

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: 27-1303	Period: From 07/01/2016 To 06/30/2017	Worksheet S Parts I-III Date/Time Prepared: 11/27/2017 3:51 pm
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PART I - COST REPORT STATUS

Provider use only

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

Date: 11/27/2017 Time: 3:51 pm

Contractor use only

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

6. Date Received:
 7. Contractor No.

8. Initial Report for this Provider CCN
 9. Final Report for this Provider CCN

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

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 GRANITE COUNTY MEDICAL CENTER (27-1303) for the cost reporting period beginning 07/01/2016 and ending 06/30/2017 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

 Title

 Date

Cost Center Description	Title V 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	23,854	11,983	0	0	1.00
2.00 Subprovider - IPF	0	0	0		0	2.00
3.00 Subprovider - IRF	0	0	0		0	3.00
4.00 SUBPROVIDER I						4.00
5.00 Swing bed - SNF	0	141,313	0		0	5.00
6.00 Swing bed - NF	0				0	6.00
7.00 SKILLED NURSING FACILITY	0	0	0		0	7.00
8.00 NURSING FACILITY	0				0	8.00
10.00 RURAL HEALTH CLINIC I	0		347		0	10.00
11.00 FEDERALLY QUALIFIED HEALTH CENTER I	0		0		0	11.00
200.00 Total	0	165,167	12,330	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: 27-1303	Period: From 07/01/2016 To 06/30/2017	Worksheet S-2 Part I Date/Time Prepared: 11/27/2017 3:31 pm
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1.00	2.00	3.00	4.00	1.00	2.00
Hospital and Hospital Health Care Complex Address:					
Street: 310 SANSOME STREET		PO Box: 729			
City: PHILIPSBURG		State: MT		Zip Code: 59858- County: GRANITE	

	Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)				
						V	XVIII	XIX		
1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00			
Hospital and Hospital-Based Component Identification:										
3.00	Hospital	GRANITE COUNTY MEDICAL CENTER	271303	99927	1	07/01/1999	N	0	0	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	GRANITE COUNTY SWING BED	27Z303	99927		11/07/2002	N	0	N	7.00
8.00	Swing Beds - NF	GRANITE COUNTY SWING BED - NF	27Z303	99927		11/07/2002	N		N	8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
10.01	ICF/IID									10.01
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	GRANITE COUNTY CLINIC	273400	99927		08/01/2002	N	0	N	15.00
16.00	Hospital-Based Health Clinic - FOHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
17.10	Hospital-Based (CORF) I									17.10
18.00	Renal Dialysis									18.00
19.00	Other									19.00

						From:	To:		
						1.00	2.00		
20.00	Cost Reporting Period (mm/dd/yyyy)					07/01/2016	06/30/2017	20.00	
21.00	Type of Control (see instructions)					11		21.00	

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

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		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of- State Medicaid paid days	Out-of- State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days		
		1.00	2.00	3.00	4.00	5.00	6.00		
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0		25.00	
		Urban/Rural		S		Date of Geogr			
		1.00		2.00					
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.					2		26.00	
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.					2		27.00	
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.					0		35.00	
		Beginning:		Ending:					
		1.00		2.00					
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.							36.00	
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.					0		37.00	
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)					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	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.					N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y" for yes or "N" for no.					N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.					N	N	N	48.00
Teaching Hospitals									
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.					N			56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.								57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.					N			58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.					N			59.00
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)					N			60.00
		Y/N		IME		Direct GME			
		1.00		2.00		3.00			
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)					0.00		0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00		0.00				61.01

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	Y/N	IME	Direct GME	IME	Direct GME		
	1.00	2.00	3.00	4.00	5.00		
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)	0.00	0.00				61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)	0.00	0.00				61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).	0.00	0.00				61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)	0.00	0.00				61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)	0.00	0.00				61.06
		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count		
		1.00	2.00	3.00	4.00		
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column 4, direct GME FTE unweighted count.			0.00	0.00		61.10
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column 4, direct GME FTE unweighted count.			0.00	0.00		61.20
					1.00		
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
63.00	Teaching Hospitals that Claim Residents in Nonprovider Settings 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	

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

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				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	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.			N	Y	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.					92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.			N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.			N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00		0.00		95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.			N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00		0.00		97.00
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.			N	108.00	
		Physical	Occupational	Speech	Respiratory	
		1.00	2.00	3.00	4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N	109.00
				1.00		
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (410A Demo) for the current cost reporting period? Enter "Y" for yes or "N" for no.			N		110.00
				1.00	2.00	3.00
Miscellaneous Cost Reporting Information						
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.			N		0 115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.			N	116.00	
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.			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	Losses	Insurance		
		1.00	2.00	3.00		
118.01	List amounts of malpractice premiums and paid losses:	0	0	0		118.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 27-1303	Period: From 07/01/2016 To 06/30/2017	Worksheet S-2 Part I Date/Time Prepared: 11/27/2017 3:31 pm		
		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		
DO NOT USE THIS LINE						
119.00	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	119.00		
120.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	N		120.00		
121.00	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		121.00		
Transplant Center Information						
122.00	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		122.00		
125.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			125.00		
126.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00		
127.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00		
128.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00		
129.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00		
130.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00		
131.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00		
132.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00		
133.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			133.00		
All Providers						
134.00	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		134.00		
		1.00	2.00	3.00		
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.						
141.00	Name:	Contractor's Name:	Contractor's Number:	141.00		
142.00	Street:	PO Box:		142.00		
143.00	City:	State:	Zip Code:	143.00		
				1.00		
144.00	Are provider based physicians' costs included in Worksheet A?			Y		
		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		
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.			N		
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.			N		
		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	Y	Y	N	N	155.00
156.00	Subprovider - IPF	N	N	N	N	156.00
157.00	Subprovider - IRF	N	N	N	N	157.00
158.00	SUBPROVIDER					158.00
159.00	SNF	N	N	N	N	159.00
160.00	HOME HEALTH AGENCY	N	N	N	N	160.00
161.00	CMHC			N	N	161.00
161.10	CORF		N	N	N	161.10

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 27-1303			Period: From 07/01/2016 To 06/30/2017		Worksheet S-2 Part I Date/Time Prepared: 11/27/2017 3:31 pm	
							1.00	
Multi campus								
165.00	Is this hospital part of a Multi campus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.						N	165.00
		Name	County	State	Zip Code	CBSA	FTE/Campus	
		0	1.00	2.00	3.00	4.00	5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00	166.00
							1.00	
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.						N	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)						0	168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)							168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)						0.00	169.00
							Beginning	Ending
							1.00	2.00
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)							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	0
								171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 27-1303		Period: From 07/01/2016 To 06/30/2017		Worksheet S-2 Part II Date/Time Prepared: 11/27/2017 3:31 pm	
		Y/N	Date				
		1.00	2.00				
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.							
COMPLETED BY ALL HOSPITALS							
Provider Organization and Operation							
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N					1.00
		Y/N	Date				
		1.00	2.00				
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N					2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N					3.00
		Y/N	Type				
		1.00	2.00				
Financial Data and Reports							
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	01/31/2018			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)	Y	11/01/2017	Y	11/01/2017		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)	N		N			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: 27-1303	Period: From 07/01/2016 To 06/30/2017	Worksheet S-2 Part II Date/Time Prepared: 11/27/2017 3:31 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		N		29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.		N		30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.		N		31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.		N		32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.		N		33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.		Y		34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.		N		35.00
			Y/N	Date	
			1.00	2.00	
Home Office Costs					
36.00	Were home office costs claimed on the cost report?		N		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.		N		37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.		N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.		N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.		N		40.00
				1.00	2.00
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	ERIK		PROSSER	41.00
42.00	Enter the employer/company name of the cost report preparer.	WI PFLI LLP			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	509.232.2709		EPROSSER@WI PFLI . COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 27-1303

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

Worksheet S-2
Part II
Date/Time Prepared:
11/27/2017 3:31 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.	SENIOR MANAGER	41.00
42.00	Enter the employer/company name of the cost report preparer.		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.		43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 27-1303

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

Worksheet S-3
Part I
Date/Time Prepared:
11/27/2017 3:31 pm

Component	Worksheet A	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P	
	Line Number				Visits / Trips	Title V
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	25	9,125	912.98	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	912.98	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	43.00				0	13.00
14.00 Total (see instructions)		25	9,125	912.98	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF	41.00	0	0		0	17.00
18.00 SUBPROVIDER	42.00	0	0		0	18.00
19.00 SKILLED NURSING FACILITY	44.00	0	0		0	19.00
20.00 NURSING FACILITY	45.00	0	0		0	20.00
20.01 ICF/MR	45.01	0	0	0.00	0	20.01
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)	115.00					23.00
24.00 HOSPICE	116.00	0	0			24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
25.10 CMHC - CORF	99.10				0	25.10
26.00 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: 27-1303

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

Worksheet S-3
Part I
Date/Time Prepared:
11/27/2017 3:31 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)	19	1	44			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	124		158			5.00
6.00 Hospital Adults & Peds. Swing Bed NF		5,112	7,330			6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	143	5,113	7,532			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		0	0			13.00
14.00 Total (see instructions)	143	5,113	7,532	0.00	30.24	14.00
15.00 CAH visits	0	0	0			15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF	0	0	0	0.00	0.00	17.00
18.00 SUBPROVIDER				0.00	0.00	18.00
19.00 SKILLED NURSING FACILITY	0	0	0	0.00	0.00	19.00
20.00 NURSING FACILITY				0.00	0.00	20.00
20.01 ICF/MR	0	0	0	0.00	0.00	20.01
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)				0.00	0.00	23.00
24.00 HOSPICE	0	0	0	0.00	0.00	24.00
24.10 HOSPICE (non-distinct part)	0	0	0			24.10
25.00 CMHC - CMHC						25.00
25.10 CMHC - CORF	0	0	0	0.00	0.00	25.10
26.00 RHC (CONSOLIDATED)	889	0	3,011	0.00	4.51	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	34.75	27.00
28.00 Observation Bed Days		0	9			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: 27-1303

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

Worksheet S-3
Part I
Date/Time Prepared:
11/27/2017 3:31 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	7	1	12	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	7	1	12	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF	0.00	0	0	0	0	17.00
18.00	SUBPROVIDER	0.00	0		0	0	18.00
19.00	SKILLED NURSING FACILITY	0.00					19.00
20.00	NURSING FACILITY	0.00					20.00
20.01	ICF/MR	0.00	0	0	0	0	20.01
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)	0.00					23.00
24.00	HOSPICE	0.00					24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
25.10	CMHC - CORF	0.00					25.10
26.00	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: 27-1303 Component CCN: 27-3400		Period: From 07/01/2016 To 06/30/2017		Worksheet S-8 Date/Time Prepared: 11/27/2017 3:31 pm	
		RHC I		Cost			
				1.00			
1.00	Clinic Address and Identification Street	310 SANSOME STREET				1.00	
		City		State		ZIP Code	
		1.00		2.00		3.00	
2.00	City, State, ZIP Code, County	PHILIPSBURG		MT		59858	
				1.00			
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban			0		3.00	
		Grant Award		Date			
		1.00		2.00			
4.00		Source of Federal Funds				4.00	
5.00		Community Health Center (Section 330(d), PHS Act)				5.00	
6.00		Migrant Health Center (Section 329(d), PHS Act)				6.00	
7.00		Health Services for the Homeless (Section 340(d), PHS Act)				7.00	
8.00		Appalachian Regional Commission				8.00	
9.00		Look-Alikes				8.00	
9.00		OTHER (SPECIFY)				9.00	
				1.00		2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2. (Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)	N		0		10.00	
		Sunday		Monday		Tuesday	
		from to		from to		from	
		1.00 2.00		3.00 4.00		5.00	
11.00	Facility hours of operations (1) Clinic						
				1.00		2.00	
12.00	Have you received an approval for an exception to the productivity standard?	N				12.00	
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.	Y		2		13.00	
		Provider name		CCN number			
		1.00		2.00			
14.00	RHC/FQHC name, CCN number	GRANITE COUNTY CLINIC		273400		14.00	
14.01		MARGO BOWERS		273404		14.01	
		Y/N		V		XVIII	
		1.00		2.00		3.00	
						XIX	
						Total Visits	
						5.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)					15.00	
		County					
		4.00					
2.00	City, State, ZIP Code, County	GRANITE				2.00	
		Tuesday		Wednesday		Thursday	
		to		from to		from to	
		6.00		7.00 8.00		9.00 10.00	
11.00	Facility hours of operations (1) Clinic						

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 27-1303
Component CCN: 27-3400

