This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g).

FORM APPROVED
OMB NO. 0938-0050
EXPIRES 05-31-2019

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 14-0015	Period: From 10/01/2016 To 09/30/2017	Worksheet S Parts I-III Date/Time Prepared: 2/28/2018 10:42 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 2/28/2018 Time: 10:42 am
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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

PART II - CERTIFICATION

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

CERTIFICATION BY CHIEF FINANCIAL 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 BLESSING HOSPITAL (14-0015) for the cost reporting period beginning 10/01/2016 and ending 09/30/2017 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.

[ ] I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification statement to be the legally binding equivalent of my original signature.

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

____
Title

____
Date

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	-529,338	-10,290	0	0	1.00
2.00	Subprovider - IPF	0	105,561	129		0	2.00
3.00	Subprovider - IRF	0	-13,802	-42		0	3.00
5.00	Swing bed - SNF	0	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
7.00	SKILLED NURSING FACILITY	0	42,608	-31,167		0	7.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
10.00	RURAL HEALTH CLINIC I	0		24,841		0	10.00
200.00	Total	0	-394,971	-16,529	0	0	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-0015 | Period: From 10/01/2016 To 09/30/2017 | Worksheet S-2 Part I Date/Time Prepared: 2/28/2018 10:40 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 1005 BROADWAY	PO Box:			1.00
2.00	City: QUINCY	State: IL	Zip Code: 62301	County:	2.00

		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
	Hospital and Hospital-Based Component Identification:									
3.00	Hospital	BLESSING HOSPITAL	140015	99914	1	07/01/1966	N	P	O	3.00
4.00	Subprovider - IPF	BLESSING PSYCHIATRIC UNIT	14S015	99914	4	10/01/1993	N	P	O	4.00
5.00	Subprovider - IRF	BELSSING REHAB UNIT	14T015	99914	5	10/01/1985	N	P	O	5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF	BLESSING SKILLED CARE UNIT	145643	99914		06/20/1989	N	P	N	9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA	BLESSING HOME CARE	147031	99914		12/01/1984	N	P	N	12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice	HOSPICE OF ADAMS COUNTY	141501	99914		06/01/1984				14.00
15.00	Hospital-Based Health Clinic - RHC	GOLDEN CLINIC	143422	99914		09/08/1996	N	O	N	15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	10/01/2016	09/30/2017	20.00
21.00	Type of Control (see instructions)	2		21.00
	Inpatient PPS Information			
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	Y	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	Y	22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N	22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.	N	N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	3	N	23.00

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	5,534	784	896	231	629	226	24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	153	0	0	0	44		25.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-0015 | Period: From 10/01/2016 To 09/30/2017 | Worksheet S-2 Part I Date/Time Prepared: 2/28/2018 10:40 am

		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.	1		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.	10/01/2016	09/30/2017	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)(i) or (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)(i) or (ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	N	N	39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	N	N	40.00

		V	XVIII	XIX	
		1.00	2.00	3.00	
	Prospective Payment System (PPS)-Capital				
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300(b) 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.	Y			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.	N			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

		NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code	
		1.00	2.00	3.00	
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under §413.85? (see instructions)	Y			60.00
60.01	If line 60 is yes, complete columns 2 and 3 for each program. (see instructions)		20.00	1	60.01
60.02	If line 60 is yes, complete columns 2 and 3 for each program. (see instructions)		23.01	1	60.02
60.03	If line 60 is yes, complete columns 2 and 3 for each program. (see instructions)		23.02	1	60.03
60.04	If line 60 is yes, complete columns 2 and 3 for each program. (see instructions)		23.03	1	60.04

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 14-0015	Period: From 10/01/2016 To 09/30/2017	Worksheet S-2 Part I Date/Time Prepared: 2/28/2018 10:40 am

		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00	0.00			61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)		0.00	0.00			61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)		0.00	0.00			61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).		0.00	0.00			61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)		0.00	0.00			61.05
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. Enter in column 4, the 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. Enter in column 4, the direct GME FTE unweighted count.			0.00	0.00	61.20

		1.00	
	ACA Provisions Affecting the Health Resources and Services Administration (HRSA)		
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)	0.00	62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)	0.00	62.01
	Teaching Hospitals that Claim Residents in Nonprovider Settings		
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)	N	63.00

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

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

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

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

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

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

		V	XIX	
		1.00	2.00	
	Title V and XIX Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00
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
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.06
	Rural Providers			
105.00	Does this hospital qualify as a CAH?	N		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)			106.00
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II.			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.					109.00

		1.00	
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration)for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.	N	110.00

		1.00	2.00	
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N		111.00

		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.	Y			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1			118.00

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	619,530	2,110,113	0	118.01

		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	Y		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	Y	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N		122.00
	Transplant Center Information			
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	14H132	140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 14-0015	Period: From 10/01/2016 To 09/30/2017	Worksheet S-2 Part I Date/Time Prepared: 2/28/2018 10:40 am

	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: BLESSING CORPORATE SERVICES	Contractor's Name: NATIONAL GOVERNMENT SERVICES	Contractor's Number: 131	141.00
142.00	Street: BROADWAY AT 11TH STREET	PO Box:		142.00
143.00	City: QUINCY	State: IL	Zip Code: 62301	143.00

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

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

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

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

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

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

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

		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)	12/08/2010	03/07/2011	170.00

		1.00	2.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)	N	0	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 14-0015	Period: From 10/01/2016 To 09/30/2017	Worksheet S-2 Part II Date/Time Prepared: 2/28/2018 10:40 am

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

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

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

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

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

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	N		N		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	12/31/2017	Y	12/31/2017	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 14-0015	Period: From 10/01/2016 To 09/30/2017	Worksheet S-2 Part II Date/Time Prepared: 2/28/2018 10:40 am

		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00

		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00

		1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)		
	Capital Related Cost		
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions	N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.	N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions	N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.	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.	N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions	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.	Y	35.00

		Y/N	Date	
		1.00	2.00	
	Home Office Costs			
36.00	Were home office costs claimed on the cost report?	Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.	Y		37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.	N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.	Y		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.	Y		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.	CONNIE	ZIEGLER	41.00
42.00	Enter the employer/company name of the cost report preparer.	BLESSING CORPORATE SERVICES		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	217-223-8400, X4159	CZIEGLER@BLESSINGHOSPITAL.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 14-0015	Period: From 10/01/2016 To 09/30/2017	Worksheet S-2 Part II Date/Time Prepared: 2/28/2018 10:40 am

		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.	REIMBURSEMENT COORDINATOR		41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 14-0015 | Period: From 10/01/2016 To 09/30/2017 | Worksheet S-3 Part I Date/Time Prepared: 2/28/2018 10:40 am

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	203	74,095	0.00	0	1.00
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		203	74,095	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	25	9,125	0.00	0	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)		228	83,220	0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF	40.00	41	14,965		0	16.00
17.00	SUBPROVIDER - IRF	41.00	18	6,570		0	17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	44.00	20	7,300		0	19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	101.00				0	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						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
26.00	RURAL HEALTH CLINIC	88.00				0	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		307				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
33.01	LTCH site neutral days and discharges						33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 14-0015 | Period: From 10/01/2016 To 09/30/2017 | Worksheet S-3 Part I Date/Time Prepared: 2/28/2018 10:40 am

	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)	23,763	4,719	39,938			1.00
2.00	HMO and other (see instructions)	3,327	1,645				2.00
3.00	HMO IPF Subprovider	66	600				3.00
4.00	HMO IRF Subprovider	471	44				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	23,763	4,719	39,938			7.00
8.00	INTENSIVE CARE UNIT	2,590	675	5,048			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		1,035	2,301			13.00
14.00	Total (see instructions)	26,353	6,429	47,287	16.22	1,868.35	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF	1,351	5,960	11,621	0.46	85.56	16.00
17.00	SUBPROVIDER - IRF	2,973	153	4,516	0.52	26.85	17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	4,255	5	5,917	0.00	30.81	19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	32,350	0	48,700	0.00	49.22	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	0	0	0	0.00	22.33	24.00
24.10	HOSPICE (non-distinct part)	0	0	0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	2,123	0	6,794	0.00	7.15	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)				17.20	2,090.27	27.00
28.00	Observation Bed Days		0	6,340			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			742			30.00
31.00	Employee discount days - IRF			110			31.00
32.00	Labor & delivery days (see instructions)	0	226	405			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
33.01	LTCH site neutral days and discharges	0					33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 14-0015 | Period: From 10/01/2016 To 09/30/2017 | Worksheet S-3 Part I Date/Time Prepared: 2/28/2018 10:40 am

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	5,968	1,764	11,871	1.00
2.00	HMO and other (see instructions)			742	206		2.00
3.00	HMO IPF Subprovider				117		3.00
4.00	HMO IRF Subprovider				4		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	5,968	1,764	11,871	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF	0.00	0	220	1,123	2,140	16.00
17.00	SUBPROVIDER - IRF	0.00	0	215	14	326	17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	0.00					19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0.00					22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	0.00					24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	0.00					26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01

HOSPITAL WAGE INDEX INFORMATION	Provider CCN: 14-0015	Period: From 10/01/2016 To 09/30/2017	Worksheet S-3 Part II Date/Time Prepared: 2/28/2018 10:40 am

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA							
	SALARIES							
1.00	Total salaries (see instructions)	200.00	115,017,331	0	115,017,331	4,337,603.91	26.52	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3.00
4.00	Physician-Part A - Administrative		210,883	0	210,883	1,324.00	159.28	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician and Non Physician-Part B		8,279,602	0	8,279,602	44,441.10	186.31	5.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		374,301	0	374,301	14,306.48	26.16	6.00
7.00	Interns & residents (in an approved program)	21.00	1,040,755	0	1,040,755	37,358.78	27.86	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	1,615,286	-26,323	1,588,963	62,855.33	25.28	9.00
10.00	Excluded area salaries (see instructions)		14,777,141	939,389	15,716,530	560,700.61	28.03	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		2,642,346	0	2,642,346	36,437.40	72.52	11.00
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00	12.00
13.00	Contract labor: Physician-Part A - Administrative		560,108	0	560,108	3,457.00	162.02	13.00
14.00	Home office and/or related orgainzation salaries and wage-related costs		0	0	0	0.00	0.00	14.00
14.01	Home office salaries		5,803,506	0	5,803,506	71,441.07	81.23	14.01
14.02	Related organization salaries		0	0	0	0.00	0.00	14.02
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
	WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		28,921,088	0	28,921,088			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		5,257,883	0	5,257,883			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		0	0	0			21.00
22.00	Physician Part A - Administrative		33,018	0	33,018			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		1,257,526	0	1,257,526			23.00
24.00	Wage-related costs (RHC/FQHC)		117,802	0	117,802			24.00
25.00	Interns & residents (in an approved program)		315,494	0	315,494			25.00
25.50	Home office wage-related (core)		1,285,361	0	1,285,361			25.50
25.51	Related organization wage-related (core)		0	0	0			25.51
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0			25.52
25.53	Home office & Contract Physicians Part A - Teaching - wage-related (core)		0	0	0			25.53
	OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	2,435,053	0	2,435,053	149,258.40	16.31	26.00
27.00	Administrative & General	5.00	16,914,496	-17,527	16,896,969	685,593.15	24.65	27.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 14-0015 | Period: From 10/01/2016 To 09/30/2017 | Worksheet S-3 Part II Date/Time Prepared: 2/28/2018 10:40 am

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
28.00	Administrative & General under contract (see inst.)		1,038,757	0	1,038,757	4,835.62	214.81	28.00
29.00	Maintenance & Repairs	6.00	2,459,871	0	2,459,871	116,778.41	21.06	29.00
30.00	Operation of Plant	7.00	0	0	0	0.00	0.00	30.00
31.00	Laundry & Linen Service	8.00	36,923	0	36,923	2,821.96	13.08	31.00
32.00	Housekeeping	9.00	2,349,445	0	2,349,445	169,611.76	13.85	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	2,285,049	-1,445,751	839,298	69,191.70	12.13	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	1,445,751	1,445,751	102,436.86	14.11	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	6,706,800	-28,238	6,678,562	212,367.27	31.45	38.00
39.00	Central Services and Supply	14.00	0	0	0	0.00	0.00	39.00
40.00	Pharmacy	15.00	0	0	0	0.00	0.00	40.00
41.00	Medical Records & Medical Records Library	16.00	2,645,027	0	2,645,027	181,830.90	14.55	41.00
42.00	Social Service	17.00	0	0	0	0.00	0.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 14-0015 | Period: From 10/01/2016 To 09/30/2017 | Worksheet S-3 Part III Date/Time Prepared: 2/28/2018 10:40 am

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)		106,361,430	0	106,361,430	4,246,333.17	25.05	1.00
2.00	Excluded area salaries (see instructions)		16,392,427	913,066	17,305,493	623,555.94	27.75	2.00
3.00	Subtotal salaries (line 1 minus line 2)		89,969,003	-913,066	89,055,937	3,622,777.23	24.58	3.00
4.00	Subtotal other wages & related costs (see inst.)		9,005,960	0	9,005,960	111,335.47	80.89	4.00
5.00	Subtotal wage-related costs (see inst.)		30,239,467	0	30,239,467	0.00	33.96	5.00
6.00	Total (sum of lines 3 thru 5)		129,214,430	-913,066	128,301,364	3,734,112.70	34.36	6.00
7.00	Total overhead cost (see instructions)		36,871,421	-45,765	36,825,656	1,694,726.03	21.73	7.00

HOSPITAL WAGE RELATED COSTS	Provider CCN: 14-0015	Period: From 10/01/2016 To 09/30/2017	Worksheet S-3 Part IV Date/Time Prepared: 2/28/2018 10:40 am

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	4,782,827	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	1,096,322	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	0	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)	0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	19,906,013	8.02
8.03	Health Insurance (Purchased)	0	8.03
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	0	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	134,080	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	340,502	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	562,754	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	0	16.00
	TAXES		
17.00	FICA-Employers Portion Only	7,929,115	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	128,264	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
	OTHER		
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	1,022,935	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	35,902,812	24.00
	Part B - Other than Core Related Cost		
25.00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST | Provider CCN: 14-0015 | Period: From 10/01/2016 To 09/30/2017 | Worksheet S-3 Part V Date/Time Prepared: 2/28/2018 10:40 am

	Cost Center Description	Contract Labor	Benefit Cost	
		1.00	2.00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	2,655,916	35,902,812	1.00
2.00	Hospital	2,642,346	28,921,088	2.00
3.00	Subprovider - IPF	799	1,319,748	3.00
4.00	Subprovider - IRF	6,322	437,157	4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF	6,449	482,770	8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA	0	945,835	11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice	0	434,508	13.00
14.00	Hospital-Based Health Clinic RHC	0	117,802	14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis	0	0	17.00
18.00	Other	0	3,243,904	18.00

HOME HEALTH AGENCY STATISTICAL DATA

Provider CCN: 14-0015 | Component CCN: 14-7031 | Period: From 10/01/2016 To 09/30/2017 | Worksheet S-4 | Date/Time Prepared: 2/28/2018 10:40 am

Home Health Agency I — PPS

		1.00	
0.00	County	ADAMS	0.00

		Title V	Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	5.00	
	HOME HEALTH AGENCY STATISTICAL DATA						
1.00	Home Health Aide Hours	0	12,346	0	3,950	16,296	1.00
2.00	Unduplicated Census Count (see instructions)	0.00	943.00	0.00	770.00	1,713.00	2.00

		Enter the number of hours in your normal work week	Number of Employees (Full Time Equivalent) Staff	Contract	Total	
		0	1.00	2.00	3.00	
	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES					
3.00	Administrator and Assistant Administrator(s)	40.00	1.00	0.00	1.00	3.00
4.00	Director(s) and Assistant Director(s)		0.00	0.00	0.00	4.00
5.00	Other Administrative Personnel		8.58	0.00	8.58	5.00
6.00	Direct Nursing Service		16.58	0.00	16.58	6.00
7.00	Nursing Supervisor		0.00	0.00	0.00	7.00
8.00	Physical Therapy Service		11.14	0.00	11.14	8.00
9.00	Physical Therapy Supervisor		0.00	0.00	0.00	9.00
10.00	Occupational Therapy Service		2.66	0.00	2.66	10.00
11.00	Occupational Therapy Supervisor		0.00	0.00	0.00	11.00
12.00	Speech Pathology Service		0.43	0.00	0.43	12.00
13.00	Speech Pathology Supervisor		0.00	0.00	0.00	13.00
14.00	Medical Social Service		1.00	0.00	1.00	14.00
15.00	Medical Social Service Supervisor		0.00	0.00	0.00	15.00
16.00	Home Health Aide		7.83	0.00	7.83	16.00
17.00	Home Health Aide Supervisor		0.00	0.00	0.00	17.00
18.00	Other (specify)		0.00	0.00	0.00	18.00
	HOME HEALTH AGENCY CBSA CODES					
19.00	Enter in column 1 the number of CBSAs where you provided services during the cost reporting period.		4			19.00
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).		99914			20.00
20.01			99926			20.01
20.02			50089			20.02
20.03			41180			20.03

		Full Episodes Without Outliers	Full Episodes With Outliers	LUPA Episodes	PEP Only Episodes	Total (cols. 1-4)	
		1.00	2.00	3.00	4.00	5.00	
	PPS ACTIVITY DATA						
21.00	Skilled Nursing Visits	12,404	4,428	262	92	17,186	21.00
22.00	Skilled Nursing Visit Charges	2,009,368	717,328	42,444	14,904	2,784,044	22.00
23.00	Physical Therapy Visits	7,452	434	65	55	8,006	23.00
24.00	Physical Therapy Visit Charges	1,207,224	70,308	10,530	8,910	1,296,972	24.00
25.00	Occupational Therapy Visits	2,185	336	16	8	2,545	25.00
26.00	Occupational Therapy Visit Charges	353,970	54,432	2,592	1,296	412,290	26.00
27.00	Speech Pathology Visits	188	46	1	0	235	27.00
28.00	Speech Pathology Visit Charges	30,456	7,452	162	0	38,070	28.00
29.00	Medical Social Service Visits	33	7	0	0	40	29.00
30.00	Medical Social Service Visit Charges	5,346	1,134	0	0	6,480	30.00
31.00	Home Health Aide Visits	3,104	1,227	6	1	4,338	31.00
32.00	Home Health Aide Visit Charges	279,360	110,430	540	90	390,420	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	25,366	6,478	350	156	32,350	33.00
34.00	Other Charges	0	0	0	0	0	34.00
35.00	Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)	3,885,724	961,084	56,268	25,200	4,928,276	35.00
36.00	Total Number of Episodes (standard/non outlier)	1,327		127	16	1,470	36.00
37.00	Total Number of Outlier Episodes		113		0	113	37.00
38.00	Total Non-Routine Medical Supply Charges	62,486	61,575	2,084	420	126,565	38.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA | Provider CCN: 14-0015 | Period: From 10/01/2016 To 09/30/2017 | Worksheet S-7 Date/Time Prepared: 2/28/2018 10:40 am

		1.00	2.00	
1.00	If this facility contains a hospital-based SNF, were all patients under managed care or was there no Medicare utilization? Enter "Y" for yes in column 1 and do not complete the rest of this worksheet.			1.00
2.00	Does this hospital have an agreement under either section 1883 or section 1913 for swing beds? Enter "Y" for yes or "N" for no in column 1. If yes, enter the agreement date (mm/dd/yyyy) in column 2.			2.00

		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
		1.00	2.00	3.00	4.00	
3.00		RUX	0	0	0	3.00
4.00		RUL	0	0	0	4.00
5.00		RVX	0	0	0	5.00
6.00		RVL	0	0	0	6.00
7.00		RHX	24	0	24	7.00
8.00		RHL	157	0	157	8.00
9.00		RMX	62	0	62	9.00
10.00		RML	85	0	85	10.00
11.00		RLX	0	0	0	11.00
12.00		RUC	16	0	16	12.00
13.00		RUB	0	0	0	13.00
14.00		RUA	0	0	0	14.00
15.00		RVC	2	0	2	15.00
16.00		RVB	23	0	23	16.00
17.00		RVA	0	0	0	17.00
18.00		RHC	731	0	731	18.00
19.00		RHB	893	0	893	19.00
20.00		RHA	811	0	811	20.00
21.00		RMC	341	0	341	21.00
22.00		RMB	200	0	200	22.00
23.00		RMA	111	0	111	23.00
24.00		RLB	0	0	0	24.00
25.00		RLA	0	0	0	25.00
26.00		ES3	0	0	0	26.00
27.00		ES2	31	0	31	27.00
28.00		ES1	45	0	45	28.00
29.00		HE2	0	0	0	29.00
30.00		HE1	21	0	21	30.00
31.00		HD2	43	0	43	31.00
32.00		HD1	56	0	56	32.00
33.00		HC2	37	0	37	33.00
34.00		HC1	73	0	73	34.00
35.00		HB2	9	0	9	35.00
36.00		HB1	171	0	171	36.00
37.00		LE2	0	0	0	37.00
38.00		LE1	8	0	8	38.00
39.00		LD2	12	0	12	39.00
40.00		LD1	14	0	14	40.00
41.00		LC2	0	0	0	41.00
42.00		LC1	19	0	19	42.00
43.00		LB2	4	0	4	43.00
44.00		LB1	24	0	24	44.00
45.00		CE2	0	0	0	45.00
46.00		CE1	6	0	6	46.00
47.00		CD2	0	0	0	47.00
48.00		CD1	7	0	7	48.00
49.00		CC2	0	0	0	49.00
50.00		CC1	2	0	2	50.00
51.00		CB2	0	0	0	51.00
52.00		CB1	73	0	73	52.00
53.00		CA2	0	0	0	53.00
54.00		CA1	106	0	106	54.00
55.00		SE3	0	0	0	55.00
56.00		SE2	0	0	0	56.00
57.00		SE1	0	0	0	57.00
58.00		SSC	0	0	0	58.00
59.00		SSB	0	0	0	59.00
60.00		SSA	0	0	0	60.00
61.00		IB2	0	0	0	61.00
62.00		IB1	0	0	0	62.00
63.00		IA2	0	0	0	63.00
64.00		IA1	0	0	0	64.00
65.00		BB2	0	0	0	65.00
66.00		BB1	4	0	4	66.00
67.00		BA2	0	0	0	67.00
68.00		BA1	0	0	0	68.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA | Provider CCN: 14-0015 | Period: From 10/01/2016 To 09/30/2017 | Worksheet S-7 Date/Time Prepared: 2/28/2018 10:40 am

		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
		1.00	2.00	3.00	4.00	
69.00		PE2	0	0	0	69.00
70.00		PE1	15	0	15	70.00
71.00		PD2	0	0	0	71.00
72.00		PD1	5	0	5	72.00
73.00		PC2	0	0	0	73.00
74.00		PC1	0	0	0	74.00
75.00		PB2	0	0	0	75.00
76.00		PB1	14	0	14	76.00
77.00		PA2	0	0	0	77.00
78.00		PA1	0	0	0	78.00
199.00		AAA	0	0	0	199.00
200.00	TOTAL		4,255	0	4,255	200.00

		CBSA at Beginning of Cost Reporting Period	CBSA on/after October 1 of the Cost Reporting Period (if applicable)	
		1.00	2.00	
	SNF SERVICES			
201.00	Enter in column 1 the SNF CBSA code or 5 character non-CBSA code if a rural facility, in effect at the beginning of the cost reporting period. Enter in column 2, the code in effect on or after October 1 of the cost reporting period (if applicable).	99914	99914	201.00

		Expenses	Percentage	Associated with Direct Patient Care and Related Expenses?	
		1.00	2.00	3.00	
	A notice published in the Federal Register Volume 68, No. 149 August 4, 2003 provided for an increase in the RUG payments beginning 10/01/2003. Congress expected this increase to be used for direct patient care and related expenses. For lines 202 through 207: Enter in column 1 the amount of the expense for each category. Enter in column 2 the percentage of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 7, column 3. In column 3, enter "Y" for yes or "N" for no if the spending reflects increases associated with direct patient care and related expenses for each category. (see instructions)				
202.00	Staffing	1,615,286	28.21	Y	202.00
203.00	Recruitment	0	0.00		203.00
204.00	Retention of employees	0	0.00		204.00
205.00	Training	0	0.00		205.00
206.00	OTHER (SPECIFY)	0	0.00		206.00
207.00	Total SNF revenue (Worksheet G-2, Part I, line 7, column 3)	5,726,654			207.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA	Provider CCN: 14-0015 Component CCN: 14-3422	Period: From 10/01/2016 To 09/30/2017	Worksheet S-8 Date/Time Prepared: 2/28/2018 10:40 am
		RHC I	Cost

		1.00	
	Clinic Address and Identification		
1.00	Street	102 PRAIRIE MILLS ROAD	1.00

		City	State	ZIP Code	
		1.00	2.00	3.00	
2.00	City, State, ZIP Code, County	GOLDEN	IL	62339	2.00

		1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban	0	3.00

		Grant Award	Date	
		1.00	2.00	
	Source of Federal Funds			
4.00	Community Health Center (Section 330(d), PHS Act)			4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)			5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)			6.00
7.00	Appalachian Regional Commission			7.00
8.00	Look-Alikes			8.00
9.00	OTHER (SPECIFY)			9.00

		1.00	2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)	N	0	10.00

		Sunday		Monday		Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
	Facility hours of operations (1)						
11.00	Clinic			09:00	17:00	09:00	11.00

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

		Provider name	CCN number	
		1.00	2.00	
14.00	RHC/FQHC name, CCN number			14.00

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

		County	
		4.00	
2.00	City, State, ZIP Code, County	ADAMS	2.00

		Tuesday	Wednesday		Thursday		
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)						
11.00	Clinic	17:00	08:00	17:00	09:00	17:00	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA	Provider CCN: 14-0015 Component CCN: 14-3422	Period: From 10/01/2016 To 09/30/2017	Worksheet S-8 Date/Time Prepared: 2/28/2018 10:40 am
		RHC I	Cost

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	Clinic	09:00	17:00				11.00

HOSPITAL-BASED HOSPICE IDENTIFICATION DATA

Provider CCN: 14-0015 | Hospice CCN: 14-1501 | Period: From 10/01/2016 To 09/30/2017 | Worksheet S-9 PARTS I THROUGH IV | Date/Time Prepared: 2/28/2018 10:40 am

Hospice I

		Unduplicated Days						
		Title XVIII	Title XIX	Title XVIII Skilled Nursing Facility	Title XIX Nursing Facility	All Other	Total (sum of cols. 1, 2 & 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART I - ENROLLMENT DAYS FOR COST REPORTING PERIODS BEGINNING BEFORE OCTOBER 1, 2015							
1.00	Hospice Continuous Home Care							1.00
2.00	Hospice Routine Home Care							2.00
3.00	Hospice Inpatient Respite Care							3.00
4.00	Hospice General Inpatient Care							4.00
5.00	Total Hospice Days							5.00
	Part II - CENSUS DATA FOR COST REPORTING PERIODS BEGINNING BEFORE OCTOBER 1, 2015							
6.00	Number of patients receiving hospice care							6.00
7.00	Total number of unduplicated Continuous Care hours billable to Medicare							7.00
8.00	Average Length of Stay (line 5 / line 6)							8.00
9.00	Unduplicated census count							9.00

NOTE: Parts I and II, columns 1 and 2 also include the days reported in columns 3 and 4.

		Title XVIII	Title XIX	Other	Total (sum of cols. 1 through 3)	
		1.00	2.00	3.00	4.00	
	PART III - ENROLLMENT DAYS FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2015					
10.00	Hospice Continuous Home Care	0	0	0	0	10.00
11.00	Hospice Routine Home Care	12,064	309	878	13,251	11.00
12.00	Hospice Inpatient Respite Care	13	0	0	13	12.00
13.00	Hospice General Inpatient Care	279	12	38	329	13.00
14.00	Total Hospice Days	12,356	321	916	13,593	14.00
	PART IV - CONTRACTED STATISTICAL DATA FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2015					
15.00	Hospice Inpatient Respite Care	0	0	0	0	15.00
16.00	Hospice General Inpatient Care	0	0	0	0	16.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 14-0015 | Period: From 10/01/2016 To 09/30/2017 | Worksheet S-10 | Date/Time Prepared: 2/28/2018 10:40 am

Line	Description	1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.208946	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	22,335,818	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 and/or supplemental payments from Medicaid?	N	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	13,494,053	5.00
6.00	Medicaid charges	190,098,547	6.00
7.00	Medicaid cost (line 1 times line 6)	39,720,331	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)	3,890,460	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)	3,890,460	19.00

Line	Description	Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
	Uncompensated Care (see instructions for each line)				
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	18,675,019	8,070,680	26,745,699	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	3,902,071	8,070,680	11,972,751	21.00
22.00	Payments received from patients for amounts previously written off as charity care	37,302	39,861	77,163	22.00
23.00	Cost of charity care (line 21 minus line 22)	3,864,769	8,030,819	11,895,588	23.00

Line	Description	1.00	
24.00	Does the amount on 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)	15,398,585	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	1,199,182	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	1,844,895	27.01
28.00	Non-Medicare bad debt expense (line 26 minus line 27.01)	13,553,690	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	3,477,702	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	15,373,290	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	19,263,750	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-0015 | Period: From 10/01/2016 To 09/30/2017 | Worksheet A | Date/Time Prepared: 2/28/2018 10:40 am

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
	GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT		0	0	0	0	1.00
1.01	00101	CAP REL COSTS-BUTLER BUILDING		652	652	27,156	27,808	1.01
1.02	00102	CAP REL COSTS-OLD BLDG & FIXTURES		4,191,591	4,191,591	52,158	4,243,749	1.02
1.03	00103	CAP REL COSTS-NEW BLDG & FIXTURES		1,362,045	1,362,045	1,081,643	2,443,688	1.03
1.04	00104	CAP REL COSTS-14TH STREET		74,693	74,693	752,405	827,098	1.04
1.05	00105	CAP REL COSTS-MOB PHASE I		0	0	52,128	52,128	1.05
1.06	00106	CAP REL COSTS-BBC		0	0	263,651	263,651	1.06
1.07	00107	CAP REL COSTS-BEC		0	0	130,265	130,265	1.07
2.00	00200	CAP REL COSTS-MVBLE EQUIP		9,852,574	9,852,574	233,052	10,085,626	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,435,053	36,840,609	39,275,662	0	39,275,662	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	16,914,496	104,624,109	121,538,605	-413,773	121,124,832	5.00
6.00	00600	MAINTENANCE & REPAIRS	2,459,871	5,319,869	7,779,740	0	7,779,740	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	36,923	1,129,079	1,166,002	0	1,166,002	8.00
9.00	00900	HOUSEKEEPING	2,349,445	1,080,862	3,430,307	0	3,430,307	9.00
10.00	01000	DIETARY	2,285,049	3,819,717	6,104,766	-3,862,486	2,242,280	10.00
11.00	01100	CAFETERIA	0	0	0	3,862,486	3,862,486	11.00
13.00	01300	NURSING ADMINISTRATION	6,706,800	513,032	7,219,832	-28,311	7,191,521	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,645,027	784,432	3,429,459	0	3,429,459	16.00
20.00	02000	NURSING SCHOOL	3,319,494	2,164,585	5,484,079	955,961	6,440,040	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	1,040,755	0	1,040,755	0	1,040,755	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	1,887,815	1,887,815	0	1,887,815	22.00
23.00	02300	PARAMED ED PRGM	0	0	0	0	0	23.00
23.01	02301	PARAMED ED PRGM-RADIOLOGY	274,237	4,042	278,279	0	278,279	23.01
23.02	02302	PARAMED ED PRGM-LABORATORY	65,157	3,255	68,412	0	68,412	23.02
23.03	02303	PARAMED ED PRGM-PHARMACY	278,295	13,115	291,410	0	291,410	23.03
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	15,063,206	2,955,701	18,018,907	-704,465	17,314,442	30.00
31.00	03100	INTENSIVE CARE UNIT	3,453,662	2,004,790	5,458,452	-272,540	5,185,912	31.00
40.00	04000	SUBPROVIDER - IPF	4,360,370	106,839	4,467,209	-17,845	4,449,364	40.00
41.00	04100	SUBPROVIDER - IRF	1,480,702	143,584	1,624,286	-47,406	1,576,880	41.00
43.00	04300	NURSERY	469,245	82,577	551,822	-74,193	477,629	43.00
44.00	04400	SKILLED NURSING FACILITY	1,615,286	136,475	1,751,761	-42,083	1,709,678	44.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	9,466,271	18,390,831	27,857,102	-13,035,634	14,821,468	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,246,371	304,283	1,550,654	-154,280	1,396,374	52.00
53.00	05300	ANESTHESIOLOGY	175,725	686,838	862,563	-297,616	564,947	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,374,937	1,936,470	6,311,407	-345,212	5,966,195	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	1,086,420	414,444	1,500,864	-6,907	1,493,957	55.00
57.00	05700	CT SCAN	514,838	273,515	788,353	-22,959	765,394	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	315,789	155,951	471,740	-69	471,671	58.00
60.00	06000	LABORATORY	3,199,937	3,454,768	6,654,705	-129,196	6,525,509	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	135,421	1,265,155	1,400,576	0	1,400,576	62.00
65.00	06500	RESPIRATORY THERAPY	2,122,045	401,394	2,523,439	-155,995	2,367,444	65.00
66.00	06600	PHYSICAL THERAPY	1,260,075	56,537	1,316,612	-2,082	1,314,530	66.00
67.00	06700	OCCUPATIONAL THERAPY	621,616	6,494	628,110	-216	627,894	67.00
68.00	06800	SPEECH PATHOLOGY	240,473	6,196	246,669	-523	246,146	68.00
69.00	06900	ELECTROCARDIOLOGY	1,802,142	6,612,040	8,414,182	-5,863,847	2,550,335	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	378,139	111,899	490,038	-17	490,021	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	774,362	590,715	1,365,077	8,264,421	9,629,498	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	12,221,936	12,221,936	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,816,336	14,447,205	18,263,541	-13,591	18,249,950	73.00
74.00	07400	RENAL DIALYSIS	0	759,767	759,767	-279	759,488	74.00
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	429,610	548,086	977,696	-974	976,722	88.00
90.00	09000	CLINIC	393,916	78,079	471,995	0	471,995	90.00
90.01	09001	OUTPATIENT INFUSION	495,471	41,748	537,219	-18,620	518,599	90.01
91.00	09100	EMERGENCY	9,915,478	1,886,269	11,801,747	-167,365	11,634,382	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	3,113,065	1,482,541	4,595,606	-2,338	4,593,268	101.00
	SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE		2,262,247	2,262,247	-2,262,247	0	113.00
116.00	11600	HOSPICE	1,412,588	543,018	1,955,606	21,338	1,976,944	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	114,544,098	235,812,532	350,356,630	-24,469	350,332,161	118.00
	NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	754	31,030	31,784	0	31,784	192.00
192.01	19201	FASTCARE	270,103	61,185	331,288	0	331,288	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	DENMAN SERVICES	0	0	0	0	0	193.01

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-0015 | Period: From 10/01/2016 To 09/30/2017 | Worksheet A | Date/Time Prepared: 2/28/2018 10:40 am

