.							
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)					0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					0	22.00
23.00	Total salary equivalency (see instructions)					126,904	23.00
PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE							
Standard Travel Allowance							
24.00	Therapists (line 3 times column 2, line 11)					9,883	24.00
25.00	Assistants (line 4 times column 3, line 11)					342	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					10,225	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)					1,466	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					11,691	28.00
Optional Travel Allowance and Optional Travel Expense							
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)					0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)					0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)					0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)					11,691	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE							
Standard Travel Expense							
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00
Optional Travel Allowance and Optional Travel Expense							
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.							
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 14-1324		Period: From 04/01/2016 To 03/31/2017		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 7/26/2017 12:26 pm	
				Occupational Therapy		Cost	
						1.00	
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00
		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
PART V - OVERTIME COMPUTATION							
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
CALCULATION OF LIMIT							
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
DETERMINATION OF OVERTIME ALLOWANCE							
52.00	Adjusted hourly salary equivalency amount (see instructions)	76.01	57.00	0.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00
						1.00	
Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT							
57.00	Salary equivalency amount (from line 23)					126,904	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))					11,691	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)					138,595	63.00
64.00	Total cost of outside supplier services (from your records)					107,756	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)					0	65.00
LINE 33 CALCULATION							
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others					10,225	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others					1,466	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27					11,691	100.02
LINE 34 CALCULATION							
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others					1,466	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					1,466	101.02
LINE 35 CALCULATION							
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others					0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others					0	102.01
102.02	Line 35 = sum of lines 31 and 32					0	102.02

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 14-1324		Period: From 04/01/2016 To 03/31/2017		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 7/26/2017 12:26 pm	
		Speech Pathology		Cost			
				1.00			
PART I - GENERAL INFORMATION							
1.00	Total number of weeks worked (excluding aides) (see instructions)					20	1.00
2.00	Line 1 multiplied by 15 hours per week					300	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					45	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	125.48	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	73.04	0.00	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	36.52	36.52	0.00			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01
						1.00	
Part II - SALARY EQUIVALENCY COMPUTATION							
14.00	Supervisors (column 1, line 9 times column 1, line 10)					0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					9,165	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)					9,165	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)					9,165	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)					73.04	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					21,912	22.00
23.00	Total salary equivalency (see instructions)					21,912	23.00
PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE							
Standard Travel Allowance							
24.00	Therapists (line 3 times column 2, line 11)					1,643	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)					1,643	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)					242	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					1,885	28.00
Optional Travel Allowance and Optional Travel Expense							
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)					0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)					0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)					0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)					1,885	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE							
Standard Travel Expense							
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00
Optional Travel Allowance and Optional Travel Expense							
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.							
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 14-1324				Period: From 04/01/2016 To 03/31/2017		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 7/26/2017 12:26 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			
PART V - OVERTIME COMPUTATION									
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00		47.00	
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00	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	
CALCULATION OF LIMIT									
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00		50.00	
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50 (see instructions)	0.00	0.00	0.00	0.00	0.00		51.00	
DETERMINATION OF OVERTIME ALLOWANCE									
52.00	Adjusted hourly salary equivalency amount (see instructions)	73.04	0.00	0.00	0.00			52.00	
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0			53.00	
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0			54.00	
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0			55.00	
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0		56.00	
						1.00			
Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT									
57.00	Salary equivalency amount (from line 23)					21,912		57.00	
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35)					1,885		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)					23,797		63.00	
64.00	Total cost of outside supplier services (from your records)					9,570		64.00	
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)					0		65.00	
LINE 33 CALCULATION									
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others					1,643		100.00	
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others					242		100.01	
100.02	Line 33 = line 28 = sum of lines 26 and 27					1,885		100.02	
LINE 34 CALCULATION									
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others					242		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					242		101.02	
LINE 35 CALCULATION									
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others					0		102.00	
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others					0		102.01	
102.02	Line 35 = sum of lines 31 and 32					0		102.02	

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1324

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

Worksheet B
Part I
Date/Time Prepared:
7/26/2017 12:26 pm

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT	
		BLDG & FIXT	BLDG & FIXT - EFM BLDG	MVBLE EQUIP		
		1.00	1.01	2.00		
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	239,461	239,461			1.00
1.01 00101	CAP REL COSTS-BLDG & FIXT - EFM BLDG	43,695	0	43,695		1.01
2.00 00200	CAP REL COSTS-MVBLE EQUIP	521,751			521,751	2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	2,330,303	1,430	0	2,907	2,334,640
5.01 00580	CASHIERING/ACCOUNTS RECEIVABLE	1,267,491	4,827	643	10,328	394,147
5.02 00591	OTHER ADMIN AND GENERAL	3,603,446	61,915	11,172	134,801	139,228
6.00 00600	MAINTENANCE & REPAIRS	308,801	6,354	0	12,921	74,036
7.00 00700	OPERATION OF PLANT	278,176	44,662	1,296	91,856	0
8.00 00800	LAUNDRY & LINEN SERVICE	66,685	4,681	0	9,520	28,102
9.00 00900	HOUSEKEEPING	185,713	984	293	2,234	96,718
10.00 01000	DIETARY	152,478	6,283	0	12,778	48,930
11.00 01100	CAFETERIA	134,526	2,546	2,288	6,999	53,352
13.00 01300	NURSING ADMINISTRATION	159,646	1,703	0	3,464	14,265
16.00 01600	MEDICAL RECORDS & LIBRARY	299,608	10,598	0	21,553	116,975
19.00 01900	NONPHYSICIAN ANESTHETISTS	238,411	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	1,285,874	21,131	0	42,972	402,421
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	755,985	14,106	0	28,687	111,126
53.00 05300	ANESTHESIOLOGY	6,308	0	0	0	0
54.00 05400	RADIOLOGY-DIAGNOSTIC	1,036,850	12,332	0	25,079	129,100
60.00 06000	LABORATORY	864,445	5,590	2,480	13,343	153,921
64.00 06400	INTRAVENOUS THERAPY	0	0	0	0	0
65.00 06500	RESPIRATORY THERAPY	352,938	4,351	0	8,847	84,450
66.00 06600	PHYSICAL THERAPY	486,989	6,402	0	13,020	0
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	142,843	0	0	0	0
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0
73.00 07300	DRUGS CHARGED TO PATIENTS	1,000,322	3,031	0	6,164	43,081
OUTPATIENT SERVICE COST CENTERS						
88.00 08800	RURAL HEALTH CLINIC	2,718,034	20,138	25,523	61,267	358,769
90.00 09000	CLINIC	0	0	0	0	0
91.00 09100	EMERGENCY	1,521,959	6,093	0	12,392	86,019
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					
118.00	SUBTOTALS (SUM OF LINES 1-117)	20,002,738	239,157	43,695	521,132	2,334,640
NONREIMBURSABLE COST CENTERS						
192.00 19200	PHYSICIANS' PRIVATE OFFICES	10,407	304	0	619	0
194.00 07950	MARKETING	7,283	0	0	0	0
194.01 07951	340B	164,364	0	0	0	0
200.00	Cross Foot Adjustments					
201.00	Negative Cost Centers		0	0	0	0
202.00	TOTAL (sum lines 118-201)	20,184,792	239,461	43,695	521,751	2,334,640