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

Worksheet S-8
Date/Time Prepared:
11/27/2017 3:31 pm

		RHC I		Cost		
		Friday		Saturday		
		from	to	from	to	
11.00	Facility hours of operations (1) Clinic	11.00	12.00	13.00	14.00	11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 27-1303	Period: From 07/01/2016 To 06/30/2017	Worksheet S-10 Date/Time Prepared: 11/27/2017 3:31 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)		1.261213	1.00	
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid		55,550	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		1,728	5.00	
6.00	Medicaid charges		56,558	6.00	
7.00	Medicaid cost (line 1 times line 6)		71,332	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)		14,054	8.00	
Children's Health Insurance Program (CHIP) (see instructions for each line)					
9.00	Net revenue from stand-alone CHIP		0	9.00	
10.00	Stand-alone CHIP charges		0	10.00	
11.00	Stand-alone CHIP cost (line 1 times line 10)		0	11.00	
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)		0	12.00	
Other state or local government indigent care program (see instructions for each line)					
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)		0	13.00	
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)		0	14.00	
15.00	State or local indigent care program cost (line 1 times line 14)		0	15.00	
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)		0	16.00	
Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)					
17.00	Private grants, donations, or endowment income restricted to funding charity care		0	17.00	
18.00	Government grants, appropriations or transfers for support of hospital operations		0	18.00	
19.00	Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		14,054	19.00	
			Uninsured patients	Insured patients	Total (col. 1 + col. 2)
			1.00	2.00	3.00
Uncompensated Care (see instructions for each line)					
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	2,216	0	2,216	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	2,795	0	2,795	21.00
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	2,795	0	2,795	23.00
			1.00		
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?		N		24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit		0		25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)		47,307		26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)		2,600		27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)		3,998		27.01
28.00	Non-Medicare bad debt expense (line 26 minus line 27.01)		43,309		28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)		56,020		29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		58,815		30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		72,869		31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 27-1303

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

Worksheet A
Date/Time Prepared:
11/27/2017 3:31 pm

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +/- col. 4)	
		1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	00100		46,648	46,648	36,490	83,138	1.00
2.00	00200		64,794	64,794	3,587	68,381	2.00
3.00	00300		0	0	0	0	3.00
4.00	00400	0	537,204	537,204	0	537,204	4.00
5.00	00500	152,101	950,927	1,103,028	-319,057	783,971	5.00
7.00	00700	44,438	90,566	135,004	0	135,004	7.00
8.00	00800	21,447	5,725	27,172	0	27,172	8.00
9.00	00900	50,878	17,434	68,312	0	68,312	9.00
10.00	01000	84,599	74,710	159,309	0	159,309	10.00
11.00	01100	0	0	0	0	0	11.00
13.00	01300	59,422	0	59,422	58,029	117,451	13.00
17.00	01700	0	0	0	0	0	17.00
17.01	01701	53,576	2,569	56,145	0	56,145	17.01
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	437,725	360,531	798,256	66,559	864,815	30.00
41.00	04100	0	0	0	0	0	41.00
42.00	04200	0	0	0	0	0	42.00
43.00	04300	0	0	0	0	0	43.00
44.00	04400	0	0	0	0	0	44.00
45.00	04500	0	0	0	0	0	45.00
45.01	04510	0	0	0	0	0	45.01
ANCILLARY SERVICE COST CENTERS							
50.00	05000	0	0	0	0	0	50.00
51.00	05100	0	0	0	0	0	51.00
52.00	05200	0	0	0	0	0	52.00
53.00	05300	0	0	0	0	0	53.00
54.00	05400	15,421	6,962	22,383	0	22,383	54.00
57.00	05700	0	0	0	0	0	57.00
58.00	05800	0	0	0	0	0	58.00
59.00	05900	0	0	0	0	0	59.00
60.00	06000	77,040	210,971	288,011	0	288,011	60.00
60.01	06001	0	0	0	0	0	60.01
64.00	06400	0	0	0	0	0	64.00
65.00	06500	0	0	0	0	0	65.00
66.00	06600	54,914	3,520	58,434	0	58,434	66.00
68.00	06800	0	0	0	0	0	68.00
69.00	06900	0	0	0	1,377	1,377	69.00
71.00	07100	10,286	78,436	88,722	0	88,722	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	95,949	95,949	0	95,949	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	377,886	18,149	396,035	155,498	551,533	88.00
89.00	08900	0	0	0	0	0	89.00
90.00	09000	0	0	0	0	0	90.00
91.00	09100	117,081	6,011	123,092	24,492	147,584	91.00
92.00	09200	0	0	0	0	0	92.00
93.00	04040	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS							
94.00	09400	0	0	0	0	0	94.00
95.00	09500	0	0	0	0	0	95.00
99.10	09910	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS							
109.00	10900	0	0	0	0	0	109.00
110.00	11000	0	0	0	0	0	110.00
111.00	11100	0	0	0	0	0	111.00
113.00	11300	0	26,975	26,975	-26,975	0	113.00
114.00	11400	0	0	0	0	0	114.00
115.00	11500	0	0	0	0	0	115.00
116.00	11600	0	0	0	0	0	116.00
118.00		1,556,814	2,598,081	4,154,895	0	4,154,895	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
191.00	19100	0	0	0	0	0	191.00
192.00	19200	0	0	0	0	0	192.00
192.01	19201	0	0	0	0	0	192.01
193.00	19300	0	0	0	0	0	193.00
194.00	07950	0	0	0	0	0	194.00
194.01	07951	0	0	0	0	0	194.01
194.02	07952	0	0	0	0	0	194.02
200.00		1,556,814	2,598,081	4,154,895	0	4,154,895	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 27-1303

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

Worksheet A
Date/Time Prepared:
11/27/2017 3:31 pm

Cost Center Description		Adjustments (See A-8)	Net Expenses For Allocation		
		6.00	7.00		
GENERAL SERVICE COST CENTERS					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	42,027	125,165	1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	-26,094	42,287	2.00
3.00	00300	OTHER CAPITAL RELATED COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-8,250	528,954	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-192,043	591,928	5.00
7.00	00700	OPERATION OF PLANT	0	135,004	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	27,172	8.00
9.00	00900	HOUSEKEEPING	0	68,312	9.00
10.00	01000	DIETARY	-224	159,085	10.00
11.00	01100	CAFETERIA	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	117,451	13.00
17.00	01700	SOCIAL SERVICE	0	0	17.00
17.01	01701	ACTIVITIES	0	56,145	17.01
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-18,591	846,224	30.00
41.00	04100	SUBPROVIDER - I RF	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	42.00
43.00	04300	NURSERY	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	44.00
45.00	04500	NURSING FACILITY	0	0	45.00
45.01	04510	ICF/MR	0	0	45.01
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	22,383	54.00
57.00	05700	CT SCAN	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000	LABORATORY	0	288,011	60.00
60.01	06001	BLOOD LABORATORY	0	0	60.01
64.00	06400	INTRAVENOUS THERAPY	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	58,434	66.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,377	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	88,722	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	95,949	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	6	551,539	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	89.00
90.00	09000	CLINIC	0	0	90.00
91.00	09100	EMERGENCY	-11,926	135,658	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	93.00
OTHER REIMBURSABLE COST CENTERS					
94.00	09400	HOME PROGRAM DIALYSIS	0	0	94.00
95.00	09500	AMBULANCE SERVICES	0	0	95.00
99.10	09910	CORF	0	0	99.10
SPECIAL PURPOSE COST CENTERS					
109.00	10900	PANCREAS ACQUISITION	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	111.00
113.00	11300	INTEREST EXPENSE	0	0	113.00
114.00	11400	UTILIZATION REVIEW-SNF	0	0	114.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	115.00
116.00	11600	HOSPICE	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-215,095	3,939,800	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
191.00	19100	RESEARCH	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	192.00
192.01	19201	RETAIL PHARMACY SERVICES	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	193.00
194.00	07950	JAIL MEALS	0	0	194.00
194.01	07951	BEAUTY SHOP	0	0	194.01
194.02	07952	DENTAL CLINIC	0	0	194.02
200.00		TOTAL (SUM OF LINES 118-199)	-215,095	3,939,800	200.00

RECLASSIFICATIONS

Provider CCN: 27-1303

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

Worksheet A-6

Date/Time Prepared:
11/27/2017 3:31 pm

		Increases			
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
A - TO RECLASS INTEREST EXPENSES					
1.00	NEW CAP REL COSTS-BLDG & FI XT	1.00	0	21,975	1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	5,000	2.00
	O		0	26,975	
B - TO RECLASS INSURANCE EXPENSE					
1.00	NEW CAP REL COSTS-BLDG & FI XT	1.00	0	14,515	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	3,587	2.00
	O		0	18,102	
C - TO RECLASS EKG RELATED SALARIES					
1.00	ELECTROCARDIOLOGY	69.00	1,377	0	1.00
2.00	O	0.00	0	0	2.00
			1,377	0	
G - TO RECLASS CEO CONTRACT SERVICES					
1.00	RURAL HEALTH CLINIC	88.00	0	5,224	1.00
2.00	ADULTS & PEDIATRICS	30.00	0	50,721	2.00
3.00	NURSING ADMINISTRATION	13.00	0	58,029	3.00
	O		0	113,974	
H - TO RECLASS DR. JONES CONTRACT SERVICE					
1.00	ADULTS & PEDIATRICS	30.00	0	15,914	1.00
2.00	RURAL HEALTH CLINIC	88.00	0	150,274	2.00
3.00	EMERGENCY	91.00	0	25,793	3.00
	O		0	191,981	
500.00	Grand Total: Increases		1,377	351,032	500.00

RECLASSIFICATIONS

Provider CCN: 27-1303

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

Worksheet A-6

Date/Time Prepared:
11/27/2017 3:31 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
A - TO RECLASS INTEREST EXPENSES							
1.00	INTEREST EXPENSE	113.00	0	26,975	11		1.00
2.00		0.00	0	0	11		2.00
	0		0	26,975			
B - TO RECLASS INSURANCE EXPENSE							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	18,102	12		1.00
2.00		0.00	0	0	12		2.00
	0		0	18,102			
C - TO RECLASS EKG RELATED SALARIES							
1.00	ADULTS & PEDIATRICS	30.00	76	0	0		1.00
2.00	EMERGENCY	91.00	1,301	0	0		2.00
	0		1,377	0			
G - TO RECLASS CEO CONTRACT SERVICES							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	113,974	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
	0		0	113,974			
H - TO RECLASS DR. JONES CONTRACT SERVICE							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	191,981	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
	0		0	191,981			
500.00	Grand Total: Decreases		1,377	351,032			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 27-1303

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

Worksheet A-7
Part I
Date/Time Prepared:
11/27/2017 3:31 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	65,000	0	0	0	0	1.00
2.00	Land Improvements	0	0	0	0	0	2.00
3.00	Buildings and Fixtures	1,144,488	0	0	0	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	816,984	35,402	0	35,402	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	2,026,472	35,402	0	35,402	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	2,026,472	35,402	0	35,402	0	10.00
		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	65,000	0				1.00
2.00	Land Improvements	0	0				2.00
3.00	Buildings and Fixtures	1,144,488	0				3.00
4.00	Building Improvements	0	0				4.00
5.00	Fixed Equipment	0	0				5.00
6.00	Movable Equipment	852,386	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	2,061,874	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	2,061,874	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 27-1303

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

Worksheet A-7
Part II
Date/Time Prepared:
11/27/2017 3:31 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	NEW CAP REL COSTS-BLDG & FIXT	46,648	0	0	0	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	64,794	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	111,442	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	NEW CAP REL COSTS-BLDG & FIXT	0	46,648				1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	64,794				2.00
3.00	Total (sum of lines 1-2)	0	111,442				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 27-1303

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

Worksheet A-7
Part III
Date/Time Prepared:
11/27/2017 3:31 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	NEW CAP REL COSTS-BLDG & FIXT	1,144,488	0	1,144,488	0.573140	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	852,386	0	852,386	0.426860	0	2.00
3.00	Total (sum of lines 1-2)	1,996,874	0	1,996,874	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	88,675	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	38,700	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	127,375	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	21,975	14,515	0	0	125,165	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	3,587	0	0	42,287	2.00
3.00	Total (sum of lines 1-2)	21,975	18,102	0	0	167,452	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 27-1303

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

Worksheet A-8

Date/Time Prepared:
11/27/2017 3:31 pm

Line #	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
				3.00	4.00		
1.00	2.00	3.00	4.00	5.00			
1.00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)			ONEW CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)			ONEW CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)	A	-5,270	ADMINISTRATIVE & GENERAL	5.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)	A	-2,677	ADULTS & PEDIATRICS	30.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-27,840			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	51,758			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-224	DIETARY	10.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients	B	-12	ADMINISTRATIVE & GENERAL	5.00	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	-18	ADMINISTRATIVE & GENERAL	5.00	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3		RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)			UTILIZATION REVIEW-SNF	114.00		25.00
26.00	Depreciation - NEW CAP REL COSTS-BLDG & FIXT			ONEW CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - NEW CAP REL COSTS-MVBLE EQUIP			ONEW CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		*** Cost Center Deleted ***	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)			ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00