		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	
193.02	19302	MEALS ON WHEELS	0	0	0	0	0	193.02
193.03	19303	UNUSED SPACE	0	0	0	0	0	193.03
193.04	19304	HEALTH EDUCATION	0	0	0	0	0	193.04
193.05	19305	RENTED SPACE	0	0	0	24,469	24,469	193.05
193.06	19306	AUGUSTA PHARMACY	202,376	662,653	865,029	0	865,029	193.06
200.00		TOTAL (SUM OF LINES 118 through 199)	115,017,331	236,567,400	351,584,731	0	351,584,731	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-0015 | Period: From 10/01/2016 To 09/30/2017 | Worksheet A | Date/Time Prepared: 2/28/2018 10:40 am

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
		GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT	0	0	1.00
1.01	00101	CAP REL COSTS-BUTLER BUILDING	9,787	37,595	1.01
1.02	00102	CAP REL COSTS-OLD BLDG & FIXTURES	-3,805,975	437,774	1.02
1.03	00103	CAP REL COSTS-NEW BLDG & FIXTURES	3,747,139	6,190,827	1.03
1.04	00104	CAP REL COSTS-14TH STREET	-748,818	78,280	1.04
1.05	00105	CAP REL COSTS-MOB PHASE I	-42,311	9,817	1.05
1.06	00106	CAP REL COSTS-BBC	-168,747	94,904	1.06
1.07	00107	CAP REL COSTS-BEC	0	130,265	1.07
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2,988,978	13,074,604	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-32,323,795	6,951,867	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-65,560,767	55,564,065	5.00
6.00	00600	MAINTENANCE & REPAIRS	-981,047	6,798,693	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	67,176	1,233,178	8.00
9.00	00900	HOUSEKEEPING	-292,724	3,137,583	9.00
10.00	01000	DIETARY	-535,499	1,706,781	10.00
11.00	01100	CAFETERIA	-1,381,480	2,481,006	11.00
13.00	01300	NURSING ADMINISTRATION	-263,176	6,928,345	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,076,955	5,506,414	16.00
20.00	02000	NURSING SCHOOL	-4,161,620	2,278,420	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	1,040,755	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	1,887,815	22.00
23.00	02300	PARAMED ED PRGM	0	0	23.00
23.01	02301	PARAMED ED PRGM-RADIOLOGY	-69,048	209,231	23.01
23.02	02302	PARAMED ED PRGM-LABORATORY	-28,825	39,587	23.02
23.03	02303	PARAMED ED PRGM-PHARMACY	0	291,410	23.03
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	-53,755	17,260,687	30.00
31.00	03100	INTENSIVE CARE UNIT	-1,513,031	3,672,881	31.00
40.00	04000	SUBPROVIDER - IPF	-2,259	4,447,105	40.00
41.00	04100	SUBPROVIDER - IRF	-9,467	1,567,413	41.00
43.00	04300	NURSERY	0	477,629	43.00
44.00	04400	SKILLED NURSING FACILITY	-430	1,709,248	44.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	-1,186,697	13,634,771	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,396,374	52.00
53.00	05300	ANESTHESIOLOGY	-17,742	547,205	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-1,000,268	4,965,927	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	-5,510	1,488,447	55.00
57.00	05700	CT SCAN	-927	764,467	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	471,671	58.00
60.00	06000	LABORATORY	-23,565	6,501,944	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	1,400,576	62.00
65.00	06500	RESPIRATORY THERAPY	-20,795	2,346,649	65.00
66.00	06600	PHYSICAL THERAPY	0	1,314,530	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	627,894	67.00
68.00	06800	SPEECH PATHOLOGY	0	246,146	68.00
69.00	06900	ELECTROCARDIOLOGY	-19,264	2,531,071	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	-25,270	464,751	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	-46,536	9,582,962	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	12,221,936	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-2,724,667	15,525,283	73.00
74.00	07400	RENAL DIALYSIS	0	759,488	74.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	-36,393	940,329	88.00
90.00	09000	CLINIC	0	471,995	90.00
90.01	09001	OUTPATIENT INFUSION	-152,412	366,187	90.01
91.00	09100	EMERGENCY	-6,413,718	5,220,664	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
		OTHER REIMBURSABLE COST CENTERS			
101.00	10100	HOME HEALTH AGENCY	-12,746	4,580,522	101.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE	0	0	113.00
116.00	11600	HOSPICE	115,394	2,092,338	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-114,623,855	235,708,306	118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	31,784	192.00
192.01	19201	FASTCARE	-1,307	329,981	192.01
193.00	19300	NONPAID WORKERS	0	0	193.00
193.01	19301	DENMAN SERVICES	0	0	193.01
193.02	19302	MEALS ON WHEELS	0	0	193.02
193.03	19303	UNUSED SPACE	0	0	193.03

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-0015 | Period: From 10/01/2016 To 09/30/2017 | Worksheet A Date/Time Prepared: 2/28/2018 10:40 am

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
193.04	19304	HEALTH EDUCATION	0	0	193.04
193.05	19305	RENTED SPACE	0	24,469	193.05
193.06	19306	AUGUSTA PHARMACY	0	865,029	193.06
200.00		TOTAL (SUM OF LINES 118 through 199)	-114,625,162	236,959,569	200.00

RECLASSIFICATIONS	Provider CCN: 14-0015	Period: From 10/01/2016 To 09/30/2017	Worksheet A-6 Date/Time Prepared: 2/28/2018 10:40 am

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - RECLASS CAFETERIA COSTS				
1.00	CAFETERIA	11.00	1,445,751	2,416,735	1.00
	TOTALS		1,445,751	2,416,735	
	B - RECLASS C-SECTION COSTS				
1.00	OPERATING ROOM	50.00	12,374	0	1.00
	TOTALS		12,374	0	
	C - RECLASS BBC AND BEC RENT EXPENSE				
1.00	CAP REL COSTS-BBC	1.06	0	263,651	1.00
2.00	CAP REL COSTS-BEC	1.07	0	130,265	2.00
	TOTALS		0	393,916	
	D - RECLASS CAPITAL RELATD INSURANCE COS				
1.00	CAP REL COSTS-BUTLER BUILDING	1.01	0	27,156	1.00
2.00	CAP REL COSTS-OLD BLDG & FIXTURES	1.02	0	52,158	2.00
3.00	CAP REL COSTS-NEW BLDG & FIXTURES	1.03	0	75,340	3.00
4.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	9,049	4.00
	TOTALS		0	163,703	
	E - RECLASS VOLUNTEER SERVICES				
1.00	HOSPICE	116.00	17,527	4,013	1.00
	TOTALS		17,527	4,013	
	F - RECLASS HEALTH EDUCATION				
1.00	RENTED SPACE	193.05	24,396	73	1.00
	TOTALS		24,396	73	
	G - RECLASS INTEREST EXPENSE				
1.00	CAP REL COSTS-NEW BLDG & FIXTURES	1.03	0	1,006,303	1.00
2.00	CAP REL COSTS-14TH STREET	1.04	0	752,405	2.00
3.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	224,003	3.00
4.00	ADMINISTRATIVE & GENERAL	5.00	0	279,536	4.00
	TOTALS		0	2,262,247	
	H - RECLASS ER PHYSICIAN MALPRACTIC INS				
1.00	EMERGENCY	91.00	0	62,022	1.00
	TOTALS		0	62,022	
	I - RECLASS CHARGABLE MEDICAL SUPPLIES				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	8,264,421	1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	12,221,936	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
22.00		0.00	0	0	22.00
23.00		0.00	0	0	23.00
24.00		0.00	0	0	24.00
25.00		0.00	0	0	25.00
26.00		0.00	0	0	26.00
27.00		0.00	0	0	27.00
	TOTALS		0	20,486,357	
	J - RECLASS PRECEPTOR PAY				
1.00	NURSING SCHOOL	20.00	955,961	0	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00

RECLASSIFICATIONS | Provider CCN: 14-0015 | Period: From 10/01/2016 To 09/30/2017 | Worksheet A-6 Date/Time Prepared: 2/28/2018 10:40 am

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
	TOTALS		955,961	0	
	K - RECLASS RENT EXPENSE				
1.00	CAP REL COSTS-MOB PHASE I	1.05	0	52,128	1.00
	TOTALS		0	52,128	
500.00	Grand Total: Increases		2,456,009	25,841,194	500.00

RECLASSIFICATIONS | Provider CCN: 14-0015 | Period: From 10/01/2016 To 09/30/2017 | Worksheet A-6 | Date/Time Prepared: 2/28/2018 10:40 am

	Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
	A - RECLASS CAFETERIA COSTS					
1.00	DIETARY	10.00	1,445,751	2,416,735	0	1.00
	TOTALS		1,445,751	2,416,735		
	B - RECLASS C-SECTION COSTS					
1.00	DELIVERY ROOM & LABOR ROOM	52.00	12,374	0	0	1.00
	TOTALS		12,374	0		
	C - RECLASS BBC AND BEC RENT EXPENSE					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	393,916	10	1.00
2.00		0.00	0	0	10	2.00
	TOTALS		0	393,916		
	D - RECLASS CAPITAL RELATD INSURANCE COS					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	163,703	12	1.00
2.00		0.00	0	0	12	2.00
3.00		0.00	0	0	12	3.00
4.00		0.00	0	0	12	4.00
	TOTALS		0	163,703		
	E - RECLASS VOLUNTEER SERVICES					
1.00	ADMINISTRATIVE & GENERAL	5.00	17,527	4,013	0	1.00
	TOTALS		17,527	4,013		
	F - RECLASS HEALTH EDUCATION					
1.00	NURSING ADMINISTRATION	13.00	24,396	73	0	1.00
	TOTALS		24,396	73		
	G - RECLASS INTEREST EXPENSE					
1.00	INTEREST EXPENSE	113.00	0	2,262,247	11	1.00
2.00		0.00	0	0	11	2.00
3.00		0.00	0	0	11	3.00
4.00		0.00	0	0	11	4.00
	TOTALS		0	2,262,247		
	H - RECLASS ER PHYSICIAN MALPRACTIC INS					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	62,022	0	1.00
	TOTALS		0	62,022		
	I - RECLASS CHARGABLE MEDICAL SUPPLIES					
1.00	ADULTS & PEDIATRICS	30.00	0	248,390	0	1.00
2.00	INTENSIVE CARE UNIT	31.00	0	150,319	0	2.00
3.00	SUBPROVIDER - IPF	40.00	0	1,217	0	3.00
4.00	SUBPROVIDER - IRF	41.00	0	5,539	0	4.00
5.00	NURSERY	43.00	0	42,549	0	5.00
6.00	SKILLED NURSING FACILITY	44.00	0	15,760	0	6.00
7.00	OPERATING ROOM	50.00	0	12,953,033	0	7.00
8.00	DELIVERY ROOM & LABOR ROOM	52.00	0	127,301	0	8.00
9.00	ANESTHESIOLOGY	53.00	0	297,616	0	9.00
10.00	RADIOLOGY-DIAGNOSTIC	54.00	0	345,212	0	10.00
11.00	RADIOLOGY-THERAPEUTIC	55.00	0	6,907	0	11.00
12.00	CT SCAN	57.00	0	22,959	0	12.00
13.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	69	0	13.00
14.00	LABORATORY	60.00	0	129,196	0	14.00
15.00	RESPIRATORY THERAPY	65.00	0	153,022	0	15.00
16.00	PHYSICAL THERAPY	66.00	0	2,082	0	16.00
17.00	OCCUPATIONAL THERAPY	67.00	0	216	0	17.00
18.00	SPEECH PATHOLOGY	68.00	0	523	0	18.00
19.00	ELECTROCARDIOLOGY	69.00	0	5,863,847	0	19.00
20.00	ELECTROENCEPHALOGRAPHY	70.00	0	17	0	20.00
21.00	DRUGS CHARGED TO PATIENTS	73.00	0	13,591	0	21.00
22.00	RENAL DIALYSIS	74.00	0	279	0	22.00
23.00	RURAL HEALTH CLINIC	88.00	0	974	0	23.00
24.00	OUTPATIENT INFUSION	90.01	0	4,881	0	24.00
25.00	EMERGENCY	91.00	0	98,318	0	25.00
26.00	HOME HEALTH AGENCY	101.00	0	2,338	0	26.00
27.00	HOSPICE	116.00	0	202	0	27.00
	TOTALS		0	20,486,357		
	J - RECLASS PRECEPTOR PAY					
1.00	NURSING ADMINISTRATION	13.00	3,842	0	0	1.00
2.00	ADULTS & PEDIATRICS	30.00	456,075	0	0	2.00
3.00	INTENSIVE CARE UNIT	31.00	122,221	0	0	3.00
4.00	SUBPROVIDER - IPF	40.00	16,628	0	0	4.00
5.00	SUBPROVIDER - IRF	41.00	41,867	0	0	5.00
6.00	NURSERY	43.00	31,644	0	0	6.00
7.00	SKILLED NURSING FACILITY	44.00	26,323	0	0	7.00
8.00	OPERATING ROOM	50.00	94,975	0	0	8.00
9.00	DELIVERY ROOM & LABOR ROOM	52.00	14,605	0	0	9.00
10.00	RESPIRATORY THERAPY	65.00	2,973	0	0	10.00
11.00	OUTPATIENT INFUSION	90.01	13,739	0	0	11.00
12.00	EMERGENCY	91.00	131,069	0	0	12.00

RECLASSIFICATIONS

Provider CCN: 14-0015 | Period: From 10/01/2016 To 09/30/2017 | Worksheet A-6 | Date/Time Prepared: 2/28/2018 10:40 am

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	TOTALS		955,961	0			
	K - RECLASS RENT EXPENSE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	52,128	10		1.00
	TOTALS		0	52,128			
500.00	Grand Total: Decreases		2,456,009	25,841,194			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-0015 | Period: From 10/01/2016 To 09/30/2017 | Worksheet A-7 Part I Date/Time Prepared: 2/28/2018 10:40 am

			Acquisitions				
		Beginning Balances	Purchases	Donation	Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	13,428,256	967,411	0	967,411	0	1.00
2.00	Land Improvements	6,626,178	598,184	0	598,184	41,249	2.00
3.00	Buildings and Fixtures	134,829,853	8,034,709	0	8,034,709	3,483,551	3.00
4.00	Building Improvements	3,564,673	0	0	0	0	4.00
5.00	Fixed Equipment	67,891,306	7,101,153	0	7,101,153	9,541,928	5.00
6.00	Movable Equipment	144,902,354	13,899,289	0	13,899,289	2,671,210	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	371,242,620	30,600,746	0	30,600,746	15,737,938	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	371,242,620	30,600,746	0	30,600,746	15,737,938	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	14,395,667	0	1.00
2.00	Land Improvements	7,183,113	0	2.00
3.00	Buildings and Fixtures	139,381,011	0	3.00
4.00	Building Improvements	3,564,673	0	4.00
5.00	Fixed Equipment	65,450,531	0	5.00
6.00	Movable Equipment	156,130,433	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	386,105,428	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	386,105,428	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0015 | Period: From 10/01/2016 To 09/30/2017 | Worksheet A-7 Part II | Date/Time Prepared: 2/28/2018 10:40 am

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	0	0	1.00
1.01	CAP REL COSTS-BUTLER BUILDING	652	0	0	0	0	1.01
1.02	CAP REL COSTS-OLD BLDG & FIXTURES	4,191,591	0	0	0	0	1.02
1.03	CAP REL COSTS-NEW BLDG & FIXTURES	1,362,045	0	0	0	0	1.03
1.04	CAP REL COSTS-14TH STREET	74,693	0	0	0	0	1.04
1.05	CAP REL COSTS-MOB PHASE I	0	0	0	0	0	1.05
1.06	CAP REL COSTS-BBC	0	0	0	0	0	1.06
1.07	CAP REL COSTS-BEC	0	0	0	0	0	1.07
2.00	CAP REL COSTS-MVBLE EQUIP	9,852,574	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	15,481,555	0	0	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL		
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
		14.00	15.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	0	1.00
1.01	CAP REL COSTS-BUTLER BUILDING	0	652	1.01
1.02	CAP REL COSTS-OLD BLDG & FIXTURES	0	4,191,591	1.02
1.03	CAP REL COSTS-NEW BLDG & FIXTURES	0	1,362,045	1.03
1.04	CAP REL COSTS-14TH STREET	0	74,693	1.04
1.05	CAP REL COSTS-MOB PHASE I	0	0	1.05
1.06	CAP REL COSTS-BBC	0	0	1.06
1.07	CAP REL COSTS-BEC	0	0	1.07
2.00	CAP REL COSTS-MVBLE EQUIP	0	9,852,574	2.00
3.00	Total (sum of lines 1-2)	0	15,481,555	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-0015 | Period: From 10/01/2016 To 09/30/2017 | Worksheet A-7 Part III Date/Time Prepared: 2/28/2018 10:40 am

	Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	0.000000	0	1.00
1.01	CAP REL COSTS-BUTLER BUILDING	305,716	0	305,716	0.000839	0	1.01
1.02	CAP REL COSTS-OLD BLDG & FIXTURES	161,699,640	0	161,699,640	0.443588	0	1.02
1.03	CAP REL COSTS-NEW BLDG & FIXTURES	46,390,859	0	46,390,859	0.127263	0	1.03
1.04	CAP REL COSTS-14TH STREET	0	0	0	0.000000	0	1.04
1.05	CAP REL COSTS-MOB PHASE I	0	0	0	0.000000	0	1.05
1.06	CAP REL COSTS-BBC	0	0	0	0.000000	0	1.06
1.07	CAP REL COSTS-BEC	0	0	0	0.000000	0	1.07
2.00	CAP REL COSTS-MVBLE EQUIP	156,130,433	0	156,130,433	0.428310	0	2.00
3.00	Total (sum of lines 1-2)	364,526,648	0	364,526,648	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	0	0	1.00
1.01	CAP REL COSTS-BUTLER BUILDING	0	0	0	10,439	0	1.01
1.02	CAP REL COSTS-OLD BLDG & FIXTURES	0	0	0	385,616	0	1.02
1.03	CAP REL COSTS-NEW BLDG & FIXTURES	0	0	0	6,825,109	0	1.03
1.04	CAP REL COSTS-14TH STREET	0	0	0	78,279	0	1.04
1.05	CAP REL COSTS-MOB PHASE I	0	0	0	0	9,817	1.05
1.06	CAP REL COSTS-BBC	0	0	0	2,627	92,277	1.06
1.07	CAP REL COSTS-BEC	0	0	0	0	130,265	1.07
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	13,193,235	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	20,495,305	232,359	3.00

	Cost Center Description	SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	0	0	1.00
1.01	CAP REL COSTS-BUTLER BUILDING	0	27,156	0	0	37,595	1.01
1.02	CAP REL COSTS-OLD BLDG & FIXTURES	0	52,158	0	0	437,774	1.02
1.03	CAP REL COSTS-NEW BLDG & FIXTURES	-709,622	75,340	0	0	6,190,827	1.03
1.04	CAP REL COSTS-14TH STREET	1	0	0	0	78,280	1.04
1.05	CAP REL COSTS-MOB PHASE I	0	0	0	0	9,817	1.05
1.06	CAP REL COSTS-BBC	0	0	0	0	94,904	1.06
1.07	CAP REL COSTS-BEC	0	0	0	0	130,265	1.07
2.00	CAP REL COSTS-MVBLE EQUIP	-127,680	9,049	0	0	13,074,604	2.00
3.00	Total (sum of lines 1-2)	-837,301	163,703	0	0	20,054,066	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-0015 | Period: From 10/01/2016 To 09/30/2017 | Worksheet A-8 | Date/Time Prepared: 2/28/2018 10:40 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
				Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
1.01	Investment income - CAP REL COSTS-BUTLER BUILDING (chapter 2)		0	CAP REL COSTS-BUTLER BUILDING	1.01	0	1.01
1.02	Investment income - CAP REL COSTS-OLD BLDG & FIXTURES (chapter 2)		0	CAP REL COSTS-OLD BLDG & FIXTURES	1.02	0	1.02
1.03	Investment income - CAP REL COSTS-NEW BLDG & FIXTURES (chapter 2)		0	CAP REL COSTS-NEW BLDG & FIXTURES	1.03	0	1.03
1.04	Investment income - CAP REL COSTS-14TH STREET (chapter 2)		0	CAP REL COSTS-14TH STREET	1.04	0	1.04
1.05	Investment income - CAP REL COSTS-MOB PHASE I (chapter 2)		0	CAP REL COSTS-MOB PHASE I	1.05	0	1.05
1.06	Investment income - CAP REL COSTS-BBC (chapter 2)		0	CAP REL COSTS-BBC	1.06	0	1.06
1.07	Investment income - CAP REL COSTS-BEC (chapter 2)		0	CAP REL COSTS-BEC	1.07	0	1.07
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)	B	-757,520	ADMINISTRATIVE & GENERAL	5.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-202,367	ADMINISTRATIVE & GENERAL	5.00	0	7.00
8.00	Television and radio service (chapter 21)	A	-57,504	CAP REL COSTS-MVBLE EQUIP	2.00	9	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-25,203,227			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	14,162,635			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-1,381,480	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients	A	-2,481,828	DRUGS CHARGED TO PATIENTS	73.00	0	17.00
18.00	Sale of medical records and abstracts	B	-88,382	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)	B	-4,066,357	NURSING SCHOOL	20.00	0	19.00
20.00	Vending machines	B	-21,876	DIETARY	10.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00

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	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
				Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
26.01	Depreciation - CAP REL COSTS-BUTLER BUILDING		0	CAP REL COSTS-BUTLER BUILDING	1.01	0	26.01
26.02	Depreciation - CAP REL COSTS-OLD BLDG & FIXTURES		0	CAP REL COSTS-OLD BLDG & FIXTURES	1.02	0	26.02
26.03	Depreciation - CAP REL COSTS-NEW BLDG & FIXTURES		0	CAP REL COSTS-NEW BLDG & FIXTURES	1.03	0	26.03
26.04	Depreciation - CAP REL COSTS-14TH STREET		0	CAP REL COSTS-14TH STREET	1.04	0	26.04
26.05	Depreciation - CAP REL COSTS-MOB PHASE I		0	CAP REL COSTS-MOB PHASE I	1.05	0	26.05
26.06	Depreciation - CAP REL COSTS-BBC		0	CAP REL COSTS-BBC	1.06	0	26.06
26.07	Depreciation - CAP REL COSTS-BEC		0	CAP REL COSTS-BEC	1.07	0	26.07
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	RENTAL INSURANCE EXPENSE	A	-10,928	ADMINISTRATIVE & GENERAL	5.00	0	33.00
33.01	MISCELLANEOUS INCOME	B	-15,361	MEDICAL RECORDS & LIBRARY	16.00	0	33.01
33.02	DAMAGED GOODS	B	-55,295	ADMINISTRATIVE & GENERAL	5.00	0	33.02
33.03	CHILD CARE CENTER	B	-1,747,131	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.03
33.04	BOOKKEEPING FEES	B	-142,444	ADMINISTRATIVE & GENERAL	5.00	0	33.04
33.05	RADIOLOGY TUITION	B	-69,048	PARAMED ED PRGM-RADIOLOGY	23.01	0	33.05
33.06	PRINT SHOP	B	-75,800	ADMINISTRATIVE & GENERAL	5.00	0	33.06
33.07	HEALTH PROMOTIONS	B	-106,065	NURSING ADMINISTRATION	13.00	0	33.07
33.08	HOUSEKEEPING SERVICES	B	-292,724	HOUSEKEEPING	9.00	0	33.08
33.09	ADVERTISING	A	-330,366	ADMINISTRATIVE & GENERAL	5.00	0	33.09
33.10	ADVERTISING	A	-333	DIETARY	10.00	0	33.10
33.11	ADVERTISING	A	-35,263	NURSING SCHOOL	20.00	0	33.11
33.12	ADVERTISING	A	-200	SUBPROVIDER - IPF	40.00	0	33.12
33.13	ADVERTISING	A	-5,537	RADIOLOGY-DIAGNOSTIC	54.00	0	33.13
33.14	ADVERTISING	A	-12	RADIOLOGY-THERAPEUTIC	55.00	0	33.14
33.15	ADVERTISING	A	-406	RURAL HEALTH CLINIC	88.00	0	33.15
33.16	ADVERTISING	A	-12,727	HOME HEALTH AGENCY	101.00	0	33.16
33.17	ADVERTISING	A	-1,307	FASTCARE	192.01	0	33.17
33.18	RENTAL PROPERTY EXPENSE	A	-709,622	CAP REL COSTS-NEW BLDG & FIXTURES	1.03	11	33.18
33.19	RENTAL PROPERTY EXPENSE	A	-127,679	CAP REL COSTS-MVBLE EQUIP	2.00	11	33.19
33.20	REAL ESTATE TAXES ON RENTAL	A	-100,704	MAINTENANCE & REPAIRS	6.00	0	33.20
33.21	RENTAL PROPERTY EXPENSE	A	-50,557	MAINTENANCE & REPAIRS	6.00	0	33.21
33.22	INTEREST INCOME	A	-1,006,303	CAP REL COSTS-NEW BLDG & FIXTURES	1.03	11	33.22
33.23	INTEREST INCOME	A	-752,404	CAP REL COSTS-14TH STREET	1.04	11	33.23
33.24	INTEREST INCOME	A	-224,004	CAP REL COSTS-MVBLE EQUIP	2.00	11	33.24
33.25	INTEREST INCOME	A	-279,535	ADMINISTRATIVE & GENERAL	5.00	0	33.25
33.26	DIETARY OUTSIDE SERVICES-SALARIES	A	-42,932	DIETARY	10.00	0	33.26
33.27	DIETARY OUTSIDE SERVICES-BENEFITS	A	-13,425	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.27
33.28	PHYSICIAN RECRUITMENT	A	-299,096	ADMINISTRATIVE & GENERAL	5.00	0	33.28
33.29	LOBBYING EXPENSE	A	-42,241	ADMINISTRATIVE & GENERAL	5.00	0	33.29
33.30	TRANSFER TO PARENT	A	-12,842,977	ADMINISTRATIVE & GENERAL	5.00	0	33.30
33.31	ER PHYSICIAN BENEFITS	A	-468,572	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.31
33.32	ALCOHOL RELATED EXPENSES	A	-3,000	ADMINISTRATIVE & GENERAL	5.00	0	33.32
33.33	BOOK TO MEDICARE DEPRECIATION	A	57,086	CAP REL COSTS-NEW BLDG & FIXTURES	1.03	9	33.33
33.34	GROUND FEES	B	-63,473	MAINTENANCE & REPAIRS	6.00	0	33.34

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	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
				Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.35	LABORATORY TUITION	B	-28,825	PARAMED ED PRGM-LABORATORY	23.02	0	33.35
33.36	CV SURGEON BENEFITS	A	-62,509	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.36
33.37	SELF-FUNDED HEALTH INSURANCE	A	-19,900,980	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.37
33.38	LEASED EQUIPMENT	B	-867	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.38
33.39	STUDER GROUP EXPENSE	A	-439,043	ADMINISTRATIVE & GENERAL	5.00	0	33.39
33.40	TRAUMA ON-CALL	A	-1,329,733	ADMINISTRATIVE & GENERAL	5.00	0	33.40
33.41	NON-HOSPITAL DEPRECIATION	A	-54,575	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.41
33.42	MISCELLANEOUS INCOME	B	-69,442	ADMINISTRATIVE & GENERAL	5.00	0	33.42
33.43	MISCELLANEOUS INCOME	B	-12,885	RESPIRATORY THERAPY	65.00	0	33.43
33.44	MISCELLANEOUS INCOME	B	-10,905	ADMINISTRATIVE & GENERAL	5.00	0	33.44
33.45	MISCELLANEOUS INCOME	B	-979,328	ADMINISTRATIVE & GENERAL	5.00	0	33.45
33.46	MISCELLANEOUS INCOME	B	-33,333	DIETARY	10.00	0	33.46
33.47	MISCELLANEOUS INCOME	B	-6,180	LABORATORY	60.00	0	33.47
33.48	MISCELLANEOUS INCOME	B	-68,596	DRUGS CHARGED TO PATIENTS	73.00	0	33.48
33.49	MISCELLANEOUS INCOME	B	-2,004	ELECTROCARDIOLOGY	69.00	0	33.49
33.50	MISCELLANEOUS INCOME	B	-15,137	RADIOLOGY-DIAGNOSTIC	54.00	0	33.50
33.51	CARE COORDINATION	B	-9,508	ADMINISTRATIVE & GENERAL	5.00	0	33.51
33.52	MISCELLANEOUS INCOME	B	-1,878,153	ADMINISTRATIVE & GENERAL	5.00	0	33.52
33.53	OUTSIDE CATERING	B	-24,700	DIETARY	10.00	0	33.53
33.54	BH JAVA	B	-408,198	DIETARY	10.00	0	33.54
33.55	BPS EXPENSES	A	-28,808,999	ADMINISTRATIVE & GENERAL	5.00	0	33.55
33.56	ECHO OUTREACH SALARIES	A	-11,384	ELECTROCARDIOLOGY	69.00	0	33.56
33.57	ECHO OUTREACH BENEFITS	A	-3,560	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.57
33.58	PHARMACY COVERAGE SALARIES	A	-47,833	DRUGS CHARGED TO PATIENTS	73.00	0	33.58
33.59	PHARMACY COVERAGE BENEFITS	A	-14,957	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.59
33.60	PHARMACY COVERAGE EXPENSES	A	-30,518	DRUGS CHARGED TO PATIENTS	73.00	0	33.60
33.61	INFORMATION SYSTEMS WAGES	A	-4,402,355	ADMINISTRATIVE & GENERAL	5.00	0	33.61
33.62	INFORMATION SYSTEMS BENEFITS	A	-1,703,389	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.62
33.63	INFORMATION SYSTEMS EXPENSES	A	-7,947,670	ADMINISTRATIVE & GENERAL	5.00	0	33.63
33.64	INTEREST FROM INSURANCE	B	-449,450	ADMINISTRATIVE & GENERAL	5.00	0	33.64
33.65	PAIN MGMT NP SALARIES	A	-109,223	OPERATING ROOM	50.00	0	33.65
33.66	PAIN MGMT NP BENETITS	A	-34,154	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.66
33.67	PA AND NP IN EMERGENCY DEPARTMENT	A	-544,505	EMERGENCY	91.00	0	33.67
33.68	PA AND NP IN EMERGENCY DEPARTMENT	A	-170,267	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.68
33.69	COLLEGE OF NURSING LOBBYING	A	-60,000	NURSING SCHOOL	20.00	0	33.69
33.70	LOBBYING EXPENSE	A	-3,078	SUBPROVIDER - IRF	41.00	0	33.70
33.71	HIM SALARIES	A	-2,645,027	MEDICAL RECORDS & LIBRARY	16.00	0	33.71
33.72	PFS AND PT ACCESS SALARIES	A	-2,627,347	ADMINISTRATIVE & GENERAL	5.00	0	33.72
33.73	HIM EXPENSES	A	-784,432	MEDICAL RECORDS & LIBRARY	16.00	0	33.73
33.74	PFS AND PT ACCESS EXPENSES	A	-2,149,938	ADMINISTRATIVE & GENERAL	5.00	0	33.74
33.75	DECISION SUPPORT SALARIES	A	-413,568	ADMINISTRATIVE & GENERAL	5.00	0	33.75
33.76	DECISION SUPPORT EXPENSES	A	-40,857	ADMINISTRATIVE & GENERAL	5.00	0	33.76
33.77	HUMAN RESOURCES SALARIES	A	-782,663	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.77
33.78	HUMAN RESOURCES EXPENSES	A	-551,243	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.78
33.79	MISCELLANEOUS INCOME	B	-95,892	DRUGS CHARGED TO PATIENTS	73.00	0	33.79
33.80	MISCELLANEOUS INCOME	B	-259,641	MAINTENANCE & REPAIRS	6.00	0	33.80
33.81	HOSPICE RESPITE AND INPATIENT PMT	A	7,016	HOSPICE	116.00	0	33.81
33.82	HOSPITAL SERVICES TO HOSPICE PTS	A	108,378	HOSPICE	116.00	0	33.82
33.83	DEPRECIATION ADJUSTMENT	A	9,787	CAP REL COSTS-BUTLER BUILDING	1.01	9	33.83
33.84	DEPRECIATION ADJUSTMENT	A	-3,805,975	CAP REL COSTS-OLD BLDG & FIXTURES	1.02	9	33.84
33.85	DEPRECIATION ADJUSTMENT	A	5,405,978	CAP REL COSTS-NEW BLDG & FIXTURES	1.03	9	33.85
33.86	DEPRECIATION ADJUSTMENT	A	3,586	CAP REL COSTS-14TH STREET	1.04	9	33.86
33.87	DEPRECIATION ADJUSTMENT	A	2,627	CAP REL COSTS-BBC	1.06	9	33.87
33.88	DEPRECIATION ADJUSTMENT	A	3,453,607	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.88
33.89	ONCOLOGISTS BENEFITS	A	-112,424	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.89
33.90	WELLNESS CENTER RENT	A	297,400	ADMINISTRATIVE & GENERAL	5.00	0	33.90
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-114,625,162				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.

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-0015 | Period: From 10/01/2016 To 09/30/2017 | Worksheet A-8 | Date/Time Prepared: 2/28/2018 10:40 am

			Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
	1.00	2.00	3.00	4.00	5.00	

B. Amount Received - if cost cannot be determined.
(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.
Note: See instructions for column 5 referencing to Worksheet A-7.

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	Provider CCN: 14-0015	Period: From 10/01/2016 To 09/30/2017	Worksheet A-8-1 Date/Time Prepared: 2/28/2018 10:40 am

	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	6.00	MAINTENANCE & REPAIRS	BIO-MED MAINTENANCE	575,497	1,082,169	1.00
2.00	30.00	ADULTS & PEDIATRICS	BIO-MED MAINTENANCE	336	632	2.00
3.00	50.00	OPERATING ROOM	BIO-MED MAINTENANCE	11,846	22,276	3.00
4.00	53.00	ANESTHESIOLOGY	BIO-MED MAINTENANCE	20,153	37,895	4.00
4.01	54.00	RADIOLOGY-DIAGNOSTIC	BIO-MED MAINTENANCE	1,501	2,822	4.01
4.02	55.00	RADIOLOGY-THERAPEUTIC	BIO-MED MAINTENANCE	6,245	11,743	4.02
4.03	57.00	CT SCAN	BIO-MED MAINTENANCE	1,053	1,980	4.03
4.04	60.00	LABORATORY	BIO-MED MAINTENANCE	2,708	5,093	4.04
4.05	65.00	RESPIRATORY THERAPY	BIO-MED MAINTENANCE	862	1,621	4.05
4.06	69.00	ELECTROCARDIOLOGY	BIO-MED MAINTENANCE	3,699	6,956	4.06
4.07	71.00	MEDICAL SUPPLIES CHARGED TO	BIO-MED MAINTENANCE	766	1,440	4.07
4.08	88.00	RURAL HEALTH CLINIC	BIO-MED MAINTENANCE	18	33	4.08
4.09	91.00	EMERGENCY	BIO-MED MAINTENANCE	266	500	4.09
4.10	101.00	HOME HEALTH AGENCY	BIO-MED MAINTENANCE	22	41	4.10
4.11	69.00	ELECTROCARDIOLOGY	BIO-MED MAINTENACE	11	20	4.11
4.12	8.00	LAUNDRY & LINEN SERVICE	LAUNDRY	1,177,531	1,110,355	4.12
4.13	88.00	RURAL HEALTH CLINIC	EAST ADAMS RENT	31,963	78,092	4.13
4.14	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE	32,303,252	15,951,283	4.14
4.15	16.00	MEDICAL RECORDS & LIBRARY	HOME OFFICE	5,610,157	0	4.15
4.16	4.00	EMPLOYEE BENEFITS DEPARTMENT	BCS BENEFITS	0	6,663,334	4.16
4.17	1.05	CAP REL COSTS-MOB PHASE I	CARE COORDINATION RENT	11,381	53,692	4.17
4.18	10.00	DIETARY	DIETICIAN	0	4,127	4.18
4.19	4.00	EMPLOYEE BENEFITS DEPARTMENT	DIETICIAN BENEFITS	0	1,291	4.19
4.20	5.00	ADMINISTRATIVE & GENERAL	ACCOUNTS PAYABLE	0	5,143	4.20
4.21	4.00	EMPLOYEE BENEFITS DEPARTMENT	ACCOUNTS PAYABLE BENEFITS	0	1,608	4.21
4.22	13.00	NURSING ADMINISTRATION	INFORMATICS/CARE MANAGEMENT	0	157,111	4.22
4.23	4.00	EMPLOYEE BENEFITS DEPARTMENT	INFORMATICS/CARE MGMT BENEFI	0	48,627	4.23
4.24	70.00	ELECTROENCEPHALOGRAPHY	SLEEP STUDIES	0	19,622	4.24
4.25	4.00	EMPLOYEE BENEFITS DEPARTMENT	SLEEP STUDIES BENEFITS	0	6,136	4.25
4.26	70.00	ELECTROENCEPHALOGRAPHY	SLEEP STUDIES EXPENSES	0	2,244	4.26
4.27	30.00	ADULTS & PEDIATRICS	TELEMETRY	0	35,249	4.27
4.28	4.00	EMPLOYEE BENEFITS DEPARTMENT	TELEMETRY BENEFITS	0	11,022	4.28
4.29	5.00	ADMINISTRATIVE & GENERAL	CARE COORDINATION	0	38,893	4.29
4.30	4.00	EMPLOYEE BENEFITS DEPARTMENT	CARE COORDINATION BENEFITS	0	12,162	4.30
4.31	71.00	MEDICAL SUPPLIES CHARGED TO	PURCHASING AGENT	0	45,862	4.31
4.32	4.00	EMPLOYEE BENEFITS DEPARTMENT	PURCHASING AGENT BENEFITS	0	14,341	4.32
4.33	88.00	RURAL HEALTH CLINIC	BEHAVIORAL HEALTH PROVIDERS	30,069	19,912	4.33
4.34	1.06	CAP REL COSTS-BBC	BBC RENT	0	171,374	4.34
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			39,789,336	25,626,701	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	Related Organization(s) and/or Home Office: 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.