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1324

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

Worksheet B
Part I
Date/Time Prepared:
7/26/2017 12:26 pm

Cost Center Description		CASHIERING/ACCOUNTS RECEIVABLE	Subtotal	OTHER ADMIN AND GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT		
		5.01	5A.01	5.02	6.00	7.00		
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00	
1.01	00101	CAP REL COSTS-BLDG & FIXT - EFM BLDG					1.01	
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00	
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00	
5.01	00580	CASHIERING/ACCOUNTS RECEIVABLE	1,677,436				5.01	
5.02	00591	OTHER ADMIN AND GENERAL	0	3,950,562	3,950,562		5.02	
6.00	00600	MAINTENANCE & REPAIRS	0	402,112	97,853	499,965	6.00	
7.00	00700	OPERATION OF PLANT	0	415,990	101,230	127,288	7.00	
8.00	00800	LAUNDRY & LINEN SERVICE	0	108,988	26,522	13,193	8.00	
9.00	00900	HOUSEKEEPING	0	285,942	69,583	3,096	9.00	
10.00	01000	DIETARY	0	220,469	53,651	17,706	10.00	
11.00	01100	CAFETERIA	0	199,711	48,599	9,699	11.00	
13.00	01300	NURSING ADMINISTRATION	0	179,078	43,578	4,800	13.00	
16.00	01600	MEDICAL RECORDS & LIBRARY	0	448,734	109,199	29,867	16.00	
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	238,411	58,017	0	19.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	154,063	1,906,461	463,933	59,547	102,981	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	146,135	1,056,039	256,985	39,752	68,747	50.00
53.00	05300	ANESTHESIOLOGY	40,366	46,674	11,358	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	388,697	1,592,058	387,424	34,753	60,103	54.00
60.00	06000	LABORATORY	273,469	1,313,248	319,576	18,490	31,976	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	52,311	502,897	122,379	12,260	21,203	65.00
66.00	06600	PHYSICAL THERAPY	87,638	594,049	144,561	18,042	31,202	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	69,988	212,831	51,792	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	128,325	1,180,923	287,375	8,542	14,773	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	202,563	3,386,294	824,044	84,900	146,827	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	133,716	1,760,179	428,336	17,172	29,697	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,677,271	20,001,650	3,905,995	499,107	643,024	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	165	11,495	2,797	858	1,484	192.00
194.00	07950	MARKETING	0	7,283	1,772	0	0	194.00
194.01	07951	340B	0	164,364	39,998	0	0	194.01
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)	1,677,436	20,184,792	3,950,562	499,965	644,508	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1324

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

Worksheet B
Part I
Date/Time Prepared:
7/26/2017 12:26 pm

Cost Center Description		LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
		8.00	9.00	10.00	11.00	13.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
1.01	00101						1.01
2.00	00200						2.00
4.00	00400						4.00
5.01	00580						5.01
5.02	00591						5.02
6.00	00600						6.00
7.00	00700						7.00
8.00	00800	171,518					8.00
9.00	00900	32,009	395,984				9.00
10.00	01000	1,322	19,673	343,442			10.00
11.00	01100	0	10,776	0	285,558		11.00
13.00	01300	0	5,333	0	2,772	243,861	13.00
16.00	01600	0	33,185	0	22,721	0	16.00
19.00	01900	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	89,112	66,163	343,442	78,194	134,963	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	23,397	44,169	0	21,600	37,283	50.00
53.00	05300	0	0	0	0	0	53.00
54.00	05400	11,502	38,615	0	25,095	0	54.00
60.00	06000	118	20,544	0	29,907	0	60.00
64.00	06400	0	0	0	0	0	64.00
65.00	06500	0	13,622	0	16,401	28,308	65.00
66.00	06600	3,901	20,046	0	0	0	66.00
71.00	07100	0	0	0	0	0	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	9,491	0	8,374	14,454	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	4,585	94,335	0	63,778	0	88.00
90.00	09000	0	0	0	0	0	90.00
91.00	09100	5,572	19,079	0	16,716	28,853	91.00
92.00	09200						92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		171,518	395,031	343,442	285,558	243,861	118.00
NONREIMBURSABLE COST CENTERS							
192.00	19200	0	953	0	0	0	192.00
194.00	07950	0	0	0	0	0	194.00
194.01	07951	0	0	0	0	0	194.01
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		171,518	395,984	343,442	285,558	243,861	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1324

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

Worksheet B
Part I
Date/Time Prepared:
7/26/2017 12:26 pm

Cost Center Description		MEDICAL RECORDS & LIBRARY	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		16.00	19.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - EFM BLDG					1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00580	CASHIERING/ACCOUNTS RECEIVABLE					5.01
5.02	00591	OTHER ADMIN AND GENERAL					5.02
6.00	00600	MAINTENANCE & REPAIRS					6.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	695,358				16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	296,428			19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	63,870	0	3,308,666	-24,242	3,284,424
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	60,583	0	1,608,555	0	1,608,555
53.00	05300	ANESTHESIOLOGY	16,735	296,428	371,195	0	371,195
54.00	05400	RADIOLOGY-DIAGNOSTIC	161,155	0	2,310,705	0	2,310,705
60.00	06000	LABORATORY	113,371	0	1,847,230	0	1,847,230
64.00	06400	INTRAVENOUS THERAPY	0	0	0	22,392	22,392
65.00	06500	RESPIRATORY THERAPY	21,687	0	738,757	1,850	740,607
66.00	06600	PHYSICAL THERAPY	36,332	0	848,133	0	848,133
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	29,015	0	293,638	0	293,638
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	53,199	0	1,577,131	0	1,577,131
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	83,976	0	4,688,739	0	4,688,739
90.00	09000	CLINIC	0	0	0	0	0
91.00	09100	EMERGENCY	55,435	0	2,361,039	0	2,361,039
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0	
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					
118.00		SUBTOTALS (SUM OF LINES 1-117)	695,358	296,428	19,953,788	0	19,953,788
NONREIMBURSABLE COST CENTERS							
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	17,587	0	17,587
194.00	07950	MARKETING	0	0	9,055	0	9,055
194.01	07951	340B	0	0	204,362	0	204,362
200.00		Cross Foot Adjustments			0	0	0
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118-201)	695,358	296,428	20,184,792	0	20,184,792

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1324

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

Worksheet B
Part II
Date/Time Prepared:
7/26/2017 12:26 pm

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS			Subtotal	
		BLDG & FIXT	BLDG & FIXT - EFM BLDG	MVBLE EQUIP		
		1.00	1.01	2.00		
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT					1.00
1.01 00101	CAP REL COSTS-BLDG & FIXT - EFM BLDG					1.01
2.00 00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	1,430	0	2,907	4,337 4.00
5.01 00580	CASHIERING/ACCOUNTS RECEIVABLE	0	4,827	643	10,328	15,798 5.01
5.02 00591	OTHER ADMIN AND GENERAL	0	61,915	11,172	134,801	207,888 5.02
6.00 00600	MAINTENANCE & REPAIRS	0	6,354	0	12,921	19,275 6.00
7.00 00700	OPERATION OF PLANT	0	44,662	1,296	91,856	137,814 7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	4,681	0	9,520	14,201 8.00
9.00 00900	HOUSEKEEPING	0	984	293	2,234	3,511 9.00
10.00 01000	DIETARY	0	6,283	0	12,778	19,061 10.00
11.00 01100	CAFETERIA	0	2,546	2,288	6,999	11,833 11.00
13.00 01300	NURSING ADMINISTRATION	0	1,703	0	3,464	5,167 13.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	10,598	0	21,553	32,151 16.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0 19.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	301	21,131	0	42,972	64,404 30.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	0	14,106	0	28,687	42,793 50.00
53.00 05300	ANESTHESIOLOGY	0	0	0	0	0 53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	11,009	12,332	0	25,079	48,420 54.00
60.00 06000	LABORATORY	7,125	5,590	2,480	13,343	28,538 60.00
64.00 06400	INTRAVENOUS THERAPY	0	0	0	0	0 64.00
65.00 06500	RESPIRATORY THERAPY	0	4,351	0	8,847	13,198 65.00
66.00 06600	PHYSICAL THERAPY	0	6,402	0	13,020	19,422 66.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0 71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0 72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	3,031	0	6,164	9,195 73.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800	RURAL HEALTH CLINIC	0	20,138	25,523	61,267	106,928 88.00
90.00 09000	CLINIC	0	0	0	0	0 90.00
91.00 09100	EMERGENCY	0	6,093	0	12,392	18,485 91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					0 92.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					
118.00	SUBTOTALS (SUM OF LINES 1-117)	18,435	239,157	43,695	521,132	822,419 118.00
NONREIMBURSABLE COST CENTERS						
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	304	0	619	923 192.00
194.00 07950	MARKETING	0	0	0	0	0 194.00
194.01 07951	340B	0	0	0	0	0 194.01
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)	18,435	239,461	43,695	521,751	823,342 202.00