Provider CCN: 27-1303
 Period: From 07/01/2016 To 06/30/2017
 Worksheet A-8
 Date/Time Prepared: 11/27/2017 3:31 pm

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
			Cost Center	Line #		
			1.00	2.00		
33.00 LOBBYING EXPENSES	A	-14	ADMINISTRATIVE & GENERAL	5.00	0	33.00
34.00 ADVERTISING	A	-600	ADMINISTRATIVE & GENERAL	5.00	0	34.00
36.00 GRANT INCOME	B	-193,488	ADMINISTRATIVE & GENERAL	5.00	0	36.00
37.00 GRANT INCOME	B	-8,250	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	37.00
38.00 ADMIN	B	-2,078	ADMINISTRATIVE & GENERAL	5.00	0	38.00
40.00 DENTAL EQUIPMENT DEPRECIATION	B	-26,094	NEW CAP REL COSTS-MVBLE EQUIP	2.00	9	40.00
41.00 INSURANCE	B	-197	ADMINISTRATIVE & GENERAL	5.00	0	41.00
43.00 INTEREST INCOME	B	-44	ADMINISTRATIVE & GENERAL	5.00	0	43.00
43.01 PHARMACY	B	-47	ADMINISTRATIVE & GENERAL	5.00	0	43.01
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-215,095				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: 27-1303

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

Worksheet A-8-1

Date/Time Prepared:
11/27/2017 3:31 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	5.00	ADMINISTRATIVE & GENERAL	COUNTY COSTS	9,725	0 1.00
2.00	88.00	RURAL HEALTH CLINIC	CLINIC DEPRECIATION	6	0 2.00
3.00	1.00	NEW CAP REL COSTS-BLDG & FIX	BUILDING DEPRECIATION	42,027	0 3.00
4.00	0.00			0	0 4.00
5.00	0			51,758	0 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	GRANITE COUNTY	100.00	6.00
7.00		0.00		0.00	7.00
8.00		0.00		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: 27-1303

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

Worksheet A-8-1

Date/Time Prepared:
11/27/2017 3:31 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	9,725	0		1.00
2.00	6	0		2.00
3.00	42,027	9		3.00
4.00	0	0		4.00
5.00	51,758			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	GOVERNMENT		6.00
7.00			7.00
8.00			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: 27-1303

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

Worksheet A-8-2

Date/Time Prepared:
11/27/2017 3:31 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	177,468	11,926	165,542	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	15,914	15,914	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			193,382	27,840	165,542	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	91.00	EMERGENCY	0	0	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	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	11,926	1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	15,914	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	27,840	200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 27-1303

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

Worksheet B
Part I
Date/Time Prepared:
11/27/2017 3:31 pm

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
		NEW BLDG & FIXT	NEW MVBLE EQUIP			
	0	1.00	2.00	4.00	4A	
GENERAL SERVICE COST CENTERS						
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT	125,165	125,165				1.00
2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP	42,287		42,287			2.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	528,954	0	0	528,954		4.00
5.00 00500 ADMINISTRATIVE & GENERAL	591,928	30,273	7,966	51,679	681,846	5.00
7.00 00700 OPERATION OF PLANT	135,004	8,547	16,484	15,099	175,134	7.00
8.00 00800 LAUNDRY & LINEN SERVICE	27,172	1,965	0	7,287	36,424	8.00
9.00 00900 HOUSEKEEPING	68,312	1,000	0	17,287	86,599	9.00
10.00 01000 DIETARY	159,085	12,175	0	28,744	200,004	10.00
11.00 01100 CAFETERIA	0	0	0	0	0	11.00
13.00 01300 NURSING ADMINISTRATION	117,451	1,067	0	20,190	138,708	13.00
17.00 01700 SOCIAL SERVICE	0	0	0	0	0	17.00
17.01 01701 ACTIVITIES	56,145	3,813	0	18,203	78,161	17.01
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000 ADULTS & PEDIATRICS	846,224	38,870	13,229	148,697	1,047,020	30.00
41.00 04100 SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00 04200 SUBPROVIDER	0	0	0	0	0	42.00
43.00 04300 NURSERY	0	0	0	0	0	43.00
44.00 04400 SKILLED NURSING FACILITY	0	0	0	0	0	44.00
45.00 04500 NURSING FACILITY	0	0	0	0	0	45.00
45.01 04510 ICF/MR	0	0	0	0	0	45.01
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	0	0	0	0	50.00
51.00 05100 RECOVERY ROOM	0	0	0	0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00 05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	22,383	1,078	1,309	5,240	30,010	54.00
57.00 05700 CT SCAN	0	0	0	0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00 06000 LABORATORY	288,011	1,943	0	26,176	316,130	60.00
60.01 06001 BLOOD LABORATORY	0	0	0	0	0	60.01
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	58,434	2,325	0	18,658	79,417	66.00
68.00 06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	1,377	163	0	468	2,008	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	88,722	5,610	0	3,495	97,827	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	95,949	505	0	0	96,454	73.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	551,539	11,175	1,505	128,393	692,612	88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00 09000 CLINIC	0	0	0	0	0	90.00
91.00 09100 EMERGENCY	135,658	2,499	1,794	39,338	179,289	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00 04040 OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS						
94.00 09400 HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
95.00 09500 AMBULANCE SERVICES	0	0	0	0	0	95.00
99.10 09910 CORF	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS						
109.00 10900 PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00 11000 INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00 11100 ISLET ACQUISITION	0	0	0	0	0	111.00
113.00 11300 INTEREST EXPENSE	0	0	0	0	0	113.00
114.00 11400 UTILIZATION REVIEW-SNF	0	0	0	0	0	114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
116.00 11600 HOSPICE	0	0	0	0	0	116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	3,939,800	123,008	42,287	528,954	3,937,643	118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00 19100 RESEARCH	0	0	0	0	0	191.00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01 19201 RETAIL PHARMACY SERVICES	0	0	0	0	0	192.01
193.00 19300 NONPAID WORKERS	0	0	0	0	0	193.00
194.00 07950 JAIL MEALS	0	0	0	0	0	194.00
194.01 07951 BEAUTY SHOP	0	270	0	0	270	194.01
194.02 07952 DENTAL CLINIC	0	1,887	0	0	1,887	194.02

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 27-1303

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

Worksheet B
Part I
Date/Time Prepared:
11/27/2017 3:31 pm

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
		NEW BLDG & FIXT	NEW MVBLE EQUIP			
	0	1.00	2.00	4.00	4A	
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)	3,939,800	125,165	42,287	528,954	3,939,800	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 27-1303

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

Worksheet B
Part I
Date/Time Prepared:
11/27/2017 3:31 pm

Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	681,846				5.00
7.00	00700	OPERATION OF PLANT	36,653	211,787			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	7,623	4,934	48,981		8.00
9.00	00900	HOUSEKEEPING	18,124	2,510	597	107,830	9.00
10.00	01000	DIETARY	41,858	30,565	419	15,745	288,591
11.00	01100	CAFETERIA	0	0	0	0	17,784
13.00	01300	NURSING ADMINISTRATION	29,030	2,679	0	1,380	0
17.00	01700	SOCIAL SERVICE	0	0	0	0	0
17.01	01701	ACTIVITIES	16,358	9,573	0	4,931	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	219,125	97,589	45,628	50,267	270,807
41.00	04100	SUBPROVIDER - I R F	0	0	0	0	0
42.00	04200	SUBPROVIDER	0	0	0	0	0
43.00	04300	NURSERY	0	0	0	0	0
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0
45.00	04500	NURSING FACILITY	0	0	0	0	0
45.01	04510	ICF/MR	0	0	0	0	0
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	0
51.00	05100	RECOVERY ROOM	0	0	0	0	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,281	2,707	134	1,394	0
57.00	05700	CT SCAN	0	0	0	0	0
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0
60.00	06000	LABORATORY	66,162	4,878	0	2,513	0
60.01	06001	BLOOD LABORATORY	0	0	0	0	0
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0
66.00	06600	PHYSICAL THERAPY	16,621	5,837	1,406	3,007	0
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0
69.00	06900	ELECTROCARDIOLOGY	420	409	0	211	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	20,474	14,084	0	7,255	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	20,187	1,269	0	654	0
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	144,955	23,065	0	14,452	0
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0
90.00	09000	CLINIC	0	0	0	0	0
91.00	09100	EMERGENCY	37,523	6,274	433	3,232	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0
OTHER REIMBURSABLE COST CENTERS							
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	0
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0
99.10	09910	CORF	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS							
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0
111.00	11100	ISLET ACQUISITION	0	0	0	0	0
113.00	11300	INTEREST EXPENSE	0	0	0	0	0
114.00	11400	UTILIZATION REVIEW-SNF	0	0	0	0	0
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0
116.00	11600	HOSPICE	0	0	0	0	0
118.00		SUBTOTALS (SUM OF LINES 1-117)	681,394	206,373	48,617	105,041	288,591
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0
191.00	19100	RESEARCH	0	0	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0
192.01	19201	RETAIL PHARMACY SERVICES	0	0	0	0	0
193.00	19300	NONPAID WORKERS	0	0	0	0	0
194.00	07950	JAIL MEALS	0	0	0	0	0
194.01	07951	BEAUTY SHOP	57	677	228	349	0
194.02	07952	DENTAL CLINIC	395	4,737	136	2,440	0
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118-201)	681,846	211,787	48,981	107,830	288,591

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 27-1303

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

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Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	SOCIAL SERVICE	ACTIVITIES	Subtotal	
		11.00	13.00	17.00	17.01	24.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	17,784					11.00
13.00	01300	784	172,581				13.00
17.00	01700	0	0	0			17.00
17.01	01701	1,720	23,676	0	134,419		17.01
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	9,733	133,933	0	134,419	2,008,521	30.00
41.00	04100	0	0	0	0	0	41.00
42.00	04200	0	0	0	0	0	42.00
43.00	04300	0	0	0	0	0	43.00
44.00	04400	0	0	0	0	0	44.00
45.00	04500	0	0	0	0	0	45.00
45.01	04510	0	0	0	0	0	45.01
ANCILLARY SERVICE COST CENTERS							
50.00	05000	0	0	0	0	0	50.00
51.00	05100	0	0	0	0	0	51.00
52.00	05200	0	0	0	0	0	52.00
53.00	05300	0	0	0	0	0	53.00
54.00	05400	25	0	0	0	40,551	54.00
57.00	05700	0	0	0	0	0	57.00
58.00	05800	0	0	0	0	0	58.00
59.00	05900	0	0	0	0	0	59.00
60.00	06000	902	0	0	0	390,585	60.00
60.01	06001	0	0	0	0	0	60.01
64.00	06400	0	0	0	0	0	64.00
65.00	06500	0	0	0	0	0	65.00
66.00	06600	632	0	0	0	106,920	66.00
68.00	06800	0	0	0	0	0	68.00
69.00	06900	0	0	0	0	3,048	69.00
71.00	07100	489	0	0	0	140,129	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	0	0	0	118,564	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	3,499	14,972	0	0	893,555	88.00
89.00	08900	0	0	0	0	0	89.00
90.00	09000	0	0	0	0	0	90.00
91.00	09100	0	0	0	0	226,751	91.00
92.00	09200	0	0	0	0	0	92.00
93.00	04040	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS							
94.00	09400	0	0	0	0	0	94.00
95.00	09500	0	0	0	0	0	95.00
99.10	09910	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS							
109.00	10900	0	0	0	0	0	109.00
110.00	11000	0	0	0	0	0	110.00
111.00	11100	0	0	0	0	0	111.00
113.00	11300	0	0	0	0	0	113.00
114.00	11400	0	0	0	0	0	114.00
115.00	11500	0	0	0	0	0	115.00
116.00	11600	0	0	0	0	0	116.00
118.00		17,784	172,581	0	134,419	3,928,624	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
191.00	19100	0	0	0	0	0	191.00
192.00	19200	0	0	0	0	0	192.00
192.01	19201	0	0	0	0	0	192.01
193.00	19300	0	0	0	0	0	193.00
194.00	07950	0	0	0	0	0	194.00
194.01	07951	0	0	0	0	1,581	194.01
194.02	07952	0	0	0	0	9,595	194.02
200.00		0	0	0	0	0	200.00
201.00		0	0	0	0	0	201.00
202.00		17,784	172,581	0	134,419	3,939,800	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 27-1303