	Symbol (1)	Name	Percentage of Ownership	Name	Percentage of Ownership	
6.00	G		0.00	DENMAN SERVICES	0.00	6.00
7.00	G		0.00	DENMAN SERVICES	0.00	7.00
8.00	G		0.00	BLESSING FOUND	0.00	8.00
9.00	B		0.00	BLESS CORP SVCS	0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:	BROTHER/SISTER				100.00

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	Provider CCN: 14-0015	Period: From 10/01/2016 To 09/30/2017	Worksheet A-8-1 Date/Time Prepared: 2/28/2018 10:40 am

				Related Organization(s) and/or Home Office		
	Symbol (1)	Name	Percentage of Ownership	Name	Percentage of Ownership	
	1.00	2.00	3.00	4.00	5.00	

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	Provider CCN: 14-0015	Period: From 10/01/2016 To 09/30/2017	Worksheet A-8-1 Date/Time Prepared: 2/28/2018 10:40 am

	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	-506,672	0	1.00
2.00	-296	0	2.00
3.00	-10,430	0	3.00
4.00	-17,742	0	4.00
4.01	-1,321	0	4.01
4.02	-5,498	0	4.02
4.03	-927	0	4.03
4.04	-2,385	0	4.04
4.05	-759	0	4.05
4.06	-3,257	0	4.06
4.07	-674	0	4.07
4.08	-15	0	4.08
4.09	-234	0	4.09
4.10	-19	0	4.10
4.11	-9	0	4.11
4.12	67,176	0	4.12
4.13	-46,129	0	4.13
4.14	16,351,969	0	4.14
4.15	5,610,157	0	4.15
4.16	-6,663,334	0	4.16
4.17	-42,311	10	4.17
4.18	-4,127	0	4.18
4.19	-1,291	0	4.19
4.20	-5,143	0	4.20
4.21	-1,608	0	4.21
4.22	-157,111	0	4.22
4.23	-48,627	0	4.23
4.24	-19,622	0	4.24
4.25	-6,136	0	4.25
4.26	-2,244	0	4.26
4.27	-35,249	0	4.27
4.28	-11,022	0	4.28
4.29	-38,893	0	4.29
4.30	-12,162	0	4.30
4.31	-45,862	0	4.31
4.32	-14,341	0	4.32
4.33	10,157	0	4.33
4.34	-171,374	10	4.34
5.00	14,162,635		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 request information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under title XVIII.

6.00	BIO-MED MAINT		6.00
7.00	LAUNDRY		7.00
8.00	FUND RAISING		8.00
9.00	HOME OFFICE		9.00
10.00			10.00
100.00			100.00

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	Provider CCN: 14-0015	Period: From 10/01/2016 To 09/30/2017	Worksheet A-8-1 Date/Time Prepared: 2/28/2018 10:40 am

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

(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.
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D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organization.
E. Individual is director, officer, administrator, or key person of provider and related organization.
F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 14-0015 | Period: From 10/01/2016 To 09/30/2017 | Worksheet A-8-2 | Date/Time Prepared: 2/28/2018 10:40 am

	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	5.00	ADMINISTRATIVE & GENERAL	2,704,877	2,386,347	318,530	211,500	1,733	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	2,179,736	2,179,736	0	0	0	2.00
3.00	30.00	ADULTS & PEDIATRICS	29,047	0	29,047	211,500	208	3.00
4.00	30.00	ADULTS & PEDIATRICS	32,175	0	32,175	211,500	215	4.00
5.00	31.00	INTENSIVE CARE UNIT	1,397,284	1,397,284	0	0	0	5.00
6.00	31.00	INTENSIVE CARE UNIT	115,747	115,747	0	0	0	6.00
7.00	40.00	SUBPROVIDER - IPF	4,500	0	4,500	181,300	28	7.00
8.00	41.00	SUBPROVIDER - IRF	34,250	0	34,250	211,500	274	8.00
9.00	44.00	SKILLED NURSING FACILITY	1,650	0	1,650	211,500	12	9.00
10.00	50.00	OPERATING ROOM	22,000	0	22,000	211,500	110	10.00
11.00	60.00	LABORATORY	15,000	15,000	0	0	0	11.00
12.00	65.00	RESPIRATORY THERAPY	14,550	0	14,550	211,500	97	12.00
13.00	65.00	RESPIRATORY THERAPY	7,650	0	7,650	211,500	51	13.00
14.00	70.00	ELECTROENCEPHALOGRAPHY	10,350	0	10,350	211,500	69	14.00
15.00	69.00	ELECTROCARDIOLOGY	7,530	0	7,530	211,500	58	15.00
16.00	69.00	ELECTROCARDIOLOGY	4,650	0	4,650	246,400	31	16.00
17.00	70.00	ELECTROENCEPHALOGRAPHY	375	0	375	211,500	3	17.00
18.00	91.00	EMERGENCY	31,200	0	31,200	211,500	240	18.00
19.00	91.00	EMERGENCY	234,648	166,648	68,000	211,500	759	19.00
20.00	91.00	EMERGENCY	5,626,076	5,626,076	0	0	0	20.00
21.00	91.00	EMERGENCY	179,683	0	179,683	211,500	1,084	21.00
22.00	50.00	OPERATING ROOM	5,213	0	5,213	211,500	37	22.00
23.00	50.00	OPERATING ROOM	40,038	0	40,038	246,400	86	23.00
24.00	5.00	ADMINISTRATIVE & GENERAL	10,859,838	10,859,838	0	0	0	24.00
25.00	54.00	RADIOLOGY-DIAGNOSTIC	978,273	978,273	0	0	0	25.00
26.00	90.01	OUTPATIENT INFUSION	152,412	152,412	0	0	0	26.00
27.00	50.00	OPERATING ROOM	211,125	211,125	0	0	0	27.00
28.00	50.00	OPERATING ROOM	813,803	813,803	0	0	0	28.00
200.00			25,713,680	24,902,289	811,391		5,095	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	5.00	ADMINISTRATIVE & GENERAL	176,216	8,811	0	0	0	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	0	0	2.00
3.00	30.00	ADULTS & PEDIATRICS	21,150	1,058	0	0	0	3.00
4.00	30.00	ADULTS & PEDIATRICS	21,862	1,093	0	0	0	4.00
5.00	31.00	INTENSIVE CARE UNIT	0	0	0	0	0	5.00
6.00	31.00	INTENSIVE CARE UNIT	0	0	0	0	0	6.00
7.00	40.00	SUBPROVIDER - IPF	2,441	122	0	0	0	7.00
8.00	41.00	SUBPROVIDER - IRF	27,861	1,393	0	0	0	8.00
9.00	44.00	SKILLED NURSING FACILITY	1,220	61	0	0	0	9.00
10.00	50.00	OPERATING ROOM	11,185	559	0	0	0	10.00
11.00	60.00	LABORATORY	0	0	0	0	0	11.00
12.00	65.00	RESPIRATORY THERAPY	9,863	493	0	0	0	12.00
13.00	65.00	RESPIRATORY THERAPY	5,186	259	0	0	0	13.00
14.00	70.00	ELECTROENCEPHALOGRAPHY	7,016	351	0	0	0	14.00
15.00	69.00	ELECTROCARDIOLOGY	5,898	295	0	0	0	15.00
16.00	69.00	ELECTROCARDIOLOGY	3,672	184	0	0	0	16.00
17.00	70.00	ELECTROENCEPHALOGRAPHY	305	15	0	0	0	17.00
18.00	91.00	EMERGENCY	24,404	1,220	0	0	0	18.00
19.00	91.00	EMERGENCY	77,177	3,859	0	0	0	19.00
20.00	91.00	EMERGENCY	0	0	0	0	0	20.00
21.00	91.00	EMERGENCY	110,224	5,511	0	0	0	21.00
22.00	50.00	OPERATING ROOM	3,762	188	0	0	0	22.00
23.00	50.00	OPERATING ROOM	10,188	509	0	0	0	23.00
24.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	0	0	24.00
25.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	25.00
26.00	90.01	OUTPATIENT INFUSION	0	0	0	0	0	26.00
27.00	50.00	OPERATING ROOM	0	0	0	0	0	27.00
28.00	50.00	OPERATING ROOM	0	0	0	0	0	28.00
200.00			519,630	25,981	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	5.00	ADMINISTRATIVE & GENERAL	0	176,216	142,314	2,528,661	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	2,179,736	2.00
3.00	30.00	ADULTS & PEDIATRICS	0	21,150	7,897	7,897	3.00
4.00	30.00	ADULTS & PEDIATRICS	0	21,862	10,313	10,313	4.00
5.00	31.00	INTENSIVE CARE UNIT	0	0	0	1,397,284	5.00

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 14-0015 | Period: From 10/01/2016 To 09/30/2017 | Worksheet A-8-2 | Date/Time Prepared: 2/28/2018 10:40 am

	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		
6.00	31.00	INTENSIVE CARE UNIT	0	0	0	115,747		6.00
7.00	40.00	SUBPROVIDER - IPF	0	2,441	2,059	2,059		7.00
8.00	41.00	SUBPROVIDER - IRF	0	27,861	6,389	6,389		8.00
9.00	44.00	SKILLED NURSING FACILITY	0	1,220	430	430		9.00
10.00	50.00	OPERATING ROOM	0	11,185	10,815	10,815		10.00
11.00	60.00	LABORATORY	0	0	0	15,000		11.00
12.00	65.00	RESPIRATORY THERAPY	0	9,863	4,687	4,687		12.00
13.00	65.00	RESPIRATORY THERAPY	0	5,186	2,464	2,464		13.00
14.00	70.00	ELECTROENCEPHALOGRAPHY	0	7,016	3,334	3,334		14.00
15.00	69.00	ELECTROCARDIOLOGY	0	5,898	1,632	1,632		15.00
16.00	69.00	ELECTROCARDIOLOGY	0	3,672	978	978		16.00
17.00	70.00	ELECTROENCEPHALOGRAPHY	0	305	70	70		17.00
18.00	91.00	EMERGENCY	0	24,404	6,796	6,796		18.00
19.00	91.00	EMERGENCY	0	77,177	0	166,648		19.00
20.00	91.00	EMERGENCY	0	0	0	5,626,076		20.00
21.00	91.00	EMERGENCY	0	110,224	69,459	69,459		21.00
22.00	50.00	OPERATING ROOM	0	3,762	1,451	1,451		22.00
23.00	50.00	OPERATING ROOM	0	10,188	29,850	29,850		23.00
24.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	10,859,838		24.00
25.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	978,273		25.00
26.00	90.01	OUTPATIENT INFUSION	0	0	0	152,412		26.00
27.00	50.00	OPERATING ROOM	0	0	0	211,125		27.00
28.00	50.00	OPERATING ROOM	0	0	0	813,803		28.00
200.00			0	519,630	300,938	25,203,227		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0015 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B Part I Date/Time Prepared: 2/28/2018 10:40 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS				
				BLDG & FIXT	BUTLER BUILDING	OLD BLDG & FIXTURES	NEW BLDG & FIXTURES	
			0	1.00	1.01	1.02	1.03	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	0	0				1.00
1.01	00101	CAP REL COSTS-BUTLER BUILDING	37,595	0	37,595			1.01
1.02	00102	CAP REL COSTS-OLD BLDG & FIXTURES	437,774	0	0	437,774		1.02
1.03	00103	CAP REL COSTS-NEW BLDG & FIXTURES	6,190,827	0	0	0	6,190,827	1.03
1.04	00104	CAP REL COSTS-14TH STREET	78,280	0	0	0	0	1.04
1.05	00105	CAP REL COSTS-MOB PHASE I	9,817	0	0	0	0	1.05
1.06	00106	CAP REL COSTS-BBC	94,904	0	0	0	0	1.06
1.07	00107	CAP REL COSTS-BEC	130,265	0	0	0	0	1.07
2.00	00200	CAP REL COSTS-MVBLE EQUIP	13,074,604					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	6,951,867	0	0	18,642	56,335	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	55,564,065	0	392	97,732	1,156,898	5.00
6.00	00600	MAINTENANCE & REPAIRS	6,798,693	0	7,919	65,742	700,465	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,233,178	0	0	6,191	19,958	8.00
9.00	00900	HOUSEKEEPING	3,137,583	0	0	15,677	8,113	9.00
10.00	01000	DIETARY	1,706,781	0	0	275	127,175	10.00
11.00	01100	CAFETERIA	2,481,006	0	0	0	82,049	11.00
13.00	01300	NURSING ADMINISTRATION	6,928,345	0	0	15,071	5,817	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	5,506,414	0	0	3,094	60,543	16.00
20.00	02000	NURSING SCHOOL	2,278,420	0	27,413	0	222,142	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	1,040,755	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	1,887,815	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM	0	0	0	0	0	23.00
23.01	02301	PARAMED ED PRGM-RADIOLOGY	209,231	0	0	0	5,220	23.01
23.02	02302	PARAMED ED PRGM-LABORATORY	39,587	0	0	0	5,220	23.02
23.03	02303	PARAMED ED PRGM-PHARMACY	291,410	0	0	0	0	23.03
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	17,260,687	0	0	3,003	1,353,323	30.00
31.00	03100	INTENSIVE CARE UNIT	3,672,881	0	0	36,486	117,282	31.00
40.00	04000	SUBPROVIDER - IPF	4,447,105	0	0	0	368,739	40.00
41.00	04100	SUBPROVIDER - IRF	1,567,413	0	0	18,147	55,981	41.00
43.00	04300	NURSERY	477,629	0	0	0	36,083	43.00
44.00	04400	SKILLED NURSING FACILITY	1,709,248	0	0	0	121,682	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	13,634,771	0	0	40,105	271,426	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,396,374	0	0	23,653	21,051	52.00
53.00	05300	ANESTHESIOLOGY	547,205	0	0	2,185	6,858	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,965,927	0	0	5,314	162,944	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	1,488,447	0	0	0	139,769	55.00
57.00	05700	CT SCAN	764,467	0	0	2,105	9,822	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	471,671	0	0	0	20,970	58.00
60.00	06000	LABORATORY	6,501,944	0	0	2,408	108,856	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	1,400,576	0	0	0	3,895	62.00
65.00	06500	RESPIRATORY THERAPY	2,346,649	0	0	7,464	0	65.00
66.00	06600	PHYSICAL THERAPY	1,314,530	0	0	0	34,646	66.00
67.00	06700	OCCUPATIONAL THERAPY	627,894	0	0	0	16,610	67.00
68.00	06800	SPEECH PATHOLOGY	246,146	0	0	0	5,624	68.00
69.00	06900	ELECTROCARDIOLOGY	2,531,071	0	0	29,405	45,733	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	464,751	0	0	7,607	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	9,582,962	0	754	0	63,072	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	12,221,936	0	1,117	0	93,267	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	15,525,283	0	0	1,121	38,673	73.00
74.00	07400	RENAL DIALYSIS	759,488	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	940,329	0	0	0	0	88.00
90.00	09000	CLINIC	471,995	0	0	0	0	90.00
90.01	09001	OUTPATIENT INFUSION	366,187	0	0	0	35,355	90.01
91.00	09100	EMERGENCY	5,220,664	0	0	20,340	150,664	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	4,580,522	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	2,092,338	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	235,708,306	0	37,595	421,767	5,732,260	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	10,234	8,032	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	31,784	0	0	0	0	192.00
192.01	19201	FASTCARE	329,981	0	0	0	0	192.01

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0015 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B Part I | Date/Time Prepared: 2/28/2018 10:40 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS				
				BLDG & FIXT	BUTLER BUILDING	OLD BLDG & FIXTURES	NEW BLDG & FIXTURES	
			0	1.00	1.01	1.02	1.03	
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	DENMAN SERVICES	0	0	0	0	10,116	193.01
193.02	19302	MEALS ON WHEELS	0	0	0	0	0	193.02
193.03	19303	UNUSED SPACE	0	0	0	3,720	204,530	193.03
193.04	19304	HEALTH EDUCATION	0	0	0	0	0	193.04
193.05	19305	RENTED SPACE	24,469	0	0	2,053	235,889	193.05
193.06	19306	AUGUSTA PHARMACY	865,029	0	0	0	0	193.06
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	236,959,569	0	37,595	437,774	6,190,827	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0015 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B Part I Date/Time Prepared: 2/28/2018 10:40 am

		Cost Center Description	CAPITAL RELATED COSTS					
			14TH STREET	MOB PHASE I	BBC	BEC	MVBLE EQUIP	
			1.04	1.05	1.06	1.07	2.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BUTLER BUILDING						1.01
1.02	00102	CAP REL COSTS-OLD BLDG & FIXTURES						1.02
1.03	00103	CAP REL COSTS-NEW BLDG & FIXTURES						1.03
1.04	00104	CAP REL COSTS-14TH STREET	78,280					1.04
1.05	00105	CAP REL COSTS-MOB PHASE I	0	9,817				1.05
1.06	00106	CAP REL COSTS-BBC	0	0	94,904			1.06
1.07	00107	CAP REL COSTS-BEC	0	0	0	130,265		1.07
2.00	00200	CAP REL COSTS-MVBLE EQUIP					13,074,604	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	314	0	0	0	124,013	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	9,845	9,817	9,536	53,363	3,993,275	5.00
6.00	00600	MAINTENANCE & REPAIRS	19,186	0	0	0	333,123	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	114	0	0	0	4,072	8.00
9.00	00900	HOUSEKEEPING	797	0	0	0	82,525	9.00
10.00	01000	DIETARY	0	0	0	0	86,357	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	3,582	0	0	20,813	895,318	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	498	0	0	0	75,483	16.00
20.00	02000	NURSING SCHOOL	1,914	0	0	28,290	65,748	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	758	22.00
23.00	02300	PARAMED ED PRGM	0	0	0	0	0	23.00
23.01	02301	PARAMED ED PRGM-RADIOLOGY	473	0	0	6,861	0	23.01
23.02	02302	PARAMED ED PRGM-LABORATORY	0	0	0	0	2,649	23.02
23.03	02303	PARAMED ED PRGM-PHARMACY	0	0	0	0	0	23.03
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	1,295,059	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	118,123	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	12,870	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	19,198	41.00
43.00	04300	NURSERY	0	0	0	0	25,219	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	634	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	2,364,262	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	41,093	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	161,235	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	670,760	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	721,007	55.00
57.00	05700	CT SCAN	0	0	0	0	104,580	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	155,364	58.00
60.00	06000	LABORATORY	102	0	0	0	223,783	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	13,814	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	8,678	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	5,175	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	3,593	68.00
69.00	06900	ELECTROCARDIOLOGY	75	0	0	0	663,596	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	37,070	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	18	0	0	0	60,659	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	27	0	0	0	89,711	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	99	0	0	0	343,037	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	7,553	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	OUTPATIENT INFUSION	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	1,951	0	0	11,071	160,811	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	1,491	0	0	9,867	6,703	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0	72,676	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	40,486	9,817	9,536	130,265	13,049,584	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	1,215	192.00
192.01	19201	FASTCARE	0	0	0	0	21,995	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	DENMAN SERVICES	0	0	0	0	283	193.01
193.02	19302	MEALS ON WHEELS	0	0	0	0	0	193.02
193.03	19303	UNUSED SPACE	37,221	0	0	0	0	193.03

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0015 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B Part I Date/Time Prepared: 2/28/2018 10:40 am

		Cost Center Description	CAPITAL RELATED COSTS					
			14TH STREET	MOB PHASE I	BBC	BEC	MVBLE EQUIP	
			1.04	1.05	1.06	1.07	2.00	
193.04	19304	HEALTH EDUCATION	0	0	0	0	0	193.04
193.05	19305	RENTED SPACE	573	0	85,368	0	0	193.05
193.06	19306	AUGUSTA PHARMACY	0	0	0	0	1,527	193.06
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	78,280	9,817	94,904	130,265	13,074,604	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0015 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B Part I Date/Time Prepared: 2/28/2018 10:40 am

		Cost Center Description	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	LAUNDRY & LINEN SERVICE	
			4.00	4A	5.00	6.00	8.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BUTLER BUILDING						1.01
1.02	00102	CAP REL COSTS-OLD BLDG & FIXTURES						1.02
1.03	00103	CAP REL COSTS-NEW BLDG & FIXTURES						1.03
1.04	00104	CAP REL COSTS-14TH STREET						1.04
1.05	00105	CAP REL COSTS-MOB PHASE I						1.05
1.06	00106	CAP REL COSTS-BBC						1.06
1.07	00107	CAP REL COSTS-BEC						1.07
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	7,151,171					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	401,070	61,295,993	61,295,993			5.00
6.00	00600	MAINTENANCE & REPAIRS	197,028	8,122,156	2,834,145	10,956,301		6.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,957	1,266,470	441,922	69,551	1,777,943	8.00
9.00	00900	HOUSEKEEPING	188,183	3,432,878	1,197,868	116,912	39,204	9.00
10.00	01000	DIETARY	63,456	1,984,044	692,312	223,322	2,513	10.00
11.00	01100	CAFETERIA	115,800	2,678,855	934,760	143,179	0	11.00
13.00	01300	NURSING ADMINISTRATION	522,477	8,391,423	2,928,103	260,904	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	5,646,032	1,970,126	215,360	0	16.00
20.00	02000	NURSING SCHOOL	342,451	2,966,378	1,035,088	728,801	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	83,361	1,124,116	392,249	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	1,888,573	658,999	0	0	22.00
23.00	02300	PARAMED ED PRGM	0	0	0	0	0	23.00
23.01	02301	PARAMED ED PRGM-RADIOLOGY	21,966	243,751	85,054	35,482	0	23.01
23.02	02302	PARAMED ED PRGM-LABORATORY	5,219	52,675	18,380	9,109	0	23.02
23.03	02303	PARAMED ED PRGM-PHARMACY	22,291	313,701	109,463	0	0	23.03
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,167,189	21,079,261	7,355,346	2,376,855	854,245	30.00
31.00	03100	INTENSIVE CARE UNIT	266,838	4,211,610	1,469,599	389,749	67,144	31.00
40.00	04000	SUBPROVIDER - IPF	347,921	5,176,635	1,806,335	643,469	37,924	40.00
41.00	04100	SUBPROVIDER - IRF	115,246	1,775,985	619,712	189,747	84,814	41.00
43.00	04300	NURSERY	35,051	573,982	200,285	62,966	13,677	43.00
44.00	04400	SKILLED NURSING FACILITY	127,271	1,958,835	683,516	212,342	31,741	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	677,672	16,988,236	5,927,875	677,097	135,784	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	97,670	1,579,841	551,270	156,719	62,313	52.00
53.00	05300	ANESTHESIOLOGY	14,075	731,558	255,270	23,054	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	272,063	6,077,008	2,120,511	311,302	34,040	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	87,019	2,436,242	850,102	243,904	30,093	55.00
57.00	05700	CT SCAN	41,237	922,211	321,796	27,820	8,510	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	25,294	673,299	234,941	36,594	2,398	58.00
60.00	06000	LABORATORY	256,305	7,093,398	2,475,170	205,140	2,343	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	10,847	1,429,132	498,681	6,796	0	62.00
65.00	06500	RESPIRATORY THERAPY	169,731	2,523,844	880,670	37,865	0	65.00
66.00	06600	PHYSICAL THERAPY	100,928	1,458,782	509,027	60,460	126	66.00
67.00	06700	OCCUPATIONAL THERAPY	49,790	699,469	244,073	28,985	0	67.00
68.00	06800	SPEECH PATHOLOGY	19,261	274,624	95,827	9,815	0	68.00
69.00	06900	ELECTROCARDIOLOGY	143,434	3,413,314	1,191,042	231,159	100,543	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	28,716	538,144	187,780	38,588	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	21,347	9,728,812	3,394,772	117,001	28,472	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	37,004	12,443,062	4,341,882	173,047	54,659	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	301,846	16,210,059	5,656,338	76,065	0	73.00
74.00	07400	RENAL DIALYSIS	0	767,041	267,651	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	34,410	974,739	340,125	0	0	88.00
90.00	09000	CLINIC	31,551	503,546	175,707	0	0	90.00
90.01	09001	OUTPATIENT INFUSION	26,378	427,920	149,318	61,695	0	90.01
91.00	09100	EMERGENCY	275,065	5,840,566	2,038,007	443,272	152,778	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0				92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	249,347	4,847,930	1,691,637	61,554	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	114,548	2,279,562	795,430	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	7,111,313	235,045,692	60,628,164	8,705,680	1,743,321	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	18,266	6,374	65,932	16,620	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	60	33,059	11,536	0	18,002	192.00
192.01	19201	FASTCARE	21,634	373,610	130,367	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	DENMAN SERVICES	0	10,399	3,629	17,652	0	193.01
193.02	19302	MEALS ON WHEELS	0	0	0	0	0	193.02
193.03	19303	UNUSED SPACE	0	245,471	85,655	1,474,636	0	193.03

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0015 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B Part I Date/Time Prepared: 2/28/2018 10:40 am

		Cost Center Description	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	LAUNDRY & LINEN SERVICE	
			4.00	4A	5.00	6.00	8.00	
193.04	19304	HEALTH EDUCATION	1,954	1,954	682	0	0	193.04
193.05	19305	RENTED SPACE	0	348,352	121,554	692,401	0	193.05
193.06	19306	AUGUSTA PHARMACY	16,210	882,766	308,032	0	0	193.06
200.00		Cross Foot Adjustments		0				200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	7,151,171	236,959,569	61,295,993	10,956,301	1,777,943	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0015 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B Part I Date/Time Prepared: 2/28/2018 10:40 am

		Cost Center Description	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	
			9.00	10.00	11.00	13.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BUTLER BUILDING						1.01
1.02	00102	CAP REL COSTS-OLD BLDG & FIXTURES						1.02
1.03	00103	CAP REL COSTS-NEW BLDG & FIXTURES						1.03
1.04	00104	CAP REL COSTS-14TH STREET						1.04
1.05	00105	CAP REL COSTS-MOB PHASE I						1.05
1.06	00106	CAP REL COSTS-BBC						1.06
1.07	00107	CAP REL COSTS-BEC						1.07
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING	4,786,862					9.00
10.00	01000	DIETARY	114,984	3,017,175				10.00
11.00	01100	CAFETERIA	73,757	0	3,830,551			11.00
13.00	01300	NURSING ADMINISTRATION	134,372	0	302,656	12,017,458		13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	110,912	0	0	0	7,942,430	16.00
20.00	02000	NURSING SCHOOL	375,307	0	218,558	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	54,471	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM	0	0	0	0	0	23.00
23.01	02301	PARAMED ED PRGM-RADIOLOGY	18,277	0	11,859	0	0	23.01
23.02	02302	PARAMED ED PRGM-LABORATORY	4,673	0	3,059	0	0	23.02
23.03	02303	PARAMED ED PRGM-PHARMACY	0	0	10,336	0	0	23.03
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,224,017	1,807,474	831,688	4,128,659	4,733,065	30.00
31.00	03100	INTENSIVE CARE UNIT	200,725	226,829	168,857	838,233	593,965	31.00
40.00	04000	SUBPROVIDER - IPF	331,349	516,551	257,846	1,280,020	1,352,647	40.00
41.00	04100	SUBPROVIDER - IRF	97,725	203,992	78,024	387,339	534,166	41.00
43.00	04300	NURSERY	32,436	0	19,721	97,908	12,143	43.00
44.00	04400	SKILLED NURSING FACILITY	109,339	262,329	91,650	454,976	686,916	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	348,701	0	453,514	2,251,325	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	80,697	0	61,737	306,485	0	52.00
53.00	05300	ANESTHESIOLOGY	11,892	0	12,478	61,962	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	160,330	0	187,154	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	125,627	0	44,533	0	0	55.00
57.00	05700	CT SCAN	14,344	0	23,652	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	18,832	0	14,200	0	0	58.00
60.00	06000	LABORATORY	105,637	0	208,057	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	3,517	0	9,353	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	19,480	0	112,719	0	0	65.00
66.00	06600	PHYSICAL THERAPY	31,141	0	51,114	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	14,946	0	27,418	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	5,044	0	10,137	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	119,056	0	83,866	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	19,850	0	22,405	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	51,176	0	26,082	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	98,188	0	43,065	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	39,192	0	139,054	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	20,108	0	0	90.00
90.01	09001	OUTPATIENT INFUSION	31,788	0	14,565	0	0	90.01
91.00	09100	EMERGENCY	228,256	0	215,400	1,069,264	29,528	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	31,696	0	0	741,085	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	340,926	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	4,387,263	3,017,175	3,829,336	11,958,182	7,942,430	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	33,963	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	FASTCARE	0	0	0	59,276	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	DENMAN SERVICES	9,069	0	0	0	0	193.01
193.02	19302	MEALS ON WHEELS	0	0	0	0	0	193.02
193.03	19303	UNUSED SPACE	0	0	0	0	0	193.03

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0015 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B Part I Date/Time Prepared: 2/28/2018 10:40 am

		Cost Center Description	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	
			9.00	10.00	11.00	13.00	16.00	
193.04	19304	HEALTH EDUCATION	0	0	1,215	0	0	193.04
193.05	19305	RENTED SPACE	356,567	0	0	0	0	193.05
193.06	19306	AUGUSTA PHARMACY	0	0	0	0	0	193.06
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	4,786,862	3,017,175	3,830,551	12,017,458	7,942,430	202.00

		Cost Center Description	NURSING SCHOOL	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES	INTERNS & RESIDENTS SERVICES-OTHER PRGM COSTS	PARAMED ED PRGM	PARAMED ED PRGM-RADIOLOGY	
			20.00	21.00	22.00	23.00	23.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BUTLER BUILDING						1.01
1.02	00102	CAP REL COSTS-OLD BLDG & FIXTURES						1.02
1.03	00103	CAP REL COSTS-NEW BLDG & FIXTURES						1.03
1.04	00104	CAP REL COSTS-14TH STREET						1.04
1.05	00105	CAP REL COSTS-MOB PHASE I						1.05
1.06	00106	CAP REL COSTS-BBC						1.06
1.07	00107	CAP REL COSTS-BEC						1.07
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
20.00	02000	NURSING SCHOOL	5,324,132					20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD		1,570,836				21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD			2,547,572			22.00
23.00	02300	PARAMED ED PRGM				0		23.00
23.01	02301	PARAMED ED PRGM-RADIOLOGY					394,423	23.01
23.02	02302	PARAMED ED PRGM-LABORATORY						23.02
23.03	02303	PARAMED ED PRGM-PHARMACY						23.03
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,781,310	1,017,315	1,649,875	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	390,784	48,708	78,994	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	312,723	57,460	93,189	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	38,391	64,995	105,408	0	0	41.00
43.00	04300	NURSERY	68,783	50,002	81,093	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	44,789	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	195,792	62,483	101,335	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	201,231	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	12,481	20,242	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	394,423	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
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
60.00	06000	LABORATORY	0	16,211	26,290	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	48,708	78,994	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	53,731	87,141	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	OUTPATIENT INFUSION	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	232,743	138,742	225,011	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	12,477	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	45,109			0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	5,324,132	1,570,836	2,547,572	0	394,423	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	FASTCARE	0	0	0	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	DENMAN SERVICES	0	0	0	0	0	193.01
193.02	19302	MEALS ON WHEELS	0	0	0	0	0	193.02

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0015 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B Part I Date/Time Prepared: 2/28/2018 10:40 am

		Cost Center Description	NURSING SCHOOL	INTERNS & RESIDENTS		PARAMED ED PRGM	PARAMED ED PRGM-RADIOLOGY	
				SERVICES-SALARY & FRINGES	SERVICES-OTHER PRGM COSTS			
			20.00	21.00	22.00	23.00	23.01	
193.03	19303	UNUSED SPACE	0	0	0	0	0	193.03
193.04	19304	HEALTH EDUCATION	0	0	0	0	0	193.04
193.05	19305	RENTED SPACE	0	0	0	0	0	193.05
193.06	19306	AUGUSTA PHARMACY	0	0	0	0	0	193.06
200.00		Cross Foot Adjustments	0	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	5,324,132	1,570,836	2,547,572	0	394,423	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0015 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B Part I Date/Time Prepared: 2/28/2018 10:40 am