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 14-1324		Period: From 04/01/2016 To 03/31/2017		Worksheet B Part II Date/Time Prepared: 7/26/2017 12:26 pm	
Cost Center Description			EMPLOYEE BENEFITS DEPARTMENT	CASHIERING/ACCOUNTS RECEIVABLE	OTHER ADMIN AND GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	
			4.00	5.01	5.02	6.00	7.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - EFM BLDG						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4,337					4.00
5.01	00580	CASHIERING/ACCOUNTS RECEIVABLE	732	16,530				5.01
5.02	00591	OTHER ADMIN AND GENERAL	259	0	208,147			5.02
6.00	00600	MAINTENANCE & REPAIRS	138	0	5,155	24,568		6.00
7.00	00700	OPERATION OF PLANT	0	0	5,333	6,254	149,401	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	52	0	1,397	648	5,289	8.00
9.00	00900	HOUSEKEEPING	180	0	3,666	152	1,241	9.00
10.00	01000	DIETARY	91	0	2,827	870	7,098	10.00
11.00	01100	CAFETERIA	99	0	2,560	477	3,888	11.00
13.00	01300	NURSING ADMINISTRATION	27	0	2,296	236	1,924	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	217	0	5,753	1,468	11,973	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	3,057	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	747	1,518	24,443	2,926	23,872	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	206	1,440	13,539	1,953	15,936	50.00
53.00	05300	ANESTHESIOLOGY	0	398	598	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	240	3,828	20,412	1,708	13,932	54.00
60.00	06000	LABORATORY	286	2,695	16,837	909	7,412	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	157	516	6,448	602	4,915	65.00
66.00	06600	PHYSICAL THERAPY	0	864	7,616	887	7,233	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	690	2,729	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	80	1,265	15,141	420	3,424	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	666	1,996	43,426	4,172	34,036	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	160	1,318	22,567	844	6,884	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	4,337	16,528	205,800	24,526	149,057	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	2	147	42	344	192.00
194.00	07950	MARKETING	0	0	93	0	0	194.00
194.01	07951	340B	0	0	2,107	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	4,337	16,530	208,147	24,568	149,401	202.00

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 14-1324	Period: From 04/01/2016 To 03/31/2017	Worksheet B Part II Date/Time Prepared: 7/26/2017 12:26 pm		
Cost Center Description			LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION
			8.00	9.00	10.00	11.00	13.00
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - EFM BLDG					1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00580	CASHIERING/ACCOUNTS RECEIVABLE					5.01
5.02	00591	OTHER ADMIN AND GENERAL					5.02
6.00	00600	MAINTENANCE & REPAIRS					6.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	21,587				8.00
9.00	00900	HOUSEKEEPING	4,029	12,779			9.00
10.00	01000	DIETARY	166	635	30,748		10.00
11.00	01100	CAFETERIA	0	348	0	19,205	11.00
13.00	01300	NURSING ADMINISTRATION	0	172	0	186	10,008
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,071	0	1,528	0
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	11,215	2,135	30,748	5,260	5,539
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	2,945	1,425	0	1,453	1,530
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,448	1,246	0	1,688	0
60.00	06000	LABORATORY	15	663	0	2,011	0
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	0	440	0	1,103	1,162
66.00	06600	PHYSICAL THERAPY	491	647	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	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	306	0	563	593
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	577	3,044	0	4,289	0
90.00	09000	CLINIC	0	0	0	0	0
91.00	09100	EMERGENCY	701	616	0	1,124	1,184
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					
118.00		SUBTOTALS (SUM OF LINES 1-117)	21,587	12,748	30,748	19,205	10,008
NONREIMBURSABLE COST CENTERS							
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	31	0	0	0
194.00	07950	MARKETING	0	0	0	0	0
194.01	07951	340B	0	0	0	0	0
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118-201)	21,587	12,779	30,748	19,205	10,008

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1324

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

Worksheet B
Part II
Date/Time Prepared:
7/26/2017 12:26 pm

Cost Center Description		MEDICAL RECORDS & LIBRARY	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		16.00	19.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - EFM BLDG					1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00580	CASHIERING/ACCOUNTS RECEIVABLE					5.01
5.02	00591	OTHER ADMIN AND GENERAL					5.02
6.00	00600	MAINTENANCE & REPAIRS					6.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	54,161				16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	3,057			19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	4,974	177,781	0	177,781	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	4,718	87,938	0	87,938	50.00
53.00	05300	ANESTHESIOLOGY	1,303	2,299	0	2,299	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	12,557	105,479	0	105,479	54.00
60.00	06000	LABORATORY	8,830	68,196	0	68,196	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	1,689	30,230	0	30,230	65.00
66.00	06600	PHYSICAL THERAPY	2,830	39,990	0	39,990	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,260	5,679	0	5,679	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,143	35,130	0	35,130	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	6,540	205,674	0	205,674	88.00
90.00	09000	CLINIC	0	0	0	0	90.00
91.00	09100	EMERGENCY	4,317	58,200	0	58,200	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0		92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	54,161	0	816,596	0	816,596
NONREIMBURSABLE COST CENTERS							
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	1,489	0	1,489	192.00
194.00	07950	MARKETING	0	93	0	93	194.00
194.01	07951	340B	0	2,107	0	2,107	194.01
200.00		Cross Foot Adjustments		3,057	0	3,057	200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	54,161	3,057	0	823,342	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1324

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

Worksheet B-1

Date/Time Prepared:
7/26/2017 12:26 pm

Cost Center Description	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT (FTES)	CASHIERING/ACCOUNTS RECEIVABLE (GROSS CHARGES)	
	BLDG & FIXT (SQUARE FEET)	BLDG & FIXT - EFM BLDG (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)			
	1.00	1.01	2.00			
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	54,271				1.00
1.01 00101	CAP REL COSTS-BLDG & FIXT - EFM BLDG	0	3,876			1.01
2.00 00200	CAP REL COSTS-MVBLE EQUIP			58,147		2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	324	0	324	16,366	4.00
5.01 00580	CASHIERING/ACCOUNTS RECEIVABLE	1,094	57	1,151	2,763	45,171,875
5.02 00591	OTHER ADMIN AND GENERAL	14,032	991	15,023	976	0
6.00 00600	MAINTENANCE & REPAIRS	1,440	0	1,440	519	0
7.00 00700	OPERATION OF PLANT	10,122	115	10,237	0	0
8.00 00800	LAUNDRY & LINEN SERVICE	1,061	0	1,061	197	0
9.00 00900	HOUSEKEEPING	223	26	249	678	0
10.00 01000	DIETARY	1,424	0	1,424	343	0
11.00 01100	CAFETERIA	577	203	780	374	0
13.00 01300	NURSING ADMINISTRATION	386	0	386	100	0
16.00 01600	MEDICAL RECORDS & LIBRARY	2,402	0	2,402	820	0
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	4,789	0	4,789	2,821	4,148,719
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	3,197	0	3,197	779	3,935,246
53.00 05300	ANESTHESIOLOGY	0	0	0	0	1,087,020
54.00 05400	RADIOLOGY-DIAGNOSTIC	2,795	0	2,795	905	10,467,707
60.00 06000	LABORATORY	1,267	220	1,487	1,079	7,364,176
64.00 06400	INTRAVENOUS THERAPY	0	0	0	0	0
65.00 06500	RESPIRATORY THERAPY	986	0	986	592	1,408,676
66.00 06600	PHYSICAL THERAPY	1,451	0	1,451	0	2,359,984
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	1,884,695
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0
73.00 07300	DRUGS CHARGED TO PATIENTS	687	0	687	302	3,455,626
OUTPATIENT SERVICE COST CENTERS						
88.00 08800	RURAL HEALTH CLINIC	4,564	2,264	6,828	2,515	5,454,770
90.00 09000	CLINIC	0	0	0	0	0
91.00 09100	EMERGENCY	1,381	0	1,381	603	3,600,820
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					
118.00	SUBTOTALS (SUM OF LINES 1-117)	54,202	3,876	58,078	16,366	45,167,439
NONREIMBURSABLE COST CENTERS						
192.00 19200	PHYSICIANS' PRIVATE OFFICES	69	0	69	0	4,436
194.00 07950	MARKETING	0	0	0	0	0
194.01 07951	340B	0	0	0	0	0
200.00	Cross Foot Adjustments					
201.00	Negative Cost Centers					
202.00	Cost to be allocated (per Wkst. B, Part I)	239,461	43,695	521,751	2,334,640	1,677,436
203.00	Unit cost multiplier (Wkst. B, Part I)	4.412320	11.273220	8.972965	142.651839	0.037135
204.00	Cost to be allocated (per Wkst. B, Part II)				4,337	16,530
205.00	Unit cost multiplier (Wkst. B, Part II)				0.265001	0.000366