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

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Cost Center Description		Intern & Residents Cost & Post Stepdown Adjustments	Total	
		25.00	26.00	
GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT		4.00
5.00	00500	ADMINISTRATIVE & GENERAL		5.00
7.00	00700	OPERATION OF PLANT		7.00
8.00	00800	LAUNDRY & LINEN SERVICE		8.00
9.00	00900	HOUSEKEEPING		9.00
10.00	01000	DIETARY		10.00
11.00	01100	CAFETERIA		11.00
13.00	01300	NURSING ADMINISTRATION		13.00
17.00	01700	SOCIAL SERVICE		17.00
17.01	01701	ACTIVITIES		17.01
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	2,008,521	30.00
41.00	04100	SUBPROVIDER - IRF	0	41.00
42.00	04200	SUBPROVIDER	0	42.00
43.00	04300	NURSERY	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	44.00
45.00	04500	NURSING FACILITY	0	45.00
45.01	04510	ICF/MR	0	45.01
ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	50.00
51.00	05100	RECOVERY ROOM	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	52.00
53.00	05300	ANESTHESIOLOGY	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	40,551	54.00
57.00	05700	CT SCAN	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	59.00
60.00	06000	LABORATORY	390,585	60.00
60.01	06001	BLOOD LABORATORY	0	60.01
64.00	06400	INTRAVENOUS THERAPY	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	65.00
66.00	06600	PHYSICAL THERAPY	106,920	66.00
68.00	06800	SPEECH PATHOLOGY	0	68.00
69.00	06900	ELECTROCARDIOLOGY	3,048	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	140,129	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	118,564	73.00
OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	893,555	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	89.00
90.00	09000	CLINIC	0	90.00
91.00	09100	EMERGENCY	226,751	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	93.00
OTHER REIMBURSABLE COST CENTERS				
94.00	09400	HOME PROGRAM DIALYSIS	0	94.00
95.00	09500	AMBULANCE SERVICES	0	95.00
99.10	09910	CORF	0	99.10
SPECIAL PURPOSE COST CENTERS				
109.00	10900	PANCREAS ACQUISITION	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	110.00
111.00	11100	ISLET ACQUISITION	0	111.00
113.00	11300	INTEREST EXPENSE	0	113.00
114.00	11400	UTILIZATION REVIEW-SNF	0	114.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	115.00
116.00	11600	HOSPICE	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	3,928,624	118.00
NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	190.00
191.00	19100	RESEARCH	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	192.00
192.01	19201	RETAIL PHARMACY SERVICES	0	192.01
193.00	19300	NONPAID WORKERS	0	193.00
194.00	07950	JAIL MEALS	0	194.00
194.01	07951	BEAUTY SHOP	1,581	194.01
194.02	07952	DENTAL CLINIC	9,595	194.02
200.00		Cross Foot Adjustments	0	200.00
201.00		Negative Cost Centers	0	201.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 27-1303

Period:
From 07/01/2016
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Cost Center Description		Intern & Residents Cost & Post Stepdown Adjustments	Total	
202.00	TOTAL (sum lines 118-201)	25.00	3,939,800	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 27-1303

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

Worksheet B
Part II
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Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		NEW BLDG & FIXT	NEW MVBLE EQUIP			
		0	1.00			
GENERAL SERVICE COST CENTERS						
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	0	30,273	7,966	38,239	5.00
7.00 00700	OPERATION OF PLANT	0	8,547	16,484	25,031	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	1,965	0	1,965	8.00
9.00 00900	HOUSEKEEPING	0	1,000	0	1,000	9.00
10.00 01000	DIETARY	0	12,175	0	12,175	10.00
11.00 01100	CAFETERIA	0	0	0	0	11.00
13.00 01300	NURSING ADMINISTRATION	0	1,067	0	1,067	13.00
17.00 01700	SOCIAL SERVICE	0	0	0	0	17.00
17.01 01701	ACTIVITIES	0	3,813	0	3,813	17.01
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	0	38,870	13,229	52,099	30.00
41.00 04100	SUBPROVIDER - IRF	0	0	0	0	41.00
42.00 04200	SUBPROVIDER	0	0	0	0	42.00
43.00 04300	NURSERY	0	0	0	0	43.00
44.00 04400	SKILLED NURSING FACILITY	0	0	0	0	44.00
45.00 04500	NURSING FACILITY	0	0	0	0	45.00
45.01 04510	ICF/MR	0	0	0	0	45.01
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	0	0	0	0	50.00
51.00 05100	RECOVERY ROOM	0	0	0	0	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00 05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	1,078	1,309	2,387	54.00
57.00 05700	CT SCAN	0	0	0	0	57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
59.00 05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00 06000	LABORATORY	0	1,943	0	1,943	60.00
60.01 06001	BLOOD LABORATORY	0	0	0	0	60.01
64.00 06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00 06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00 06600	PHYSICAL THERAPY	0	2,325	0	2,325	66.00
68.00 06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00 06900	ELECTROCARDIOLOGY	0	163	0	163	69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	5,610	0	5,610	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	505	0	505	73.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800	RURAL HEALTH CLINIC	0	11,175	1,505	12,680	88.00
89.00 08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00
90.00 09000	CLINIC	0	0	0	0	90.00
91.00 09100	EMERGENCY	0	2,499	1,794	4,293	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
93.00 04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS						
94.00 09400	HOME PROGRAM DIALYSIS	0	0	0	0	94.00
95.00 09500	AMBULANCE SERVICES	0	0	0	0	95.00
99.10 09910	CORF	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS						
109.00 10900	PANCREAS ACQUISITION	0	0	0	0	109.00
110.00 11000	INTESTINAL ACQUISITION	0	0	0	0	110.00
111.00 11100	ISLET ACQUISITION	0	0	0	0	111.00
113.00 11300	INTEREST EXPENSE	0	0	0	0	113.00
114.00 11400	UTILIZATION REVIEW-SNF	0	0	0	0	114.00
115.00 11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	115.00
116.00 11600	HOSPICE	0	0	0	0	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	123,008	42,287	165,295	118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
191.00 19100	RESEARCH	0	0	0	0	191.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
192.01 19201	RETAIL PHARMACY SERVICES	0	0	0	0	192.01
193.00 19300	NONPAID WORKERS	0	0	0	0	193.00
194.00 07950	JAIL MEALS	0	0	0	0	194.00
194.01 07951	BEAUTY SHOP	0	270	0	270	194.01
194.02 07952	DENTAL CLINIC	0	1,887	0	1,887	194.02
200.00	Cross Foot Adjustments				0	200.00

Cost Center Description		Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			NEW BLDG & FIXT	NEW MVBLE EQUIP			
		0	1.00	2.00	2A	4.00	
201.00	Negative Cost Centers		0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	0	125,165	42,287	167,452	0	202.00

Provider CCN: 27-1303

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

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Part II
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ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 27-1303	Period: From 07/01/2016 To 06/30/2017	Worksheet B Part II Date/Time Prepared: 11/27/2017 3:31 pm		
Cost Center Description			ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY
			5.00	7.00	8.00	9.00	10.00
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	38,239				5.00
7.00	00700	OPERATION OF PLANT	2,056	27,087			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	428	631	3,024		8.00
9.00	00900	HOUSEKEEPING	1,016	321	37	2,374	9.00
10.00	01000	DIETARY	2,347	3,909	26	347	18,804
11.00	01100	CAFETERIA	0	0	0	0	1,159
13.00	01300	NURSING ADMINISTRATION	1,628	343	0	30	0
17.00	01700	SOCIAL SERVICE	0	0	0	0	0
17.01	01701	ACTIVITIES	917	1,224	0	109	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	12,291	12,482	2,817	1,106	17,645
41.00	04100	SUBPROVIDER - I R F	0	0	0	0	0
42.00	04200	SUBPROVIDER	0	0	0	0	0
43.00	04300	NURSERY	0	0	0	0	0
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0
45.00	04500	NURSING FACILITY	0	0	0	0	0
45.01	04510	ICF/MR	0	0	0	0	0
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	0
51.00	05100	RECOVERY ROOM	0	0	0	0	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	352	346	8	31	0
57.00	05700	CT SCAN	0	0	0	0	0
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0
60.00	06000	LABORATORY	3,710	624	0	55	0
60.01	06001	BLOOD LABORATORY	0	0	0	0	0
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0
66.00	06600	PHYSICAL THERAPY	932	747	87	66	0
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0
69.00	06900	ELECTROCARDIOLOGY	24	52	0	5	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,148	1,801	0	160	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	1,132	162	0	14	0
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	8,129	2,950	0	318	0
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0
90.00	09000	CLINIC	0	0	0	0	0
91.00	09100	EMERGENCY	2,104	802	27	71	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0
OTHER REIMBURSABLE COST CENTERS							
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	0
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0
99.10	09910	CORF	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS							
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0
111.00	11100	ISLET ACQUISITION	0	0	0	0	0
113.00	11300	INTEREST EXPENSE	0	0	0	0	0
114.00	11400	UTILIZATION REVIEW-SNF	0	0	0	0	0
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0
116.00	11600	HOSPICE	0	0	0	0	0
118.00		SUBTOTALS (SUM OF LINES 1-117)	38,214	26,394	3,002	2,312	18,804
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0
191.00	19100	RESEARCH	0	0	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0
192.01	19201	RETAIL PHARMACY SERVICES	0	0	0	0	0
193.00	19300	NONPAID WORKERS	0	0	0	0	0
194.00	07950	JAIL MEALS	0	0	0	0	0
194.01	07951	BEAUTY SHOP	3	87	14	8	0
194.02	07952	DENTAL CLINIC	22	606	8	54	0
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118-201)	38,239	27,087	3,024	2,374	18,804

ALLOCATION OF CAPITAL RELATED COSTS				Provider CCN: 27-1303	Period: From 07/01/2016 To 06/30/2017	Worksheet B Part II Date/Time Prepared: 11/27/2017 3:31 pm	
Cost Center Description			CAFETERIA	NURSING ADMINISTRATION	SOCIAL SERVICE	ACTIVITIES	Subtotal
			11.00	13.00	17.00	17.01	24.00
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA	1,159				11.00
13.00	01300	NURSING ADMINISTRATION	51	3,119			13.00
17.00	01700	SOCIAL SERVICE	0	0	0		17.00
17.01	01701	ACTIVITIES	112	428	0	6,603	17.01
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	634	2,420	0	6,603	30.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	42.00
43.00	04300	NURSERY	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	45.00
45.01	04510	ICF/MR	0	0	0	0	45.01
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2	0	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	59	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	60.01
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	41	0	0	0	66.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	32	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	228	271	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	7,297	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS							
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	94.00
95.00	09500	AMBULANCE SERVICES	0	0	0	0	95.00
99.10	09910	CORF	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS							
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE					113.00
114.00	11400	UTILIZATION REVIEW-SNF					114.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	115.00
116.00	11600	HOSPICE	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,159	3,119	0	6,603	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
192.01	19201	RETAIL PHARMACY SERVICES	0	0	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	193.00
194.00	07950	JAIL MEALS	0	0	0	0	194.00
194.01	07951	BEAUTY SHOP	0	0	0	0	194.01
194.02	07952	DENTAL CLINIC	0	0	0	0	194.02
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	1,159	3,119	0	6,603	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 27-1303

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

Worksheet B
Part II
Date/Time Prepared:
11/27/2017 3:31 pm

Cost Center Description		Intern & Residents Cost & Post Stepdown Adjustments	Total	
		25.00	26.00	
GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT		4.00
5.00	00500	ADMINISTRATIVE & GENERAL		5.00
7.00	00700	OPERATION OF PLANT		7.00
8.00	00800	LAUNDRY & LINEN SERVICE		8.00
9.00	00900	HOUSEKEEPING		9.00
10.00	01000	DIETARY		10.00
11.00	01100	CAFETERIA		11.00
13.00	01300	NURSING ADMINISTRATION		13.00
17.00	01700	SOCIAL SERVICE		17.00
17.01	01701	ACTIVITIES		17.01
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	108,097	30.00
41.00	04100	SUBPROVIDER - IRF	0	41.00
42.00	04200	SUBPROVIDER	0	42.00
43.00	04300	NURSERY	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	44.00
45.00	04500	NURSING FACILITY	0	45.00
45.01	04510	ICF/MR	0	45.01
ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	50.00
51.00	05100	RECOVERY ROOM	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	52.00
53.00	05300	ANESTHESIOLOGY	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,126	54.00
57.00	05700	CT SCAN	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	59.00
60.00	06000	LABORATORY	6,391	60.00
60.01	06001	BLOOD LABORATORY	0	60.01
64.00	06400	INTRAVENOUS THERAPY	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	65.00
66.00	06600	PHYSICAL THERAPY	4,198	66.00
68.00	06800	SPEECH PATHOLOGY	0	68.00
69.00	06900	ELECTROCARDIOLOGY	244	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	8,751	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,813	73.00
OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	24,576	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	89.00
90.00	09000	CLINIC	0	90.00
91.00	09100	EMERGENCY	7,297	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	93.00
OTHER REIMBURSABLE COST CENTERS				
94.00	09400	HOME PROGRAM DIALYSIS	0	94.00
95.00	09500	AMBULANCE SERVICES	0	95.00
99.10	09910	CORF	0	99.10
SPECIAL PURPOSE COST CENTERS				
109.00	10900	PANCREAS ACQUISITION	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	110.00
111.00	11100	ISLET ACQUISITION	0	111.00
113.00	11300	INTEREST EXPENSE		113.00
114.00	11400	UTILIZATION REVIEW-SNF		114.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	115.00
116.00	11600	HOSPICE	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	164,493	118.00
NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	190.00
191.00	19100	RESEARCH	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	192.00
192.01	19201	RETAIL PHARMACY SERVICES	0	192.01
193.00	19300	NONPAID WORKERS	0	193.00
194.00	07950	JAIL MEALS	0	194.00
194.01	07951	BEAUTY SHOP	382	194.01
194.02	07952	DENTAL CLINIC	2,577	194.02
200.00		Cross Foot Adjustments	0	200.00
201.00		Negative Cost Centers	0	201.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 27-1303		Period: From 07/01/2016 To 06/30/2017	Worksheet B Part II Date/Time Prepared: 11/27/2017 3:31 pm
Cost Center Description		Intern & Residents Cost & Post Stepdown Adjustments	Total		
202.00	TOTAL (sum lines 118-201)	25.00	26.00		
		0	167,452		
				202.00	