		Cost Center Description	PARAMED ED PRGM-LABORATORY	PARAMED ED PRGM-PHARMACY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			23.02	23.03	24.00	25.00	26.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BUTLER BUILDING						1.01
1.02	00102	CAP REL COSTS-OLD BLDG & FIXTURES						1.02
1.03	00103	CAP REL COSTS-NEW BLDG & FIXTURES						1.03
1.04	00104	CAP REL COSTS-14TH STREET						1.04
1.05	00105	CAP REL COSTS-MOB PHASE I						1.05
1.06	00106	CAP REL COSTS-BBC						1.06
1.07	00107	CAP REL COSTS-BEC						1.07
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
20.00	02000	NURSING SCHOOL						20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD						21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD						22.00
23.00	02300	PARAMED ED PRGM						23.00
23.01	02301	PARAMED ED PRGM-RADIOLOGY						23.01
23.02	02302	PARAMED ED PRGM-LABORATORY	87,896					23.02
23.03	02303	PARAMED ED PRGM-PHARMACY		433,500				23.03
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	50,839,110	-2,667,190	48,171,920	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	8,685,197	-127,702	8,557,495	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	11,866,148	-150,649	11,715,499	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	4,180,298	-170,403	4,009,895	41.00
43.00	04300	NURSERY	0	0	1,212,996	-131,095	1,081,901	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	4,536,433	0	4,536,433	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	27,142,142	-163,818	26,978,324	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	3,000,293	0	3,000,293	52.00
53.00	05300	ANESTHESIOLOGY	0	0	1,128,937	-32,723	1,096,214	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	9,284,768	0	9,284,768	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	3,730,501	0	3,730,501	55.00
57.00	05700	CT SCAN	0	0	1,318,333	0	1,318,333	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	980,264	0	980,264	58.00
60.00	06000	LABORATORY	87,896	0	10,220,142	-42,501	10,177,641	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	1,947,479	0	1,947,479	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	3,574,578	0	3,574,578	65.00
66.00	06600	PHYSICAL THERAPY	0	0	2,110,650	0	2,110,650	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	1,014,891	0	1,014,891	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	395,447	0	395,447	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	5,266,682	-127,702	5,138,980	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	947,639	-140,872	806,767	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	13,346,315	0	13,346,315	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	17,153,903	0	17,153,903	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	433,500	22,554,208	0	22,554,208	73.00
74.00	07400	RENAL DIALYSIS	0	0	1,034,692	0	1,034,692	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	1,314,864	0	1,314,864	88.00
90.00	09000	CLINIC	0	0	699,361	0	699,361	90.00
90.01	09001	OUTPATIENT INFUSION	0	0	685,286	0	685,286	90.01
91.00	09100	EMERGENCY	0	0	10,613,567	-363,753	10,249,814	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	7,386,379	0	7,386,379	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	3,461,027	0	3,461,027	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	87,896	433,500	231,632,530	-4,118,408	227,514,122	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	141,155	0	141,155	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	62,597	0	62,597	192.00
192.01	19201	FASTCARE	0	0	563,253	0	563,253	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	DENMAN SERVICES	0	0	40,749	0	40,749	193.01

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		Cost Center Description	PARAMED ED PRGM-LABORATORY	PARAMED ED PRGM-PHARMACY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			23.02	23.03	24.00	25.00	26.00	
193.02	19302	MEALS ON WHEELS	0	0	0	0	0	193.02
193.03	19303	UNUSED SPACE	0	0	1,805,762	0	1,805,762	193.03
193.04	19304	HEALTH EDUCATION	0	0	3,851	0	3,851	193.04
193.05	19305	RENTED SPACE	0	0	1,518,874	0	1,518,874	193.05
193.06	19306	AUGUSTA PHARMACY	0	0	1,190,798	0	1,190,798	193.06
200.00		Cross Foot Adjustments	0	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	87,896	433,500	236,959,569	-4,118,408	232,841,161	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0015 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B Part II Date/Time Prepared: 2/28/2018 10:40 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	BUTLER BUILDING	OLD BLDG & FIXTURES	NEW BLDG & FIXTURES	
			0	1.00	1.01	1.02	1.03	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BUTLER BUILDING						1.01
1.02	00102	CAP REL COSTS-OLD BLDG & FIXTURES						1.02
1.03	00103	CAP REL COSTS-NEW BLDG & FIXTURES						1.03
1.04	00104	CAP REL COSTS-14TH STREET						1.04
1.05	00105	CAP REL COSTS-MOB PHASE I						1.05
1.06	00106	CAP REL COSTS-BBC						1.06
1.07	00107	CAP REL COSTS-BEC						1.07
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	18,642	56,335	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	805,331	0	392	97,732	1,156,898	5.00
6.00	00600	MAINTENANCE & REPAIRS	463	0	7,919	65,742	700,465	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	6,191	19,958	8.00
9.00	00900	HOUSEKEEPING	0	0	0	15,677	8,113	9.00
10.00	01000	DIETARY	431,702	0	0	275	127,175	10.00
11.00	01100	CAFETERIA	0	0	0	0	82,049	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	15,071	5,817	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	3,094	60,543	16.00
20.00	02000	NURSING SCHOOL	0	0	27,413	0	222,142	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM	0	0	0	0	0	23.00
23.01	02301	PARAMED ED PRGM-RADIOLOGY	0	0	0	0	5,220	23.01
23.02	02302	PARAMED ED PRGM-LABORATORY	0	0	0	0	5,220	23.02
23.03	02303	PARAMED ED PRGM-PHARMACY	0	0	0	0	0	23.03
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	72,484	0	0	3,003	1,353,323	30.00
31.00	03100	INTENSIVE CARE UNIT	17,221	0	0	36,486	117,282	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	368,739	40.00
41.00	04100	SUBPROVIDER - IRF	5,985	0	0	18,147	55,981	41.00
43.00	04300	NURSERY	0	0	0	0	36,083	43.00
44.00	04400	SKILLED NURSING FACILITY	15,804	0	0	0	121,682	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,100,081	0	0	40,105	271,426	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	23,653	21,051	52.00
53.00	05300	ANESTHESIOLOGY	17,370	0	0	2,185	6,858	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	415,006	0	0	5,314	162,944	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	139,769	55.00
57.00	05700	CT SCAN	0	0	0	2,105	9,822	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	20,970	58.00
60.00	06000	LABORATORY	148,294	0	0	2,408	108,856	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	3,895	62.00
65.00	06500	RESPIRATORY THERAPY	80,645	0	0	7,464	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	34,646	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	16,610	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	5,624	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	29,405	45,733	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	44,473	0	0	7,607	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	28,334	0	754	0	63,072	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	41,905	0	1,117	0	93,267	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,121	38,673	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	32,373	0	0	0	0	88.00
90.00	09000	CLINIC	67,486	0	0	0	0	90.00
90.01	09001	OUTPATIENT INFUSION	0	0	0	0	35,355	90.01
91.00	09100	EMERGENCY	0	0	0	20,340	150,664	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	2,585	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	127,128	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	3,454,670	0	37,595	421,767	5,732,260	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	10,234	8,032	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	FASTCARE	40,900	0	0	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0015 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B Part II Date/Time Prepared: 2/28/2018 10:40 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS				
				BLDG & FIXT	BUTLER BUILDING	OLD BLDG & FIXTURES	NEW BLDG & FIXTURES	
			0	1.00	1.01	1.02	1.03	
193.01	19301	DENMAN SERVICES	0	0	0	0	10,116	193.01
193.02	19302	MEALS ON WHEELS	0	0	0	0	0	193.02
193.03	19303	UNUSED SPACE	0	0	0	3,720	204,530	193.03
193.04	19304	HEALTH EDUCATION	0	0	0	0	0	193.04
193.05	19305	RENTED SPACE	0	0	0	2,053	235,889	193.05
193.06	19306	AUGUSTA PHARMACY	0	0	0	0	0	193.06
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	3,495,570	0	37,595	437,774	6,190,827	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0015 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B Part II | Date/Time Prepared: 2/28/2018 10:40 am

			CAPITAL RELATED COSTS					
		Cost Center Description	14TH STREET	MOB PHASE I	BBC	BEC	MVBLE EQUIP	
			1.04	1.05	1.06	1.07	2.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BUTLER BUILDING						1.01
1.02	00102	CAP REL COSTS-OLD BLDG & FIXTURES						1.02
1.03	00103	CAP REL COSTS-NEW BLDG & FIXTURES						1.03
1.04	00104	CAP REL COSTS-14TH STREET						1.04
1.05	00105	CAP REL COSTS-MOB PHASE I						1.05
1.06	00106	CAP REL COSTS-BBC						1.06
1.07	00107	CAP REL COSTS-BEC						1.07
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	314	0	0	0	124,013	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	9,845	9,817	9,536	53,363	3,993,275	5.00
6.00	00600	MAINTENANCE & REPAIRS	19,186	0	0	0	333,123	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	114	0	0	0	4,072	8.00
9.00	00900	HOUSEKEEPING	797	0	0	0	82,525	9.00
10.00	01000	DIETARY	0	0	0	0	86,357	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	3,582	0	0	20,813	895,318	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	498	0	0	0	75,483	16.00
20.00	02000	NURSING SCHOOL	1,914	0	0	28,290	65,748	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	758	22.00
23.00	02300	PARAMED ED PRGM	0	0	0	0	0	23.00
23.01	02301	PARAMED ED PRGM-RADIOLOGY	473	0	0	6,861	0	23.01
23.02	02302	PARAMED ED PRGM-LABORATORY	0	0	0	0	2,649	23.02
23.03	02303	PARAMED ED PRGM-PHARMACY	0	0	0	0	0	23.03
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	1,295,059	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	118,123	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	12,870	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	19,198	41.00
43.00	04300	NURSERY	0	0	0	0	25,219	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	634	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	2,364,262	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	41,093	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	161,235	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	670,760	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	721,007	55.00
57.00	05700	CT SCAN	0	0	0	0	104,580	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	155,364	58.00
60.00	06000	LABORATORY	102	0	0	0	223,783	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	13,814	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	8,678	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	5,175	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	3,593	68.00
69.00	06900	ELECTROCARDIOLOGY	75	0	0	0	663,596	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	37,070	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	18	0	0	0	60,659	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	27	0	0	0	89,711	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	99	0	0	0	343,037	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	7,553	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	OUTPATIENT INFUSION	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	1,951	0	0	11,071	160,811	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	1,491	0	0	9,867	6,703	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0	72,676	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	40,486	9,817	9,536	130,265	13,049,584	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	1,215	192.00
192.01	19201	FASTCARE	0	0	0	0	21,995	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	DENMAN SERVICES	0	0	0	0	283	193.01
193.02	19302	MEALS ON WHEELS	0	0	0	0	0	193.02
193.03	19303	UNUSED SPACE	37,221	0	0	0	0	193.03

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0015 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B Part II Date/Time Prepared: 2/28/2018 10:40 am

			CAPITAL RELATED COSTS					
		Cost Center Description	14TH STREET	MOB PHASE I	BBC	BEC	MVBLE EQUIP	
			1.04	1.05	1.06	1.07	2.00	
193.04	19304	HEALTH EDUCATION	0	0	0	0	0	193.04
193.05	19305	RENTED SPACE	573	0	85,368	0	0	193.05
193.06	19306	AUGUSTA PHARMACY	0	0	0	0	1,527	193.06
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	78,280	9,817	94,904	130,265	13,074,604	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0015 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B Part II Date/Time Prepared: 2/28/2018 10:40 am

		Cost Center Description	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	LAUNDRY & LINEN SERVICE	
			2A	4.00	5.00	6.00	8.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BUTLER BUILDING						1.01
1.02	00102	CAP REL COSTS-OLD BLDG & FIXTURES						1.02
1.03	00103	CAP REL COSTS-NEW BLDG & FIXTURES						1.03
1.04	00104	CAP REL COSTS-14TH STREET						1.04
1.05	00105	CAP REL COSTS-MOB PHASE I						1.05
1.06	00106	CAP REL COSTS-BBC						1.06
1.07	00107	CAP REL COSTS-BEC						1.07
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	199,304	199,304				4.00
5.00	00500	ADMINISTRATIVE & GENERAL	6,136,189	11,176	6,147,365			5.00
6.00	00600	MAINTENANCE & REPAIRS	1,126,898	5,490	284,235	1,416,623		6.00
8.00	00800	LAUNDRY & LINEN SERVICE	30,335	82	44,320	8,993	83,730	8.00
9.00	00900	HOUSEKEEPING	107,112	5,244	120,134	15,116	1,846	9.00
10.00	01000	DIETARY	645,509	1,768	69,432	28,875	118	10.00
11.00	01100	CAFETERIA	82,049	3,227	93,747	18,513	0	11.00
13.00	01300	NURSING ADMINISTRATION	940,601	14,559	293,658	33,734	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	139,618	0	197,583	27,846	0	16.00
20.00	02000	NURSING SCHOOL	345,507	9,543	103,808	94,232	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	2,323	39,338	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	758	0	66,091	0	0	22.00
23.00	02300	PARAMED ED PRGM	0	0	0	0	0	23.00
23.01	02301	PARAMED ED PRGM-RADIOLOGY	12,554	612	8,530	4,588	0	23.01
23.02	02302	PARAMED ED PRGM-LABORATORY	7,869	145	1,843	1,178	0	23.02
23.03	02303	PARAMED ED PRGM-PHARMACY	0	621	10,978	0	0	23.03
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,723,869	32,557	737,688	307,321	40,229	30.00
31.00	03100	INTENSIVE CARE UNIT	289,112	7,436	147,385	50,394	3,162	31.00
40.00	04000	SUBPROVIDER - IPF	381,609	9,695	181,156	83,199	1,786	40.00
41.00	04100	SUBPROVIDER - IRF	99,311	3,211	62,151	24,534	3,994	41.00
43.00	04300	NURSERY	61,302	977	20,087	8,141	644	43.00
44.00	04400	SKILLED NURSING FACILITY	138,120	3,547	68,549	27,455	1,495	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,775,874	18,884	594,503	87,547	6,395	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	85,797	2,722	55,287	20,263	2,935	52.00
53.00	05300	ANESTHESIOLOGY	187,648	392	25,601	2,981	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,254,024	7,581	212,665	40,251	1,603	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	860,776	2,425	85,256	31,536	1,417	55.00
57.00	05700	CT SCAN	116,507	1,149	32,273	3,597	401	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	176,334	705	23,562	4,731	113	58.00
60.00	06000	LABORATORY	483,443	7,142	248,233	26,524	110	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	17,709	302	50,012	879	0	62.00
65.00	06500	RESPIRATORY THERAPY	88,109	4,730	88,322	4,896	0	65.00
66.00	06600	PHYSICAL THERAPY	43,324	2,812	51,050	7,817	6	66.00
67.00	06700	OCCUPATIONAL THERAPY	21,785	1,387	24,478	3,748	0	67.00
68.00	06800	SPEECH PATHOLOGY	9,217	537	9,610	1,269	0	68.00
69.00	06900	ELECTROCARDIOLOGY	738,809	3,997	119,449	29,888	4,735	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	89,150	800	18,832	4,989	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	152,837	595	340,460	15,128	1,341	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	226,027	1,031	435,445	22,375	2,574	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	382,930	8,411	567,271	9,835	0	73.00
74.00	07400	RENAL DIALYSIS	7,553	0	26,843	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	32,373	959	34,111	0	0	88.00
90.00	09000	CLINIC	67,486	879	17,622	0	0	90.00
90.01	09001	OUTPATIENT INFUSION	35,355	735	14,975	7,977	0	90.01
91.00	09100	EMERGENCY	344,837	7,665	204,391	57,314	7,195	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0					92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	20,646	6,948	169,653	7,959	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	199,804	3,192	79,773	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	22,885,980	198,193	6,080,390	1,125,623	82,099	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	18,266	0	639	8,525	783	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,215	2	1,157	0	848	192.00
192.01	19201	FASTCARE	62,895	603	13,074	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	DENMAN SERVICES	10,399	0	364	2,282	0	193.01
193.02	19302	MEALS ON WHEELS	0	0	0	0	0	193.02
193.03	19303	UNUSED SPACE	245,471	0	8,590	190,667	0	193.03

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0015 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B Part II Date/Time Prepared: 2/28/2018 10:40 am

		Cost Center Description	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	LAUNDRY & LINEN SERVICE	
			2A	4.00	5.00	6.00	8.00	
193.04	19304	HEALTH EDUCATION	0	54	68	0	0	193.04
193.05	19305	RENTED SPACE	323,883	0	12,191	89,526	0	193.05
193.06	19306	AUGUSTA PHARMACY	1,527	452	30,892	0	0	193.06
200.00		Cross Foot Adjustments	0					200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	23,549,636	199,304	6,147,365	1,416,623	83,730	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0015 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B Part II Date/Time Prepared: 2/28/2018 10:40 am

		Cost Center Description	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	
			9.00	10.00	11.00	13.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BUTLER BUILDING						1.01
1.02	00102	CAP REL COSTS-OLD BLDG & FIXTURES						1.02
1.03	00103	CAP REL COSTS-NEW BLDG & FIXTURES						1.03
1.04	00104	CAP REL COSTS-14TH STREET						1.04
1.05	00105	CAP REL COSTS-MOB PHASE I						1.05
1.06	00106	CAP REL COSTS-BBC						1.06
1.07	00107	CAP REL COSTS-BEC						1.07
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING	249,452					9.00
10.00	01000	DIETARY	5,992	751,694				10.00
11.00	01100	CAFETERIA	3,844	0	201,380			11.00
13.00	01300	NURSING ADMINISTRATION	7,002	0	15,911	1,305,465		13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	5,780	0	0	0	370,827	16.00
20.00	02000	NURSING SCHOOL	19,558	0	11,490	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	2,864	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM	0	0	0	0	0	23.00
23.01	02301	PARAMED ED PRGM-RADIOLOGY	952	0	623	0	0	23.01
23.02	02302	PARAMED ED PRGM-LABORATORY	244	0	161	0	0	23.02
23.03	02303	PARAMED ED PRGM-PHARMACY	0	0	543	0	0	23.03
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	63,786	450,311	43,724	448,499	220,983	30.00
31.00	03100	INTENSIVE CARE UNIT	10,460	56,512	8,877	91,058	27,732	31.00
40.00	04000	SUBPROVIDER - IPF	17,267	128,693	13,556	139,049	63,154	40.00
41.00	04100	SUBPROVIDER - IRF	5,093	50,822	4,102	42,077	24,940	41.00
43.00	04300	NURSERY	1,690	0	1,037	10,636	567	43.00
44.00	04400	SKILLED NURSING FACILITY	5,698	65,356	4,818	49,424	32,072	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	18,171	0	23,842	244,563	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,205	0	3,246	33,294	0	52.00
53.00	05300	ANESTHESIOLOGY	620	0	656	6,731	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,355	0	9,839	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	6,547	0	2,341	0	0	55.00
57.00	05700	CT SCAN	747	0	1,243	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	981	0	747	0	0	58.00
60.00	06000	LABORATORY	5,505	0	10,938	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	183	0	492	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	1,015	0	5,926	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,623	0	2,687	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	779	0	1,441	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	263	0	533	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	6,204	0	4,409	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,034	0	1,178	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,667	0	1,371	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	5,117	0	2,264	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,042	0	7,310	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	1,057	0	0	90.00
90.01	09001	OUTPATIENT INFUSION	1,657	0	766	0	0	90.01
91.00	09100	EMERGENCY	11,895	0	11,324	116,155	1,379	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	1,652	0	0	80,505	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	37,035	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	228,628	751,694	201,316	1,299,026	370,827	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,770	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	FASTCARE	0	0	0	6,439	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	DENMAN SERVICES	473	0	0	0	0	193.01
193.02	19302	MEALS ON WHEELS	0	0	0	0	0	193.02
193.03	19303	UNUSED SPACE	0	0	0	0	0	193.03

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0015 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B Part II Date/Time Prepared: 2/28/2018 10:40 am

		Cost Center Description	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	
			9.00	10.00	11.00	13.00	16.00	
193.04	19304	HEALTH EDUCATION	0	0	64	0	0	193.04
193.05	19305	RENTED SPACE	18,581	0	0	0	0	193.05
193.06	19306	AUGUSTA PHARMACY	0	0	0	0	0	193.06
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	249,452	751,694	201,380	1,305,465	370,827	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0015 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B Part II Date/Time Prepared: 2/28/2018 10:40 am

		Cost Center Description	NURSING SCHOOL	INTERNS & RESIDENTS		PARAMED ED PRGM	PARAMED ED PRGM-RADIOLOGY	
				SERVICES-SALARY & FRINGES	SERVICES-OTHER PRGM COSTS			
			20.00	21.00	22.00	23.00	23.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BUTLER BUILDING						1.01
1.02	00102	CAP REL COSTS-OLD BLDG & FIXTURES						1.02
1.03	00103	CAP REL COSTS-NEW BLDG & FIXTURES						1.03
1.04	00104	CAP REL COSTS-14TH STREET						1.04
1.05	00105	CAP REL COSTS-MOB PHASE I						1.05
1.06	00106	CAP REL COSTS-BBC						1.06
1.07	00107	CAP REL COSTS-BEC						1.07
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
20.00	02000	NURSING SCHOOL	584,138					20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD		44,525				21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD			66,849			22.00
23.00	02300	PARAMED ED PRGM				0		23.00
23.01	02301	PARAMED ED PRGM-RADIOLOGY					27,859	23.01
23.02	02302	PARAMED ED PRGM-LABORATORY						23.02
23.03	02303	PARAMED ED PRGM-PHARMACY						23.03
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS						30.00
31.00	03100	INTENSIVE CARE UNIT						31.00
40.00	04000	SUBPROVIDER - IPF						40.00
41.00	04100	SUBPROVIDER - IRF						41.00
43.00	04300	NURSERY						43.00
44.00	04400	SKILLED NURSING FACILITY						44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM						50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM						52.00
53.00	05300	ANESTHESIOLOGY						53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC						54.00
55.00	05500	RADIOLOGY-THERAPEUTIC						55.00
57.00	05700	CT SCAN						57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)						58.00
60.00	06000	LABORATORY						60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS						62.00
65.00	06500	RESPIRATORY THERAPY						65.00
66.00	06600	PHYSICAL THERAPY						66.00
67.00	06700	OCCUPATIONAL THERAPY						67.00
68.00	06800	SPEECH PATHOLOGY						68.00
69.00	06900	ELECTROCARDIOLOGY						69.00
70.00	07000	ELECTROENCEPHALOGRAPHY						70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS						71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS						72.00
73.00	07300	DRUGS CHARGED TO PATIENTS						73.00
74.00	07400	RENAL DIALYSIS						74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC						88.00
90.00	09000	CLINIC						90.00
90.01	09001	OUTPATIENT INFUSION						90.01
91.00	09100	EMERGENCY						91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY						101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE						116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	0	0	0	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN						190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES						192.00
192.01	19201	FASTCARE						192.01
193.00	19300	NONPAID WORKERS						193.00
193.01	19301	DENMAN SERVICES						193.01
193.02	19302	MEALS ON WHEELS						193.02

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0015 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B Part II Date/Time Prepared: 2/28/2018 10:40 am

		Cost Center Description	NURSING SCHOOL	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES	INTERNS & RESIDENTS SERVICES-OTHER PRGM COSTS	PARAMED ED PRGM	PARAMED ED PRGM-RADIOLOGY	
			20.00	21.00	22.00	23.00	23.01	
193.03	19303	UNUSED SPACE						193.03
193.04	19304	HEALTH EDUCATION						193.04
193.05	19305	RENTED SPACE						193.05
193.06	19306	AUGUSTA PHARMACY						193.06
200.00		Cross Foot Adjustments	584,138	44,525	66,849	0	27,859	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	584,138	44,525	66,849	0	27,859	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0015 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B Part II Date/Time Prepared: 2/28/2018 10:40 am

		Cost Center Description	PARAMED ED PRGM-LABORATORY	PARAMED ED PRGM-PHARMACY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			23.02	23.03	24.00	25.00	26.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BUTLER BUILDING						1.01
1.02	00102	CAP REL COSTS-OLD BLDG & FIXTURES						1.02
1.03	00103	CAP REL COSTS-NEW BLDG & FIXTURES						1.03
1.04	00104	CAP REL COSTS-14TH STREET						1.04
1.05	00105	CAP REL COSTS-MOB PHASE I						1.05
1.06	00106	CAP REL COSTS-BBC						1.06
1.07	00107	CAP REL COSTS-BEC						1.07
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
20.00	02000	NURSING SCHOOL						20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD						21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD						22.00
23.00	02300	PARAMED ED PRGM						23.00
23.01	02301	PARAMED ED PRGM-RADIOLOGY						23.01
23.02	02302	PARAMED ED PRGM-LABORATORY	11,440					23.02
23.03	02303	PARAMED ED PRGM-PHARMACY		12,142				23.03
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS			5,068,967	0	5,068,967	30.00
31.00	03100	INTENSIVE CARE UNIT			692,128	0	692,128	31.00
40.00	04000	SUBPROVIDER - IPF			1,019,164	0	1,019,164	40.00
41.00	04100	SUBPROVIDER - IRF			320,235	0	320,235	41.00
43.00	04300	NURSERY			105,081	0	105,081	43.00
44.00	04400	SKILLED NURSING FACILITY			396,534	0	396,534	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM			4,769,779	0	4,769,779	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM			207,749	0	207,749	52.00
53.00	05300	ANESTHESIOLOGY			224,629	0	224,629	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC			1,534,318	0	1,534,318	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC			990,298	0	990,298	55.00
57.00	05700	CT SCAN			155,917	0	155,917	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)			207,173	0	207,173	58.00
60.00	06000	LABORATORY			781,895	0	781,895	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS			69,577	0	69,577	62.00
65.00	06500	RESPIRATORY THERAPY			192,998	0	192,998	65.00
66.00	06600	PHYSICAL THERAPY			109,319	0	109,319	66.00
67.00	06700	OCCUPATIONAL THERAPY			53,618	0	53,618	67.00
68.00	06800	SPEECH PATHOLOGY			21,429	0	21,429	68.00
69.00	06900	ELECTROCARDIOLOGY			907,491	0	907,491	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY			115,983	0	115,983	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS			514,399	0	514,399	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS			694,833	0	694,833	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS			977,799	0	977,799	73.00
74.00	07400	RENAL DIALYSIS			34,396	0	34,396	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC			67,443	0	67,443	88.00
90.00	09000	CLINIC			87,044	0	87,044	90.00
90.01	09001	OUTPATIENT INFUSION			61,465	0	61,465	90.01
91.00	09100	EMERGENCY			762,155	0	762,155	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY			287,363	0	287,363	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE			319,804	0	319,804	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	0	21,750,983	0	21,750,983	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN			29,983	0	29,983	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES			3,222	0	3,222	192.00
192.01	19201	FASTCARE			83,011	0	83,011	192.01
193.00	19300	NONPAID WORKERS			0	0	0	193.00
193.01	19301	DENMAN SERVICES			13,518	0	13,518	193.01

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0015 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B Part II Date/Time Prepared: 2/28/2018 10:40 am

		Cost Center Description	PARAMED ED PRGM-LABORATORY	PARAMED ED PRGM-PHARMACY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			23.02	23.03	24.00	25.00	26.00	
193.02	19302	MEALS ON WHEELS			0	0	0	193.02
193.03	19303	UNUSED SPACE			444,728	0	444,728	193.03
193.04	19304	HEALTH EDUCATION			186	0	186	193.04
193.05	19305	RENTED SPACE			444,181	0	444,181	193.05
193.06	19306	AUGUSTA PHARMACY			32,871	0	32,871	193.06
200.00		Cross Foot Adjustments	11,440	12,142	746,953	0	746,953	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	11,440	12,142	23,549,636	0	23,549,636	202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0015 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B-1 Date/Time Prepared: 2/28/2018 10:40 am

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	BUTLER BUILDING (SQUARE FEET)	OLD BLDG & FIXTURES (SQUARE FEET)	NEW BLDG & FIXTURES (SQUARE FEET)	14TH STREET (SQUARE FEET)	
			1.00	1.01	1.02	1.03	1.04	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	0					1.00
1.01	00101	CAP REL COSTS-BUTLER BUILDING	0	18,141				1.01
1.02	00102	CAP REL COSTS-OLD BLDG & FIXTURES	0	0	125,802			1.02
1.03	00103	CAP REL COSTS-NEW BLDG & FIXTURES	0	0	0	611,999		1.03
1.04	00104	CAP REL COSTS-14TH STREET	0	0	0	0	129,300	1.04
1.05	00105	CAP REL COSTS-MOB PHASE I	0	0	0	0	0	1.05
1.06	00106	CAP REL COSTS-BBC	0	0	0	0	0	1.06
1.07	00107	CAP REL COSTS-BEC	0	0	0	0	0	1.07
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	5,357	5,569	519	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	189	28,085	114,366	16,262	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	3,821	18,892	69,245	31,691	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	1,779	1,973	188	8.00
9.00	00900	HOUSEKEEPING	0	0	4,505	802	1,316	9.00
10.00	01000	DIETARY	0	0	79	12,572	0	10.00
11.00	01100	CAFETERIA	0	0	0	8,111	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	4,331	575	5,917	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	889	5,985	823	16.00
20.00	02000	NURSING SCHOOL	0	13,228	0	21,960	3,162	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM	0	0	0	0	0	23.00
23.01	02301	PARAMED ED PRGM-RADIOLOGY	0	0	0	516	782	23.01
23.02	02302	PARAMED ED PRGM-LABORATORY	0	0	0	516	0	23.02
23.03	02303	PARAMED ED PRGM-PHARMACY	0	0	0	0	0	23.03
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	863	133,784	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	10,485	11,594	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	36,452	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	5,215	5,534	0	41.00
43.00	04300	NURSERY	0	0	0	3,567	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	12,029	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	11,525	26,832	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	6,797	2,081	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	628	678	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	1,527	16,108	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	13,817	0	55.00
57.00	05700	CT SCAN	0	0	605	971	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	2,073	0	58.00
60.00	06000	LABORATORY	0	0	692	10,761	168	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	385	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	2,145	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	3,425	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,642	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	556	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	8,450	4,521	124	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	2,186	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	364	0	6,235	29	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	539	0	9,220	44	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	322	3,823	164	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	OUTPATIENT INFUSION	0	0	0	3,495	0	90.01
91.00	09100	EMERGENCY	0	0	5,845	14,894	3,223	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	2,463	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	18,141	121,202	566,667	66,875	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	2,941	794	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	FASTCARE	0	0	0	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	DENMAN SERVICES	0	0	0	1,000	0	193.01

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0015 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B-1 Date/Time Prepared: 2/28/2018 10:40 am

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	BUTLER BUILDING (SQUARE FEET)	OLD BLDG & FIXTURES (SQUARE FEET)	NEW BLDG & FIXTURES (SQUARE FEET)	14TH STREET (SQUARE FEET)	
			1.00	1.01	1.02	1.03	1.04	
193.02	19302	MEALS ON WHEELS	0	0	0	0	0	193.02
193.03	19303	UNUSED SPACE	0	0	1,069	20,219	61,478	193.03
193.04	19304	HEALTH EDUCATION	0	0	0	0	0	193.04
193.05	19305	RENTED SPACE	0	0	590	23,319	947	193.05
193.06	19306	AUGUSTA PHARMACY	0	0	0	0	0	193.06
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	0	37,595	437,774	6,190,827	78,280	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000	2.072377	3.479865	10.115747	0.605414	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)						204.00
205.00		Unit cost multiplier (Wkst. B, Part II)						205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0015 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B-1 | Date/Time Prepared: 2/28/2018 10:40 am

		Cost Center Description	CAPITAL RELATED COSTS					
			MOB PHASE I (SQUARE FEET)	BBC (SQUARE FEET)	BEC (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	
			1.05	1.06	1.07	2.00	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BUTLER BUILDING						1.01
1.02	00102	CAP REL COSTS-OLD BLDG & FIXTURES						1.02
1.03	00103	CAP REL COSTS-NEW BLDG & FIXTURES						1.03
1.04	00104	CAP REL COSTS-14TH STREET						1.04
1.05	00105	CAP REL COSTS-MOB PHASE I	2,472					1.05
1.06	00106	CAP REL COSTS-BBC	0	15,973				1.06
1.07	00107	CAP REL COSTS-BEC	0	0	13,519			1.07
2.00	00200	CAP REL COSTS-MVBLE EQUIP				13,250,194		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	125,678	89,281,102	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,472	1,605	5,538	4,046,902	5,007,308	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	337,597	2,459,871	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	4,127	36,923	8.00
9.00	00900	HOUSEKEEPING	0	0	0	83,633	2,349,445	9.00
10.00	01000	DIETARY	0	0	0	87,517	792,239	10.00
11.00	01100	CAFETERIA	0	0	0	0	1,445,751	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	2,160	907,342	6,523,056	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	76,497	0	16.00
20.00	02000	NURSING SCHOOL	0	0	2,936	66,631	4,275,455	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	1,040,755	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	768	0	22.00
23.00	02300	PARAMED ED PRGM	0	0	0	0	0	23.00
23.01	02301	PARAMED ED PRGM-RADIOLOGY	0	0	712	0	274,237	23.01
23.02	02302	PARAMED ED PRGM-LABORATORY	0	0	0	2,685	65,157	23.02
23.03	02303	PARAMED ED PRGM-PHARMACY	0	0	0	0	278,295	23.03
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	1,312,452	14,571,882	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	119,709	3,331,441	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	13,043	4,343,742	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	19,456	1,438,835	41.00
43.00	04300	NURSERY	0	0	0	25,558	437,601	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	643	1,588,963	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	2,396,014	8,460,644	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	41,645	1,219,392	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	163,400	175,725	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	679,768	3,396,665	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	730,690	1,086,420	55.00
57.00	05700	CT SCAN	0	0	0	105,984	514,838	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	157,451	315,789	58.00
60.00	06000	LABORATORY	0	0	0	226,788	3,199,937	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	14,000	135,421	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	2,119,072	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	8,795	1,260,075	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	5,244	621,616	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	3,641	240,473	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	672,508	1,790,758	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	37,568	358,517	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	61,474	266,516	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	90,916	461,984	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	347,644	3,768,503	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	7,654	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	429,610	88.00
90.00	09000	CLINIC	0	0	0	0	393,916	90.00
90.01	09001	OUTPATIENT INFUSION	0	0	0	0	329,321	90.01
91.00	09100	EMERGENCY	0	0	1,149	162,971	3,434,145	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	1,024	6,793	3,113,065	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	73,652	1,430,115	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,472	1,605	13,519	13,224,838	88,783,473	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	1,231	754	192.00
192.01	19201	FASTCARE	0	0	0	22,290	270,103	192.01

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0015 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B-1 | Date/Time Prepared: 2/28/2018 10:40 am

		Cost Center Description	CAPITAL RELATED COSTS					
			MOB PHASE I (SQUARE FEET)	BBC (SQUARE FEET)	BEC (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	
			1.05	1.06	1.07	2.00	4.00	
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	DENMAN SERVICES	0	0	0	287	0	193.01
193.02	19302	MEALS ON WHEELS	0	0	0	0	0	193.02
193.03	19303	UNUSED SPACE	0	0	0	0	0	193.03
193.04	19304	HEALTH EDUCATION	0	0	0	0	24,396	193.04
193.05	19305	RENTED SPACE	0	14,368	0	0	0	193.05
193.06	19306	AUGUSTA PHARMACY	0	0	0	1,548	202,376	193.06
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	9,817	94,904	130,265	13,074,604	7,151,171	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	3.971278	5.941526	9.635698	0.986748	0.080097	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)					199,304	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)					0.002232	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0015 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B-1 | Date/Time Prepared: 2/28/2018 10:40 am