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1324

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

Worksheet B-1

Date/Time Prepared:
7/26/2017 12:26 pm

Cost Center Description		Reconciliation	OTHER ADMIN AND GENERAL (ACCUM. COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	
		5A.02	5.02	6.00	7.00	8.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - EFM BLDG					1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00580	CASHIERING/ACCOUNTS RECEIVABLE					5.01
5.02	00591	OTHER ADMIN AND GENERAL	-3,950,562	16,234,230			5.02
6.00	00600	MAINTENANCE & REPAIRS	0	402,112	40,209		6.00
7.00	00700	OPERATION OF PLANT	0	415,990	10,237	29,972	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	108,988	1,061	1,061	107,548
9.00	00900	HOUSEKEEPING	0	285,942	249	249	20,071
10.00	01000	DIETARY	0	220,469	1,424	1,424	829
11.00	01100	CAFETERIA	0	199,711	780	780	0
13.00	01300	NURSING ADMINISTRATION	0	179,078	386	386	0
16.00	01600	MEDICAL RECORDS & LIBRARY	0	448,734	2,402	2,402	0
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	238,411	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	1,906,461	4,789	4,789	55,876
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	1,056,039	3,197	3,197	14,671
53.00	05300	ANESTHESIOLOGY	0	46,674	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,592,058	2,795	2,795	7,212
60.00	06000	LABORATORY	0	1,313,248	1,487	1,487	74
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	0	502,897	986	986	0
66.00	06600	PHYSICAL THERAPY	0	594,049	1,451	1,451	2,446
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	212,831	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,180,923	687	687	0
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	3,386,294	6,828	6,828	2,875
90.00	09000	CLINIC	0	0	0	0	0
91.00	09100	EMERGENCY	0	1,760,179	1,381	1,381	3,494
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					
118.00		SUBTOTALS (SUM OF LINES 1-117)	-3,950,562	16,051,088	40,140	29,903	107,548
NONREIMBURSABLE COST CENTERS							
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	11,495	69	69	0
194.00	07950	MARKETING	0	7,283	0	0	0
194.01	07951	340B	0	164,364	0	0	0
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers					
202.00		Cost to be allocated (per Wkst. B, Part I)		3,950,562	499,965	644,508	171,518
203.00		Unit cost multiplier (Wkst. B, Part I)		0.243348	12.434157	21.503670	1.594804
204.00		Cost to be allocated (per Wkst. B, Part II)		208,147	24,568	149,401	21,587
205.00		Unit cost multiplier (Wkst. B, Part II)		0.012821	0.611007	4.984686	0.200720

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1324

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

Worksheet B-1

Date/Time Prepared:
7/26/2017 12:26 pm

Cost Center Description		HOUSEKEEPING (SQUARE FEET)	DIETARY (TOTAL PATIENT DAYS)	CAFETERIA (HOURS)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	
		9.00	10.00	11.00	13.00	16.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
1.01	00101						1.01
2.00	00200						2.00
4.00	00400						4.00
5.01	00580						5.01
5.02	00591						5.02
6.00	00600						6.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900	28,662					9.00
10.00	01000	1,424	2,119				10.00
11.00	01100	780	0	214,283			11.00
13.00	01300	386	0	2,080	106,021		13.00
16.00	01600	2,402	0	17,050	0	45,167,439	16.00
19.00	01900	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	4,789	2,119	58,677	58,677	4,148,719	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	3,197	0	16,209	16,209	3,935,246	50.00
53.00	05300	0	0	0	0	1,087,020	53.00
54.00	05400	2,795	0	18,831	0	10,467,707	54.00
60.00	06000	1,487	0	22,442	0	7,364,176	60.00
64.00	06400	0	0	0	0	0	64.00
65.00	06500	986	0	12,307	12,307	1,408,676	65.00
66.00	06600	1,451	0	0	0	2,359,984	66.00
71.00	07100	0	0	0	0	1,884,695	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	687	0	6,284	6,284	3,455,626	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	6,828	0	47,859	0	5,454,770	88.00
90.00	09000	0	0	0	0	0	90.00
91.00	09100	1,381	0	12,544	12,544	3,600,820	91.00
92.00	09200						92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		28,593	2,119	214,283	106,021	45,167,439	118.00
NONREIMBURSABLE COST CENTERS							
192.00	19200	69	0	0	0	0	192.00
194.00	07950	0	0	0	0	0	194.00
194.01	07951	0	0	0	0	0	194.01
200.00							200.00
201.00							201.00
202.00		395,984	343,442	285,558	243,861	695,358	202.00
203.00		13.815644	162.077395	1.332621	2.300120	0.015395	203.00
204.00		12,779	30,748	19,205	10,008	54,161	204.00
205.00		0.445852	14.510618	0.089624	0.094396	0.001199	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1324

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

Worksheet B-1

Date/Time Prepared:
7/26/2017 12:26 pm

Cost Center Description		NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	
		19.00	
GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT	1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - EFM BLDG	1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4.00
5.01	00580	CASHIERING/ACCOUNTS RECEIVABLE	5.01
5.02	00591	OTHER ADMIN AND GENERAL	5.02
6.00	00600	MAINTENANCE & REPAIRS	6.00
7.00	00700	OPERATION OF PLANT	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	8.00
9.00	00900	HOUSEKEEPING	9.00
10.00	01000	DIETARY	10.00
11.00	01100	CAFETERIA	11.00
13.00	01300	NURSING ADMINISTRATION	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	19.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	30.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	50.00
53.00	05300	ANESTHESIOLOGY	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
60.00	06000	LABORATORY	60.00
64.00	06400	INTRAVENOUS THERAPY	64.00
65.00	06500	RESPIRATORY THERAPY	65.00
66.00	06600	PHYSICAL THERAPY	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	88.00
90.00	09000	CLINIC	90.00
91.00	09100	EMERGENCY	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	92.00
SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	118.00
NONREIMBURSABLE COST CENTERS			
192.00	19200	PHYSICIANS' PRIVATE OFFICES	192.00
194.00	07950	MARKETING	194.00
194.01	07951	340B	194.01
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)	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	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