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 27-1303

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

Worksheet B-1
Date/Time Prepared:
11/27/2017 3:31 pm

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (DOLLAR VALUE)				
	1.00	2.00				
GENERAL SERVICE COST CENTERS						
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT	22,289				1.00
2.00 00200	NEW CAP REL COSTS-MVBLE EQUIP		38,484			2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	1,556,814		4.00
5.00 00500	ADMINISTRATIVE & GENERAL	5,391	7,250	152,101	-681,846	3,257,954
7.00 00700	OPERATION OF PLANT	1,522	15,001	44,438	0	175,134
8.00 00800	LAUNDRY & LINEN SERVICE	350	0	21,447	0	36,424
9.00 00900	HOUSEKEEPING	178	0	50,878	0	86,599
10.00 01000	DIETARY	2,168	0	84,599	0	200,004
11.00 01100	CAFETERIA	0	0	0	0	0
13.00 01300	NURSING ADMINISTRATION	190	0	59,422	0	138,708
17.00 01700	SOCIAL SERVICE	0	0	0	0	0
17.01 01701	ACTIVITIES	679	0	53,576	0	78,161
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	6,922	12,039	437,649	0	1,047,020
41.00 04100	SUBPROVIDER - IRF	0	0	0	0	0
42.00 04200	SUBPROVIDER	0	0	0	0	0
43.00 04300	NURSERY	0	0	0	0	0
44.00 04400	SKILLED NURSING FACILITY	0	0	0	0	0
45.00 04500	NURSING FACILITY	0	0	0	0	0
45.01 04510	ICF/MR	0	0	0	0	0
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	0	0	0	0	0
51.00 05100	RECOVERY ROOM	0	0	0	0	0
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0
53.00 05300	ANESTHESIOLOGY	0	0	0	0	0
54.00 05400	RADIOLOGY-DIAGNOSTIC	192	1,191	15,421	0	30,010
57.00 05700	CT SCAN	0	0	0	0	0
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0
59.00 05900	CARDIAC CATHETERIZATION	0	0	0	0	0
60.00 06000	LABORATORY	346	0	77,040	0	316,130
60.01 06001	BLOOD LABORATORY	0	0	0	0	0
64.00 06400	INTRAVENOUS THERAPY	0	0	0	0	0
65.00 06500	RESPIRATORY THERAPY	0	0	0	0	0
66.00 06600	PHYSICAL THERAPY	414	0	54,914	0	79,417
68.00 06800	SPEECH PATHOLOGY	0	0	0	0	0
69.00 06900	ELECTROCARDIOLOGY	29	0	1,377	0	2,008
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	999	0	10,286	0	97,827
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0
73.00 07300	DRUGS CHARGED TO PATIENTS	90	0	0	0	96,454
OUTPATIENT SERVICE COST CENTERS						
88.00 08800	RURAL HEALTH CLINIC	1,990	1,370	377,886	0	692,612
89.00 08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0
90.00 09000	CLINIC	0	0	0	0	0
91.00 09100	EMERGENCY	445	1,633	115,780	0	179,289
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0
93.00 04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0
OTHER REIMBURSABLE COST CENTERS						
94.00 09400	HOME PROGRAM DIALYSIS	0	0	0	0	0
95.00 09500	AMBULANCE SERVICES	0	0	0	0	0
99.10 09910	CORF	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS						
109.00 10900	PANCREAS ACQUISITION	0	0	0	0	0
110.00 11000	INTESTINAL ACQUISITION	0	0	0	0	0
111.00 11100	ISLET ACQUISITION	0	0	0	0	0
113.00 11300	INTEREST EXPENSE	0	0	0	0	0
114.00 11400	UTILIZATION REVIEW-SNF	0	0	0	0	0
115.00 11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0
116.00 11600	HOSPICE	0	0	0	0	0
118.00	SUBTOTALS (SUM OF LINES 1-117)	21,905	38,484	1,556,814	-681,846	3,255,797
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0
191.00 19100	RESEARCH	0	0	0	0	0
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0
192.01 19201	RETAIL PHARMACY SERVICES	0	0	0	0	0
193.00 19300	NONPAID WORKERS	0	0	0	0	0
194.00 07950	JAIL MEALS	0	0	0	0	0
194.01 07951	BEAUTY SHOP	48	0	0	0	270
194.02 07952	DENTAL CLINIC	336	0	0	0	1,887

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 27-1303

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

Worksheet B-1
Date/Time Prepared:
11/27/2017 3:31 pm

Cost Center Description		CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
		NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (DOLLAR VALUE)				
		1.00	2.00				
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	125,165	42,287	528,954		681,846	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	5.615550	1.098820	0.339767		0.209287	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)			0		38,239	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)			0.000000		0.011737	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 27-1303

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

Worksheet B-1

Date/Time Prepared:
11/27/2017 3:31 pm

Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S X 100)	
		7.00	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT	15,022				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	350	49,758			8.00
9.00	00900	HOUSEKEEPING	178	606	14,848		9.00
10.00	01000	DIETARY	2,168	426	2,168	26,775	10.00
11.00	01100	CAFETERIA	0	0	0	1,650	2,109
13.00	01300	NURSING ADMINISTRATION	190	0	190	0	93
17.00	01700	SOCIAL SERVICE	0	0	0	0	0
17.01	01701	ACTIVITIES	679	0	679	0	204
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	6,922	46,352	6,922	25,125	1,154
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0
42.00	04200	SUBPROVIDER	0	0	0	0	0
43.00	04300	NURSERY	0	0	0	0	0
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0
45.00	04500	NURSING FACILITY	0	0	0	0	0
45.01	04510	ICF/MR	0	0	0	0	0
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	0
51.00	05100	RECOVERY ROOM	0	0	0	0	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	192	136	192	0	3
57.00	05700	CT SCAN	0	0	0	0	0
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0
60.00	06000	LABORATORY	346	0	346	0	107
60.01	06001	BLOOD LABORATORY	0	0	0	0	0
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0
66.00	06600	PHYSICAL THERAPY	414	1,428	414	0	75
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0
69.00	06900	ELECTROCARDIOLOGY	29	0	29	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	999	0	999	0	58
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	90	0	90	0	0
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	1,636	0	1,990	0	415
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0
90.00	09000	CLINIC	0	0	0	0	0
91.00	09100	EMERGENCY	445	440	445	0	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0
OTHER REIMBURSABLE COST CENTERS							
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	0
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0
99.10	09910	CORF	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS							
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0
111.00	11100	ISLET ACQUISITION	0	0	0	0	0
113.00	11300	INTEREST EXPENSE	0	0	0	0	0
114.00	11400	UTILIZATION REVIEW-SNF	0	0	0	0	0
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0
116.00	11600	HOSPICE	0	0	0	0	0
118.00		SUBTOTALS (SUM OF LINES 1-117)	14,638	49,388	14,464	26,775	2,109
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0
191.00	19100	RESEARCH	0	0	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0
192.01	19201	RETAIL PHARMACY SERVICES	0	0	0	0	0
193.00	19300	NONPAID WORKERS	0	0	0	0	0
194.00	07950	JAIL MEALS	0	0	0	0	0
194.01	07951	BEAUTY SHOP	48	232	48	0	0
194.02	07952	DENTAL CLINIC	336	138	336	0	0
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers					

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 27-1303

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

Worksheet B-1

Date/Time Prepared:
11/27/2017 3:31 pm

Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S X 100)	
		7.00	8.00	9.00	10.00	11.00	
202.00	Cost to be allocated (per Wkst. B, Part I)	211,787	48,981	107,830	288,591	17,784	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	14.098456	0.984384	7.262258	10.778375	8.432432	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	27,087	3,024	2,374	18,804	1,159	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	1.803155	0.060774	0.159887	0.702297	0.549550	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 27-1303

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

Worksheet B-1
Date/Time Prepared:
11/27/2017 3:31 pm

Cost Center Description		NURSING ADMINISTRATION (FTE'S X 100)	SOCIAL SERVICE (PATIENT DAYS)	ACTIVITIES (PATIENT DAYS)	
		13.00	17.00	17.01	
GENERAL SERVICE COST CENTERS					
1.00	00100				1.00
2.00	00200				2.00
4.00	00400				4.00
5.00	00500				5.00
7.00	00700				7.00
8.00	00800				8.00
9.00	00900				9.00
10.00	01000				10.00
11.00	01100				11.00
13.00	01300	1,487			13.00
17.00	01700	0	100		17.00
17.01	01701	204	0	100	17.01
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	1,154	100	100	30.00
41.00	04100	0	0	0	41.00
42.00	04200	0	0	0	42.00
43.00	04300	0	0	0	43.00
44.00	04400	0	0	0	44.00
45.00	04500	0	0	0	45.00
45.01	04510	0	0	0	45.01
ANCILLARY SERVICE COST CENTERS					
50.00	05000	0	0	0	50.00
51.00	05100	0	0	0	51.00
52.00	05200	0	0	0	52.00
53.00	05300	0	0	0	53.00
54.00	05400	0	0	0	54.00
57.00	05700	0	0	0	57.00
58.00	05800	0	0	0	58.00
59.00	05900	0	0	0	59.00
60.00	06000	0	0	0	60.00
60.01	06001	0	0	0	60.01
64.00	06400	0	0	0	64.00
65.00	06500	0	0	0	65.00
66.00	06600	0	0	0	66.00
68.00	06800	0	0	0	68.00
69.00	06900	0	0	0	69.00
71.00	07100	0	0	0	71.00
72.00	07200	0	0	0	72.00
73.00	07300	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	129	0	0	88.00
89.00	08900	0	0	0	89.00
90.00	09000	0	0	0	90.00
91.00	09100	0	0	0	91.00
92.00	09200	0	0	0	92.00
93.00	04040	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS					
94.00	09400	0	0	0	94.00
95.00	09500	0	0	0	95.00
99.10	09910	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS					
109.00	10900	0	0	0	109.00
110.00	11000	0	0	0	110.00
111.00	11100	0	0	0	111.00
113.00	11300	0	0	0	113.00
114.00	11400	0	0	0	114.00
115.00	11500	0	0	0	115.00
116.00	11600	0	0	0	116.00
118.00		1,487	100	100	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	0	0	0	190.00
191.00	19100	0	0	0	191.00
192.00	19200	0	0	0	192.00
192.01	19201	0	0	0	192.01
193.00	19300	0	0	0	193.00
194.00	07950	0	0	0	194.00
194.01	07951	0	0	0	194.01
194.02	07952	0	0	0	194.02
200.00					200.00
201.00					201.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 27-1303

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

Worksheet B-1
Date/Time Prepared:
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Cost Center Description		NURSING ADMINISTRATION	SOCIAL SERVICE	ACTIVITIES (PATIENT DAYS)	
		(FTE'S X 100)	(PATIENT DAYS)	(PATIENT DAYS)	
		13.00	17.00	17.01	
202.00	Cost to be allocated (per Wkst. B, Part I)	172,581	0	134,419	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	116.059852	0.000000	1,344.190000	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	3,119	0	6,603	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	2.097512	0.000000	66.030000	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 27-1303