		Cost Center Description	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	
			5A	5.00	6.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BUTLER BUILDING						1.01
1.02	00102	CAP REL COSTS-OLD BLDG & FIXTURES						1.02
1.03	00103	CAP REL COSTS-NEW BLDG & FIXTURES						1.03
1.04	00104	CAP REL COSTS-14TH STREET						1.04
1.05	00105	CAP REL COSTS-MOB PHASE I						1.05
1.06	00106	CAP REL COSTS-BBC						1.06
1.07	00107	CAP REL COSTS-BEC						1.07
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-61,295,993	175,663,576				5.00
6.00	00600	MAINTENANCE & REPAIRS	0	8,122,156	620,666			6.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	1,266,470	3,940	1,131,998		8.00
9.00	00900	HOUSEKEEPING	0	3,432,878	6,623	24,961	103,452	9.00
10.00	01000	DIETARY	0	1,984,044	12,651	1,600	2,485	10.00
11.00	01100	CAFETERIA	0	2,678,855	8,111	0	1,594	11.00
13.00	01300	NURSING ADMINISTRATION	0	8,391,423	14,780	0	2,904	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	5,646,032	12,200	0	2,397	16.00
20.00	02000	NURSING SCHOOL	0	2,966,378	41,286	0	8,111	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	1,124,116	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	1,888,573	0	0	0	22.00
23.00	02300	PARAMED ED PRGM	0	0	0	0	0	23.00
23.01	02301	PARAMED ED PRGM-RADIOLOGY	0	243,751	2,010	0	395	23.01
23.02	02302	PARAMED ED PRGM-LABORATORY	0	52,675	516	0	101	23.02
23.03	02303	PARAMED ED PRGM-PHARMACY	0	313,701	0	0	0	23.03
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	21,079,261	134,647	543,888	26,453	30.00
31.00	03100	INTENSIVE CARE UNIT	0	4,211,610	22,079	42,750	4,338	31.00
40.00	04000	SUBPROVIDER - IPF	0	5,176,635	36,452	24,146	7,161	40.00
41.00	04100	SUBPROVIDER - IRF	0	1,775,985	10,749	54,000	2,112	41.00
43.00	04300	NURSERY	0	573,982	3,567	8,708	701	43.00
44.00	04400	SKILLED NURSING FACILITY	0	1,958,835	12,029	20,209	2,363	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	16,988,236	38,357	86,452	7,536	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,579,841	8,878	39,674	1,744	52.00
53.00	05300	ANESTHESIOLOGY	0	731,558	1,306	0	257	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	6,077,008	17,635	21,673	3,465	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	2,436,242	13,817	19,160	2,715	55.00
57.00	05700	CT SCAN	0	922,211	1,576	5,418	310	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	673,299	2,073	1,527	407	58.00
60.00	06000	LABORATORY	0	7,093,398	11,621	1,492	2,283	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	1,429,132	385	0	76	62.00
65.00	06500	RESPIRATORY THERAPY	0	2,523,844	2,145	0	421	65.00
66.00	06600	PHYSICAL THERAPY	0	1,458,782	3,425	80	673	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	699,469	1,642	0	323	67.00
68.00	06800	SPEECH PATHOLOGY	0	274,624	556	0	109	68.00
69.00	06900	ELECTROCARDIOLOGY	0	3,413,314	13,095	64,015	2,573	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	538,144	2,186	0	429	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	9,728,812	6,628	18,128	1,106	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	12,443,062	9,803	34,801	2,122	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	16,210,059	4,309	0	847	73.00
74.00	07400	RENAL DIALYSIS	0	767,041	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	974,739	0	0	0	88.00
90.00	09000	CLINIC	0	503,546	0	0	0	90.00
90.01	09001	OUTPATIENT INFUSION	0	427,920	3,495	0	687	90.01
91.00	09100	EMERGENCY	0	5,840,566	25,111	97,272	4,933	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	4,847,930	3,487	0	685	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	2,279,562	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-61,295,993	173,749,699	493,170	1,109,954	94,816	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	18,266	3,735	10,582	734	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	33,059	0	11,462	0	192.00
192.01	19201	FASTCARE	0	373,610	0	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	DENMAN SERVICES	0	10,399	1,000	0	196	193.01
193.02	19302	MEALS ON WHEELS	0	0	0	0	0	193.02

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0015 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B-1 | Date/Time Prepared: 2/28/2018 10:40 am

		Cost Center Description	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	
			5A	5.00	6.00	8.00	9.00	
193.03	19303	UNUSED SPACE	0	245,471	83,537	0	0	193.03
193.04	19304	HEALTH EDUCATION	0	1,954	0	0	0	193.04
193.05	19305	RENTED SPACE	0	348,352	39,224	0	7,706	193.05
193.06	19306	AUGUSTA PHARMACY	0	882,766	0	0	0	193.06
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)		61,295,993	10,956,301	1,777,943	4,786,862	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)		0.348940	17.652491	1.570624	46.271334	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)		6,147,365	1,416,623	83,730	249,452	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)		0.034995	2.282424	0.073967	2.411283	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0015 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B-1 | Date/Time Prepared: 2/28/2018 10:40 am

		Cost Center Description	DIETARY (MEALS SERVED)	CAFETERIA (MEALS SERVED)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	NURSING SCHOOL (ASSIGNED TIME)	
			10.00	11.00	13.00	16.00	20.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BUTLER BUILDING						1.01
1.02	00102	CAP REL COSTS-OLD BLDG & FIXTURES						1.02
1.03	00103	CAP REL COSTS-NEW BLDG & FIXTURES						1.03
1.04	00104	CAP REL COSTS-14TH STREET						1.04
1.05	00105	CAP REL COSTS-MOB PHASE I						1.05
1.06	00106	CAP REL COSTS-BBC						1.06
1.07	00107	CAP REL COSTS-BEC						1.07
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	201,345					10.00
11.00	01100	CAFETERIA	0	346,901				11.00
13.00	01300	NURSING ADMINISTRATION	0	27,409	1,660,214			13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	181,831		16.00
20.00	02000	NURSING SCHOOL	0	19,793	0	0	33,284	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	4,933	0	0		21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0		22.00
23.00	02300	PARAMED ED PRGM	0	0	0	0		23.00
23.01	02301	PARAMED ED PRGM-RADIOLOGY	0	1,074	0	0		23.01
23.02	02302	PARAMED ED PRGM-LABORATORY	0	277	0	0		23.02
23.03	02303	PARAMED ED PRGM-PHARMACY	0	936	0	0		23.03
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	120,618	75,319	570,375	108,357	23,639	30.00
31.00	03100	INTENSIVE CARE UNIT	15,137	15,292	115,802	13,598	2,443	31.00
40.00	04000	SUBPROVIDER - IPF	34,471	23,351	176,835	30,967	1,955	40.00
41.00	04100	SUBPROVIDER - IRF	13,613	7,066	53,511	12,229	240	41.00
43.00	04300	NURSERY	0	1,786	13,526	278	430	43.00
44.00	04400	SKILLED NURSING FACILITY	17,506	8,300	62,855	15,726	280	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	41,071	311,021	0	1,224	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	5,591	42,341	0	1,258	52.00
53.00	05300	ANESTHESIOLOGY	0	1,130	8,560	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	16,949	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	4,033	0	0	0	55.00
57.00	05700	CT SCAN	0	2,142	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	1,286	0	0	0	58.00
60.00	06000	LABORATORY	0	18,842	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	847	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	10,208	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	4,629	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	2,483	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	918	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	7,595	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	2,029	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2,362	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	3,900	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	12,593	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	1,821	0	0	0	90.00
90.01	09001	OUTPATIENT INFUSION	0	1,319	0	0	0	90.01
91.00	09100	EMERGENCY	0	19,507	147,719	676	1,455	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	102,381	0	78	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	47,099	0	282	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	201,345	346,791	1,652,025	181,831	33,284	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	FASTCARE	0	0	8,189	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	DENMAN SERVICES	0	0	0	0	0	193.01

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0015 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B-1 Date/Time Prepared: 2/28/2018 10:40 am

		Cost Center Description	DIETARY (MEALS SERVED)	CAFETERIA (MEALS SERVED)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	NURSING SCHOOL (ASSIGNED TIME)	
			10.00	11.00	13.00	16.00	20.00	
193.02	19302	MEALS ON WHEELS	0	0	0	0	0	193.02
193.03	19303	UNUSED SPACE	0	0	0	0	0	193.03
193.04	19304	HEALTH EDUCATION	0	110	0	0	0	193.04
193.05	19305	RENTED SPACE	0	0	0	0	0	193.05
193.06	19306	AUGUSTA PHARMACY	0	0	0	0	0	193.06
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	3,017,175	3,830,551	12,017,458	7,942,430	5,324,132	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	14.985100	11.042202	7.238499	43.680286	159.960702	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	751,694	201,380	1,305,465	370,827	584,138	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	3.733363	0.580511	0.786323	2.039405	17.550114	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0015 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B-1 | Date/Time Prepared: 2/28/2018 10:40 am

		Cost Center Description	INTERNS & RESIDENTS					
			SERVICES-SALARY & FRINGES (ASSIGNED TIME)	SERVICES-OTHER PRGM COSTS (ASSIGNED TIME)	PARAMED ED PRGM (ASSIGNED TIME)	PARAMED ED PRGM-RADIOLOGY (ASSIGNED TIME)	PARAMED ED PRGM-LABORATORY (ASSIGNED TIME)	
			21.00	22.00	23.00	23.01	23.02	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BUTLER BUILDING						1.01
1.02	00102	CAP REL COSTS-OLD BLDG & FIXTURES						1.02
1.03	00103	CAP REL COSTS-NEW BLDG & FIXTURES						1.03
1.04	00104	CAP REL COSTS-14TH STREET						1.04
1.05	00105	CAP REL COSTS-MOB PHASE I						1.05
1.06	00106	CAP REL COSTS-BBC						1.06
1.07	00107	CAP REL COSTS-BEC						1.07
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
20.00	02000	NURSING SCHOOL						20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	20,640					21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD		20,640				22.00
23.00	02300	PARAMED ED PRGM			0			23.00
23.01	02301	PARAMED ED PRGM-RADIOLOGY				100		23.01
23.02	02302	PARAMED ED PRGM-LABORATORY					100	23.02
23.03	02303	PARAMED ED PRGM-PHARMACY						23.03
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	13,367	13,367	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	640	640	0	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	755	755	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	854	854	0	0	0	41.00
43.00	04300	NURSERY	657	657	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	821	821	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	164	164	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	100	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
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
60.00	06000	LABORATORY	213	213	0	0	100	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	640	640	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	706	706	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	OUTPATIENT INFUSION	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	1,823	1,823	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE			0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	20,640	20,640	0	100	100	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	FASTCARE	0	0	0	0	0	192.01

COST ALLOCATION - STATISTICAL BASIS	Provider CCN: 14-0015	Period: From 10/01/2016 To 09/30/2017	Worksheet B-1 Date/Time Prepared: 2/28/2018 10:40 am

		Cost Center Description	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES (ASSIGNED TIME)	INTERNS & RESIDENTS SERVICES-OTHER PRGM COSTS (ASSIGNED TIME)	PARAMED ED PRGM (ASSIGNED TIME)	PARAMED ED PRGM-RADIOLOGY (ASSIGNED TIME)	PARAMED ED PRGM-LABORATORY (ASSIGNED TIME)	
			21.00	22.00	23.00	23.01	23.02	
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	DENMAN SERVICES	0	0	0	0	0	193.01
193.02	19302	MEALS ON WHEELS	0	0	0	0	0	193.02
193.03	19303	UNUSED SPACE	0	0	0	0	0	193.03
193.04	19304	HEALTH EDUCATION	0	0	0	0	0	193.04
193.05	19305	RENTED SPACE	0	0	0	0	0	193.05
193.06	19306	AUGUSTA PHARMACY	0	0	0	0	0	193.06
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,570,836	2,547,572	0	394,423	87,896	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	76.106395	123.428876	0.000000	3,944.230000	878.960000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	44,525	66,849	0	27,859	11,440	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	2.157219	3.238808	0.000000	278.590000	114.400000	205.00

		Cost Center Description	PARAMED ED PRGM-PHARMACY (ASSIGNED TIME)	
			23.03	
		GENERAL SERVICE COST CENTERS		
1.00	00100	CAP REL COSTS-BLDG & FIXT		1.00
1.01	00101	CAP REL COSTS-BUTLER BUILDING		1.01
1.02	00102	CAP REL COSTS-OLD BLDG & FIXTURES		1.02
1.03	00103	CAP REL COSTS-NEW BLDG & FIXTURES		1.03
1.04	00104	CAP REL COSTS-14TH STREET		1.04
1.05	00105	CAP REL COSTS-MOB PHASE I		1.05
1.06	00106	CAP REL COSTS-BBC		1.06
1.07	00107	CAP REL COSTS-BEC		1.07
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT		4.00
5.00	00500	ADMINISTRATIVE & GENERAL		5.00
6.00	00600	MAINTENANCE & REPAIRS		6.00
8.00	00800	LAUNDRY & LINEN SERVICE		8.00
9.00	00900	HOUSEKEEPING		9.00
10.00	01000	DIETARY		10.00
11.00	01100	CAFETERIA		11.00
13.00	01300	NURSING ADMINISTRATION		13.00
16.00	01600	MEDICAL RECORDS & LIBRARY		16.00
20.00	02000	NURSING SCHOOL		20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD		21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD		22.00
23.00	02300	PARAMED ED PRGM		23.00
23.01	02301	PARAMED ED PRGM-RADIOLOGY		23.01
23.02	02302	PARAMED ED PRGM-LABORATORY		23.02
23.03	02303	PARAMED ED PRGM-PHARMACY	100	23.03
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	41.00
43.00	04300	NURSERY	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	44.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	52.00
53.00	05300	ANESTHESIOLOGY	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	55.00
57.00	05700	CT SCAN	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	58.00
60.00	06000	LABORATORY	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	65.00
66.00	06600	PHYSICAL THERAPY	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	100	73.00
74.00	07400	RENAL DIALYSIS	0	74.00
		OUTPATIENT SERVICE COST CENTERS		
88.00	08800	RURAL HEALTH CLINIC	0	88.00
90.00	09000	CLINIC	0	90.00
90.01	09001	OUTPATIENT INFUSION	0	90.01
91.00	09100	EMERGENCY	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		92.00
		OTHER REIMBURSABLE COST CENTERS		
101.00	10100	HOME HEALTH AGENCY	0	101.00
		SPECIAL PURPOSE COST CENTERS		
113.00	11300	INTEREST EXPENSE		113.00
116.00	11600	HOSPICE	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	100	118.00
		NONREIMBURSABLE COST CENTERS		
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	192.00
192.01	19201	FASTCARE	0	192.01
193.00	19300	NONPAID WORKERS	0	193.00
193.01	19301	DENMAN SERVICES	0	193.01
193.02	19302	MEALS ON WHEELS	0	193.02

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0015 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B-1 | Date/Time Prepared: 2/28/2018 10:40 am

		Cost Center Description	PARAMED ED PRGM-PHARMACY (ASSIGNED TIME)	
			23.03	
193.03	19303	UNUSED SPACE	0	193.03
193.04	19304	HEALTH EDUCATION	0	193.04
193.05	19305	RENTED SPACE	0	193.05
193.06	19306	AUGUSTA PHARMACY	0	193.06
200.00		Cross Foot Adjustments		200.00
201.00		Negative Cost Centers		201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	433,500	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	4,335.000000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	12,142	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	121.420000	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0015 | Period: From 10/01/2016 To 09/30/2017 | Worksheet C Part I Date/Time Prepared: 2/28/2018 10:40 am

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		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	48,171,920		48,171,920	18,210	48,190,130	30.00
31.00	03100	INTENSIVE CARE UNIT	8,557,495		8,557,495	0	8,557,495	31.00
40.00	04000	SUBPROVIDER - IPF	11,715,499		11,715,499	2,059	11,717,558	40.00
41.00	04100	SUBPROVIDER - IRF	4,009,895		4,009,895	6,389	4,016,284	41.00
43.00	04300	NURSERY	1,081,901		1,081,901	0	1,081,901	43.00
44.00	04400	SKILLED NURSING FACILITY	4,536,433		4,536,433	430	4,536,863	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	26,978,324		26,978,324	42,116	27,020,440	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,000,293		3,000,293	0	3,000,293	52.00
53.00	05300	ANESTHESIOLOGY	1,096,214		1,096,214	0	1,096,214	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	9,284,768		9,284,768	0	9,284,768	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	3,730,501		3,730,501	0	3,730,501	55.00
57.00	05700	CT SCAN	1,318,333		1,318,333	0	1,318,333	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	980,264		980,264	0	980,264	58.00
60.00	06000	LABORATORY	10,177,641		10,177,641	0	10,177,641	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	1,947,479		1,947,479	0	1,947,479	62.00
65.00	06500	RESPIRATORY THERAPY	3,574,578	0	3,574,578	7,151	3,581,729	65.00
66.00	06600	PHYSICAL THERAPY	2,110,650	0	2,110,650	0	2,110,650	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,014,891	0	1,014,891	0	1,014,891	67.00
68.00	06800	SPEECH PATHOLOGY	395,447	0	395,447	0	395,447	68.00
69.00	06900	ELECTROCARDIOLOGY	5,138,980		5,138,980	2,610	5,141,590	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	806,767		806,767	3,404	810,171	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	13,346,315		13,346,315	0	13,346,315	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	17,153,903		17,153,903	0	17,153,903	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	22,554,208		22,554,208	0	22,554,208	73.00
74.00	07400	RENAL DIALYSIS	1,034,692		1,034,692	0	1,034,692	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,314,864		1,314,864	0	1,314,864	88.00
90.00	09000	CLINIC	699,361		699,361	0	699,361	90.00
90.01	09001	OUTPATIENT INFUSION	685,286		685,286	0	685,286	90.01
91.00	09100	EMERGENCY	10,249,814		10,249,814	76,255	10,326,069	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	6,601,969		6,601,969		6,601,969	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	7,386,379		7,386,379		7,386,379	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	3,461,027		3,461,027		3,461,027	116.00
200.00		Subtotal (see instructions)	234,116,091	0	234,116,091	158,624	234,274,715	200.00
201.00		Less Observation Beds	6,601,969		6,601,969		6,601,969	201.00
202.00		Total (see instructions)	227,514,122	0	227,514,122	158,624	227,672,746	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0015 | Period: From 10/01/2016 To 09/30/2017 | Worksheet C Part I Date/Time Prepared: 2/28/2018 10:40 am

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		Cost Center Description	Charges Inpatient	Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	83,202,982		83,202,982			30.00
31.00	03100	INTENSIVE CARE UNIT	37,218,453		37,218,453			31.00
40.00	04000	SUBPROVIDER - IPF	25,339,411		25,339,411			40.00
41.00	04100	SUBPROVIDER - IRF	5,584,292		5,584,292			41.00
43.00	04300	NURSERY	3,247,959		3,247,959			43.00
44.00	04400	SKILLED NURSING FACILITY	5,712,590		5,712,590			44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	36,382,811	89,070,738	125,453,549	0.215046	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	6,577,837	692,753	7,270,590	0.412662	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	11,020,282	17,386,782	28,407,064	0.038589	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	14,576,391	37,259,563	51,835,954	0.179118	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	755,584	18,044,832	18,800,416	0.198427	0.000000	55.00
57.00	05700	CT SCAN	25,587,705	47,453,131	73,040,836	0.018049	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	6,799,780	13,778,861	20,578,641	0.047635	0.000000	58.00
60.00	06000	LABORATORY	52,876,730	63,840,121	116,716,851	0.087199	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	3,912,661	2,150,236	6,062,897	0.321213	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	16,490,073	3,694,224	20,184,297	0.177097	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	3,926,213	404,039	4,330,252	0.487420	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,978,871	92,423	3,071,294	0.330444	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	1,093,293	250,465	1,343,758	0.294284	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	38,321,778	52,617,818	90,939,596	0.056510	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	299,110	2,623,981	2,923,091	0.275998	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	38,769,800	42,187,293	80,957,093	0.164857	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	27,811,107	27,982,624	55,793,731	0.307452	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	89,583,329	42,782,588	132,365,917	0.170393	0.000000	73.00
74.00	07400	RENAL DIALYSIS	2,109,046	0	2,109,046	0.490597	0.000000	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	769,286	769,286			88.00
90.00	09000	CLINIC	335	737,127	737,462	0.948335	0.000000	90.00
90.01	09001	OUTPATIENT INFUSION	35,754	2,030,894	2,066,648	0.331593	0.000000	90.01
91.00	09100	EMERGENCY	14,103,265	31,947,531	46,050,796	0.222576	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	3,030,568	23,159,112	26,189,680	0.252083	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	6,747,511	6,747,511			101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	79,838	3,732,140	3,811,978			116.00
200.00		Subtotal (see instructions)	557,427,848	531,436,073	1,088,863,921			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	557,427,848	531,436,073	1,088,863,921			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0015 | Period: From 10/01/2016 To 09/30/2017 | Worksheet C Part I Date/Time Prepared: 2/28/2018 10:40 am

Title XVIII | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
40.00	04000	SUBPROVIDER - IPF		40.00
41.00	04100	SUBPROVIDER - IRF		41.00
43.00	04300	NURSERY		43.00
44.00	04400	SKILLED NURSING FACILITY		44.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.215382	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.412662	52.00
53.00	05300	ANESTHESIOLOGY	0.038589	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.179118	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.198427	55.00
57.00	05700	CT SCAN	0.018049	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.047635	58.00
60.00	06000	LABORATORY	0.087199	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.321213	62.00
65.00	06500	RESPIRATORY THERAPY	0.177451	65.00
66.00	06600	PHYSICAL THERAPY	0.487420	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.330444	67.00
68.00	06800	SPEECH PATHOLOGY	0.294284	68.00
69.00	06900	ELECTROCARDIOLOGY	0.056539	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.277162	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.164857	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.307452	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.170393	73.00
74.00	07400	RENAL DIALYSIS	0.490597	74.00
		OUTPATIENT SERVICE COST CENTERS		
88.00	08800	RURAL HEALTH CLINIC		88.00
90.00	09000	CLINIC	0.948335	90.00
90.01	09001	OUTPATIENT INFUSION	0.331593	90.01
91.00	09100	EMERGENCY	0.224232	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.252083	92.00
		OTHER REIMBURSABLE COST CENTERS		
101.00	10100	HOME HEALTH AGENCY		101.00
		SPECIAL PURPOSE COST CENTERS		
113.00	11300	INTEREST EXPENSE		113.00
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: 14-0015 | Period: From 10/01/2016 To 09/30/2017 | Worksheet C Part I Date/Time Prepared: 2/28/2018 10:40 am

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs: Total Costs	Costs: RCE Disallowance	Costs: Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	48,171,920		48,171,920	18,210	48,190,130	30.00
31.00	03100	INTENSIVE CARE UNIT	8,557,495		8,557,495	0	8,557,495	31.00
40.00	04000	SUBPROVIDER - IPF	11,715,499		11,715,499	2,059	11,717,558	40.00
41.00	04100	SUBPROVIDER - IRF	4,009,895		4,009,895	6,389	4,016,284	41.00
43.00	04300	NURSERY	1,081,901		1,081,901	0	1,081,901	43.00
44.00	04400	SKILLED NURSING FACILITY	4,536,433		4,536,433	430	4,536,863	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	26,978,324		26,978,324	42,116	27,020,440	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,000,293		3,000,293	0	3,000,293	52.00
53.00	05300	ANESTHESIOLOGY	1,096,214		1,096,214	0	1,096,214	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	9,284,768		9,284,768	0	9,284,768	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	3,730,501		3,730,501	0	3,730,501	55.00
57.00	05700	CT SCAN	1,318,333		1,318,333	0	1,318,333	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	980,264		980,264	0	980,264	58.00
60.00	06000	LABORATORY	10,177,641		10,177,641	0	10,177,641	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	1,947,479		1,947,479	0	1,947,479	62.00
65.00	06500	RESPIRATORY THERAPY	3,574,578	0	3,574,578	7,151	3,581,729	65.00
66.00	06600	PHYSICAL THERAPY	2,110,650	0	2,110,650	0	2,110,650	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,014,891	0	1,014,891	0	1,014,891	67.00
68.00	06800	SPEECH PATHOLOGY	395,447	0	395,447	0	395,447	68.00
69.00	06900	ELECTROCARDIOLOGY	5,138,980		5,138,980	2,610	5,141,590	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	806,767		806,767	3,404	810,171	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	13,346,315		13,346,315	0	13,346,315	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	17,153,903		17,153,903	0	17,153,903	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	22,554,208		22,554,208	0	22,554,208	73.00
74.00	07400	RENAL DIALYSIS	1,034,692		1,034,692	0	1,034,692	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,314,864		1,314,864	0	1,314,864	88.00
90.00	09000	CLINIC	699,361		699,361	0	699,361	90.00
90.01	09001	OUTPATIENT INFUSION	685,286		685,286	0	685,286	90.01
91.00	09100	EMERGENCY	10,249,814		10,249,814	76,255	10,326,069	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	6,601,969		6,601,969		6,601,969	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	7,386,379		7,386,379		7,386,379	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	3,461,027		3,461,027		3,461,027	116.00
200.00		Subtotal (see instructions)	234,116,091	0	234,116,091	158,624	234,274,715	200.00
201.00		Less Observation Beds	6,601,969		6,601,969		6,601,969	201.00
202.00		Total (see instructions)	227,514,122	0	227,514,122	158,624	227,672,746	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0015 | Period: From 10/01/2016 To 09/30/2017 | Worksheet C Part I | Date/Time Prepared: 2/28/2018 10:40 am

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	83,202,982		83,202,982			30.00
31.00	03100	INTENSIVE CARE UNIT	37,218,453		37,218,453			31.00
40.00	04000	SUBPROVIDER - IPF	25,339,411		25,339,411			40.00
41.00	04100	SUBPROVIDER - IRF	5,584,292		5,584,292			41.00
43.00	04300	NURSERY	3,247,959		3,247,959			43.00
44.00	04400	SKILLED NURSING FACILITY	5,712,590		5,712,590			44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	36,382,811	89,070,738	125,453,549	0.215046	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	6,577,837	692,753	7,270,590	0.412662	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	11,020,282	17,386,782	28,407,064	0.038589	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	14,576,391	37,259,563	51,835,954	0.179118	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	755,584	18,044,832	18,800,416	0.198427	0.000000	55.00
57.00	05700	CT SCAN	25,587,705	47,453,131	73,040,836	0.018049	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	6,799,780	13,778,861	20,578,641	0.047635	0.000000	58.00
60.00	06000	LABORATORY	52,876,730	63,840,121	116,716,851	0.087199	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	3,912,661	2,150,236	6,062,897	0.321213	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	16,490,073	3,694,224	20,184,297	0.177097	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	3,926,213	404,039	4,330,252	0.487420	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,978,871	92,423	3,071,294	0.330444	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	1,093,293	250,465	1,343,758	0.294284	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	38,321,778	52,617,818	90,939,596	0.056510	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	299,110	2,623,981	2,923,091	0.275998	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	38,769,800	42,187,293	80,957,093	0.164857	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	27,811,107	27,982,624	55,793,731	0.307452	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	89,583,329	42,782,588	132,365,917	0.170393	0.000000	73.00
74.00	07400	RENAL DIALYSIS	2,109,046	0	2,109,046	0.490597	0.000000	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	769,286	769,286	1.709200	0.000000	88.00
90.00	09000	CLINIC	335	737,127	737,462	0.948335	0.000000	90.00
90.01	09001	OUTPATIENT INFUSION	35,754	2,030,894	2,066,648	0.331593	0.000000	90.01
91.00	09100	EMERGENCY	14,103,265	31,947,531	46,050,796	0.222576	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	3,030,568	23,159,112	26,189,680	0.252083	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	6,747,511	6,747,511			101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	79,838	3,732,140	3,811,978			116.00
200.00		Subtotal (see instructions)	557,427,848	531,436,073	1,088,863,921			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	557,427,848	531,436,073	1,088,863,921			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0015 | Period: From 10/01/2016 To 09/30/2017 | Worksheet C Part I | Date/Time Prepared: 2/28/2018 10:40 am

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
40.00	04000	SUBPROVIDER - IPF		40.00
41.00	04100	SUBPROVIDER - IRF		41.00
43.00	04300	NURSERY		43.00
44.00	04400	SKILLED NURSING FACILITY		44.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.000000	50.00
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
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	55.00
57.00	05700	CT SCAN	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	58.00
60.00	06000	LABORATORY	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	70.00
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
74.00	07400	RENAL DIALYSIS	0.000000	74.00
		OUTPATIENT SERVICE COST CENTERS		
88.00	08800	RURAL HEALTH CLINIC	0.000000	88.00
90.00	09000	CLINIC	0.000000	90.00
90.01	09001	OUTPATIENT INFUSION	0.000000	90.01
91.00	09100	EMERGENCY	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS		
101.00	10100	HOME HEALTH AGENCY		101.00
		SPECIAL PURPOSE COST CENTERS		
113.00	11300	INTEREST EXPENSE		113.00
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 ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 14-0015 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part I Date/Time Prepared: 2/28/2018 10:40 am

Title XVIII | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	5,068,967	0	5,068,967	46,278	109.53	30.00
31.00	INTENSIVE CARE UNIT	692,128		692,128	5,048	137.11	31.00
40.00	SUBPROVIDER - IPF	1,019,164	0	1,019,164	11,621	87.70	40.00
41.00	SUBPROVIDER - IRF	320,235	0	320,235	4,516	70.91	41.00
43.00	NURSERY	105,081		105,081	2,301	45.67	43.00
44.00	SKILLED NURSING FACILITY	396,534		396,534	5,917	67.02	44.00
200.00	Total (lines 30 through 199)	7,602,109		7,602,109	75,681		200.00

	Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)	
		6.00	7.00	
	INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	ADULTS & PEDIATRICS	23,763	2,602,761	30.00
31.00	INTENSIVE CARE UNIT	2,590	355,115	31.00
40.00	SUBPROVIDER - IPF	1,351	118,483	40.00
41.00	SUBPROVIDER - IRF	2,973	210,815	41.00
43.00	NURSERY	0	0	43.00
44.00	SKILLED NURSING FACILITY	4,255	285,170	44.00
200.00	Total (lines 30 through 199)	34,932	3,572,344	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 14-0015 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part II | Date/Time Prepared: 2/28/2018 10:40 am

Title XVIII | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,769,779	125,453,549	0.038020	17,881,859	679,868	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	207,749	7,270,590	0.028574	35,133	1,004	52.00
53.00	05300	ANESTHESIOLOGY	224,629	28,407,064	0.007908	5,060,421	40,018	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,534,318	51,835,954	0.029599	8,267,428	244,708	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	990,298	18,800,416	0.052674	413,042	21,757	55.00
57.00	05700	CT SCAN	155,917	73,040,836	0.002135	12,986,901	27,727	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	207,173	20,578,641	0.010067	3,513,708	35,372	58.00
60.00	06000	LABORATORY	781,895	116,716,851	0.006699	28,186,482	188,821	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	69,577	6,062,897	0.011476	2,176,246	24,975	62.00
65.00	06500	RESPIRATORY THERAPY	192,998	20,184,297	0.009562	9,818,642	93,886	65.00
66.00	06600	PHYSICAL THERAPY	109,319	4,330,252	0.025245	1,181,974	29,839	66.00
67.00	06700	OCCUPATIONAL THERAPY	53,618	3,071,294	0.017458	682,714	11,919	67.00
68.00	06800	SPEECH PATHOLOGY	21,429	1,343,758	0.015947	399,470	6,370	68.00
69.00	06900	ELECTROCARDIOLOGY	907,491	90,939,596	0.009979	21,924,941	218,789	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	115,983	2,923,091	0.039678	157,628	6,254	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	514,399	80,957,093	0.006354	18,860,966	119,843	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	694,833	55,793,731	0.012454	15,854,182	197,448	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	977,799	132,365,917	0.007387	45,103,874	333,182	73.00
74.00	07400	RENAL DIALYSIS	34,396	2,109,046	0.016309	1,005,923	16,406	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	67,443	769,286	0.087670	0	0	88.00
90.00	09000	CLINIC	87,044	737,462	0.118032	335	40	90.00
90.01	09001	OUTPATIENT INFUSION	61,465	2,066,648	0.029741	29,014	863	90.01
91.00	09100	EMERGENCY	762,155	46,050,796	0.016550	6,593,755	109,127	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	694,441	26,189,680	0.026516	1,683,820	44,648	92.00
200.00		Total (lines 50 through 199)	14,236,148	917,998,745		201,818,458	2,452,864	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 14-0015 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part III Date/Time Prepared: 2/28/2018 10:40 am

Title XVIII | Hospital | PPS

		Cost Center Description	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
			1A	1.00	2A	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	3,781,310	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	390,784	0	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	312,723	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	38,391	0	0	0	41.00
43.00	04300	NURSERY	0	68,783	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	44,789	0	0		44.00
200.00		Total (lines 30 through 199)	0	4,636,780	0	0	0	200.00

		Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
			4.00	5.00	6.00	7.00	8.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	3,781,310	46,278	81.71	23,763	30.00
31.00	03100	INTENSIVE CARE UNIT		390,784	5,048	77.41	2,590	31.00
40.00	04000	SUBPROVIDER - IPF	0	312,723	11,621	26.91	1,351	40.00
41.00	04100	SUBPROVIDER - IRF	0	38,391	4,516	8.50	2,973	41.00
43.00	04300	NURSERY		68,783	2,301	29.89	0	43.00
44.00	04400	SKILLED NURSING FACILITY		44,789	5,917	7.57	4,255	44.00
200.00		Total (lines 30 through 199)		4,636,780	75,681		34,932	200.00

		Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
			9.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS	1,941,675	30.00
31.00	03100	INTENSIVE CARE UNIT	200,492	31.00
40.00	04000	SUBPROVIDER - IPF	36,355	40.00
41.00	04100	SUBPROVIDER - IRF	25,271	41.00
43.00	04300	NURSERY	0	43.00
44.00	04400	SKILLED NURSING FACILITY	32,210	44.00
200.00		Total (lines 30 through 199)	2,236,003	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 14-0015 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part IV Date/Time Prepared: 2/28/2018 10:40 am

Title XVIII | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	195,792	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	201,231	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	394,423	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
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
60.00	06000	LABORATORY	0	0	0	0	87,896	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	433,500	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	OUTPATIENT INFUSION	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	0	232,743	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	518,030	0	0	92.00
200.00		Total (lines 50 through 199)	0	0	1,147,796	0	915,819	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0015 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part IV | Date/Time Prepared: 2/28/2018 10:40 am

Title XVIII | Hospital | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	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)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	195,792	195,792	125,453,549	0.001561	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	201,231	201,231	7,270,590	0.027677	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	28,407,064	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	394,423	394,423	51,835,954	0.007609	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	18,800,416	0.000000	55.00
57.00	05700	CT SCAN	0	0	0	73,040,836	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	20,578,641	0.000000	58.00
60.00	06000	LABORATORY	0	87,896	87,896	116,716,851	0.000753	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	6,062,897	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	20,184,297	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	4,330,252	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	3,071,294	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	1,343,758	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	90,939,596	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	2,923,091	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	80,957,093	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	55,793,731	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	433,500	433,500	132,365,917	0.003275	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	2,109,046	0.000000	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	769,286	0.000000	88.00
90.00	09000	CLINIC	0	0	0	737,462	0.000000	90.00
90.01	09001	OUTPATIENT INFUSION	0	0	0	2,066,648	0.000000	90.01
91.00	09100	EMERGENCY	0	232,743	232,743	46,050,796	0.005054	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	518,030	518,030	26,189,680	0.019780	92.00
200.00		Total (lines 50 through 199)	0	2,063,615	2,063,615	917,998,745		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0015 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part IV | Date/Time Prepared: 2/28/2018 10:40 am