	Description	Worksheet		Amount	
		Part	Line No.		
		1.00	2.00		
1.00	ADJ FOR EPO COSTS IN RENAL DIALYSIS	1	74.00	0	1.00
2.00	ADJ FOR EPO COSTS IN HOME PROGRAM	1	94.00	0	2.00
3.00	ADJ FOR ARANESP COSTS IN RENAL DIALYSIS	1	74.00	0	3.00
4.00	ADJ FOR ARANESP COSTS IN HOME PROGRAM	1	94.00	0	4.00
5.00	ADJ FOR ESA COSTS IN RENAL DIALYSIS	1	74.00	0	5.00
6.00	ADJ FOR ESA COSTS IN HOME PROGRAM	1	94.00	0	6.00
7.00	IV THERAPY	1	64.00	22,392	7.00
8.00	EKG	1	65.00	1,850	8.00
9.00	IV THERAPY & EKG	1	30.00	-24,242	9.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1324

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

Worksheet C
Part I
Date/Time Prepared:
7/26/2017 12:26 pm

Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		
				Total Costs	RCE Disallowance	
		1.00	2.00	3.00	4.00	5.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	3,284,424		3,284,424	0	0 30.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	1,608,555		1,608,555	0	0 50.00
53.00	05300 ANESTHESIOLOGY	371,195		371,195	0	0 53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	2,310,705		2,310,705	0	0 54.00
60.00	06000 LABORATORY	1,847,230		1,847,230	0	0 60.00
64.00	06400 INTRAVENOUS THERAPY	22,392		22,392	0	0 64.00
65.00	06500 RESPIRATORY THERAPY	740,607	0	740,607	0	0 65.00
66.00	06600 PHYSICAL THERAPY	848,133	0	848,133	0	0 66.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	293,638		293,638	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	1,577,131		1,577,131	0	0 73.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC	4,688,739		4,688,739	0	0 88.00
90.00	09000 CLINIC	0		0	0	0 90.00
91.00	09100 EMERGENCY	2,361,039		2,361,039	0	0 91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	449,874		449,874	0	0 92.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300 INTEREST EXPENSE					113.00
200.00	Subtotal (see instructions)	20,403,662	0	20,403,662	0	0 200.00
201.00	Less Observation Beds	449,874		449,874		0 201.00
202.00	Total (see instructions)	19,953,788	0	19,953,788	0	0 202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1324

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

Worksheet C
Part I
Date/Time Prepared:
7/26/2017 12:26 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
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	3,165,538		3,165,538		30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	77,266	3,857,980	3,935,246	0.408756	50.00
53.00	05300	ANESTHESIOLOGY	50,170	1,036,850	1,087,020	0.341479	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	615,663	9,852,044	10,467,707	0.220746	54.00
60.00	06000	LABORATORY	843,995	6,520,181	7,364,176	0.250840	60.00
64.00	06400	INTRAVENOUS THERAPY	115,133	249,385	364,518	0.061429	64.00
65.00	06500	RESPIRATORY THERAPY	623,766	831,862	1,455,628	0.508789	65.00
66.00	06600	PHYSICAL THERAPY	601,949	1,758,035	2,359,984	0.359381	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	929,687	955,008	1,884,695	0.155801	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,519,772	1,935,854	3,455,626	0.456395	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	5,454,770	5,454,770		88.00
90.00	09000	CLINIC	0	0	0	0.000000	90.00
91.00	09100	EMERGENCY	106,068	3,494,752	3,600,820	0.655695	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	42,471	529,240	571,711	0.786891	92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (see instructions)	8,691,478	36,475,961	45,167,439		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	8,691,478	36,475,961	45,167,439		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 14-1324	Period: From 04/01/2016 To 03/31/2017	Worksheet C Part I Date/Time Prepared: 7/26/2017 12:26 pm
Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital Cost
	INPATIENT ROUTINE SERVICE COST CENTERS	11.00		
30.00	03000 ADULTS & PEDIATRICS			30.00
	ANCILLARY SERVICE COST CENTERS			
50.00	05000 OPERATING ROOM	0.000000		50.00
53.00	05300 ANESTHESIOLOGY	0.000000		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	06000 LABORATORY	0.000000		60.00
64.00	06400 INTRAVENOUS THERAPY	0.000000		64.00
65.00	06500 RESPIRATORY THERAPY	0.000000		65.00
66.00	06600 PHYSICAL THERAPY	0.000000		66.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000		73.00
	OUTPATIENT SERVICE COST CENTERS			
88.00	08800 RURAL HEALTH CLINIC			88.00
90.00	09000 CLINIC	0.000000		90.00
91.00	09100 EMERGENCY	0.000000		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
	SPECIAL PURPOSE COST CENTERS			
113.00	11300 INTEREST EXPENSE			113.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 14-1324	Period: From 04/01/2016 To 03/31/2017	Worksheet D Part II Date/Time Prepared: 7/26/2017 12:26 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	
Title XVIII Hospital Cost							
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	87,938	3,935,246	0.022346	12,209	273	50.00
53.00	05300 ANESTHESIOLOGY	2,299	1,087,020	0.002115	5,509	12	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	105,479	10,467,707	0.010077	310,460	3,129	54.00
60.00	06000 LABORATORY	68,196	7,364,176	0.009261	484,449	4,486	60.00
64.00	06400 INTRAVENOUS THERAPY	0	364,518	0.000000	79,569	0	64.00
65.00	06500 RESPIRATORY THERAPY	30,230	1,455,628	0.020768	362,021	7,518	65.00
66.00	06600 PHYSICAL THERAPY	39,990	2,359,984	0.016945	214,521	3,635	66.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	5,679	1,884,695	0.003013	577,106	1,739	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	35,130	3,455,626	0.010166	839,163	8,531	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	205,674	5,454,770	0.037705	0	0	88.00
90.00	09000 CLINIC	0	0	0.000000	0	0	90.00
91.00	09100 EMERGENCY	58,200	3,600,820	0.016163	7,107	115	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	24,351	571,711	0.042593	0	0	92.00
200.00	Total (lines 50-199)	663,166	42,001,901		2,892,114	29,438	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-1324	Period: From 04/01/2016 To 03/31/2017	Worksheet D Part IV Date/Time Prepared: 7/26/2017 12:26 pm
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Cost Center Description	Title XVIII				Hospital		Total Cost (sum of col 1 through col 4)	
	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Cost			
	1.00	2.00	3.00	4.00	5.00			
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	296,428	0	0	0	296,428	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	296,428	0	0	0	296,428	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-1324	Period: From 04/01/2016 To 03/31/2017	Worksheet D Part IV Date/Time Prepared: 7/26/2017 12:26 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	
		6.00	7.00	8.00	9.00	10.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	3,935,246	0.000000	0.000000	12,209	50.00
53.00	05300 ANESTHESIOLOGY	0	1,087,020	0.272698	0.000000	5,509	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	10,467,707	0.000000	0.000000	310,460	54.00
60.00	06000 LABORATORY	0	7,364,176	0.000000	0.000000	484,449	60.00
64.00	06400 INTRAVENOUS THERAPY	0	364,518	0.000000	0.000000	79,569	64.00
65.00	06500 RESPIRATORY THERAPY	0	1,455,628	0.000000	0.000000	362,021	65.00
66.00	06600 PHYSICAL THERAPY	0	2,359,984	0.000000	0.000000	214,521	66.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,884,695	0.000000	0.000000	577,106	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	0.000000	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	3,455,626	0.000000	0.000000	839,163	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	0	5,454,770	0.000000	0.000000	0	88.00
90.00	09000 CLINIC	0	0	0.000000	0.000000	0	90.00
91.00	09100 EMERGENCY	0	3,600,820	0.000000	0.000000	7,107	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	571,711	0.000000	0.000000	0	92.00
200.00	Total (lines 50-199)	0	42,001,901			2,892,114	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-1324	Period: From 04/01/2016 To 03/31/2017	Worksheet D Part IV Date/Time Prepared: 7/26/2017 12:26 pm
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Cost Center Description		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	Cost
		11.00	12.00	13.00	
Title XVIII Hospital					
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0	0	0	50.00
53.00	05300 ANESTHESIOLOGY	1,502	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	54.00
60.00	06000 LABORATORY	0	0	0	60.00
64.00	06400 INTRAVENOUS THERAPY	0	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	66.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0	0	0	88.00
90.00	09000 CLINIC	0	0	0	90.00
91.00	09100 EMERGENCY	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	92.00
200.00	Total (lines 50-199)	1,502	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 14-1324	Period: From 04/01/2016 To 03/31/2017	Worksheet D Part V Date/Time Prepared: 7/26/2017 12:26 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 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
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0.408756	0	1,329,491	0	0
53.00	05300 ANESTHESIOLOGY	0.341479	0	400,325	0	0
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.220746	0	3,441,901	0	0
60.00	06000 LABORATORY	0.250840	0	3,147,993	0	0
64.00	06400 INTRAVENOUS THERAPY	0.061429	0	130,481	0	0
65.00	06500 RESPIRATORY THERAPY	0.508789	0	385,830	0	0
66.00	06600 PHYSICAL THERAPY	0.359381	0	600,833	0	0
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.155801	0	507,966	0	0
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0
73.00	07300 DRUGS CHARGED TO PATIENTS	0.456395	0	1,070,714	25	0
OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC	0.000000				0
90.00	09000 CLINIC	0.000000	0	0	0	0
91.00	09100 EMERGENCY	0.655695	0	1,117,422	25	0
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.786891	0	266,335	0	0
200.00	Subtotal (see instructions)		0	12,399,291	50	0
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0	0
202.00	Net Charges (line 200 +/- line 201)		0	12,399,291	50	0