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

Worksheet C
Part I
Date/Time Prepared:
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Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs				
				Total Costs	Hospital			
					RCE Disallowance	Total Costs		
		1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	2,008,521		2,008,521	0	0	30.00
41.00	04100	SUBPROVIDER - IRF	0		0	0	0	41.00
42.00	04200	SUBPROVIDER	0		0	0	0	42.00
43.00	04300	NURSERY	0		0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0		0	0	0	44.00
45.00	04500	NURSING FACILITY	0		0	0	0	45.00
45.01	04510	ICF/MR	0		0	0	0	45.01
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0		0	0	0	50.00
51.00	05100	RECOVERY ROOM	0		0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0		0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0		0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	40,551		40,551	0	0	54.00
57.00	05700	CT SCAN	0		0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0		0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0		0	0	0	59.00
60.00	06000	LABORATORY	390,585		390,585	0	0	60.00
60.01	06001	BLOOD LABORATORY	0		0	0	0	60.01
64.00	06400	INTRAVENOUS THERAPY	0		0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	106,920	0	106,920	0	0	66.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	3,048		3,048	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	140,129		140,129	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	118,564		118,564	0	0	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	893,555		893,555	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0	89.00
90.00	09000	CLINIC	0		0	0	0	90.00
91.00	09100	EMERGENCY	226,751		226,751	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	31,670		31,670	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0		0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS								
94.00	09400	HOME PROGRAM DIALYSIS	0		0	0	0	94.00
95.00	09500	AMBULANCE SERVICES	0		0	0	0	95.00
99.10	09910	CORF	0		0	0	0	99.10
SPECIAL PURPOSE COST CENTERS								
109.00	10900	PANCREAS ACQUISITION	0		0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0		0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0		0	0	0	111.00
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0		0	0	0	115.00
116.00	11600	HOSPICE	0		0	0	0	116.00
200.00		Subtotal (see instructions)	3,960,294	0	3,960,294	0	0	200.00
201.00		Less Observation Beds	31,670		31,670			201.00
202.00		Total (see instructions)	3,928,624	0	3,928,624	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 27-1303

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

Worksheet C
Part I
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		Title XVIII			Hospital	Cost	
Cost Center Description		Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
		Inpatient	Outpatient	Total (col. 6 + col. 7)			
		6.00	7.00	8.00	9.00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	1,978,624		1,978,624		30.00
41.00	04100	SUBPROVIDER - I RF	0		0		41.00
42.00	04200	SUBPROVIDER	0		0		42.00
43.00	04300	NURSERY	0		0		43.00
44.00	04400	SKILLED NURSING FACILITY	0		0		44.00
45.00	04500	NURSING FACILITY	0		0		45.00
45.01	04510	ICF/MR	0		0		45.01
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,696	35,079	36,775	1.102678	54.00
57.00	05700	CT SCAN	0	0	0	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	59.00
60.00	06000	LABORATORY	18,892	352,785	371,677	1.050872	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	60.01
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	9,693	125,046	134,739	0.793534	66.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	838	11,680	12,518	0.243489	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	26,334	61,060	87,394	1.603417	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	25,803	19,955	45,758	2.591110	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	15,050	309,974	325,024		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		89.00
90.00	09000	CLINIC	0	0	0	0.000000	90.00
91.00	09100	EMERGENCY	4,000	86,830	90,830	2.496433	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	500	31,119	31,619	1.001613	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0.000000	93.00
OTHER REIMBURSABLE COST CENTERS							
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0.000000	94.00
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	95.00
99.10	09910	CORF	0	0	0		99.10
SPECIAL PURPOSE COST CENTERS							
109.00	10900	PANCREAS ACQUISITION	0	0	0		109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0		110.00
111.00	11100	ISLET ACQUISITION	0	0	0		111.00
113.00	11300	INTEREST EXPENSE					113.00
114.00	11400	UTILIZATION REVIEW-SNF					114.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0		115.00
116.00	11600	HOSPICE	0	0	0		116.00
200.00		Subtotal (see instructions)	2,081,430	1,033,528	3,114,958		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	2,081,430	1,033,528	3,114,958		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 27-1303	Period: From 07/01/2016 To 06/30/2017	Worksheet C Part I Date/Time Prepared: 11/27/2017 3:31 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
41.00	04100	SUBPROVIDER - IRF			41.00
42.00	04200	SUBPROVIDER			42.00
43.00	04300	NURSERY			43.00
44.00	04400	SKILLED NURSING FACILITY			44.00
45.00	04500	NURSING FACILITY			45.00
45.01	04510	ICF/MR			45.01
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.000000		50.00
51.00	05100	RECOVERY ROOM	0.000000		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
57.00	05700	CT SCAN	0.000000		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000		58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000		59.00
60.00	06000	LABORATORY	0.000000		60.00
60.01	06001	BLOOD LABORATORY	0.000000		60.01
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
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
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
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER			89.00
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
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0.000000		93.00
OTHER REIMBURSABLE COST CENTERS					
94.00	09400	HOME PROGRAM DIALYSIS	0.000000		94.00
95.00	09500	AMBULANCE SERVICES	0.000000		95.00
99.10	09910	CORF			99.10
SPECIAL PURPOSE COST CENTERS					
109.00	10900	PANCREAS ACQUISITION			109.00
110.00	11000	INTESTINAL ACQUISITION			110.00
111.00	11100	ISLET ACQUISITION			111.00
113.00	11300	INTEREST EXPENSE			113.00
114.00	11400	UTILIZATION REVIEW-SNF			114.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)			115.00
116.00	11600	HOSPICE			116.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 27-1303

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

Worksheet C
Part I
Date/Time Prepared:
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		Title XIX		Hospital		Cost	
Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		Total 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	2,008,521		2,008,521	0	2,008,521	30.00
41.00	04100 SUBPROVIDER - IRF	0		0	0	0	41.00
42.00	04200 SUBPROVIDER	0		0	0	0	42.00
43.00	04300 NURSERY	0		0	0	0	43.00
44.00	04400 SKILLED NURSING FACILITY	0		0	0	0	44.00
45.00	04500 NURSING FACILITY	0		0	0	0	45.00
45.01	04510 ICF/MR	0		0	0	0	45.01
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0		0	0	0	50.00
51.00	05100 RECOVERY ROOM	0		0	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0		0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0		0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	40,551		40,551	0	40,551	54.00
57.00	05700 CT SCAN	0		0	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0		0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0		0	0	0	59.00
60.00	06000 LABORATORY	390,585		390,585	0	390,585	60.00
60.01	06001 BLOOD LABORATORY	0		0	0	0	60.01
64.00	06400 INTRAVENOUS THERAPY	0		0	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	106,920	0	106,920	0	106,920	66.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	3,048		3,048	0	3,048	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	140,129		140,129	0	140,129	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0		0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	118,564		118,564	0	118,564	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	893,555		893,555	0	893,555	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0	89.00
90.00	09000 CLINIC	0		0	0	0	90.00
91.00	09100 EMERGENCY	226,751		226,751	0	226,751	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	31,670		31,670	0	31,670	92.00
93.00	04040 OTHER OUTPATIENT SERVICE COST CENTER	0		0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS							
94.00	09400 HOME PROGRAM DIALYSIS	0		0	0	0	94.00
95.00	09500 AMBULANCE SERVICES	0		0	0	0	95.00
99.10	09910 CORF	0		0	0	0	99.10
SPECIAL PURPOSE COST CENTERS							
109.00	10900 PANCREAS ACQUISITION	0		0	0	0	109.00
110.00	11000 INTESTINAL ACQUISITION	0		0	0	0	110.00
111.00	11100 ISLET ACQUISITION	0		0	0	0	111.00
113.00	11300 INTEREST EXPENSE	0		0	0	0	113.00
114.00	11400 UTILIZATION REVIEW-SNF	0		0	0	0	114.00
115.00	11500 AMBULATORY SURGICAL CENTER (D.P.)	0		0	0	0	115.00
116.00	11600 HOSPICE	0		0	0	0	116.00
200.00	Subtotal (see instructions)	3,960,294	0	3,960,294	0	3,960,294	200.00
201.00	Less Observation Beds	31,670		31,670	0	31,670	201.00
202.00	Total (see instructions)	3,928,624	0	3,928,624	0	3,928,624	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 27-1303

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

Worksheet C
Part I
Date/Time Prepared:
11/27/2017 3:31 pm

		Title XIX			Hospital	Cost	
Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
	Inpatient	Outpatient	Total (col. 6 + col. 7)				
	6.00	7.00	8.00				9.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	1,978,624		1,978,624		30.00
41.00	04100	SUBPROVIDER - I RF	0		0		41.00
42.00	04200	SUBPROVIDER	0		0		42.00
43.00	04300	NURSERY	0		0		43.00
44.00	04400	SKILLED NURSING FACILITY	0		0		44.00
45.00	04500	NURSING FACILITY	0		0		45.00
45.01	04510	ICF/MR	0		0		45.01
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,696	35,079	36,775	1.102678	54.00
57.00	05700	CT SCAN	0	0	0	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	59.00
60.00	06000	LABORATORY	18,892	352,785	371,677	1.050872	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	60.01
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	9,693	125,046	134,739	0.793534	66.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	838	11,680	12,518	0.243489	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	26,334	61,060	87,394	1.603417	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	25,803	19,955	45,758	2.591110	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	15,050	309,974	325,024	2.749197	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.000000	89.00
90.00	09000	CLINIC	0	0	0	0.000000	90.00
91.00	09100	EMERGENCY	4,000	86,830	90,830	2.496433	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	500	31,119	31,619	1.001613	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0.000000	93.00
OTHER REIMBURSABLE COST CENTERS							
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0.000000	94.00
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	95.00
99.10	09910	CORF	0	0	0	0.000000	99.10
SPECIAL PURPOSE COST CENTERS							
109.00	10900	PANCREAS ACQUISITION	0	0	0		109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0		110.00
111.00	11100	ISLET ACQUISITION	0	0	0		111.00
113.00	11300	INTEREST EXPENSE					113.00
114.00	11400	UTILIZATION REVIEW-SNF					114.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0		115.00
116.00	11600	HOSPICE	0	0	0		116.00
200.00		Subtotal (see instructions)	2,081,430	1,033,528	3,114,958		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	2,081,430	1,033,528	3,114,958		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 27-1303

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

Worksheet C
Part I
Date/Time Prepared:
11/27/2017 3:31 pm

Cost Center Description		PPS Inpatient Ratio	Title XIX	Hospital	Cost
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS				30.00
41.00	04100 SUBPROVIDER - IRF				41.00
42.00	04200 SUBPROVIDER				42.00
43.00	04300 NURSERY				43.00
44.00	04400 SKILLED NURSING FACILITY				44.00
45.00	04500 NURSING FACILITY				45.00
45.01	04510 ICF/MR				45.01
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.000000			50.00
51.00	05100 RECOVERY ROOM	0.000000			51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000			52.00
53.00	05300 ANESTHESIOLOGY	0.000000			53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000			54.00
57.00	05700 CT SCAN	0.000000			57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000			58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000			59.00
60.00	06000 LABORATORY	0.000000			60.00
60.01	06001 BLOOD LABORATORY	0.000000			60.01
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
68.00	06800 SPEECH PATHOLOGY	0.000000			68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000			69.00
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	0.000000			88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0.000000			89.00
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
93.00	04040 OTHER OUTPATIENT SERVICE COST CENTER	0.000000			93.00
OTHER REIMBURSABLE COST CENTERS					
94.00	09400 HOME PROGRAM DIALYSIS	0.000000			94.00
95.00	09500 AMBULANCE SERVICES	0.000000			95.00
99.10	09910 CORF				99.10
SPECIAL PURPOSE COST CENTERS					
109.00	10900 PANCREAS ACQUISITION				109.00
110.00	11000 INTESTINAL ACQUISITION				110.00
111.00	11100 ISLET ACQUISITION				111.00
113.00	11300 INTEREST EXPENSE				113.00
114.00	11400 UTILIZATION REVIEW-SNF				114.00
115.00	11500 AMBULATORY SURGICAL CENTER (D.P.)				115.00
116.00	11600 HOSPICE				116.00
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: 27-1303

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

Worksheet D
Part II
Date/Time Prepared:
11/27/2017 3:31 pm

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)	Hospital Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0.000000	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,126	36,775	0.085003	293	25	54.00
57.00	05700	CT SCAN	0	0	0.000000	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	06000	LABORATORY	6,391	371,677	0.017195	3,920	67	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0	0	60.01
64.00	06400	INTRAVENOUS THERAPY	0	0	0.000000	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0.000000	0	0	65.00
66.00	06600	PHYSICAL THERAPY	4,198	134,739	0.031157	349	11	66.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	244	12,518	0.019492	111	2	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	8,751	87,394	0.100133	1,493	149	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	1,813	45,758	0.039621	5,216	207	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	24,576	325,024	0.075613	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
91.00	09100	EMERGENCY	7,297	90,830	0.080337	2,580	207	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,704	31,619	0.053892	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0.000000	0	0	93.00
OTHER REIMBURSABLE COST CENTERS								
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0.000000	0	0	94.00
95.00	09500	AMBULANCE SERVICES	0	0	0.000000	0	0	95.00
200.00		Total (lines 50-199)	58,100	1,136,334		13,962	668	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 27-1303

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

Worksheet D
Part IV
Date/Time Prepared:
11/27/2017 3:31 pm

Cost Center Description		Title XVIII				Hospital		Cost	
		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)			
		1.00	2.00	3.00	4.00	5.00			
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	0	60.01
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	0	66.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS									
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	0	0	94.00
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	0	95.00
200.00		Total (Lines 50-199)	0	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 27-1303