Title XVIII | Hospital | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.001561	17,881,859	27,914	31,647,125	49,401	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.027677	35,133	972	3,362	93	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	5,060,421	0	5,738,409	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.007609	8,267,428	62,907	9,890,393	75,256	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	413,042	0	13,467,155	0	55.00
57.00	05700	CT SCAN	0.000000	12,986,901	0	14,266,550	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	3,513,708	0	4,596,693	0	58.00
60.00	06000	LABORATORY	0.000753	28,186,482	21,224	9,596,962	7,227	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	2,176,246	0	872,584	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.000000	9,818,642	0	1,881,632	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	1,181,974	0	87,682	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	682,714	0	37,979	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	399,470	0	4,179	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	21,924,941	0	24,597,197	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	157,628	0	784,202	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	18,860,966	0	15,729,755	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	15,854,182	0	12,347,924	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.003275	45,103,874	147,715	12,564,341	41,148	73.00
74.00	07400	RENAL DIALYSIS	0.000000	1,005,923	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
90.00	09000	CLINIC	0.000000	335	0	309,496	0	90.00
90.01	09001	OUTPATIENT INFUSION	0.000000	29,014	0	1,042,659	0	90.01
91.00	09100	EMERGENCY	0.005054	6,593,755	33,325	7,106,491	35,916	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.019780	1,683,820	33,306	8,592,723	169,964	92.00
200.00		Total (lines 50 through 199)		201,818,458	327,363	175,165,493	379,005	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-0015 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part V Date/Time Prepared: 2/28/2018 10:40 am

Title XVIII | Hospital | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.215046	31,647,125	529	0	6,805,588	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.412662	3,362	0	0	1,387	52.00
53.00	05300	ANESTHESIOLOGY	0.038589	5,738,409	0	0	221,439	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.179118	9,890,393	0	0	1,771,547	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.198427	13,467,155	0	0	2,672,247	55.00
57.00	05700	CT SCAN	0.018049	14,266,550	0	0	257,497	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.047635	4,596,693	0	0	218,963	58.00
60.00	06000	LABORATORY	0.087199	9,596,962	972	0	836,845	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.321213	872,584	0	0	280,285	62.00
65.00	06500	RESPIRATORY THERAPY	0.177097	1,881,632	0	0	333,231	65.00
66.00	06600	PHYSICAL THERAPY	0.487420	87,682	0	0	42,738	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.330444	37,979	0	0	12,550	67.00
68.00	06800	SPEECH PATHOLOGY	0.294284	4,179	0	0	1,230	68.00
69.00	06900	ELECTROCARDIOLOGY	0.056510	24,597,197	0	0	1,389,988	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.275998	784,202	0	0	216,438	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.164857	15,729,755	0	0	2,593,160	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.307452	12,347,924	0	0	3,796,394	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.170393	12,564,341	0	0	2,140,876	73.00
74.00	07400	RENAL DIALYSIS	0.490597	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
90.00	09000	CLINIC	0.948335	309,496	0	0	293,506	90.00
90.01	09001	OUTPATIENT INFUSION	0.331593	1,042,659	0	0	345,738	90.01
91.00	09100	EMERGENCY	0.222576	7,106,491	0	0	1,581,734	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.252083	8,592,723	0	0	2,166,079	92.00
200.00		Subtotal (see instructions)		175,165,493	1,501	0	27,979,460	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		175,165,493	1,501	0	27,979,460	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-0015 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part V Date/Time Prepared: 2/28/2018 10:40 am

Title XVIII | Hospital | PPS

		Cost Center Description	Costs		
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
			6.00	7.00	
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	114	0	50.00
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
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	55.00
57.00	05700	CT SCAN	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
60.00	06000	LABORATORY	85	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
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
74.00	07400	RENAL DIALYSIS	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	0	0	88.00
90.00	09000	CLINIC	0	0	90.00
90.01	09001	OUTPATIENT INFUSION	0	0	90.01
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
200.00		Subtotal (see instructions)	199	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	199	0	202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 14-0015 | Component CCN: 14-S015 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part II | Date/Time Prepared: 2/28/2018 10:40 am

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,769,779	125,453,549	0.038020	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	207,749	7,270,590	0.028574	0	0	52.00
53.00	05300	ANESTHESIOLOGY	224,629	28,407,064	0.007908	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,534,318	51,835,954	0.029599	17,273	511	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	990,298	18,800,416	0.052674	0	0	55.00
57.00	05700	CT SCAN	155,917	73,040,836	0.002135	37,579	80	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	207,173	20,578,641	0.010067	21,582	217	58.00
60.00	06000	LABORATORY	781,895	116,716,851	0.006699	306,253	2,052	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	69,577	6,062,897	0.011476	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	192,998	20,184,297	0.009562	11,015	105	65.00
66.00	06600	PHYSICAL THERAPY	109,319	4,330,252	0.025245	1,280	32	66.00
67.00	06700	OCCUPATIONAL THERAPY	53,618	3,071,294	0.017458	377	7	67.00
68.00	06800	SPEECH PATHOLOGY	21,429	1,343,758	0.015947	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	907,491	90,939,596	0.009979	53,121	530	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	115,983	2,923,091	0.039678	904	36	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	514,399	80,957,093	0.006354	1,199	8	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	694,833	55,793,731	0.012454	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	977,799	132,365,917	0.007387	327,865	2,422	73.00
74.00	07400	RENAL DIALYSIS	34,396	2,109,046	0.016309	2,103	34	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	67,443	769,286	0.087670	0	0	88.00
90.00	09000	CLINIC	87,044	737,462	0.118032	0	0	90.00
90.01	09001	OUTPATIENT INFUSION	61,465	2,066,648	0.029741	0	0	90.01
91.00	09100	EMERGENCY	762,155	46,050,796	0.016550	185,836	3,076	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	26,189,680	0.000000	0	0	92.00
200.00		Total (lines 50 through 199)	13,541,707	917,998,745		966,387	9,110	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0015 | Component CCN: 14-S015 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part IV | Date/Time Prepared: 2/28/2018 10:40 am

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	195,792	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	201,231	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	394,423	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
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
60.00	06000	LABORATORY	0	0	0	0	87,896	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	433,500	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	OUTPATIENT INFUSION	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	0	232,743	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00		Total (lines 50 through 199)	0	0	629,766	0	915,819	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0015 | Component CCN: 14-S015 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part IV | Date/Time Prepared: 2/28/2018 10:40 am

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	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)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	195,792	195,792	125,453,549	0.001561	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	201,231	201,231	7,270,590	0.027677	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	28,407,064	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	394,423	394,423	51,835,954	0.007609	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	18,800,416	0.000000	55.00
57.00	05700	CT SCAN	0	0	0	73,040,836	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	20,578,641	0.000000	58.00
60.00	06000	LABORATORY	0	87,896	87,896	116,716,851	0.000753	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	6,062,897	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	20,184,297	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	4,330,252	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	3,071,294	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	1,343,758	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	90,939,596	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	2,923,091	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	80,957,093	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	55,793,731	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	433,500	433,500	132,365,917	0.003275	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	2,109,046	0.000000	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	769,286	0.000000	88.00
90.00	09000	CLINIC	0	0	0	737,462	0.000000	90.00
90.01	09001	OUTPATIENT INFUSION	0	0	0	2,066,648	0.000000	90.01
91.00	09100	EMERGENCY	0	232,743	232,743	46,050,796	0.005054	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	26,189,680	0.000000	92.00
200.00		Total (lines 50 through 199)	0	1,545,585	1,545,585	917,998,745		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0015 Component CCN: 14-S015	Period: From 10/01/2016 To 09/30/2017	Worksheet D Part IV Date/Time Prepared: 2/28/2018 10:40 am
	Title XVIII	Subprovider - IPF	PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.001561	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.027677	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.007609	17,273	131	261	2	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	0	0	0	0	55.00
57.00	05700	CT SCAN	0.000000	37,579	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	21,582	0	0	0	58.00
60.00	06000	LABORATORY	0.000753	306,253	231	2,764	2	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.000000	11,015	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	1,280	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	377	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	53,121	0	934	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	904	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	1,199	0	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	0.003275	327,865	1,074	909	3	73.00
74.00	07400	RENAL DIALYSIS	0.000000	2,103	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	OUTPATIENT INFUSION	0.000000	0	0	0	0	90.01
91.00	09100	EMERGENCY	0.005054	185,836	939	2,298	12	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		966,387	2,375	7,166	19	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-0015 | Component CCN: 14-S015 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part V | Date/Time Prepared: 2/28/2018 10:40 am

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.215046	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.412662	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.038589	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.179118	261	0	0	47	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.198427	0	0	0	0	55.00
57.00	05700	CT SCAN	0.018049	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.047635	0	0	0	0	58.00
60.00	06000	LABORATORY	0.087199	2,764	0	0	241	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.321213	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.177097	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.487420	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.330444	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.294284	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.056510	934	0	0	53	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.275998	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.164857	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.307452	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.170393	909	0	3,088	155	73.00
74.00	07400	RENAL DIALYSIS	0.490597	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
90.00	09000	CLINIC	0.948335	0	0	0	0	90.00
90.01	09001	OUTPATIENT INFUSION	0.331593	0	0	0	0	90.01
91.00	09100	EMERGENCY	0.222576	2,298	0	0	511	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.252083	0	0	0	0	92.00
200.00		Subtotal (see instructions)		7,166	0	3,088	1,007	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		7,166	0	3,088	1,007	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0015 | Component CCN: 14-S015 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part V | Date/Time Prepared: 2/28/2018 10:40 am

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Costs		
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
			6.00	7.00	
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0	0	50.00
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
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	55.00
57.00	05700	CT SCAN	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
60.00	06000	LABORATORY	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
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	526	73.00
74.00	07400	RENAL DIALYSIS	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	0	0	88.00
90.00	09000	CLINIC	0	0	90.00
90.01	09001	OUTPATIENT INFUSION	0	0	90.01
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
200.00		Subtotal (see instructions)	0	526	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	0	526	202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS	Provider CCN: 14-0015 Component CCN: 14-T015	Period: From 10/01/2016 To 09/30/2017	Worksheet D Part II Date/Time Prepared: 2/28/2018 10:40 am
	Title XVIII	Subprovider - IRF	PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	4,769,779	125,453,549	0.038020	25,660	976	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	207,749	7,270,590	0.028574	0	0	52.00
53.00	05300	ANESTHESIOLOGY	224,629	28,407,064	0.007908	6,694	53	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,534,318	51,835,954	0.029599	109,067	3,228	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	990,298	18,800,416	0.052674	0	0	55.00
57.00	05700	CT SCAN	155,917	73,040,836	0.002135	78,756	168	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	207,173	20,578,641	0.010067	29,981	302	58.00
60.00	06000	LABORATORY	781,895	116,716,851	0.006699	617,876	4,139	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	69,577	6,062,897	0.011476	32,461	373	62.00
65.00	06500	RESPIRATORY THERAPY	192,998	20,184,297	0.009562	222,818	2,131	65.00
66.00	06600	PHYSICAL THERAPY	109,319	4,330,252	0.025245	873,865	22,061	66.00
67.00	06700	OCCUPATIONAL THERAPY	53,618	3,071,294	0.017458	813,312	14,199	67.00
68.00	06800	SPEECH PATHOLOGY	21,429	1,343,758	0.015947	279,375	4,455	68.00
69.00	06900	ELECTROCARDIOLOGY	907,491	90,939,596	0.009979	67,599	675	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	115,983	2,923,091	0.039678	3,782	150	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	514,399	80,957,093	0.006354	80,975	515	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	694,833	55,793,731	0.012454	30,949	385	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	977,799	132,365,917	0.007387	955,804	7,061	73.00
74.00	07400	RENAL DIALYSIS	34,396	2,109,046	0.016309	57,782	942	74.00
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	67,443	769,286	0.087670	0	0	88.00
90.00	09000	CLINIC	87,044	737,462	0.118032	0	0	90.00
90.01	09001	OUTPATIENT INFUSION	61,465	2,066,648	0.029741	0	0	90.01
91.00	09100	EMERGENCY	762,155	46,050,796	0.016550	1,110	18	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	26,189,680	0.000000	0	0	92.00
200.00		Total (lines 50 through 199)	13,541,707	917,998,745		4,287,866	61,831	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0015 | Component CCN: 14-T015 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part IV | Date/Time Prepared: 2/28/2018 10:40 am

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		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	195,792	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	201,231	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	394,423	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
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
60.00	06000	LABORATORY	0	0	0	0	87,896	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	433,500	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	OUTPATIENT INFUSION	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	0	232,743	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00		Total (lines 50 through 199)	0	0	629,766	0	915,819	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0015 | Component CCN: 14-T015 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part IV | Date/Time Prepared: 2/28/2018 10:40 am

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	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)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	195,792	195,792	125,453,549	0.001561	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	201,231	201,231	7,270,590	0.027677	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	28,407,064	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	394,423	394,423	51,835,954	0.007609	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	18,800,416	0.000000	55.00
57.00	05700	CT SCAN	0	0	0	73,040,836	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	20,578,641	0.000000	58.00
60.00	06000	LABORATORY	0	87,896	87,896	116,716,851	0.000753	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	6,062,897	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	20,184,297	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	4,330,252	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	3,071,294	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	1,343,758	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	90,939,596	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	2,923,091	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	80,957,093	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	55,793,731	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	433,500	433,500	132,365,917	0.003275	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	2,109,046	0.000000	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	769,286	0.000000	88.00
90.00	09000	CLINIC	0	0	0	737,462	0.000000	90.00
90.01	09001	OUTPATIENT INFUSION	0	0	0	2,066,648	0.000000	90.01
91.00	09100	EMERGENCY	0	232,743	232,743	46,050,796	0.005054	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	26,189,680	0.000000	92.00
200.00		Total (lines 50 through 199)	0	1,545,585	1,545,585	917,998,745		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0015 Component CCN: 14-T015	Period: From 10/01/2016 To 09/30/2017	Worksheet D Part IV Date/Time Prepared: 2/28/2018 10:40 am
	Title XVIII	Subprovider - IRF	PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.001561	25,660	40	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.027677	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	6,694	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.007609	109,067	830	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	0	0	0	0	55.00
57.00	05700	CT SCAN	0.000000	78,756	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	29,981	0	0	0	58.00
60.00	06000	LABORATORY	0.000753	617,876	465	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	32,461	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.000000	222,818	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	873,865	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	813,312	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	279,375	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	67,599	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	3,782	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	80,975	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	30,949	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.003275	955,804	3,130	342	1	73.00
74.00	07400	RENAL DIALYSIS	0.000000	57,782	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	OUTPATIENT INFUSION	0.000000	0	0	0	0	90.01
91.00	09100	EMERGENCY	0.005054	1,110	6	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		4,287,866	4,471	342	1	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-0015 | Component CCN: 14-T015 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part V | Date/Time Prepared: 2/28/2018 10:40 am

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.215046	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.412662	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.038589	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.179118	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.198427	0	0	0	0	55.00
57.00	05700	CT SCAN	0.018049	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.047635	0	0	0	0	58.00
60.00	06000	LABORATORY	0.087199	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.321213	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.177097	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.487420	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.330444	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.294284	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.056510	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.275998	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.164857	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.307452	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.170393	342	0	1,464	58	73.00
74.00	07400	RENAL DIALYSIS	0.490597	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
90.00	09000	CLINIC	0.948335	0	0	0	0	90.00
90.01	09001	OUTPATIENT INFUSION	0.331593	0	0	0	0	90.01
91.00	09100	EMERGENCY	0.222576	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.252083	0	0	0	0	92.00
200.00		Subtotal (see instructions)		342	0	1,464	58	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		342	0	1,464	58	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0015 | Component CCN: 14-T015 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part V | Date/Time Prepared: 2/28/2018 10:40 am

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Costs		
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
			6.00	7.00	
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0	0	50.00
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
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	55.00
57.00	05700	CT SCAN	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
60.00	06000	LABORATORY	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
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	249	73.00
74.00	07400	RENAL DIALYSIS	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	0	0	88.00
90.00	09000	CLINIC	0	0	90.00
90.01	09001	OUTPATIENT INFUSION	0	0	90.01
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
200.00		Subtotal (see instructions)	0	249	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	0	249	202.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0015 | Component CCN: 14-5643 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part IV | Date/Time Prepared: 2/28/2018 10:40 am

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	195,792	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	201,231	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	394,423	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
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
60.00	06000	LABORATORY	0	0	0	0	87,896	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	433,500	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	OUTPATIENT INFUSION	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	0	232,743	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00		Total (lines 50 through 199)	0	0	629,766	0	915,819	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0015 | Component CCN: 14-5643 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part IV | Date/Time Prepared: 2/28/2018 10:40 am

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	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)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	195,792	195,792	125,453,549	0.001561	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	201,231	201,231	7,270,590	0.027677	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	28,407,064	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	394,423	394,423	51,835,954	0.007609	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	18,800,416	0.000000	55.00
57.00	05700	CT SCAN	0	0	0	73,040,836	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	20,578,641	0.000000	58.00
60.00	06000	LABORATORY	0	87,896	87,896	116,716,851	0.000753	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	6,062,897	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	20,184,297	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	4,330,252	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	3,071,294	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	1,343,758	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	90,939,596	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	2,923,091	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	80,957,093	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	55,793,731	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	433,500	433,500	132,365,917	0.003275	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	2,109,046	0.000000	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	769,286	0.000000	88.00
90.00	09000	CLINIC	0	0	0	737,462	0.000000	90.00
90.01	09001	OUTPATIENT INFUSION	0	0	0	2,066,648	0.000000	90.01
91.00	09100	EMERGENCY	0	232,743	232,743	46,050,796	0.005054	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	26,189,680	0.000000	92.00
200.00		Total (lines 50 through 199)	0	1,545,585	1,545,585	917,998,745		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0015 | Component CCN: 14-5643 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part IV | Date/Time Prepared: 2/28/2018 10:40 am

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.001561	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.027677	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	5,992	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.007609	191,696	1,459	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	0	0	0	0	55.00
57.00	05700	CT SCAN	0.000000	10,390	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	5,256	0	0	0	58.00
60.00	06000	LABORATORY	0.000753	1,090,768	821	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	73,589	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.000000	714,863	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	637,121	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	545,490	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	43,203	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	92,216	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	4,518	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	199,610	0	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	0.003275	2,518,846	8,249	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	47,322	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	OUTPATIENT INFUSION	0.000000	0	0	0	0	90.01
91.00	09100	EMERGENCY	0.005054	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		6,180,880	10,529	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0015 | Component CCN: 14-5643 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part V | Date/Time Prepared: 2/28/2018 10:40 am

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.215046	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.412662	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.038589	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.179118	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.198427	0	0	0	0	55.00
57.00	05700	CT SCAN	0.018049	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.047635	0	0	0	0	58.00
60.00	06000	LABORATORY	0.087199	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.321213	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.177097	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.487420	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.330444	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.294284	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.056510	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.275998	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.164857	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.307452	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.170393	0	0	38,335	0	73.00
74.00	07400	RENAL DIALYSIS	0.490597	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
90.00	09000	CLINIC	0.948335	0	0	0	0	90.00
90.01	09001	OUTPATIENT INFUSION	0.331593	0	0	0	0	90.01
91.00	09100	EMERGENCY	0.222576	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.252083	0	0	0	0	92.00
200.00		Subtotal (see instructions)		0	0	38,335	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	38,335	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 14-0015 Component CCN: 14-5643	Period: From 10/01/2016 To 09/30/2017	Worksheet D Part V Date/Time Prepared: 2/28/2018 10:40 am
	Title XVIII	Skilled Nursing Facility	PPS

		Cost Center Description	Costs		
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
			6.00	7.00	
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0	0	50.00
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
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	55.00
57.00	05700	CT SCAN	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
60.00	06000	LABORATORY	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
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	6,532	73.00
74.00	07400	RENAL DIALYSIS	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	0	0	88.00
90.00	09000	CLINIC	0	0	90.00
90.01	09001	OUTPATIENT INFUSION	0	0	90.01
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
200.00		Subtotal (see instructions)	0	6,532	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	0	6,532	202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-0015 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D-1 | Date/Time Prepared: 2/28/2018 10:40 am

Title XVIII | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	46,278	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	46,278	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)	39,938	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)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	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)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	23,763	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)	0	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	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	48,190,130	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)	0	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)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	48,190,130	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)	48,190,130	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,041.32	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	24,744,887	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)	24,744,887	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-0015 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D-1 | Date/Time Prepared: 2/28/2018 10:40 am

Title XVIII | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	8,557,495	5,048	1,695.22	2,590	4,390,620	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)	31,203,144	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	60,338,651	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)	5,100,043	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	2,780,227	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	7,880,270	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	52,458,381	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)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	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)	6,340	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,041.32	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	6,601,969	89.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 14-0015	Period: From 10/01/2016 To 09/30/2017	Worksheet D-1 Date/Time Prepared: 2/28/2018 10:40 am
	Title XVIII	Hospital	PPS

	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	5,068,967	48,190,130	0.105187	6,601,969	694,441	90.00
91.00	Nursing School cost	3,781,310	48,190,130	0.078466	6,601,969	518,030	91.00
92.00	Allied health cost	0	48,190,130	0.000000	6,601,969	0	92.00
93.00	All other Medical Education	0	48,190,130	0.000000	6,601,969	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 14-0015 Component CCN: 14-S015	Period: From 10/01/2016 To 09/30/2017	Worksheet D-1 Date/Time Prepared: 2/28/2018 10:40 am
	Title XVIII	Subprovider - IPF	PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	11,621	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	11,621	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)	11,621	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)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	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)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	1,351	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)	0	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	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	11,717,558	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)	0	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)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	11,717,558	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)	11,717,558	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,008.31	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,362,227	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	1,362,227	41.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 14-0015 Component CCN: 14-S015	Period: From 10/01/2016 To 09/30/2017	Worksheet D-1 Date/Time Prepared: 2/28/2018 10:40 am
	Title XVIII	Subprovider - IPF	PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	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)	136,229	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	1,498,456	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)	154,838	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	11,485	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	166,323	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	1,332,133	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)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	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)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0015 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D-1

Component CCN: 14-S015 | Date/Time Prepared: 2/28/2018 10:40 am

Title XVIII | Subprovider - IPF | PPS

	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	1,019,164	11,717,558	0.086978	0	0	90.00
91.00	Nursing School cost	312,723	11,717,558	0.026688	0	0	91.00
92.00	Allied health cost	0	11,717,558	0.000000	0	0	92.00
93.00	All other Medical Education	0	11,717,558	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 14-0015 Component CCN: 14-T015	Period: From 10/01/2016 To 09/30/2017	Worksheet D-1 Date/Time Prepared: 2/28/2018 10:40 am
	Title XVIII	Subprovider - IRF	PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	4,516	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	4,516	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)	4,516	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)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	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)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	2,973	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)	0	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	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	4,016,284	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)	0	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)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	4,016,284	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	4,016,284	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)	889.35	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	2,644,038	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	2,644,038	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0015 | Component CCN: 14-T015 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D-1 | Date/Time Prepared: 2/28/2018 10:40 am

Title XVIII | Subprovider - IRF | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	1,128,116	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	3,772,154	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)	236,086	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	66,302	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	302,388	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	3,469,766	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)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	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)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0015 | Component CCN: 14-T015 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D-1 | Date/Time Prepared: 2/28/2018 10:40 am

Title XVIII | Subprovider - IRF | PPS

	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	320,235	4,016,284	0.079734	0	0	90.00
91.00	Nursing School cost	38,391	4,016,284	0.009559	0	0	91.00
92.00	Allied health cost	0	4,016,284	0.000000	0	0	92.00
93.00	All other Medical Education	0	4,016,284	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 14-0015 Component CCN: 14-5643	Period: From 10/01/2016 To 09/30/2017	Worksheet D-1 Date/Time Prepared: 2/28/2018 10:40 am
	Title XVIII	Skilled Nursing Facility	PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	5,917	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	5,917	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)	5,917	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)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	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)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	4,255	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)	0	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	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	4,536,863	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)	0	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)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	4,536,863	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	4,536,863	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)		38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0015 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D-1

Component CCN: 14-5643 | Date/Time Prepared: 2/28/2018 10:40 am

Title XVIII | Skilled Nursing Facility | PPS

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)		48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)		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)		50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)		51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)		52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)		53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges		54.00
55.00	Target amount per discharge		55.00
56.00	Target amount (line 54 x line 55)		56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)		57.00
58.00	Bonus payment (see instructions)		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		59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket		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)		61.00
62.00	Relief payment (see instructions)		62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)		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)		64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)		65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)		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)		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)		68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)		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)	4,536,863	70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)	766.75	71.00
72.00	Program routine service cost (line 9 x line 71)	3,262,521	72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)	0	73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)	3,262,521	74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)	0	75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)	0.00	76.00
77.00	Program capital-related costs (line 9 x line 76)	0	77.00
78.00	Inpatient routine service cost (line 74 minus line 77)	0	78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)	0	79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)	0	80.00
81.00	Inpatient routine service cost per diem limitation	0.00	81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)	0	82.00
83.00	Reasonable inpatient routine service costs (see instructions)	3,262,521	83.00
84.00	Program inpatient ancillary services (see instructions)	1,275,646	84.00
85.00	Utilization review - physician compensation (see instructions)	0	85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)	4,538,167	86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0015 | Component CCN: 14-5643 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D-1 | Date/Time Prepared: 2/28/2018 10:40 am

Title XVIII | Skilled Nursing Facility | PPS

	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	0	0	0.000000	0	0	90.00
91.00	Nursing School cost	0	0	0.000000	0	0	91.00
92.00	Allied health cost	0	0	0.000000	0	0	92.00
93.00	All other Medical Education	0	0	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CCN: 14-0015	Period: From 10/01/2016 To 09/30/2017	Worksheet D-3 Date/Time Prepared: 2/28/2018 10:40 am
	Title XVIII	Hospital	PPS

		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		52,002,938		30.00
31.00	03100	INTENSIVE CARE UNIT		19,332,757		31.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.215382	17,881,859	3,851,431	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.412662	35,133	14,498	52.00
53.00	05300	ANESTHESIOLOGY	0.038589	5,060,421	195,277	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.179118	8,267,428	1,480,845	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.198427	413,042	81,959	55.00
57.00	05700	CT SCAN	0.018049	12,986,901	234,401	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.047635	3,513,708	167,375	58.00
60.00	06000	LABORATORY	0.087199	28,186,482	2,457,833	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.321213	2,176,246	699,039	62.00
65.00	06500	RESPIRATORY THERAPY	0.177451	9,818,642	1,742,328	65.00
66.00	06600	PHYSICAL THERAPY	0.487420	1,181,974	576,118	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.330444	682,714	225,599	67.00
68.00	06800	SPEECH PATHOLOGY	0.294284	399,470	117,558	68.00
69.00	06900	ELECTROCARDIOLOGY	0.056539	21,924,941	1,239,614	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.277162	157,628	43,688	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.164857	18,860,966	3,109,362	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.307452	15,854,182	4,874,400	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.170393	45,103,874	7,685,384	73.00
74.00	07400	RENAL DIALYSIS	0.490597	1,005,923	493,503	74.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000	CLINIC	0.948335	335	318	90.00
90.01	09001	OUTPATIENT INFUSION	0.331593	29,014	9,621	90.01
91.00	09100	EMERGENCY	0.224232	6,593,755	1,478,531	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.252083	1,683,820	424,462	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		201,818,458	31,203,144	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)		201,818,458		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 14-0015 | Component CCN: 14-S015 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D-3 | Date/Time Prepared: 2/28/2018 10:40 am

Title XVIII | Subprovider - IPF | PPS

		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		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
40.00	04000	SUBPROVIDER - IPF		2,941,957		40.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.215382	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.412662	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.038589	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.179118	17,273	3,094	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.198427	0	0	55.00
57.00	05700	CT SCAN	0.018049	37,579	678	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.047635	21,582	1,028	58.00
60.00	06000	LABORATORY	0.087199	306,253	26,705	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.321213	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.177451	11,015	1,955	65.00
66.00	06600	PHYSICAL THERAPY	0.487420	1,280	624	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.330444	377	125	67.00
68.00	06800	SPEECH PATHOLOGY	0.294284	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.056539	53,121	3,003	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.277162	904	251	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.164857	1,199	198	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.307452	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.170393	327,865	55,866	73.00
74.00	07400	RENAL DIALYSIS	0.490597	2,103	1,032	74.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000	CLINIC	0.948335	0	0	90.00
90.01	09001	OUTPATIENT INFUSION	0.331593	0	0	90.01
91.00	09100	EMERGENCY	0.224232	185,836	41,670	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.252083	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		966,387	136,229	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)		966,387		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 14-0015 | Component CCN: 14-T015 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D-3 | Date/Time Prepared: 2/28/2018 10:40 am

Title XVIII | Subprovider - IRF | PPS

		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		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
41.00	04100	SUBPROVIDER - IRF		3,696,492		41.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.215382	25,660	5,527	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.412662	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.038589	6,694	258	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.179118	109,067	19,536	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.198427	0	0	55.00
57.00	05700	CT SCAN	0.018049	78,756	1,421	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.047635	29,981	1,428	58.00
60.00	06000	LABORATORY	0.087199	617,876	53,878	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.321213	32,461	10,427	62.00
65.00	06500	RESPIRATORY THERAPY	0.177451	222,818	39,539	65.00
66.00	06600	PHYSICAL THERAPY	0.487420	873,865	425,939	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.330444	813,312	268,754	67.00
68.00	06800	SPEECH PATHOLOGY	0.294284	279,375	82,216	68.00
69.00	06900	ELECTROCARDIOLOGY	0.056539	67,599	3,822	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.277162	3,782	1,048	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.164857	80,975	13,349	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.307452	30,949	9,515	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.170393	955,804	162,862	73.00
74.00	07400	RENAL DIALYSIS	0.490597	57,782	28,348	74.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000	CLINIC	0.948335	0	0	90.00
90.01	09001	OUTPATIENT INFUSION	0.331593	0	0	90.01
91.00	09100	EMERGENCY	0.224232	1,110	249	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.252083	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		4,287,866	1,128,116	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)		4,287,866		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 14-0015 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D-3

Component CCN: 14-5643 | Date/Time Prepared: 2/28/2018 10:40 am

Title XVIII | Skilled Nursing Facility | PPS

		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		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.215046	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.412662	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.038589	5,992	231	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.179118	191,696	34,336	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.198427	0	0	55.00
57.00	05700	CT SCAN	0.018049	10,390	188	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.047635	5,256	250	58.00
60.00	06000	LABORATORY	0.087199	1,090,768	95,114	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.321213	73,589	23,638	62.00
65.00	06500	RESPIRATORY THERAPY	0.177097	714,863	126,600	65.00
66.00	06600	PHYSICAL THERAPY	0.487420	637,121	310,546	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.330444	545,490	180,254	67.00
68.00	06800	SPEECH PATHOLOGY	0.294284	43,203	12,714	68.00
69.00	06900	ELECTROCARDIOLOGY	0.056510	92,216	5,211	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.275998	4,518	1,247	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.164857	199,610	32,907	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.307452	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.170393	2,518,846	429,194	73.00
74.00	07400	RENAL DIALYSIS	0.490597	47,322	23,216	74.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000	CLINIC	0.948335	0	0	90.00
90.01	09001	OUTPATIENT INFUSION	0.331593	0	0	90.01
91.00	09100	EMERGENCY	0.222576	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.252083	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		6,180,880	1,275,646	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)		6,180,880		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0015	Period: From 10/01/2016 To 09/30/2017	Worksheet E Part A Date/Time Prepared: 2/28/2018 10:40 am
	Title XVIII	Hospital	PPS

		1.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS		
1.00	DRG Amounts Other than Outlier Payments	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)	0	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	48,627,277	1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)	0	1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)	0	1.04
2.00	Outlier payments for discharges. (see instructions)	1,499,575	2.00
2.01	Outlier reconciliation amount	0	2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)	0	2.02
3.00	Managed Care Simulated Payments	6,049,436	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)	210.63	4.00
	Indirect Medical Education Adjustment		
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)	13.16	5.00
6.00	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)	0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)	0.00	7.00
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.	0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).	0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.	0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)	0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see instructions)	13.16	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records	16.22	10.00
11.00	FTE count for residents in dental and podiatric programs.	0.00	11.00
12.00	Current year allowable FTE (see instructions)	13.16	12.00
13.00	Total allowable FTE count for the prior year.	17.01	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.	17.42	14.00
15.00	Sum of lines 12 through 14 divided by 3.	15.86	15.00
16.00	Adjustment for residents in initial years of the program	0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure	0.00	17.00
18.00	Adjusted rolling average FTE count	15.86	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).	0.075298	19.00
20.00	Prior year resident to bed ratio (see instructions)	0.080227	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)	0.075298	21.00
22.00	IME payment adjustment (see instructions)	1,958,853	22.00
22.01	IME payment adjustment - Managed Care (see instructions)	243,689	22.01
	Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA		
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C).	0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)	3.06	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)	0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)	0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)	0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)	0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)	0	28.01
29.00	Total IME payment (sum of lines 22 and 28)	1,958,853	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)	243,689	29.01
	Disproportionate Share Adjustment		
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	4.44	30.00
31.00	Percentage of Medicaid patient days (see instructions)	17.14	31.00
32.00	Sum of lines 30 and 31	21.58	32.00
33.00	Allowable disproportionate share percentage (see instructions)	7.02	33.00
34.00	Disproportionate share adjustment (see instructions)	853,409	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 14-0015 | Period: From 10/01/2016 To 09/30/2017 | Worksheet E Part A Date/Time Prepared: 2/28/2018 10:40 am

Title XVIII | Hospital | PPS

		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	Uncompensated Care Adjustment			
35.00	Total uncompensated care amount (see instructions)	0	5,977,483,147	35.00
35.01	Factor 3 (see instructions)	0.000000000	0.000197712	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	0	1,181,820	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	0	1,181,820	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	1,181,820		36.00
	Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)			
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)	0		40.00
		Before 1/1	On/After 1/1	
		1.00	1.01	
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0	0	41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0	0	41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)	0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)	0.00	0.00	45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)	0		46.00
47.00	Subtotal (see instructions)	54,120,934		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)	61,564,883		48.00

		Amount	
		1.00	
49.00	Total payment for inpatient operating costs (see instructions)	61,808,572	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)	4,222,889	50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)	0	51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).	575,410	52.00
53.00	Nursing and Allied Health Managed Care payment	0	53.00
54.00	Special add-on payments for new technologies	0	54.00
54.01	Islet isolation add-on payment	0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)	0	55.00
56.00	Cost of physicians' services in a teaching hospital (see intructions)	0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).	2,142,167	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)	327,363	58.00
59.00	Total (sum of amounts on lines 49 through 58)	69,076,401	59.00
60.00	Primary payer payments	19,709	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)	69,056,692	61.00
62.00	Deductibles billed to program beneficiaries	5,442,948	62.00
63.00	Coinsurance billed to program beneficiaries	165,060	63.00
64.00	Allowable bad debts (see instructions)	976,488	64.00
65.00	Adjusted reimbursable bad debts (see instructions)	634,717	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	595,892	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	64,083,401	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)	0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96).(For SCH see instructions)	0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	70.00
70.50	Rural Community Hospital Demonstration Project (§410A Demonstration) adjustment (see instructions)	0	70.50
70.87	Demonstration payment adjustment amount before sequestration	0	70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)	0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)	0	70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)	0	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)	0	70.91
70.92	Bundled Model 1 discount amount (see instructions)	0	70.92
70.93	HVBP payment adjustment amount (see instructions)	48,068	70.93
70.94	HRR adjustment amount (see instructions)	-374,432	70.94
70.95	Recovery of accelerated depreciation	0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0015	Period: From 10/01/2016 To 09/30/2017	Worksheet E Part A Date/Time Prepared: 2/28/2018 10:40 am
	Title XVIII	Hospital	PPS