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 14-1324	Period: From 04/01/2016 To 03/31/2017	Worksheet D Part V Date/Time Prepared: 7/26/2017 12:26 pm
	Title XVIII	Hospital	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			
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	543,437	0	50.00
53.00	05300	ANESTHESIOLOGY	136,703	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	759,786	0	54.00
60.00	06000	LABORATORY	789,643	0	60.00
64.00	06400	INTRAVENOUS THERAPY	8,015	0	64.00
65.00	06500	RESPIRATORY THERAPY	196,306	0	65.00
66.00	06600	PHYSICAL THERAPY	215,928	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	79,142	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	488,669	11	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	88.00
90.00	09000	CLINIC	0	0	90.00
91.00	09100	EMERGENCY	732,688	16	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	209,577	0	92.00
200.00		Subtotal (see instructions)	4,159,894	27	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 +/- line 201)	4,159,894	27	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 14-1324 Component CCN: 14-Z324	Period: From 04/01/2016 To 03/31/2017	Worksheet D Part V Date/Time Prepared: 7/26/2017 12:26 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.)	
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0.408756	0	0	0	50.00
53.00	05300 ANESTHESIOLOGY	0.341479	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.220746	0	0	0	54.00
60.00	06000 LABORATORY	0.250840	0	0	0	60.00
64.00	06400 INTRAVENOUS THERAPY	0.061429	0	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0.508789	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.359381	0	0	0	66.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.155801	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.456395	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC	0.000000				88.00
90.00	09000 CLINIC	0.000000	0	0	0	90.00
91.00	09100 EMERGENCY	0.655695	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.786891	0	0	0	92.00
200.00	Subtotal (see instructions)		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	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 14-1324 Component CCN: 14-Z324	Period: From 04/01/2016 To 03/31/2017	Worksheet D Part V Date/Time Prepared: 7/26/2017 12:26 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			
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
60.00	06000	LABORATORY	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	88.00
90.00	09000	CLINIC	0	0	90.00
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
200.00		Subtotal (see instructions)	0	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	202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-1324	Period: From 04/01/2016 To 03/31/2017	Worksheet D-1 Date/Time Prepared: 7/26/2017 12:26 pm
Cost Center Description		Title XVIII	Hospital	Cost
		1.00		
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		3,214	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		2,555	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		2,119	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		467	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)		156	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		27	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)		9	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		1,476	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)		424	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)		141	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		147.52	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		147.52	20.00
21.00	Total general inpatient routine service cost (see instructions)		3,284,424	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)		3,983	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)		1,328	25.00
26.00	Total swing-bed cost (see instructions)		648,135	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		2,636,289	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		2,636,289	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,031.82	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		1,522,966	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)		1,522,966	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 14-1324	Period: From 04/01/2016 To 03/31/2017	Worksheet D-1 Date/Time Prepared: 7/26/2017 12:26 pm	
Cost Center Description			Title XVIII		Hospital	Cost
	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)				940,663	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)				2,463,629	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)				437,492	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)				145,487	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)				582,979	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)				436	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)				1,031.82	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)				449,874	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-1324		Period: From 04/01/2016 To 03/31/2017		Worksheet D-1 Date/Time Prepared: 7/26/2017 12:26 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	177,781	3,284,424	0.054129	449,874	24,351	90.00
91.00	Nursing School cost	0	3,284,424	0.000000	449,874	0	91.00
92.00	Allied health cost	0	3,284,424	0.000000	449,874	0	92.00
93.00	All other Medical Education	0	3,284,424	0.000000	449,874	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-1324	Period: From 04/01/2016 To 03/31/2017	Worksheet D-3 Date/Time Prepared: 7/26/2017 12:26 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	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		1,985,490		30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.408756	12,209	4,991	50.00
53.00	05300 ANESTHESIOLOGY	0.341479	5,509	1,881	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.220746	310,460	68,533	54.00
60.00	06000 LABORATORY	0.250840	484,449	121,519	60.00
64.00	06400 INTRAVENOUS THERAPY	0.061429	79,569	4,888	64.00
65.00	06500 RESPIRATORY THERAPY	0.508789	362,021	184,192	65.00
66.00	06600 PHYSICAL THERAPY	0.359381	214,521	77,095	66.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.155801	577,106	89,914	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.456395	839,163	382,990	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000 CLINIC	0.000000	0	0	90.00
91.00	09100 EMERGENCY	0.655695	7,107	4,660	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.786891	0	0	92.00
200.00	Total (sum of lines 50-94 and 96-98)		2,892,114	940,663	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)		2,892,114		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-1324 Component CCN: 14-Z324	Period: From 04/01/2016 To 03/31/2017	Worksheet D-3 Date/Time Prepared: 7/26/2017 12:26 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	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS			0	30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.408756	20	8	50.00
53.00	05300 ANESTHESIOLOGY	0.341479	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.220746	22,196	4,900	54.00
60.00	06000 LABORATORY	0.250840	64,616	16,208	60.00
64.00	06400 INTRAVENOUS THERAPY	0.061429	2,611	160	64.00
65.00	06500 RESPIRATORY THERAPY	0.508789	96,128	48,909	65.00
66.00	06600 PHYSICAL THERAPY	0.359381	298,938	107,433	66.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.155801	141,329	22,019	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.456395	245,458	112,026	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000 CLINIC	0.000000	0	0	90.00
91.00	09100 EMERGENCY	0.655695	599	393	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.786891	0	0	92.00
200.00	Total (sum of lines 50-94 and 96-98)		871,895	312,056	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)		871,895		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-1324	Period: From 04/01/2016 To 03/31/2017	Worksheet E Part B Date/Time Prepared: 7/26/2017 12:26 pm
		Title XVIII	Hospital	Cost
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)			4,159,921 1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)			0 2.00
3.00	PPS payments			0 3.00
4.00	Outlier payment (see instructions)			0 4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)			0.000 5.00
6.00	Line 2 times line 5			0 6.00
7.00	Sum of line 3 plus line 4 divided by line 6			0.00 7.00
8.00	Transitional corridor payment (see instructions)			0 8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200			0 9.00
10.00	Organ acquisitions			0 10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)			4,159,921 11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges			0 12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)			0 13.00
14.00	Total reasonable charges (sum of lines 12 and 13)			0 14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis			0 15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a 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)			4,201,520 21.00
22.00	Interns and residents (see instructions)			0 22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)			0 23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)			0 24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance (for CAH, see instructions)			42,467 25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)			1,824,634 26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)			2,334,419 27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)			0 28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)			0 29.00
30.00	Subtotal (sum of lines 27 through 29)			2,334,419 30.00
31.00	Primary payer payments			227 31.00
32.00	Subtotal (line 30 minus line 31)			2,334,192 32.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33.00	Composite rate ESRD (from Wkst. I-5, line 11)			0 33.00
34.00	Allowable bad debts (see instructions)			468,654 34.00
35.00	Adjusted reimbursable bad debts (see instructions)			304,625 35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			355,709 36.00
37.00	Subtotal (see instructions)			2,638,817 37.00
38.00	MSP-LCC reconciliation amount from PS&R			0 38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)			0 39.50
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)			0 39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION			0 39.99
40.00	Subtotal (see instructions)			2,638,817 40.00
40.01	Sequestration adjustment (see instructions)			52,776 40.01
41.00	Interim payments			2,043,594 41.00
42.00	Tentative settlement (for contractors use only)			0 42.00
43.00	Balance due provider/program (see instructions)			542,447 43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			0 44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)			0 90.00
91.00	Outlier reconciliation adjustment amount (see instructions)			0 91.00
92.00	The rate used to calculate the Time Value of Money			0.00 92.00
93.00	Time Value of Money (see instructions)			0 93.00
94.00	Total (sum of lines 91 and 93)			0 94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-1324