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

Worksheet D
Part IV
Date/Time Prepared:
11/27/2017 3:31 pm

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)	Hospital			
					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	0	0.000000	0.000000	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0.000000	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	36,775	0.000000	0.000000	293	54.00
57.00	05700	CT SCAN	0	0	0.000000	0.000000	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0.000000	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0.000000	0	59.00
60.00	06000	LABORATORY	0	371,677	0.000000	0.000000	3,920	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0.000000	0	60.01
64.00	06400	INTRAVENOUS THERAPY	0	0	0.000000	0.000000	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0.000000	0.000000	0	65.00
66.00	06600	PHYSICAL THERAPY	0	134,739	0.000000	0.000000	349	66.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0.000000	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	12,518	0.000000	0.000000	111	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	87,394	0.000000	0.000000	1,493	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	45,758	0.000000	0.000000	5,216	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	325,024	0.000000	0.000000	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0.000000	0	89.00
90.00	09000	CLINIC	0	0	0.000000	0.000000	0	90.00
91.00	09100	EMERGENCY	0	90,830	0.000000	0.000000	2,580	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	31,619	0.000000	0.000000	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0.000000	0.000000	0	93.00
OTHER REIMBURSABLE COST CENTERS								
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0.000000	0.000000	0	94.00
95.00	09500	AMBULANCE SERVICES	0	0	0.000000	0.000000	0	95.00
200.00		Total (lines 50-199)	0	1,136,334			13,962	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 27-1303

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

Worksheet D
Part IV
Date/Time Prepared:
11/27/2017 3:31 pm

Cost Center Description		Title XVIII			Hospital	Cost
		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
		11.00	12.00	13.00		
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	0	0		50.00
51.00	05100 RECOVERY ROOM	0	0	0		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
53.00	05300 ANESTHESIOLOGY	0	0	0		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
57.00	05700 CT SCAN	0	0	0		57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0		58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0		59.00
60.00	06000 LABORATORY	0	0	0		60.00
60.01	06001 BLOOD LABORATORY	0	0	0		60.01
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
68.00	06800 SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0		69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO 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
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		89.00
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
93.00	04040 OTHER OUTPATIENT SERVICE COST CENTER	0	0	0		93.00
OTHER REIMBURSABLE COST CENTERS						
94.00	09400 HOME PROGRAM DIALYSIS	0	0	0		94.00
95.00	09500 AMBULANCE SERVICES	0	0	0		95.00
200.00	Total (lines 50-199)	0	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 27-1303

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

Worksheet D
Part V
Date/Time Prepared:
11/27/2017 3:31 pm

		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	0.000000	0	0	0	0	50.00
51.00	05100 RECOVERY ROOM	0.000000	0	0	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	1.102678	0	12,089	0	0	54.00
57.00	05700 CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000 LABORATORY	1.050872	0	157,571	0	0	60.00
60.01	06001 BLOOD LABORATORY	0.000000	0	0	0	0	60.01
64.00	06400 INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0.000000	0	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.793534	0	36,812	0	0	66.00
68.00	06800 SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.243489	0	4,948	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1.603417	0	37,412	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	2.591110	0	19,788	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	0.000000				0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0.000000				0	89.00
90.00	09000 CLINIC	0.000000	0	0	0	0	90.00
91.00	09100 EMERGENCY	2.496433	0	24,538	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1.001613	0	21,650	0	0	92.00
93.00	04040 OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS							
94.00	09400 HOME PROGRAM DIALYSIS	0.000000		0			94.00
95.00	09500 AMBULANCE SERVICES	0.000000		0			95.00
200.00	Subtotal (see instructions)		0	314,808	0	0	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0	0	201.00
202.00	Net Charges (line 200 +/- line 201)		0	314,808	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 27-1303	Period: From 07/01/2016 To 06/30/2017	Worksheet D Part V Date/Time Prepared: 11/27/2017 3:31 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	0	0		50.00
51.00 05100 RECOVERY ROOM	0	0		51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00 05300 ANESTHESIOLOGY	0	0		53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	13,330	0		54.00
57.00 05700 CT SCAN	0	0		57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0		59.00
60.00 06000 LABORATORY	165,587	0		60.00
60.01 06001 BLOOD LABORATORY	0	0		60.01
64.00 06400 INTRAVENOUS THERAPY	0	0		64.00
65.00 06500 RESPIRATORY THERAPY	0	0		65.00
66.00 06600 PHYSICAL THERAPY	29,212	0		66.00
68.00 06800 SPEECH PATHOLOGY	0	0		68.00
69.00 06900 ELECTROCARDIOLOGY	1,205	0		69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	59,987	0		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	51,273	0		73.00
OUTPATIENT SERVICE COST CENTERS				
88.00 08800 RURAL HEALTH CLINIC	0	0		88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		89.00
90.00 09000 CLINIC	0	0		90.00
91.00 09100 EMERGENCY	61,257	0		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	21,685	0		92.00
93.00 04040 OTHER OUTPATIENT SERVICE COST CENTER	0	0		93.00
OTHER REIMBURSABLE COST CENTERS				
94.00 09400 HOME PROGRAM DIALYSIS	0	0		94.00
95.00 09500 AMBULANCE SERVICES	0	0		95.00
200.00 Subtotal (see instructions)	403,536	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)	403,536	0		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 27-1303 Component CCN: 27-Z303	Period: From 07/01/2016 To 06/30/2017	Worksheet D Part V Date/Time Prepared: 11/27/2017 3:31 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	0.000000	0	0	0	0
51.00 05100 RECOVERY ROOM	0.000000	0	0	0	0
52.00 05200 DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0
53.00 05300 ANESTHESIOLOGY	0.000000	0	0	0	0
54.00 05400 RADIOLOGY-DIAGNOSTIC	1.102678	0	0	0	0
57.00 05700 CT SCAN	0.000000	0	0	0	0
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0
59.00 05900 CARDIAC CATHETERIZATION	0.000000	0	0	0	0
60.00 06000 LABORATORY	1.050872	0	0	0	0
60.01 06001 BLOOD LABORATORY	0.000000	0	0	0	0
64.00 06400 INTRAVENOUS THERAPY	0.000000	0	0	0	0
65.00 06500 RESPIRATORY THERAPY	0.000000	0	0	0	0
66.00 06600 PHYSICAL THERAPY	0.793534	0	0	0	0
68.00 06800 SPEECH PATHOLOGY	0.000000	0	0	0	0
69.00 06900 ELECTROCARDIOLOGY	0.243489	0	0	0	0
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1.603417	0	0	0	0
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0
73.00 07300 DRUGS CHARGED TO PATIENTS	2.591110	0	0	0	0
OUTPATIENT SERVICE COST CENTERS					
88.00 08800 RURAL HEALTH CLINIC	0.000000				0
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0.000000				0
90.00 09000 CLINIC	0.000000	0	0	0	0
91.00 09100 EMERGENCY	2.496433	0	0	0	0
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1.001613	0	0	0	0
93.00 04040 OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	0	0
OTHER REIMBURSABLE COST CENTERS					
94.00 09400 HOME PROGRAM DIALYSIS	0.000000		0		94.00
95.00 09500 AMBULANCE SERVICES	0.000000		0		95.00
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: 27-1303 Component CCN: 27-Z303	Period: From 07/01/2016 To 06/30/2017	Worksheet D Part V Date/Time Prepared: 11/27/2017 3:31 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
51.00 05100 RECOVERY ROOM	0	0		51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00 05300 ANESTHESIOLOGY	0	0		53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0		54.00
57.00 05700 CT SCAN	0	0		57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0		59.00
60.00 06000 LABORATORY	0	0		60.00
60.01 06001 BLOOD LABORATORY	0	0		60.01
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
68.00 06800 SPEECH PATHOLOGY	0	0		68.00
69.00 06900 ELECTROCARDIOLOGY	0	0		69.00
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
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		89.00
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
93.00 04040 OTHER OUTPATIENT SERVICE COST CENTER	0	0		93.00
OTHER REIMBURSABLE COST CENTERS				
94.00 09400 HOME PROGRAM DIALYSIS	0	0		94.00
95.00 09500 AMBULANCE SERVICES	0	0		95.00
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: 27-1303	Period: From 07/01/2016 To 06/30/2017	Worksheet D-1 Date/Time Prepared: 11/27/2017 3:31 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)		7,541	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		53	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)		44	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		158	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		3,665	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)		3,665	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		19	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		124	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		171.04	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		174.40	20.00
21.00	Total general inpatient routine service cost (see instructions)		2,008,521	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)		626,862	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)		639,176	25.00
26.00	Total swing-bed cost (see instructions)		1,822,021	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		186,500	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)		186,500	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)		3,518.88	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		66,859	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)		66,859	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 27-1303	Period: From 07/01/2016 To 06/30/2017	Worksheet D-1 Date/Time Prepared: 11/27/2017 3:31 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)	0	0	0.00	0	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)				27,096	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)				93,955	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)				0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)				436,341	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)				436,341	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)				9	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)				3,518.87	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)				31,670	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 27-1303		Period: From 07/01/2016 To 06/30/2017		Worksheet D-1 Date/Time Prepared: 11/27/2017 3:31 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	108,097	2,008,521	0.053819	31,670	1,704	90.00
91.00	Nursing School cost	0	2,008,521	0.000000	31,670	0	91.00
92.00	Allied health cost	0	2,008,521	0.000000	31,670	0	92.00
93.00	All other Medical Education	0	2,008,521	0.000000	31,670	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 27-1303	Period: From 07/01/2016 To 06/30/2017	Worksheet D-3 Date/Time Prepared: 11/27/2017 3:31 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		83,687		30.00
41.00	04100 SUBPROVIDER - I RF		0		41.00
42.00	04200 SUBPROVIDER		0		42.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.000000	0	0	50.00
51.00	05100 RECOVERY ROOM	0.000000	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	1.102678	293	323	54.00
57.00	05700 CT SCAN	0.000000	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	06000 LABORATORY	1.050872	3,920	4,119	60.00
60.01	06001 BLOOD LABORATORY	0.000000	0	0	60.01
64.00	06400 INTRAVENOUS THERAPY	0.000000	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0.000000	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.793534	349	277	66.00
68.00	06800 SPEECH PATHOLOGY	0.000000	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.243489	111	27	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1.603417	1,493	2,394	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	2.591110	5,216	13,515	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000		0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0	89.00
90.00	09000 CLINIC	0.000000	0	0	90.00
91.00	09100 EMERGENCY	2.496433	2,580	6,441	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1.001613	0	0	92.00
93.00	04040 OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	93.00
OTHER REIMBURSABLE COST CENTERS					
94.00	09400 HOME PROGRAM DIALYSIS	0.000000	0	0	94.00
95.00	09500 AMBULANCE SERVICES				95.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		13,962	27,096	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)		13,962		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 27-1303 Component CCN: 27-Z303	Period: From 07/01/2016 To 06/30/2017	Worksheet D-3 Date/Time Prepared: 11/27/2017 3:31 pm	
Cost Center Description		Title XVIII	Swing Beds - SNF	Cost	
		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		0	30.00
41.00	04100	SUBPROVIDER - I RF		0	41.00
42.00	04200	SUBPROVIDER		0	42.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.000000	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1.102678	484	54.00
57.00	05700	CT SCAN	0.000000	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	59.00
60.00	06000	LABORATORY	1.050872	7,637	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	60.01
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	0	65.00
66.00	06600	PHYSICAL THERAPY	0.793534	6,852	66.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.243489	549	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.603417	3,996	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2.591110	19,486	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0.000000		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		89.00
90.00	09000	CLINIC	0.000000	0	90.00
91.00	09100	EMERGENCY	2.496433	1,293	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.001613	400	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	93.00
OTHER REIMBURSABLE COST CENTERS					
94.00	09400	HOME PROGRAM DIALYSIS	0.000000	0	94.00
95.00	09500	AMBULANCE SERVICES			95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		40,697	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	201.00
202.00		Net charges (line 200 minus line 201)		40,697	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 27-1303	Period: From 07/01/2016 To 06/30/2017	Worksheet E Part B Date/Time Prepared: 11/27/2017 3:31 pm
		Title XVIII	Hospital	Cost
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)			403,536 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)			403,536 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)			407,571 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)			3,071 25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)			34,919 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)			357,049 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)			357,049 30.00
31.00	Primary payer payments			0 31.00
32.00	Subtotal (line 30 minus line 31)			357,049 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)			1,330 34.00
35.00	Adjusted reimbursable bad debts (see instructions)			865 35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			0 36.00
37.00	Subtotal (see instructions)			357,914 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)			357,914 40.00
40.01	Sequestration adjustment (see instructions)			7,158 40.01
41.00	Interim payments			338,773 41.00
42.00	Tentative settlement (for contractors use only)			0 42.00
43.00	Balance due provider/program (see instructions)			11,983 43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			12,532 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: 27-1303