		FFY (yyyy)	Amount	
		0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0	70.97
70.98	Low Volume Payment-3		0	70.98
70.99	HAC adjustment amount (see instructions)		0	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		63,757,037	71.00
71.01	Sequestration adjustment (see instructions)		1,275,141	71.01
71.02	Demonstration payment adjustment amount after sequestration		0	71.02
72.00	Interim payments		63,011,234	72.00
73.00	Tentative settlement (for contractor use only)		0	73.00
74.00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 73)		-529,338	74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		1,628,000	75.00
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)			
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2 (see instructions)		0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00
95.00	Time value of money for operating expenses (see instructions)		0	95.00
96.00	Time value of money for capital related expenses (see instructions)		0	96.00

		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	HSP Bonus Payment Amount			
100.00	HSP bonus amount (see instructions)		0	100.00
	HVBP Adjustment for HSP Bonus Payment			
101.00	HVBP adjustment factor (see instructions)		0.0000000000	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)		0	102.00
	HRR Adjustment for HSP Bonus Payment			
103.00	HRR adjustment factor (see instructions)		0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)		0	104.00
	Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment			
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
	Cost Reimbursement			
201.00	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)			201.00
202.00	Medicare discharges (see instructions)			202.00
203.00	Case-mix adjustment factor (see instructions)			203.00
	Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)			
204.00	Medicare target amount			204.00
205.00	Case-mix adjusted target amount (line 203 times line 204)			205.00
206.00	Medicare inpatient routine cost cap (line 202 times line 205)			206.00
	Adjustment to Medicare Part A Inpatient Reimbursement			
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)			208.00
209.00	Adjustment to Medicare IPPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
211.00	Total adjustment to Medicare IPPS payments (line 209 plus line 210) (see instructions)			211.00
	Comparision of PPS versus Cost Reimbursement			
212.00	Total adjustment to Medicare Part A IPPS payments (from line 211)			212.00
213.00	Low-volume adjustment (see instructions)			213.00
218.00	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)			218.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0015	Period: From 10/01/2016 To 09/30/2017	Worksheet E Part B Date/Time Prepared: 2/28/2018 10:40 am
	Title XVIII	Hospital	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	199	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	27,600,455	2.00
3.00	OPPS payments	28,209,459	3.00
4.00	Outlier payment (see instructions)	214,330	4.00
4.01	Outlier reconciliation amount (see instructions)	0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.897	5.00
6.00	Line 2 times line 5	24,757,608	6.00
7.00	Sum of lines 3, 4, and 4.01, 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	379,005	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	199	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	1,501	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)	1,501	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	1,501	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	1,302	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) (see instructions)	199	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, 4.01, 8 and 9)	28,802,794	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	106	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	5,473,391	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)	23,329,496	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	229,781	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)	23,559,277	30.00
31.00	Primary payer payments	18,492	31.00
32.00	Subtotal (line 30 minus line 31)	23,540,785	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)	747,449	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	485,842	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	363,839	36.00
37.00	Subtotal (see instructions)	24,026,627	37.00
38.00	MSP-LCC reconciliation amount from PS&R	1,162	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	39.50
39.97	Demonstration payment adjustment amount before sequestration	0	39.97
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)	24,025,465	40.00
40.01	Sequestration adjustment (see instructions)	480,509	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
41.00	Interim payments	23,555,246	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	-10,290	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 14-0015 | Component CCN: 14-S015 | Period: From 10/01/2016 To 09/30/2017 | Worksheet E Part B | Date/Time Prepared: 2/28/2018 10:40 am

Title XVIII | Subprovider - IPF | PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	526	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	988	2.00
3.00	OPPS payments	1,642	3.00
4.00	Outlier payment (see instructions)	0	4.00
4.01	Outlier reconciliation amount (see instructions)	0	4.01
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 lines 3, 4, and 4.01, 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	19	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	526	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	3,088	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)	3,088	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	3,088	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	2,562	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) (see instructions)	526	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, 4.01, 8 and 9)	1,661	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	0	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	2,187	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	2,187	30.00
31.00	Primary payer payments	0	31.00
32.00	Subtotal (line 30 minus line 31)	2,187	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)	0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	36.00
37.00	Subtotal (see instructions)	2,187	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
39.97	Demonstration payment adjustment amount before sequestration	0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	2,187	40.00
40.01	Sequestration adjustment (see instructions)	44	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
41.00	Interim payments	2,014	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	129	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 14-0015 | Component CCN: 14-T015 | Period: From 10/01/2016 To 09/30/2017 | Worksheet E Part B | Date/Time Prepared: 2/28/2018 10:40 am

Title XVIII | Subprovider - IRF | PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	249	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	57	2.00
3.00	OPPS payments	286	3.00
4.00	Outlier payment (see instructions)	0	4.00
4.01	Outlier reconciliation amount (see instructions)	0	4.01
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 lines 3, 4, and 4.01, 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	1	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	249	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	1,464	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)	1,464	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	1,464	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	1,215	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) (see instructions)	249	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, 4.01, 8 and 9)	287	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	0	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)	536	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)	536	30.00
31.00	Primary payer payments	0	31.00
32.00	Subtotal (line 30 minus line 31)	536	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)	0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	36.00
37.00	Subtotal (see instructions)	536	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
39.97	Demonstration payment adjustment amount before sequestration	0	39.97
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)	536	40.00
40.01	Sequestration adjustment (see instructions)	11	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
41.00	Interim payments	567	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	-42	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0015 Component CCN: 14-5643	Period: From 10/01/2016 To 09/30/2017	Worksheet E Part B Date/Time Prepared: 2/28/2018 10:40 am
	Title XVIII	Skilled Nursing Facility	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	6,532	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	OPPS payments		3.00
4.00	Outlier payment (see instructions)		4.00
4.01	Outlier reconciliation amount (see instructions)		4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)		5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	6,532	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	38,335	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)	38,335	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	38,335	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	31,803	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) (see instructions)	6,532	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, 4.01, 8 and 9)	0	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		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)	6,532	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)	6,532	30.00
31.00	Primary payer payments	0	31.00
32.00	Subtotal (line 30 minus line 31)	6,532	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)	0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	36.00
37.00	Subtotal (see instructions)	6,532	37.00
38.00	MSP-LCC reconciliation amount from PS&R		38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	39.50
39.97	Demonstration payment adjustment amount before sequestration	0	39.97
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)	6,532	40.00
40.01	Sequestration adjustment (see instructions)	131	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
41.00	Interim payments	37,568	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	-31,167	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)		90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		91.00
92.00	The rate used to calculate the Time Value of Money		92.00
93.00	Time Value of Money (see instructions)		93.00
94.00	Total (sum of lines 91 and 93)		94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED | Provider CCN: 14-0015 | Period: From 10/01/2016 To 09/30/2017 | Worksheet E-1 Part I | Date/Time Prepared: 2/28/2018 10:40 am

Title XVIII | Hospital | PPS

		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		63,865,233		23,721,144	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	07/13/2017	853,999	07/13/2017	165,898	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)		-853,999		-165,898	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)		63,011,234		23,555,246	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		529,338		10,290	6.02
7.00	Total Medicare program liability (see instructions)		62,481,896		23,544,956	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-0015 | Component CCN: 14-S015 | Period: From 10/01/2016 To 09/30/2017 | Worksheet E-1 Part I | Date/Time Prepared: 2/28/2018 10:40 am

Title XVIII | Subprovider - IPF | PPS

		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		982,182		2,014	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)		982,182		2,014	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		105,561		129	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,087,743		2,143	7.00

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED | Provider CCN: 14-0015 | Component CCN: 14-T015 | Period: From 10/01/2016 To 09/30/2017 | Worksheet E-1 Part I | Date/Time Prepared: 2/28/2018 10:40 am

Title XVIII | Subprovider - IRF | PPS

		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		4,457,716		567	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	07/13/2017	27,963		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)		-27,963		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)		4,429,753		567	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		13,802		42	6.02
7.00	Total Medicare program liability (see instructions)		4,415,951		525	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-0015 | Component CCN: 14-5643 | Period: From 10/01/2016 To 09/30/2017 | Worksheet E-1 Part I | Date/Time Prepared: 2/28/2018 10:40 am

Title XVIII | Skilled Nursing Facility | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,501,738		37,568	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)		1,501,738		37,568	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		42,608		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		31,167	6.02
7.00	Total Medicare program liability (see instructions)		1,544,346		6,401	7.00

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

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 14-0015	Period: From 10/01/2016 To 09/30/2017	Worksheet E-1 Part II Date/Time Prepared: 2/28/2018 10:40 am
	Title XVIII	Hospital	PPS

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

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0015 Component CCN: 14-S015	Period: From 10/01/2016 To 09/30/2017	Worksheet E-3 Part II Date/Time Prepared: 2/28/2018 10:40 am
	Title XVIII	Subprovider - IPF	PPS

		1.00	
	PART II - MEDICARE PART A SERVICES - IPF PPS		
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)	1,196,689	1.00
2.00	Net IPF PPS Outlier Payments	7,422	2.00
3.00	Net IPF PPS ECT Payments	0	3.00
4.00	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004. (see instructions)	0.00	4.00
4.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)	0.00	4.01
5.00	New Teaching program adjustment. (see instructions)	0.00	5.00
6.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instuctions)	0.00	6.00
7.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instuctions)	0.00	7.00
8.00	Intern and resident count for IPF PPS medical education adjustment (see instructions)	0.00	8.00
9.00	Average Daily Census (see instructions)	31.838356	9.00
10.00	Teaching Adjustment Factor {((1 + (line 8/line 9)) raised to the power of .5150 -1}.	0.000000	10.00
11.00	Teaching Adjustment (line 1 multiplied by line 10).	0	11.00
12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)	1,204,111	12.00
13.00	Nursing and Allied Health Managed Care payment (see instruction)	0	13.00
14.00	Organ acquisition (DO NOT USE THIS LINE)		14.00
15.00	Cost of physicians' services in a teaching hospital (see instructions)	0	15.00
16.00	Subtotal (see instructions)	1,204,111	16.00
17.00	Primary payer payments	0	17.00
18.00	Subtotal (line 16 less line 17).	1,204,111	18.00
19.00	Deductibles	193,760	19.00
20.00	Subtotal (line 18 minus line 19)	1,010,351	20.00
21.00	Coinsurance	8,113	21.00
22.00	Subtotal (line 20 minus line 21)	1,002,238	22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	106,114	23.00
24.00	Adjusted reimbursable bad debts (see instructions)	68,974	24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	51,249	25.00
26.00	Subtotal (sum of lines 22 and 24)	1,071,212	26.00
27.00	Direct graduate medical education payments (from Wkst. E-4, line 49)	0	27.00
28.00	Other pass through costs (see instructions)	38,730	28.00
29.00	Outlier payments reconciliation	0	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	30.50
30.99	Demonstration payment adjustment amount before sequestration	0	30.99
31.00	Total amount payable to the provider (see instructions)	1,109,942	31.00
31.01	Sequestration adjustment (see instructions)	22,199	31.01
31.02	Demonstration payment adjustment amount after sequestration	0	31.02
32.00	Interim payments	982,182	32.00
33.00	Tentative settlement (for contractor use only)	0	33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 31.02, 32 and 33)	105,561	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	35.00
	TO BE COMPLETED BY CONTRACTOR		
50.00	Original outlier amount from Worksheet E-3, Part II, line 2	7,422	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)	0	51.00
52.00	The rate used to calculate the Time Value of Money	0.00	52.00
53.00	Time Value of Money (see instructions)	0	53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0015 Component CCN: 14-T015	Period: From 10/01/2016 To 09/30/2017	Worksheet E-3 Part III Date/Time Prepared: 2/28/2018 10:40 am
	Title XVIII	Subprovider - IRF	PPS

		1.00	
	PART III - MEDICARE PART A SERVICES - IRF PPS		
1.00	Net Federal PPS Payment (see instructions)	4,364,681	1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)	0.0169	2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)	80,747	3.00
4.00	Outlier Payments	49,403	4.00
5.00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)	0.00	5.00
5.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)	0.00	5.01
6.00	New Teaching program adjustment. (see instructions)	0.00	6.00
7.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)	0.00	7.00
8.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)	0.00	8.00
9.00	Intern and resident count for IRF PPS medical education adjustment (see instructions)	0.00	9.00
10.00	Average Daily Census (see instructions)	12.372603	10.00
11.00	Teaching Adjustment Factor (see instructions)	0.000000	11.00
12.00	Teaching Adjustment (see instructions)	0	12.00
13.00	Total PPS Payment (see instructions)	4,494,831	13.00
14.00	Nursing and Allied Health Managed Care payments (see instruction)	0	14.00
15.00	Organ acquisition (DO NOT USE THIS LINE)		15.00
16.00	Cost of physicians' services in a teaching hospital (see instructions)	0	16.00
17.00	Subtotal (see instructions)	4,494,831	17.00
18.00	Primary payer payments	0	18.00
19.00	Subtotal (line 17 less line 18).	4,494,831	19.00
20.00	Deductibles	22,148	20.00
21.00	Subtotal (line 19 minus line 20)	4,472,683	21.00
22.00	Coinsurance	5,264	22.00
23.00	Subtotal (line 21 minus line 22)	4,467,419	23.00
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	13,709	24.00
25.00	Adjusted reimbursable bad debts (see instructions)	8,911	25.00
26.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	26.00
27.00	Subtotal (sum of lines 23 and 25)	4,476,330	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 49)	0	28.00
29.00	Other pass through costs (see instructions)	29,742	29.00
30.00	Outlier payments reconciliation	0	30.00
31.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	31.00
31.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	31.50
31.99	Demonstration payment adjustment amount before sequestration	0	31.99
32.00	Total amount payable to the provider (see instructions)	4,506,072	32.00
32.01	Sequestration adjustment (see instructions)	90,121	32.01
32.02	Demonstration payment adjustment amount after sequestration	0	32.02
33.00	Interim payments	4,429,753	33.00
34.00	Tentative settlement (for contractor use only)	0	34.00
35.00	Balance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34)	-13,802	35.00
36.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	36.00
	TO BE COMPLETED BY CONTRACTOR		
50.00	Original outlier amount from Wkst. E-3, Pt. III, line 4	49,403	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)	0	51.00
52.00	The rate used to calculate the Time Value of Money	0.00	52.00
53.00	Time Value of Money (see instructions)	0	53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0015 Component CCN: 14-5643	Period: From 10/01/2016 To 09/30/2017	Worksheet E-3 Part VI Date/Time Prepared: 2/28/2018 10:40 am
	Title XVIII	Skilled Nursing Facility	PPS

		1.00	
	PART VI - CALCULATION OF REIMBURSEMENT SETTLEMEMENT - ALL OTHER HEALTH SERVICES FOR TITLE XVIII PART A PPS SNF SERVICES		
	PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCTIONS)		
1.00	Resource Utilization Group Payment (RUGS)	1,581,302	1.00
2.00	Routine service other pass through costs	32,210	2.00
3.00	Ancillary service other pass through costs	10,529	3.00
4.00	Subtotal (sum of lines 1 through 3)	1,624,041	4.00
	COMPUTATION OF NET COST OF COVERED SERVICES		
5.00	Medical and other services (Do not use this line as vaccine costs are included in line 1 of W/S E, Part B. This line is now shaded.)		5.00
6.00	Deductible	0	6.00
7.00	Coinsurance	48,916	7.00
8.00	Allowable bad debts (see instructions)	1,135	8.00
9.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)	81	9.00
10.00	Adjusted reimbursable bad debts (see instructions)	738	10.00
11.00	Utilization review	0	11.00
12.00	Subtotal (sum of lines 4, 5 minus lines 6 and 7, plus lines 10 and 11)(see instructions)	1,575,863	12.00
13.00	Inpatient primary payer payments	0	13.00
14.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	14.00
14.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	14.50
14.99	Demonstration payment adjustment amount before sequestration	0	14.99
15.00	Subtotal (see instructions	1,575,863	15.00
15.01	Sequestration adjustment (see instructions)	31,517	15.01
15.02	Demonstration payment adjustment amount after sequestration	0	15.02
16.00	Interim payments	1,501,738	16.00
17.00	Tentative settlement (for contractor use only)	0	17.00
18.00	Balance due provider/program (line 15 minus lines 15.01, 15.02, 16, and 17)	42,608	18.00
19.00	Protested amounts (nonallowable cost report items) in accordance with CMS 19 Pub. 15-2, chapter 1, §115.2	0	19.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS | Provider CCN: 14-0015 | Period: From 10/01/2016 To 09/30/2017 | Worksheet E-4 | Date/Time Prepared: 2/28/2018 10:40 am

Title XVIII | Hospital | PPS

		1.00	
	COMPUTATION OF TOTAL DIRECT GME AMOUNT		
1.00	Unweighted resident FTE count for allopathic and osteopathic programs for cost reporting periods ending on or before December 31, 1996.	19.50	1.00
2.00	Unweighted FTE resident cap add-on for new programs per 42 CFR 413.79(e)(1) (see instructions)	0.00	2.00
3.00	Amount of reduction to Direct GME cap under section 422 of MMA	0.00	3.00
3.01	Direct GME cap reduction amount under ACA §5503 in accordance with 42 CFR §413.79 (m). (see instructions for cost reporting periods straddling 7/1/2011)	0.00	3.01
4.00	Adjustment (plus or minus) to the FTE cap for allopathic and osteopathic programs due to a Medicare GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f))	0.00	4.00
4.01	ACA Section 5503 increase to the Direct GME FTE Cap (see instructions for cost reporting periods straddling 7/1/2011)	0.00	4.01
4.02	ACA Section 5506 number of additional direct GME FTE cap slots (see instructions for cost reporting periods straddling 7/1/2011)	0.00	4.02
5.00	FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 plus or minus line 4 plus lines 4.01 and 4.02 plus applicable subscripts	19.50	5.00
6.00	Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)	17.25	6.00
7.00	Enter the lesser of line 5 or line 6	17.25	7.00

		Primary Care	Other	Total	
		1.00	2.00	3.00	
8.00	Weighted FTE count for physicians in an allopathic and osteopathic program for the current year.	17.25	0.00	17.25	8.00
9.00	If line 6 is less than 5 enter the amount from line 8, otherwise multiply line 8 times the result of line 5 divided by the amount on line 6.	17.25	0.00	17.25	9.00
10.00	Weighted dental and podiatric resident FTE count for the current year		0.00		10.00
10.01	Unweighted dental and podiatric resident FTE count for the current year		0.00		10.01
11.00	Total weighted FTE count	17.25	0.00		11.00
12.00	Total weighted resident FTE count for the prior cost reporting year (see instructions)	17.01	0.00		12.00
13.00	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	18.23	0.00		13.00
14.00	Rolling average FTE count (sum of lines 11 through 13 divided by 3).	17.50	0.00		14.00
15.00	Adjustment for residents in initial years of new programs	0.00	0.00		15.00
15.01	Unweighted adjustment for residents in initial years of new programs	0.00	0.00		15.01
16.00	Adjustment for residents displaced by program or hospital closure	0.00	0.00		16.00
16.01	Unweighted adjustment for residents displaced by program or hospital closure	0.00	0.00		16.01
17.00	Adjusted rolling average FTE count	17.50	0.00		17.00
18.00	Per resident amount	83,275.72	0.00		18.00
19.00	Approved amount for resident costs	1,457,325	0	1,457,325	19.00

		1.00	
20.00	Additional unweighted allopathic and osteopathic direct GME FTE resident cap slots received under 42 Sec. 413.79(c)(4)	0.00	20.00
21.00	Direct GME FTE unweighted resident count over cap (see instructions)	0.00	21.00
22.00	Allowable additional direct GME FTE Resident Count (see instructions)	0.00	22.00
23.00	Enter the locally adjustment national average per resident amount (see instructions)	0.00	23.00
24.00	Multiply line 22 time line 23	0	24.00
25.00	Total direct GME amount (sum of lines 19 and 24)	1,457,325	25.00

		Inpatient Part A	Managed care		
		1.00	2.00	3.00	
	COMPUTATION OF PROGRAM PATIENT LOAD				
26.00	Inpatient Days (see instructions)	30,677	3,864		26.00
27.00	Total Inpatient Days (see instructions)	61,528	61,528		27.00
28.00	Ratio of inpatient days to total inpatient days	0.498586	0.062801		28.00
29.00	Program direct GME amount	726,602	91,521		29.00
30.00	Reduction for direct GME payments for Medicare Advantage		12,932		30.00
31.00	Net Program direct GME amount			805,191	31.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS	Provider CCN: 14-0015	Period: From 10/01/2016 To 09/30/2017	Worksheet E-4 Date/Time Prepared: 2/28/2018 10:40 am
	Title XVIII	Hospital	PPS

		1.00	
	DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING SCHOOL AND PARAMEDICAL EDUCATION COSTS)		
32.00	Renal dialysis direct medical education costs (from Wkst. B, Pt. I, sum of col. 20 and 23, lines 74 and 94)	0	32.00
33.00	Renal dialysis and home dialysis total charges (Wkst. C, Pt. I, col. 8, sum of lines 74 and 94)	2,109,046	33.00
34.00	Ratio of direct medical education costs to total charges (line 32 ÷ line 33)	0.000000	34.00
35.00	Medicare outpatient ESRD charges (see instructions)	0	35.00
36.00	Medicare outpatient ESRD direct medical education costs (line 34 x line 35)	0	36.00
	APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII ONLY		
	Part A Reasonable Cost		
37.00	Reasonable cost (see instructions)	70,495,823	37.00
38.00	Organ acquisition costs (Wkst. D-4, Pt. III, col. 1, line 69)	0	38.00
39.00	Cost of physicians' services in a teaching hospital (see instructions)	0	39.00
40.00	Primary payer payments (see instructions)	19,709	40.00
41.00	Total Part A reasonable cost (sum of lines 37 through 39 minus line 40)	70,476,114	41.00
	Part B Reasonable Cost		
42.00	Reasonable cost (see instructions)	28,162,160	42.00
43.00	Primary payer payments (see instructions)	18,492	43.00
44.00	Total Part B reasonable cost (line 42 minus line 43)	28,143,668	44.00
45.00	Total reasonable cost (sum of lines 41 and 44)	98,619,782	45.00
46.00	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)	0.714625	46.00
47.00	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)	0.285375	47.00
	ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B		
48.00	Total program GME payment (line 31)	805,191	48.00
49.00	Part A Medicare GME payment (line 46 x 48) (title XVIII only) (see instructions)	575,410	49.00
50.00	Part B Medicare GME payment (line 47 x 48) (title XVIII only) (see instructions)	229,781	50.00

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

Provider CCN: 14-0015 | Period: From 10/01/2016 To 09/30/2017 | Worksheet G | Date/Time Prepared: 2/28/2018 10:40 am

		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	63,010,264	0	0	0	1.00
2.00	Temporary investments	148,135,384	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	267,276,165	0	0	0	4.00
5.00	Other receivable	9,181,047	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-204,127,043	0	0	0	6.00
7.00	Inventory	6,648,882	0	0	0	7.00
8.00	Prepaid expenses	6,735,940	0	0	0	8.00
9.00	Other current assets	185,825	0	0	0	9.00
10.00	Due from other funds	1,866,114	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	298,912,578	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	14,395,667	0	0	0	12.00
13.00	Land improvements	7,183,113	0	0	0	13.00
14.00	Accumulated depreciation	-4,395,986	0	0	0	14.00
15.00	Buildings	203,422,221	0	0	0	15.00
16.00	Accumulated depreciation	-50,970,225	0	0	0	16.00
17.00	Leasehold improvements	17,710,541	0	0	0	17.00
18.00	Accumulated depreciation	-30,930,227	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	156,130,433	0	0	0	23.00
24.00	Accumulated depreciation	-100,265,047	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)	212,280,490	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	17,522,219	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	10,376,166	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	27,898,385	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	539,091,453	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	18,084,137	0	0	0	37.00
38.00	Salaries, wages, and fees payable	16,482,889	0	0	0	38.00
39.00	Payroll taxes payable	909,109	0	0	0	39.00
40.00	Notes and loans payable (short term)	5,341,415	0	0	0	40.00
41.00	Deferred income	2,592,817	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	29,996,482	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	73,406,849	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	81,520,005	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	79,905,076	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	161,425,081	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	234,831,930	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	304,259,523				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	304,259,523	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	539,091,453	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-0015

Period:
From 10/01/2016
To 09/30/2017

Worksheet G-1

Date/Time Prepared:
2/28/2018 10:40 am

		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		254,686,995		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		46,166,181				2.00
3.00	Total (sum of line 1 and line 2)		300,853,176		0		3.00
4.00	CONTRIBUTIONS	2,989,431		0		0	4.00
5.00	PENSION LIABILITY ADJUSTMENT	3,365,925		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)		6,355,356		0		10.00
11.00	Subtotal (line 3 plus line 10)		307,208,532		0		11.00
12.00	NET ASSETS RELEASED	2,890,559		0		0	12.00
13.00	NET REAL AND UNREAL GAINS/LOSSES	49,686		0		0	13.00
14.00	OTHER	8,764		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)		2,949,009		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		304,259,523		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	CONTRIBUTIONS		0		4.00
5.00	PENSION LIABILITY ADJUSTMENT		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	NET ASSETS RELEASED		0		12.00
13.00	NET REAL AND UNREAL GAINS/LOSSES		0		13.00
14.00	OTHER		0		14.00
15.00			0		15.00
16.00			0		16.00
17.00			0		17.00
18.00	Total deductions (sum of lines 12-17)	0		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0	19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 14-0015 | Period: From 10/01/2016 To 09/30/2017 | Worksheet G-2 Parts I & II Date/Time Prepared: 2/28/2018 10:40 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	87,818,628		87,818,628	1.00
2.00	SUBPROVIDER - IPF	25,513,092		25,513,092	2.00
3.00	SUBPROVIDER - IRF	5,725,999		5,725,999	3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY	5,726,654		5,726,654	7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	124,784,373		124,784,373	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	37,643,915		37,643,915	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)	37,643,915		37,643,915	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	162,428,288		162,428,288	17.00
18.00	Ancillary services	426,438,140	594,465,643	1,020,903,783	18.00
19.00	Outpatient services	0	0	0	19.00
20.00	RURAL HEALTH CLINIC	0	769,286	769,286	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		6,747,511	6,747,511	22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE	79,838	3,732,140	3,811,978	26.00
27.00	NURSERY	3,492,920	0	3,492,920	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	592,439,186	605,714,580	1,198,153,766	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		351,584,731		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)		351,584,731		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 14-0015	Period: From 10/01/2016 To 09/30/2017	Worksheet G-3 Date/Time Prepared: 2/28/2018 10:40 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	1,198,153,766	1.00
2.00	Less contractual allowances and discounts on patients' accounts	835,434,666	2.00
3.00	Net patient revenues (line 1 minus line 2)	362,719,100	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	351,584,731	4.00
5.00	Net income from service to patients (line 3 minus line 4)	11,134,369	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	16,215,609	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	706,876	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	1,336,461	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	117,824	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	4,066,356	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	774,655	22.00
23.00	Governmental appropriations	0	23.00
24.00	TRANSFERS	1,694,335	24.00
24.01	TRANSFERS	1,160,213	24.01
24.02	MISCELLANEOUS	8,959,483	24.02
25.00	Total other income (sum of lines 6-24)	35,031,812	25.00
26.00	Total (line 5 plus line 25)	46,166,181	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)	46,166,181	29.00

ANALYSIS OF HOSPITAL-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 14-0015 | Period: From 10/01/2016 To 09/30/2017 | Worksheet H

HHA CCN: 14-7031 | Date/Time Prepared: 2/28/2018 10:40 am

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		Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased Services	Other Costs	Total (sum of cols. 1 thru 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures			0		0	0	1.00
2.00	Capital Related - Movable Equipment			0		0	0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0	0	0	3.00
4.00	Transportation	0	0	0	0	0	0	4.00
5.00	Administrative and General	521,048	0	0	0	0	521,048	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	1,251,683	0	169,097	0	664,834	2,085,614	6.00
7.00	Physical Therapy	785,403	0	69,597	0	273,635	1,128,635	7.00
8.00	Occupational Therapy	235,257	0	21,284	0	83,680	340,221	8.00
9.00	Speech Pathology	28,708	0	3,036	0	11,937	43,681	9.00
10.00	Medical Social Services	82,866	0	421	0	1,655	84,942	10.00
11.00	Home Health Aide	187,462	0	35,352	0	138,994	361,808	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	20,638	0	1,829	0	7,190	29,657	23.00
23.50	Telemedicine	0	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	3,113,065	0	300,616	0	1,181,925	4,595,606	24.00

		Reclassification	Reclassified Trial Balance (col. 6 + col.7)	Adjustments	Net Expenses for Allocation (col. 8 + col. 9)	
		7.00	8.00	9.00	10.00	
	GENERAL SERVICE COST CENTERS					
1.00	Capital Related - Bldg. & Fixtures	0	0	0	0	1.00
2.00	Capital Related - Movable Equipment	0	0	0	0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0	3.00
4.00	Transportation	0	0	0	0	4.00
5.00	Administrative and General	-2,338	518,710	-12,746	505,964	5.00
	HHA REIMBURSABLE SERVICES					
6.00	Skilled Nursing Care	0	2,085,614	0	2,085,614	6.00
7.00	Physical Therapy	0	1,128,635	0	1,128,635	7.00
8.00	Occupational Therapy	0	340,221	0	340,221	8.00
9.00	Speech Pathology	0	43,681	0	43,681	9.00
10.00	Medical Social Services	0	84,942	0	84,942	10.00
11.00	Home Health Aide	0	361,808	0	361,808	11.00
12.00	Supplies (see instructions)	0	0	0	0	12.00
13.00	Drugs	0	0	0	0	13.00
14.00	DME	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES					
15.00	Home Dialysis Aide Services	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	22.00
23.00	All Others (specify)	0	29,657	0	29,657	23.00
23.50	Telemedicine	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	-2,338	4,593,268	-12,746	4,580,522	24.00

Column, 6 line 24 should agree with the Worksheet A, column 3, line 101, or subscript as applicable.

COST ALLOCATION - HHA GENERAL SERVICE COST

Provider CCN: 14-0015 | HHA CCN: 14-7031 | Period: From 10/01/2016 To 09/30/2017 | Worksheet H-1 Part I | Date/Time Prepared: 2/28/2018 10:40 am

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		Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Capital Related Costs		Plant Operation & Maintenance	Transportation	Subtotal (cols. 0-4)	
			Bldgs & Fixtures	Movable Equipment				
		0	1.00	2.00	3.00	4.00	4A.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0				0	1.00
2.00	Capital Related - Movable Equipment	0		0			0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0		0	3.00
4.00	Transportation	0	0	0	0	0		4.00
5.00	Administrative and General	505,964	0	0	0	0	505,964	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	2,085,614	0	0	0	0	2,085,614	6.00
7.00	Physical Therapy	1,128,635	0	0	0	0	1,128,635	7.00
8.00	Occupational Therapy	340,221	0	0	0	0	340,221	8.00
9.00	Speech Pathology	43,681	0	0	0	0	43,681	9.00
10.00	Medical Social Services	84,942	0	0	0	0	84,942	10.00
11.00	Home Health Aide	361,808	0	0	0	0	361,808	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0		0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	29,657	0	0	0	0	29,657	23.00
23.50	Telemedicine	0	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	4,580,522	0	0	0	0	4,580,522	24.00

		Administrative & General	Total (cols. 4A + 5)	
		5.00	6.00	
	GENERAL SERVICE COST CENTERS			
1.00	Capital Related - Bldg. & Fixtures			1.00
2.00	Capital Related - Movable Equipment			2.00
3.00	Plant Operation & Maintenance			3.00
4.00	Transportation			4.00
5.00	Administrative and General	505,964		5.00
	HHA REIMBURSABLE SERVICES			
6.00	Skilled Nursing Care	258,985	2,344,599	6.00
7.00	Physical Therapy	140,149	1,268,784	7.00
8.00	Occupational Therapy	42,247	382,468	8.00
9.00	Speech Pathology	5,424	49,105	9.00
10.00	Medical Social Services	10,548	95,490	10.00
11.00	Home Health Aide	44,928	406,736	11.00
12.00	Supplies (see instructions)	0	0	12.00
13.00	Drugs	0	0	13.00
14.00	DME	0	0	14.00
	HHA NONREIMBURSABLE SERVICES			
15.00	Home Dialysis Aide Services	0	0	15.00
16.00	Respiratory Therapy	0	0	16.00
17.00	Private Duty Nursing	0	0	17.00
18.00	Clinic	0	0	18.00
19.00	Health Promotion Activities	0	0	19.00
20.00	Day Care Program	0	0	20.00
21.00	Home Delivered Meals Program	0	0	21.00
22.00	Homemaker Service	0	0	22.00
23.00	All Others (specify)	3,683	33,340	23.00
23.50	Telemedicine	0	0	23.50
24.00	Total (sum of lines 1-23)		4,580,522	24.00

COST ALLOCATION - HHA STATISTICAL BASIS

Provider CCN: 14-0015 | HHA CCN: 14-7031 | Period: From 10/01/2016 To 09/30/2017 | Worksheet H-1 Part II | Date/Time Prepared: 2/28/2018 10:40 am

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		Capital Related Costs						
		Bldgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)	Plant Operation & Maintenance (SQUARE FEET)	Transportation (MILEAGE)	Reconciliation	Administrative & General (ACCUM. COST)	
		1.00	2.00	3.00	4.00	5A.00	5.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0				0		1.00
2.00	Capital Related - Movable Equipment		0			0		2.00
3.00	Plant Operation & Maintenance	0	0	0		0		3.00
4.00	Transportation (see instructions)	0	0	0	0			4.00
5.00	Administrative and General	0	0	0	0	-505,964	4,074,558	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	0	2,085,614	6.00
7.00	Physical Therapy	0	0	0	0	0	1,128,635	7.00
8.00	Occupational Therapy	0	0	0	0	0	340,221	8.00
9.00	Speech Pathology	0	0	0	0	0	43,681	9.00
10.00	Medical Social Services	0	0	0	0	0	84,942	10.00
11.00	Home Health Aide	0	0	0	0	0	361,808	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	0	12.00
13.00	Drugs	0	0	0		0	0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	29,657	23.00
23.50	Telemedicine	0	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	0	0	0	0	-505,964	4,074,558	24.00
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0	0		505,964	25.00
26.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000		0.124176	26.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 14-0015 | HHA CCN: 14-7031 | Period: From 10/01/2016 To 09/30/2017 | Worksheet H-2 Part I | Date/Time Prepared: 2/28/2018 10:40 am

Home Health Agency I | PPS

	Cost Center Description	HHA Trial Balance (1)	CAPITAL RELATED COSTS BLDG & FIXT	BUTLER BUILDING	OLD BLDG & FIXTURES	NEW BLDG & FIXTURES	14TH STREET	
		0	1.00	1.01	1.02	1.03	1.04	
1.00	Administrative and General	0	0	0	0	0	1,491	1.00
2.00	Skilled Nursing Care	2,344,599	0	0	0	0	0	2.00
3.00	Physical Therapy	1,268,784	0	0	0	0	0	3.00
4.00	Occupational Therapy	382,468	0	0	0	0	0	4.00
5.00	Speech Pathology	49,105	0	0	0	0	0	5.00
6.00	Medical Social Services	95,490	0	0	0	0	0	6.00
7.00	Home Health Aide	406,736	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	33,340	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	4,580,522	0	0	0	0	1,491	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