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

Worksheet E-1
Part I
Date/Time Prepared:
7/26/2017 12:26 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		1,884,179		2,105,479	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	03/07/2017	50,118	03/07/2017	82,003	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	09/27/2016	66,825	09/27/2016	131,682	3.50	
3.51		12/01/2016	30,144	12/01/2016	12,206	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)		-46,851		-61,885	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)		1,837,328		2,043,594	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		308,810		542,447	6.01	
6.02	SETTLEMENT TO PROGRAM		0		0	6.02	
7.00	Total Medicare program liability (see instructions)		2,146,138		2,586,041	7.00	
				Contractor Number	NPR Date (Mo/Day/Yr)		
		0		1.00	2.00		
8.00	Name of Contractor					8.00	

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-1324
Component CCN: 14-Z324

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

Worksheet E-1
Part I
Date/Time Prepared:
7/26/2017 12:26 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		794,427		0		1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0		2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)						3.00
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER		0		0		3.01
3.02			0		0		3.02
3.03			0		0		3.03
3.04			0		0		3.04
3.05			0		0		3.05
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM	09/27/2016	89,191		0		3.50
3.51		12/01/2012	34,573		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)		-123,764		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)		670,663		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		212,365		0		6.01
6.02	SETTLEMENT TO PROGRAM		0		0		6.02
7.00	Total Medicare program liability (see instructions)		883,028		0		7.00
				Contractor Number	NPR Date (Mo/Day/Yr)		
		0		1.00	2.00		
8.00	Name of Contractor						8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT		Provider CCN: 14-1324	Period: From 04/01/2016 To 03/31/2017	Worksheet E-1 Part II Date/Time Prepared: 7/26/2017 12:26 pm
		Title XVIII	Hospital	Cost
				1.00
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14			625 1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12			1,476 2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2			0 3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12			2,119 4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			45,167,439 5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20			105,797 6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168			1 7.00
8.00	Calculation of the HIT incentive payment (see instructions)			0 8.00
9.00	Sequestration adjustment amount (see instructions)			0 9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)			0 10.00
INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)			0 30.00
31.00	Other Adjustment (specify)			0 31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)			0 32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS		Provider CCN: 14-1324 Component CCN: 14-Z324	Period: From 04/01/2016 To 03/31/2017	Worksheet E-2 Date/Time Prepared: 7/26/2017 12:26 pm
		Title XVIII	Swing Beds - SNF	Cost
		Part A	Part B	
		1.00	2.00	
COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient routine services - swing bed-SNF (see instructions)	588,809	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)	315,177	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	565	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)	903,986	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	903,986	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)	903,986	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	2,937	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)	901,049	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)	901,049	0	19.00
19.01	Sequestration adjustment (see instructions)	18,021	0	19.01
20.00	Interim payments	670,663	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)	212,365	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: 14-1324	Period: From 04/01/2016 To 03/31/2017	Worksheet E-3 Part V Date/Time Prepared: 7/26/2017 12:26 pm
		Title XVIII	Hospital	Cost
				1.00
PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT				
1.00	Inpatient services			2,463,629 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)			2,463,629 4.00
5.00	Primary payer payments			1,772 5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)			2,486,493 6.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
7.00	Routine service charges			0 7.00
8.00	Ancillary service charges			0 8.00
9.00	Organ acquisition charges, net of revenue			0 9.00
10.00	Total reasonable charges			0 10.00
Customary charges				
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis			0 11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)			0 12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)			0.000000 13.00
14.00	Total customary charges (see instructions)			0 14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)			0 15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)			0 16.00
17.00	Cost of physicians' services in a teaching hospital (see instructions)			0 17.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)			0 18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)			2,486,493 19.00
20.00	Deductibles (exclude professional component)			363,608 20.00
21.00	Excess reasonable cost (from line 16)			0 21.00
22.00	Subtotal (line 19 minus line 20 and 21)			2,122,885 22.00
23.00	Coinsurance			3,871 23.00
24.00	Subtotal (line 22 minus line 23)			2,119,014 24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			109,112 25.00
26.00	Adjusted reimbursable bad debts (see instructions)			70,923 26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			79,377 27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)			2,189,937 28.00
29.00				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)			2,189,937 30.00
30.01	Sequestration adjustment (see instructions)			43,799 30.01
31.00	Interim payments			1,837,328 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)			308,810 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: 14-1324

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

Worksheet G

Date/Time Prepared:
7/26/2017 12:26 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	16,036	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	10,149,745	0	0	0	4.00
5.00	Other receivable	563,383	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-7,026,877	0	0	0	6.00
7.00	Inventory	217,999	0	0	0	7.00
8.00	Prepaid expenses	220,481	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	831,532	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	4,972,299	0	0	0	11.00
FIXED ASSETS						
12.00	Land	183,412	0	0	0	12.00
13.00	Land improvements	43,892	0	0	0	13.00
14.00	Accumulated depreciation	-40,462	0	0	0	14.00
15.00	Buildings	3,289,503	0	0	0	15.00
16.00	Accumulated depreciation	-1,341,627	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	4,655,902	0	0	0	23.00
24.00	Accumulated depreciation	-3,800,650	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	1,361,987	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	4,351,957	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	960,781	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	0	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	960,781	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	10,285,037	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	911,044	0	0	0	37.00
38.00	Salaries, wages, and fees payable	822,187	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	450,625	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	410,033	0	0	0	43.00
44.00	Other current liabilities	1,327,150	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	3,921,039	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	2,856,621	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	2,856,621	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	6,777,660	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	3,507,377				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	3,507,377	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	10,285,037	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-1324

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

Worksheet G-1

Date/Time Prepared:
7/26/2017 12:26 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		2,401,070		0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		1,106,307			2.00
3.00	Total (sum of line 1 and line 2)		3,507,377		0	3.00
4.00	Additions (credit adjustments) (specify)	0		0		4.00
5.00		0		0		5.00
6.00		0		0		6.00
7.00		0		0		7.00
8.00		0		0		8.00
9.00		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)		3,507,377		0	11.00
12.00	Deductions (debit adjustments) (specify)	0		0		12.00
13.00		0		0		13.00
14.00		0		0		14.00
15.00		0		0		15.00
16.00		0		0		16.00
17.00		0		0		17.00
18.00	Total deductions (sum of lines 12-17)		0		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		3,507,377		0	19.00
		Endowment Fund		Plant Fund		
		6.00	7.00	8.00		
1.00	Fund balances at beginning of period	0		0		1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)					2.00
3.00	Total (sum of line 1 and line 2)	0		0		3.00
4.00	Additions (credit adjustments) (specify)		0			4.00
5.00			0			5.00
6.00			0			6.00
7.00			0			7.00
8.00			0			8.00
9.00			0			9.00
10.00	Total additions (sum of line 4-9)	0		0		10.00
11.00	Subtotal (line 3 plus line 10)	0		0		11.00
12.00	Deductions (debit adjustments) (specify)		0			12.00
13.00			0			13.00
14.00			0			14.00
15.00			0			15.00
16.00			0			16.00
17.00			0			17.00
18.00	Total deductions (sum of lines 12-17)	0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0		19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 14-1324