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

Worksheet E-1
Part I
Date/Time Prepared:
11/27/2017 3:31 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		68,006		338,773	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)						3.00
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER		0		0		3.01
3.02			0		0		3.02
3.03			0		0		3.03
3.04			0		0		3.04
3.05			0		0		3.05
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM		0		0		3.50
3.51			0		0		3.51
3.52			0		0		3.52
3.53			0		0		3.53
3.54			0		0		3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0		3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		68,006		338,773	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		23,854		11,983	6.01	
6.02	SETTLEMENT TO PROGRAM		0		0	6.02	
7.00	Total Medicare program liability (see instructions)		91,860		350,756	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: 27-1303
Component CCN: 27-Z303

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

Worksheet E-1
Part I
Date/Time Prepared:
11/27/2017 3:31 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		361,259		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		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		361,259		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		141,313		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		502,572		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 - SWING BEDS		Provider CCN: 27-1303 Component CCN: 27-Z303	Period: From 07/01/2016 To 06/30/2017	Worksheet E-2 Date/Time Prepared: 11/27/2017 3:31 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)	440,704	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)	75,404	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	124	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)	516,108	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	516,108	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)	516,108	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	4,088	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)	512,020	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)	1,244	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	809	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (see instructions)	512,829	0	19.00
19.01	Sequestration adjustment (see instructions)	10,257	0	19.01
20.00	Interim payments	361,259	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)	141,313	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: 27-1303	Period: From 07/01/2016 To 06/30/2017	Worksheet E-3 Part V Date/Time Prepared: 11/27/2017 3:31 pm
		Title XVIII	Hospital	Cost
		1.00		
PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT				
1.00	Inpatient services		93,955	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)		93,955	4.00
5.00	Primary payer payments		0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)		94,265	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)		94,265	19.00
20.00	Deductibles (exclude professional component)		1,316	20.00
21.00	Excess reasonable cost (from line 16)		0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)		92,949	22.00
23.00	Coinsurance		0	23.00
24.00	Subtotal (line 22 minus line 23)		92,949	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		1,209	25.00
26.00	Adjusted reimbursable bad debts (see instructions)		786	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)		93,735	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	29.50
29.99	Recovery of Accelerated Depreciation		0	29.99
30.00	Subtotal (see instructions)		93,735	30.00
30.01	Sequestration adjustment (see instructions)		1,875	30.01
31.00	Interim payments		68,006	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)		23,854	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 27-1303	Period: From 07/01/2016 To 06/30/2017	Worksheet E-3 Part VII Date/Time Prepared: 11/27/2017 3:31 pm	
		Title XIX	Hospital	Cost	
			Inpatient	Outpatient	
			1.00	2.00	
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES					
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient hospital/SNF/NF services		0		1.00
2.00	Medical and other services			0	2.00
3.00	Organ acquisition (certified transplant centers only)		0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		0	0	4.00
5.00	Inpatient primary payer payments		0		5.00
6.00	Outpatient primary payer payments			0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		0	0	7.00
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable Charges					
8.00	Routine service charges		0		8.00
9.00	Ancillary service charges		0	0	9.00
10.00	Organ acquisition charges, net of revenue		0		10.00
11.00	Incentive from target amount computation		0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)		0	0	12.00
CUSTOMARY CHARGES					
13.00	Amount actually collected from patients liable for payment for services on a charge basis		0	0	13.00
14.00	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	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)		0	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		0	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)		0	0	18.00
19.00	Interns and Residents (see instructions)		0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)		0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)		0	0	21.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.					
22.00	Other than outlier payments		0	0	22.00
23.00	Outlier payments		0	0	23.00
24.00	Program capital payments		0		24.00
25.00	Capital exception payments (see instructions)		0		25.00
26.00	Routine and Ancillary service other pass through costs		0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)		0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)		0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)		0	0	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT					
30.00	Excess of reasonable cost (from line 18)		0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		0	0	31.00
32.00	Deductibles		0		32.00
33.00	Coinurance		0	0	33.00
34.00	Allowable bad debts (see instructions)		0	0	34.00
35.00	Utilization review		0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		0	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	37.00
38.00	Subtotal (line 36 ± line 37)		0	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)		0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		0	0	40.00
41.00	Interim payments		0	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)		0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2		0	0	43.00

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

Provider CCN: 27-1303

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

Worksheet G
Date/Time Prepared:
11/27/2017 3:31 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	782,210	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	1,308,553	0	0	0	4.00
5.00	Other receivable	177,977	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-675,000	0	0	0	6.00
7.00	Inventory	37,760	0	0	0	7.00
8.00	Prepaid expenses	0	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	1,631,500	0	0	0	11.00
FIXED ASSETS						
12.00	Land	65,000	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	1,144,488	0	0	0	15.00
16.00	Accumulated depreciation	-692,114	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	852,386	0	0	0	23.00
24.00	Accumulated depreciation	-635,271	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	734,489	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	0	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	0	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	2,365,989	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	1,297,908	0	0	0	37.00
38.00	Salaries, wages, and fees payable	0	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	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	0	0	0	0	43.00
44.00	Other current liabilities	5,624	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	1,303,532	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	411,874	0	0	0	48.00
49.00	Other long term liabilities	2,046,707	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	2,458,581	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	3,762,113	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	-1,396,124	0	0	0	52.00
53.00	Specific purpose fund	0	0	0	0	53.00
54.00	Donor created - endowment fund balance - restricted	0	0	0	0	54.00
55.00	Donor created - endowment fund balance - unrestricted	0	0	0	0	55.00
56.00	Governing body created - endowment fund balance	0	0	0	0	56.00
57.00	Plant fund balance - invested in plant	0	0	0	0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion	0	0	0	0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	-1,396,124	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	2,365,989	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 27-1303

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

Worksheet G-1

Date/Time Prepared:
11/27/2017 3:31 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		-633,316		0		1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		-559,320				2.00
3.00	Total (sum of line 1 and line 2)		-1,192,636		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		-1,192,636		0		11.00
12.00	PY AUDIT ADJUSTMENT	203,488		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		203,488		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		-1,396,124		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	PY AUDIT ADJUSTMENT		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: 27-1303

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

Worksheet G-2
Parts I & II
Date/Time Prepared:
11/27/2017 3:31 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	146,978		146,978	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF	0		0	3.00
4.00	SUBPROVIDER	0		0	4.00
5.00	Swing bed - SNF	507,284		507,284	5.00
6.00	Swing bed - NF	1,277,738		1,277,738	6.00
7.00	SKILLED NURSING FACILITY	0		0	7.00
8.00	NURSING FACILITY	0		0	8.00
8.01	ICF/MR	0		0	8.01
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	1,932,000		1,932,000	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	1,932,000		1,932,000	17.00
18.00	Ancillary services	134,380	788,123	922,503	18.00
19.00	Outpatient services	0	0	0	19.00
20.00	RURAL HEALTH CLINIC	15,050	309,974	325,024	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES	0	0	0	23.00
24.00	CMHC				24.00
24.10	CORF	0	0	0	24.10
25.00	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	25.00
26.00	HOSPICE	0	0	0	26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	2,081,430	1,098,097	3,179,527	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		4,154,895		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)		4,154,895		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 27-1303

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

Worksheet G-3

Date/Time Prepared:
11/27/2017 3:31 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	3,179,527	1.00
2.00	Less contractual allowances and discounts on patients' accounts	409,156	2.00
3.00	Net patient revenues (line 1 minus line 2)	2,770,371	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	4,154,895	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-1,384,524	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	395,173	6.00
7.00	Income from investments	0	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	5,270	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	224	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	12	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	18	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	337,556	23.00
24.00	OTHER (SPECIFY)	0	24.00
24.01	MISC INCOME	75,996	24.01
24.02	H&R AUXILIARY	6,955	24.02
24.03	SALE OF EQUIPMENT	4,000	24.03
24.04	OTHER (SPECIFY)	0	24.04
24.05	OTHER (SPECIFY)	0	24.05
25.00	Total other income (sum of lines 6-24)	825,204	25.00
26.00	Total (line 5 plus line 25)	-559,320	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)	-559,320	29.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 27-1303

Period: From 07/01/2016

Worksheet M-1

Component CCN: 27-3400

To 06/30/2017

Date/Time Prepared: 11/27/2017 3:31 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	0	0	0	0	0	1.00
2.00	Physician Assistant	140,172	0	140,172	0	140,172	2.00
3.00	Nurse Practitioner	237,116	0	237,116	0	237,116	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	598	0	598	0	598	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)	377,886	0	377,886	0	377,886	10.00
11.00	Physician Services Under Agreement	0	0	0	150,274	150,274	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	5,224	5,224	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	155,498	155,498	14.00
15.00	Medical Supplies	0	2,882	2,882	0	2,882	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	2,882	2,882	0	2,882	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	377,886	2,882	380,768	155,498	536,266	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	0	0	0	0	29.00
30.00	Administrative Costs	0	15,267	15,267	0	15,267	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	15,267	15,267	0	15,267	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	377,886	18,149	396,035	155,498	551,533	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 27-1303

Period: From 07/01/2016

Worksheet M-1

Component CCN: 27-3400

To 06/30/2017

Date/Time Prepared: 11/27/2017 3:31 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	0	0		1.00
2.00	Physician Assistant	0	140,172		2.00
3.00	Nurse Practitioner	0	237,116		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	598		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	0		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	377,886		10.00
11.00	Physician Services Under Agreement	0	150,274		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	5,224		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	155,498		14.00
15.00	Medical Supplies	0	2,882		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	2,882		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	536,266		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	6	15,273		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	6	15,273		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	6	551,539		32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 27-1303 Component CCN: 27-3400	Period: From 07/01/2016 To 06/30/2017	Worksheet M-2 Date/Time Prepared: 11/27/2017 3:31 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	0.00	0	4,200	0	1.00
2.00	Physician Assistant	1.07	979	2,100	2,247	2.00
3.00	Nurse Practitioner	1.81	1,903	2,100	3,801	3.00
4.00	Subtotal (sum of lines 1 through 3)	2.88	2,882		6,048	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)	2.88	2,882		6,048	8.00
9.00	Physician Services Under Agreements		129		129	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)				536,266	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)				536,266	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)				15,273	14.00
15.00	Parent provider overhead allocated to facility (see instructions)				342,016	15.00
16.00	Total overhead (sum of lines 14 and 15)				357,289	16.00
17.00	Allowable GME overhead (see instructions)				0	17.00
18.00	Enter the amount from line 16				357,289	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)				357,289	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)				893,555	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 27-1303 Component CCN: 27-3400	Period: From 07/01/2016 To 06/30/2017	Worksheet M-3 Date/Time Prepared: 11/27/2017 3:31 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)			893,555	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			13,773	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			879,782	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			6,048	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)			129	5.00
6.00	Total adjusted visits (line 4 plus line 5)			6,177	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			142.43	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)	142.43	142.43		9.00
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)	0	889		10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	126,620		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	126,620		16.00
16.01	Total program charges (see instructions)(from contractor's records)		94,025		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		2,368		16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		3,189		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.)		88,585		16.04
16.05	Total program cost (see instructions)	0	91,774		16.05
17.00	Primary payer amounts		0		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		12,700		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		15,791		19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		91,774		20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		4,827		21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		96,601		22.00
23.00	Allowable bad debts (see instructions)		215		23.00
23.01	Adjusted reimbursable bad debts (see instructions)		140		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)		96,741		26.00
26.01	Sequestration adjustment (see instructions)		1,935		26.01
27.00	Interim payments		94,459		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)		347		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: 27-1303 Component CCN: 27-3400	Period: From 07/01/2016 To 06/30/2017	Worksheet M-4 Date/Time Prepared: 11/27/2017 3:31 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)	377,886	377,886	1.00	
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000026	0.006325	2.00	
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	10	2,390	3.00	
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	135	5,731	4.00	
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	145	8,121	5.00	
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	536,266	536,266	6.00	
7.00	Total overhead (from Wkst. M-2, line 19)	357,289	357,289	7.00	
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.000270	0.015144	8.00	
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	96	5,411	9.00	
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	241	13,532	10.00	
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	1	239	11.00	
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	241.00	56.62	12.00	
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	1	81	13.00	
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	241	4,586	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)		13,773	15.00	
16.00	Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3, line 21)		4,827	16.00	

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 27-1303 Component CCN: 27-3400	Period: From 07/01/2016 To 06/30/2017	Worksheet M-5 Date/Time Prepared: 11/27/2017 3:31 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		94,459	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			0		3.50
3.51			0		3.51
3.52			0		3.52
3.53			0		3.53
3.54			0		3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		94,459		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		347		6.01
6.02	SETTLEMENT TO PROGRAM		0		6.02
7.00	Total Medicare program liability (see instructions)		94,806		7.00
		Contractor Number	NPR Date (Mo/Day/Yr)		
		0	1.00	2.00	
8.00	Name of Contractor				8.00