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

Worksheet G-2
Parts I & II
Date/Time Prepared:
7/26/2017 12:26 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	2,852,446		2,852,446	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	295,987		295,987	5.00
6.00	Swing bed - NF	17,105		17,105	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)	3,165,538		3,165,538	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)	3,165,538		3,165,538	17.00
18.00	Ancillary services	5,377,401	26,997,199	32,374,600	18.00
19.00	Outpatient services	148,539	4,023,992	4,172,531	19.00
20.00	RURAL HEALTH CLINIC	0	5,454,770	5,454,770	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PROFESSIONAL FEES	0	4,436	4,436	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	8,691,478	36,480,397	45,171,875	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		18,691,620		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)		18,691,620		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-1324

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

Worksheet G-3

Date/Time Prepared:
7/26/2017 12:26 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	45,171,875	1.00
2.00	Less contractual allowances and discounts on patients' accounts	26,690,520	2.00
3.00	Net patient revenues (line 1 minus line 2)	18,481,355	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	18,691,620	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-210,265	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	4,168	6.00
7.00	Income from investments	11,414	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	782,570	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	31,684	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	20,278	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	10,672	22.00
23.00	Governmental appropriations	391,547	23.00
24.00	MISCELLANEOUS INCOME	64,239	24.00
25.00	Total other income (sum of lines 6-24)	1,316,572	25.00
26.00	Total (line 5 plus line 25)	1,106,307	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	1,106,307	29.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1324

Period: From 04/01/2016

Worksheet M-1

Component CCN: 14-8506

To 03/31/2017

Date/Time Prepared: 7/26/2017 12:26 pm

		RHC I		Cost			
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
FACILITY HEALTH CARE STAFF COSTS							
1.00	Physician	1,699,821	0	1,699,821	20,000	1,719,821	1.00
2.00	Physician Assistant	394,034	0	394,034	0	394,034	2.00
3.00	Nurse Practitioner	177,447	0	177,447	0	177,447	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	0	0	0	0	0	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	2,271,302	0	2,271,302	20,000	2,291,302	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	50,465	50,465	0	50,465	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	50,465	50,465	0	50,465	14.00
15.00	Medical Supplies	0	28,390	28,390	0	28,390	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	0	0	0	0	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	28,390	28,390	0	28,390	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	2,271,302	78,855	2,350,157	20,000	2,370,157	22.00
COSTS OTHER THAN RHC/FQHC SERVICES							
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
25.01	Telehealth	0	0	0	0	0	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs	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
FACILITY OVERHEAD							
29.00	Facility Costs	0	38,100	38,100	-38,100	0	29.00
30.00	Administrative Costs	591,913	120,511	712,424	0	712,424	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	591,913	158,611	750,524	-38,100	712,424	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	2,863,215	237,466	3,100,681	-18,100	3,082,581	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1324

Period: From 04/01/2016

Worksheet M-1

Component CCN: 14-8506

To 03/31/2017

Date/Time Prepared: 7/26/2017 12:26 pm

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	RHC I	Cost
		6.00	7.00		
FACILITY HEALTH CARE STAFF COSTS					
1.00	Physician	-359,972	1,359,849		1.00
2.00	Physician Assistant	0	394,034		2.00
3.00	Nurse Practitioner	0	177,447		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	0		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	0		9.00
10.00	Subtotal (sum of lines 1 through 9)	-359,972	1,931,330		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	50,465		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	50,465		14.00
15.00	Medical Supplies	0	28,390		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	0		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	28,390		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-359,972	2,010,185		22.00
COSTS OTHER THAN RHC/FQHC SERVICES					
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
25.01	Telehealth	0	0		25.01
25.02	Chronic Care Management	0	0		25.02
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs				27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0		28.00
FACILITY OVERHEAD					
29.00	Facility Costs	0	0		29.00
30.00	Administrative Costs	-4,575	707,849		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-4,575	707,849		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-364,547	2,718,034		32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 14-1324 Component CCN: 14-8506	Period: From 04/01/2016 To 03/31/2017	Worksheet M-2 Date/Time Prepared: 7/26/2017 12:26 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	
VISITS AND PRODUCTIVITY						
Positions						
1.00	Physician	4.06	14,262	4,200	17,052	1.00
2.00	Physician Assistant	4.93	13,114	2,100	10,353	2.00
3.00	Nurse Practitioner	0.00	0	2,100	0	3.00
4.00	Subtotal (sum of lines 1 through 3)	8.99	27,376		27,405	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)	8.99	27,376		27,405	8.00
9.00	Physician Services Under Agreements		0		0	9.00
					1.00	
DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)				2,010,185	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)				0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)				2,010,185	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)				707,849	14.00
15.00	Parent provider overhead allocated to facility (see instructions)				1,970,705	15.00
16.00	Total overhead (sum of lines 14 and 15)				2,678,554	16.00
17.00	Allowable GME overhead (see instructions)				0	17.00
18.00	Enter the amount from line 16				2,678,554	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)				2,678,554	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)				4,688,739	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 14-1324 Component CCN: 14-8506	Period: From 04/01/2016 To 03/31/2017	Worksheet M-3 Date/Time Prepared: 7/26/2017 12:26 pm
		Title XVIII	RHC I	Cost
		1.00		
DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES				
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)		4,688,739	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)		163,042	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		4,525,697	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		27,405	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)		27,405	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		165.14	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)	0.00	0.00	8.00
9.00	Rate for Program covered visits (see instructions)	165.14	165.14	9.00
CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	0	8,340	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	1,377,268	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	1,377,268	16.00
16.01	Total program charges (see instructions)(from contractor's records)		995,054	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		0	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		0	16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)		1,005,783	16.04
16.05	Total program cost (see instructions)	0	1,005,783	16.05
17.00	Primary payer amounts		952	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		120,039	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		211,698	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		1,004,831	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		91,048	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		1,095,879	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)		1,095,879	26.00
26.01	Sequestration adjustment (see instructions)		21,918	26.01
27.00	Interim payments		634,833	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)		439,128	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: 14-1324 Component CCN: 14-8506	Period: From 04/01/2016 To 03/31/2017	Worksheet M-4 Date/Time Prepared: 7/26/2017 12:26 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)		1,931,330	1,931,330	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time		0.002821	0.009920	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)		5,448	19,159	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)		28,922	16,372	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)		34,370	35,531	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)		2,010,185	2,010,185	6.00
7.00	Total overhead (from Wkst. M-2, line 19)		2,678,554	2,678,554	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)		0.017098	0.017675	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)		45,798	47,343	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)		80,168	82,874	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)		211	742	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)		379.94	111.69	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries		110	441	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)		41,793	49,255	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)			163,042	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)			91,048	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 14-1324 Component CCN: 14-8506	Period: From 04/01/2016 To 03/31/2017	Worksheet M-5 Date/Time Prepared: 7/26/2017 12:26 pm
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		RHC I	Cost	
		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		648,728	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		12/01/2016	13,895	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		-13,895	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		634,833	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		439,128	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		1,073,961	7.00
		Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00 2.00	
8.00	Name of Contractor			8.00