	Cost Center Description	CAPITAL RELATED COSTS MOB PHASE I	BBC	BEC	MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
		1.05	1.06	1.07	2.00	4.00	4A	
1.00	Administrative and General	0	0	9,867	6,703	41,734	59,795	1.00
2.00	Skilled Nursing Care	0	0	0	0	100,258	2,444,857	2.00
3.00	Physical Therapy	0	0	0	0	62,908	1,331,692	3.00
4.00	Occupational Therapy	0	0	0	0	18,843	401,311	4.00
5.00	Speech Pathology	0	0	0	0	2,299	51,404	5.00
6.00	Medical Social Services	0	0	0	0	6,637	102,127	6.00
7.00	Home Health Aide	0	0	0	0	15,015	421,751	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	1,653	34,993	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	0	0	9,867	6,703	249,347	4,847,930	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.						0.000000	21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 14-0015
HHA CCN: 14-7031

Period: From 10/01/2016 To 09/30/2017

Worksheet H-2 Part I
Date/Time Prepared: 2/28/2018 10:40 am

Home Health Agency I | PPS

	Cost Center Description	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
		5.00	6.00	8.00	9.00	10.00	11.00	
1.00	Administrative and General	20,865	61,554	0	31,696	0	0	1.00
2.00	Skilled Nursing Care	853,109	0	0	0	0	0	2.00
3.00	Physical Therapy	464,681	0	0	0	0	0	3.00
4.00	Occupational Therapy	140,033	0	0	0	0	0	4.00
5.00	Speech Pathology	17,937	0	0	0	0	0	5.00
6.00	Medical Social Services	35,636	0	0	0	0	0	6.00
7.00	Home Health Aide	147,166	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	12,210	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	1,691,637	61,554	0	31,696	0	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

	Cost Center Description	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	NURSING SCHOOL	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES	INTERNS & RESIDENTS SERVICES-OTHER PRGM COSTS	PARAMED ED PRGM	
		13.00	16.00	20.00	21.00	22.00	23.00	
1.00	Administrative and General	741,085	0	12,477	0	0	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	741,085	0	12,477	0	0	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 14-0015 | HHA CCN: 14-7031 | Period: From 10/01/2016 To 09/30/2017 | Worksheet H-2 Part I | Date/Time Prepared: 2/28/2018 10:40 am

Home Health Agency I | PPS

	Cost Center Description	PARAMED ED PRGM-RADIOLOGY	PARAMED ED PRGM-LABORATORY	PARAMED ED PRGM-PHARMACY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	
		23.01	23.02	23.03	24.00	25.00	26.00	
1.00	Administrative and General	0	0	0	927,472	0	927,472	1.00
2.00	Skilled Nursing Care	0	0	0	3,297,966	0	3,297,966	2.00
3.00	Physical Therapy	0	0	0	1,796,373	0	1,796,373	3.00
4.00	Occupational Therapy	0	0	0	541,344	0	541,344	4.00
5.00	Speech Pathology	0	0	0	69,341	0	69,341	5.00
6.00	Medical Social Services	0	0	0	137,763	0	137,763	6.00
7.00	Home Health Aide	0	0	0	568,917	0	568,917	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	47,203	0	47,203	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	0	0	0	7,386,379	0	7,386,379	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

	Cost Center Description	Allocated HHA A&G (see Part II)	Total HHA Costs	
		27.00	28.00	
1.00	Administrative and General			1.00
2.00	Skilled Nursing Care	473,574	3,771,540	2.00
3.00	Physical Therapy	257,952	2,054,325	3.00
4.00	Occupational Therapy	77,735	619,079	4.00
5.00	Speech Pathology	9,957	79,298	5.00
6.00	Medical Social Services	19,782	157,545	6.00
7.00	Home Health Aide	81,694	650,611	7.00
8.00	Supplies (see instructions)	0	0	8.00
9.00	Drugs	0	0	9.00
10.00	DME	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	11.00
12.00	Respiratory Therapy	0	0	12.00
13.00	Private Duty Nursing	0	0	13.00
14.00	Clinic	0	0	14.00
15.00	Health Promotion Activities	0	0	15.00
16.00	Day Care Program	0	0	16.00
17.00	Home Delivered Meals Program	0	0	17.00
18.00	Homemaker Service	0	0	18.00
19.00	All Others (specify)	6,778	53,981	19.00
19.50	Telemedicine	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	927,472	7,386,379	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.	0.143596		21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 14-0015 | HHA CCN: 14-7031 | Period: From 10/01/2016 To 09/30/2017 | Worksheet H-2 Part II | Date/Time Prepared: 2/28/2018 10:40 am

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	Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	BUTLER BUILDING (SQUARE FEET)	OLD BLDG & FIXTURES (SQUARE FEET)	NEW BLDG & FIXTURES (SQUARE FEET)	14TH STREET (SQUARE FEET)	MOB PHASE I (SQUARE FEET)	
		1.00	1.01	1.02	1.03	1.04	1.05	
1.00	Administrative and General	0	0	0	0	2,463	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	0	0	0	0	2,463	0	20.00
21.00	Total cost to be allocated	0	0	0	0	1,491	0	21.00
22.00	Unit cost multiplier	0.000000	0.000000	0.000000	0.000000	0.605359	0.000000	22.00

	Cost Center Description	CAPITAL RELATED COSTS BBC (SQUARE FEET)	BEC (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
		1.06	1.07	2.00	4.00	5A	5.00	
1.00	Administrative and General	0	1,024	6,793	521,048	0	59,795	1.00
2.00	Skilled Nursing Care	0	0	0	1,251,683	0	2,444,857	2.00
3.00	Physical Therapy	0	0	0	785,403	0	1,331,692	3.00
4.00	Occupational Therapy	0	0	0	235,257	0	401,311	4.00
5.00	Speech Pathology	0	0	0	28,708	0	51,404	5.00
6.00	Medical Social Services	0	0	0	82,866	0	102,127	6.00
7.00	Home Health Aide	0	0	0	187,462	0	421,751	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	20,638	0	34,993	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	0	1,024	6,793	3,113,065		4,847,930	20.00
21.00	Total cost to be allocated	0	9,867	6,703	249,347		1,691,637	21.00
22.00	Unit cost multiplier	0.000000	9.635742	0.986751	0.080097		0.348940	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 14-0015 | HHA CCN: 14-7031 | Period: From 10/01/2016 To 09/30/2017 | Worksheet H-2 Part II | Date/Time Prepared: 2/28/2018 10:40 am

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	Cost Center Description	MAINTENANCE & REPAIRS (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (MEALS SERVED)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	
		6.00	8.00	9.00	10.00	11.00	13.00	
1.00	Administrative and General	3,487	0	685	0	0	102,381	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	3,487	0	685	0	0	102,381	20.00
21.00	Total cost to be allocated	61,554	0	31,696	0	0	741,085	21.00
22.00	Unit cost multiplier	17.652423	0.000000	46.271533	0.000000	0.000000	7.238501	22.00

	Cost Center Description	MEDICAL RECORDS & LIBRARY (TIME SPENT)	NURSING SCHOOL (ASSIGNED TIME)	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES (ASSIGNED TIME)	INTERNS & RESIDENTS SERVICES-OTHER PRGM COSTS (ASSIGNED TIME)	PARAMED ED PRGM (ASSIGNED TIME)	PARAMED ED PRGM-RADIOLOGY (ASSIGNED TIME)	
		16.00	20.00	21.00	22.00	23.00	23.01	
1.00	Administrative and General	0	78	0	0	0	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	0	78	0	0	0	0	20.00
21.00	Total cost to be allocated	0	12,477	0	0	0	0	21.00
22.00	Unit cost multiplier	0.000000	159.961538	0.000000	0.000000	0.000000	0.000000	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 14-0015 | HHA CCN: 14-7031 | Period: From 10/01/2016 To 09/30/2017 | Worksheet H-2 Part II | Date/Time Prepared: 2/28/2018 10:40 am

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	Cost Center Description	PARAMED ED PRGM-LABORATORY (ASSIGNED TIME)	PARAMED ED PRGM-PHARMACY (ASSIGNED TIME)	
		23.02	23.03	
1.00	Administrative and General	0	0	1.00
2.00	Skilled Nursing Care	0	0	2.00
3.00	Physical Therapy	0	0	3.00
4.00	Occupational Therapy	0	0	4.00
5.00	Speech Pathology	0	0	5.00
6.00	Medical Social Services	0	0	6.00
7.00	Home Health Aide	0	0	7.00
8.00	Supplies (see instructions)	0	0	8.00
9.00	Drugs	0	0	9.00
10.00	DME	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	11.00
12.00	Respiratory Therapy	0	0	12.00
13.00	Private Duty Nursing	0	0	13.00
14.00	Clinic	0	0	14.00
15.00	Health Promotion Activities	0	0	15.00
16.00	Day Care Program	0	0	16.00
17.00	Home Delivered Meals Program	0	0	17.00
18.00	Homemaker Service	0	0	18.00
19.00	All Others (specify)	0	0	19.00
19.50	Telemedicine	0	0	19.50
20.00	Total (sum of lines 1-19)	0	0	20.00
21.00	Total cost to be allocated	0	0	21.00
22.00	Unit cost multiplier	0.000000	0.000000	22.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 14-0015 | HHA CCN: 14-7031 | Period: From 10/01/2016 To 09/30/2017 | Worksheet H-3 Part I | Date/Time Prepared: 2/28/2018 10:40 am

Title XVIII | Home Health Agency I | PPS

	Cost Center Description	From, Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Visits	Average Cost Per Visit (col. 3 ÷ col. 4)	
		0	1.00	2.00	3.00	4.00	5.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	2.00	3,771,540		3,771,540	27,396	137.67	1.00
2.00	Physical Therapy	3.00	2,054,325	0	2,054,325	11,569	177.57	2.00
3.00	Occupational Therapy	4.00	619,079	0	619,079	3,448	179.55	3.00
4.00	Speech Pathology	5.00	79,298	0	79,298	492	161.17	4.00
5.00	Medical Social Services	6.00	157,545		157,545	69	2,283.26	5.00
6.00	Home Health Aide	7.00	650,611		650,611	5,726	113.62	6.00
7.00	Total (sum of lines 1-6)		7,332,398	0	7,332,398	48,700		7.00

	Cost Center Description	Cost Limits	CBSA No. (1)	Program Visits Part A	Part B Not Subject to Deductibles & Coinsurance	Part B Subject to Deductibles		
		0	1.00	2.00	3.00	4.00	5.00	
	Limitation Cost Computation							
8.00	Skilled Nursing Care		99914	0	14,583			8.00
8.01	Skilled Nursing Care		99926	0	2,603			8.01
8.02	Skilled Nursing Care		50089	0	0			8.02
8.03	Skilled Nursing Care		41180	0	0			8.03
9.00	Physical Therapy		99914	0	6,741			9.00
9.01	Physical Therapy		99926	0	1,253			9.01
9.02	Physical Therapy		50089	0	0			9.02
9.03	Physical Therapy		41180	0	12			9.03
10.00	Occupational Therapy		99914	0	2,200			10.00
10.01	Occupational Therapy		99926	0	345			10.01
10.02	Occupational Therapy		50089	0	0			10.02
10.03	Occupational Therapy		41180	0	0			10.03
11.00	Speech Pathology		99914	0	214			11.00
11.01	Speech Pathology		99926	0	21			11.01
11.02	Speech Pathology		50089	0	0			11.02
11.03	Speech Pathology		41180	0	0			11.03
12.00	Medical Social Services		99914	0	38			12.00
12.01	Medical Social Services		99926	0	2			12.01
12.02	Medical Social Services		50089	0	0			12.02
12.03	Medical Social Services		41180	0	0			12.03
13.00	Home Health Aide		99914	0	3,539			13.00
13.01	Home Health Aide		99926	0	799			13.01
13.02	Home Health Aide		50089	0	0			13.02
13.03	Home Health Aide		41180	0	0			13.03
14.00	Total (sum of lines 8-13)			0	32,350			14.00

	Cost Center Description	From Wkst. H-2 Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Charges (from HHA Records)	Ratio (col. 3 ÷ col. 4)	
		0	1.00	2.00	3.00	4.00	5.00	
	Supplies and Drugs Cost Computations							
15.00	Cost of Medical Supplies	8.00	0	20,865	20,865	126,564	0.164857	15.00
16.00	Cost of Drugs	9.00	0	0	0	0	0.000000	16.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 14-0015 | HHA CCN: 14-7031 | Period: From 10/01/2016 To 09/30/2017 | Worksheet H-3 Part I | Date/Time Prepared: 2/28/2018 10:40 am

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	Cost Center Description	Program Visits			Cost of Services			
			Part B			Part B		
		Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
		6.00	7.00	8.00	9.00	10.00	11.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	0	17,186		0	2,365,997		1.00
2.00	Physical Therapy	0	8,006		0	1,421,625		2.00
3.00	Occupational Therapy	0	2,545		0	456,955		3.00
4.00	Speech Pathology	0	235		0	37,875		4.00
5.00	Medical Social Services	0	40		0	91,330		5.00
6.00	Home Health Aide	0	4,338		0	492,884		6.00
7.00	Total (sum of lines 1-6)	0	32,350		0	4,866,666		7.00

	Cost Center Description	6.00	7.00	8.00	9.00	10.00	11.00	
	Limitation Cost Computation							
8.00	Skilled Nursing Care							8.00
8.01	Skilled Nursing Care							8.01
8.02	Skilled Nursing Care							8.02
8.03	Skilled Nursing Care							8.03
9.00	Physical Therapy							9.00
9.01	Physical Therapy							9.01
9.02	Physical Therapy							9.02
9.03	Physical Therapy							9.03
10.00	Occupational Therapy							10.00
10.01	Occupational Therapy							10.01
10.02	Occupational Therapy							10.02
10.03	Occupational Therapy							10.03
11.00	Speech Pathology							11.00
11.01	Speech Pathology							11.01
11.02	Speech Pathology							11.02
11.03	Speech Pathology							11.03
12.00	Medical Social Services							12.00
12.01	Medical Social Services							12.01
12.02	Medical Social Services							12.02
12.03	Medical Social Services							12.03
13.00	Home Health Aide							13.00
13.01	Home Health Aide							13.01
13.02	Home Health Aide							13.02
13.03	Home Health Aide							13.03
14.00	Total (sum of lines 8-13)							14.00

	Cost Center Description	Program Covered Charges			Cost of Services			
			Part B			Part B		
		Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
		6.00	7.00	8.00	9.00	10.00	11.00	
	Supplies and Drugs Cost Computations							
15.00	Cost of Medical Supplies	0	126,564	0	0	20,865	0	15.00
16.00	Cost of Drugs		0	0		0	0	16.00

APPORTIONMENT OF PATIENT SERVICE COSTS	Provider CCN: 14-0015 HHA CCN: 14-7031	Period: From 10/01/2016 To 09/30/2017	Worksheet H-3 Part I Date/Time Prepared: 2/28/2018 10:40 am
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	Cost Center Description	Total Program Cost (sum of cols. 9-10)	
		12.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION		
	Cost Per Visit Computation		
1.00	Skilled Nursing Care	2,365,997	1.00
2.00	Physical Therapy	1,421,625	2.00
3.00	Occupational Therapy	456,955	3.00
4.00	Speech Pathology	37,875	4.00
5.00	Medical Social Services	91,330	5.00
6.00	Home Health Aide	492,884	6.00
7.00	Total (sum of lines 1-6)	4,866,666	7.00

	Cost Center Description		
		12.00	
	Limitation Cost Computation		
8.00	Skilled Nursing Care		8.00
8.01	Skilled Nursing Care		8.01
8.02	Skilled Nursing Care		8.02
8.03	Skilled Nursing Care		8.03
9.00	Physical Therapy		9.00
9.01	Physical Therapy		9.01
9.02	Physical Therapy		9.02
9.03	Physical Therapy		9.03
10.00	Occupational Therapy		10.00
10.01	Occupational Therapy		10.01
10.02	Occupational Therapy		10.02
10.03	Occupational Therapy		10.03
11.00	Speech Pathology		11.00
11.01	Speech Pathology		11.01
11.02	Speech Pathology		11.02
11.03	Speech Pathology		11.03
12.00	Medical Social Services		12.00
12.01	Medical Social Services		12.01
12.02	Medical Social Services		12.02
12.03	Medical Social Services		12.03
13.00	Home Health Aide		13.00
13.01	Home Health Aide		13.01
13.02	Home Health Aide		13.02
13.03	Home Health Aide		13.03
14.00	Total (sum of lines 8-13)		14.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 14-0015 | HHA CCN: 14-7031

Period: From 10/01/2016 To 09/30/2017

Worksheet H-3 Part II | Date/Time Prepared: 2/28/2018 10:40 am

Title XVIII | Home Health Agency I | PPS

	Cost Center Description	From Wkst. C, Part I, col. 9, line	Cost to Charge Ratio	Total HHA Charge (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)	Transfer to Part I as Indicated		
		0	1.00	2.00	3.00	4.00		
	PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS							
1.00	Physical Therapy	66.00	0.487420	0	0	col. 2, line 2.00		1.00
2.00	Occupational Therapy	67.00	0.330444	0	0	col. 2, line 3.00		2.00
3.00	Speech Pathology	68.00	0.294284	0	0	col. 2, line 4.00		3.00
4.00	Cost of Medical Supplies	71.00	0.164857	126,564	20,865	col. 2, line 15.00		4.00
5.00	Cost of Drugs	73.00	0.170393	0	0	col. 2, line 16.00		5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0015 HHA CCN: 14-7031	Period: From 10/01/2016 To 09/30/2017	Worksheet H-4 Part I-II Date/Time Prepared: 2/28/2018 10:40 am
	Title XVIII	Home Health Agency I	PPS

		Part A	Part B		
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
		1.00	2.00	3.00	
	PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES				
	Reasonable Cost of Part A & Part B Services				
1.00	Reasonable cost of services (see instructions)	0	0	0	1.00
2.00	Total charges	0	5,054,840	0	2.00
	Customary Charges				
3.00	Amount actually collected from patients liable for payment for services on a charge basis (from your records)	0	0	0	3.00
4.00	Amount 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(b)	0	0	0	4.00
5.00	Ratio of line 3 to line 4 (not to exceed 1.000000)	0.000000	0.000000	0.000000	5.00
6.00	Total customary charges (see instructions)	0	5,054,840	0	6.00
7.00	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)	0	5,054,840	0	7.00
8.00	Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6)	0	0	0	8.00
9.00	Primary payer amounts	0	0	0	9.00

		Part A Services	Part B Services	
		1.00	2.00	
	PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT			
10.00	Total reasonable cost (see instructions)	0	0	10.00
11.00	Total PPS Reimbursement - Full Episodes without Outliers	0	3,799,924	11.00
12.00	Total PPS Reimbursement - Full Episodes with Outliers	0	330,680	12.00
13.00	Total PPS Reimbursement - LUPA Episodes	0	51,461	13.00
14.00	Total PPS Reimbursement - PEP Episodes	0	13,285	14.00
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers	0	146,204	15.00
16.00	Total PPS Outlier Reimbursement - PEP Episodes	0	0	16.00
17.00	Total Other Payments	0	0	17.00
18.00	DME Payments	0	0	18.00
19.00	Oxygen Payments	0	0	19.00
20.00	Prosthetic and Orthotic Payments	0	0	20.00
21.00	Part B deductibles billed to Medicare patients (exclude coinsurance)		0	21.00
22.00	Subtotal (sum of lines 10 thru 20 minus line 21)	0	4,341,554	22.00
23.00	Excess reasonable cost (from line 8)	0	0	23.00
24.00	Subtotal (line 22 minus line 23)	0	4,341,554	24.00
25.00	Coinsurance billed to program patients (from your records)		0	25.00
26.00	Net cost (line 24 minus line 25)	0	4,341,554	26.00
27.00	Reimbursable bad debts (from your records)			27.00
28.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)			28.00
29.00	Total costs - current cost reporting period (line 26 plus line 27)	0	4,341,554	29.00
30.00	OTHER ADJUSTMENTS	0	-47	30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	0	30.50
30.99	Demonstration payment adjustment amount before sequestration	0	0	30.99
31.00	Subtotal (see instructions)	0	4,341,507	31.00
31.01	Sequestration adjustment (see instructions)	0	86,830	31.01
31.02	Demonstration payment adjustment amount after sequestration	0	0	31.02
32.00	Interim payments (see instructions)	0	4,254,677	32.00
33.00	Tentative settlement (for contractor use only)	0	0	33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 32, and 33)	0	0	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	35.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED HHAs FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 14-0015 HHA CCN: 14-7031	Period: From 10/01/2016 To 09/30/2017	Worksheet H-5 Date/Time Prepared: 2/28/2018 10:40 am
		Home Health Agency I	PPS

		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		0		4,254,677	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			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			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. H-4, Part II, column as appropriate, line 32)		0		4,254,677	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		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50			0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		0		4,254,677	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS

Provider CCN: 14-0015 | Hospice CCN: 14-1501 | Period: From 10/01/2016 To 09/30/2017 | Worksheet O | Date/Time Prepared: 2/28/2018 10:40 am

Hospice I

		SALARIES	OTHER	SUBTOTAL (col. 1 plus col. 2)	RECLASSIFI-CATIONS	SUBTOTAL	
		1.00	2.00	3.00	4.00	5.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT*		0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP*		0	0	0	0	2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT*	0	0	0	0	0	3.00
4.00	ADMINISTRATIVE & GENERAL*	254,805	85,473	340,278	0	340,278	4.00
5.00	PLANT OPERATION & MAINTENANCE*	0	0	0	0	0	5.00
6.00	LAUNDRY & LINEN SERVICE*	0	0	0	0	0	6.00
7.00	HOUSEKEEPING*	0	0	0	0	0	7.00
8.00	DIETARY*	0	0	0	0	0	8.00
9.00	NURSING ADMINISTRATION*	0	0	0	0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES*	0	0	0	0	0	10.00
11.00	MEDICAL RECORDS*	0	0	0	0	0	11.00
12.00	STAFF TRANSPORTATION*	0	99,271	99,271	0	99,271	12.00
13.00	VOLUNTEER SERVICE COORDINATION*	0	121,766	121,766	21,540	143,306	13.00
14.00	PHARMACY*	0	0	0	0	0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES*	0	0	0	0	0	15.00
16.00	OTHER GENERAL SERVICE*	0	0	0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES						17.00
	DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED**	0	0	0	0	0	25.00
26.00	PHYSICIAN SERVICES**	0	39,800	39,800	0	39,800	26.00
27.00	NURSE PRACTITIONER**	33,335	0	33,335	0	33,335	27.00
28.00	REGISTERED NURSE**	686,638	0	686,638	0	686,638	28.00
29.00	LPN/LVN**	0	0	0	0	0	29.00
30.00	PHYSICAL THERAPY**	0	0	0	0	0	30.00
31.00	OCCUPATIONAL THERAPY**	0	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY**	0	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES**	193,728	0	193,728	0	193,728	33.00
34.00	SPIRITUAL COUNSELING**	83,796	0	83,796	0	83,796	34.00
35.00	DIETARY COUNSELING**	0	0	0	0	0	35.00
36.00	COUNSELING - OTHER**	0	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES**	84,684	72,904	157,588	0	157,588	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN**	0	84,152	84,152	0	84,152	38.00
39.00	PATIENT TRANSPORTATION**	0	4,753	4,753	0	4,753	39.00
40.00	IMAGING SERVICES**	0	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS**	0	4,530	4,530	0	4,530	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE**	0	30,369	30,369	-202	30,167	42.00
43.00	OUTPATIENT SERVICES**	0	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY**	0	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY**	0	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)**	0	0	0	0	0	46.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM *	0	0	0	0	0	60.00
61.00	VOLUNTEER PROGRAM *	0	0	0	0	0	61.00
62.00	FUNDRAISING*	0	0	0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS*	0	0	0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM*	75,602	0	75,602	0	75,602	64.00
65.00	OTHER PHYSICIAN SERVICES*	0	0	0	0	0	65.00
66.00	RESIDENTIAL CARE*	0	0	0	0	0	66.00
67.00	ADVERTISING*	0	0	0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING*	0	0	0	0	0	68.00
69.00	THRIFT STORE*	0	0	0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD*	0	0	0	0	0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)*	0	0	0	0	0	71.00
100.00	TOTAL	1,412,588	543,018	1,955,606	21,338	1,976,944	100.00

* Transfer the amounts in column 7 to Wkst. O-5, column 1, line as appropriate.
** See instructions. Do not transfer the amounts in column 7 to Wkst. O-5.

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS

Provider CCN: 14-0015 | Hospice CCN: 14-1501 | Period: From 10/01/2016 To 09/30/2017 | Worksheet O | Date/Time Prepared: 2/28/2018 10:40 am

Hospice I

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)	
		6.00	7.00	
	GENERAL SERVICE COST CENTERS			
1.00	CAP REL COSTS-BLDG & FIXT*	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP*	0	0	2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT*	0	0	3.00
4.00	ADMINISTRATIVE & GENERAL*	0	340,278	4.00
5.00	PLANT OPERATION & MAINTENANCE*	0	0	5.00
6.00	LAUNDRY & LINEN SERVICE*	0	0	6.00
7.00	HOUSEKEEPING*	0	0	7.00
8.00	DIETARY*	0	0	8.00
9.00	NURSING ADMINISTRATION*	0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES*	0	0	10.00
11.00	MEDICAL RECORDS*	0	0	11.00
12.00	STAFF TRANSPORTATION*	0	99,271	12.00
13.00	VOLUNTEER SERVICE COORDINATION*	0	143,306	13.00
14.00	PHARMACY*	0	0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES*	0	0	15.00
16.00	OTHER GENERAL SERVICE*	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES			17.00
	DIRECT PATIENT CARE SERVICE COST CENTERS			
25.00	INPATIENT CARE-CONTRACTED**	115,394	115,394	25.00
26.00	PHYSICIAN SERVICES**	0	39,800	26.00
27.00	NURSE PRACTITIONER**	0	33,335	27.00
28.00	REGISTERED NURSE**	0	686,638	28.00
29.00	LPN/LVN**	0	0	29.00
30.00	PHYSICAL THERAPY**	0	0	30.00
31.00	OCCUPATIONAL THERAPY**	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY**	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES**	0	193,728	33.00
34.00	SPIRITUAL COUNSELING**	0	83,796	34.00
35.00	DIETARY COUNSELING**	0	0	35.00
36.00	COUNSELING - OTHER**	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES**	0	157,588	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN**	0	84,152	38.00
39.00	PATIENT TRANSPORTATION**	0	4,753	39.00
40.00	IMAGING SERVICES**	0	0	40.00
41.00	LABS & DIAGNOSTICS**	0	4,530	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE**	0	30,167	42.00
43.00	OUTPATIENT SERVICES**	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY**	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY**	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)**	0	0	46.00
	NONREIMBURSABLE COST CENTERS			
60.00	BEREAVEMENT PROGRAM *	0	0	60.00
61.00	VOLUNTEER PROGRAM *	0	0	61.00
62.00	FUNDRAISING*	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS*	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM*	0	75,602	64.00
65.00	OTHER PHYSICIAN SERVICES*	0	0	65.00
66.00	RESIDENTIAL CARE*	0	0	66.00
67.00	ADVERTISING*	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING*	0	0	68.00
69.00	THRIFT STORE*	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD*	0	0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)*	0	0	71.00
100.00	TOTAL	115,394	2,092,338	100.00

* Transfer the amounts in column 7 to Wkst. O-5, column 1, line as appropriate.
** See instructions. Do not transfer the amounts in column 7 to Wkst. O-5.

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS FOR HOSPICE ROUTINE HOME CARE

Provider CCN: 14-0015 | Hospice CCN: 14-1501 | Period: From 10/01/2016 To 09/30/2017 | Worksheet O-2 | Date/Time Prepared: 2/28/2018 10:40 am

Hospice I

		SALARIES	OTHER	SUBTOTAL (col. 1 + col. 2)	RECLASSIFI- CATIONS	SUBTOTAL	
		1.00	2.00	3.00	4.00	5.00	
	DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED						25.00
26.00	PHYSICIAN SERVICES	0	39,800	39,800	0	39,800	26.00
27.00	NURSE PRACTITIONER	33,335	0	33,335	0	33,335	27.00
28.00	REGISTERED NURSE	653,605	0	653,605	0	653,605	28.00
29.00	LPN/LVN	0	0	0	0	0	29.00
30.00	PHYSICAL THERAPY	0	0	0	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	188,523	0	188,523	0	188,523	33.00
34.00	SPIRITUAL COUNSELING	81,714	0	81,714	0	81,714	34.00
35.00	DIETARY COUNSELING	0	0	0	0	0	35.00
36.00	COUNSELING - OTHER	0	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	84,566	72,904	157,470	0	157,470	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	84,152	84,152	0	84,152	38.00
39.00	PATIENT TRANSPORTATION	0	4,753	4,753	0	4,753	39.00
40.00	IMAGING SERVICES	0	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	4,530	4,530	0	4,530	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	30,339	30,339	-202	30,137	42.00
43.00	OUTPATIENT SERVICES	0	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	0	0	0	46.00
100.00	TOTAL *	1,041,743	236,478	1,278,221	-202	1,278,019	100.00

* Transfer the amount in column 7 to Wkst. O-5, column 1, line 51.

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)	
		6.00	7.00	
	DIRECT PATIENT CARE SERVICE COST CENTERS			
25.00	INPATIENT CARE-CONTRACTED			25.00
26.00	PHYSICIAN SERVICES	0	39,800	26.00
27.00	NURSE PRACTITIONER	0	33,335	27.00
28.00	REGISTERED NURSE	0	653,605	28.00
29.00	LPN/LVN	0	0	29.00
30.00	PHYSICAL THERAPY	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0	188,523	33.00
34.00	SPIRITUAL COUNSELING	0	81,714	34.00
35.00	DIETARY COUNSELING	0	0	35.00
36.00	COUNSELING - OTHER	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	157,470	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	84,152	38.00
39.00	PATIENT TRANSPORTATION	0	4,753	39.00
40.00	IMAGING SERVICES	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	4,530	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	30,137	42.00
43.00	OUTPATIENT SERVICES	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	46.00
100.00	TOTAL *	0	1,278,019	100.00

* Transfer the amount in column 7 to Wkst. O-5, column 1, line 51.

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS FOR HOSPICE INPATIENT RESPITE CARE

Provider CCN: 14-0015 | Hospice CCN: 14-1501 | Period: From 10/01/2016 To 09/30/2017 | Worksheet O-3 | Date/Time Prepared: 2/28/2018 10:40 am

Hospice I

		SALARIES	OTHER	SUBTOTAL (col. 1 + col. 2)	RECLASSIFI-CATIONS	SUBTOTAL	
		1.00	2.00	3.00	4.00	5.00	
	DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED	0	0	0	0	0	25.00
26.00	PHYSICIAN SERVICES	0	0	0	0	0	26.00
27.00	NURSE PRACTITIONER	0	0	0	0	0	27.00
28.00	REGISTERED NURSE	577	0	577	0	577	28.00
29.00	LPN/LVN	0	0	0	0	0	29.00
30.00	PHYSICAL THERAPY	0	0	0	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	303	0	303	0	303	33.00
34.00	SPIRITUAL COUNSELING	53	0	53	0	53	34.00
35.00	DIETARY COUNSELING	0	0	0	0	0	35.00
36.00	COUNSELING - OTHER	0	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	118	0	118	0	118	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN						38.00
39.00	PATIENT TRANSPORTATION	0	0	0	0	0	39.00
40.00	IMAGING SERVICES	0	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	0	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	30	30	0	30	42.00
43.00	OUTPATIENT SERVICES	0	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	0	0	0	46.00
100.00	TOTAL *	1,051	30	1,081	0	1,081	100.00

* Transfer the amount in column 7 to Wkst. O-5, column 1, line 52.

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)	
		6.00	7.00	
	DIRECT PATIENT CARE SERVICE COST CENTERS			
25.00	INPATIENT CARE-CONTRACTED	2,214	2,214	25.00
26.00	PHYSICIAN SERVICES	0	0	26.00
27.00	NURSE PRACTITIONER	0	0	27.00
28.00	REGISTERED NURSE	0	577	28.00
29.00	LPN/LVN	0	0	29.00
30.00	PHYSICAL THERAPY	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0	303	33.00
34.00	SPIRITUAL COUNSELING	0	53	34.00
35.00	DIETARY COUNSELING	0	0	35.00
36.00	COUNSELING - OTHER	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	118	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN			38.00
39.00	PATIENT TRANSPORTATION	0	0	39.00
40.00	IMAGING SERVICES	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	30	42.00
43.00	OUTPATIENT SERVICES	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	46.00
100.00	TOTAL *	2,214	3,295	100.00

* Transfer the amount in column 7 to Wkst. O-5, column 1, line 52.

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS FOR HOSPICE GENERAL INPATIENT CARE

Provider CCN: 14-0015 | Hospice CCN: 14-1501 | Period: From 10/01/2016 To 09/30/2017 | Worksheet O-4 | Date/Time Prepared: 2/28/2018 10:40 am

Hospice I

		SALARIES	OTHER	SUBTOTAL (col. 1 + col. 2)	RECLASSIFI-CATIONS	SUBTOTAL	
		1.00	2.00	3.00	4.00	5.00	
	DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED	0	0	0	0	0	25.00
26.00	PHYSICIAN SERVICES	0	0	0	0	0	26.00
27.00	NURSE PRACTITIONER	0	0	0	0	0	27.00
28.00	REGISTERED NURSE	32,456	0	32,456	0	32,456	28.00
29.00	LPN/LVN	0	0	0	0	0	29.00
30.00	PHYSICAL THERAPY	0	0	0	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	4,902	0	4,902	0	4,902	33.00
34.00	SPIRITUAL COUNSELING	2,029	0	2,029	0	2,029	34.00
35.00	DIETARY COUNSELING	0	0	0	0	0	35.00
36.00	COUNSELING - OTHER	0	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	0	0	0	0	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN						38.00
39.00	PATIENT TRANSPORTATION	0	0	0	0	0	39.00
40.00	IMAGING SERVICES	0	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	0	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	0	0	0	42.00
43.00	OUTPATIENT SERVICES	0	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	0	0	0	46.00
100.00	TOTAL *	39,387	0	39,387	0	39,387	100.00

* Transfer the amount in column 7 to Wkst. O-5, column 1, line 53.

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)	
		6.00	7.00	
	DIRECT PATIENT CARE SERVICE COST CENTERS			
25.00	INPATIENT CARE-CONTRACTED	113,180	113,180	25.00
26.00	PHYSICIAN SERVICES	0	0	26.00
27.00	NURSE PRACTITIONER	0	0	27.00
28.00	REGISTERED NURSE	0	32,456	28.00
29.00	LPN/LVN	0	0	29.00
30.00	PHYSICAL THERAPY	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0	4,902	33.00
34.00	SPIRITUAL COUNSELING	0	2,029	34.00
35.00	DIETARY COUNSELING	0	0	35.00
36.00	COUNSELING - OTHER	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	0	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN			38.00
39.00	PATIENT TRANSPORTATION	0	0	39.00
40.00	IMAGING SERVICES	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	42.00
43.00	OUTPATIENT SERVICES	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	46.00
100.00	TOTAL *	113,180	152,567	100.00

* Transfer the amount in column 7 to Wkst. O-5, column 1, line 53.

COST ALLOCATION - DETERMINATION OF HOSPITAL-BASED HOSPICE NET EXPENSES FOR ALLOCATION

Provider CCN: 14-0015 | Hospice CCN: 14-1501 | Period: From 10/01/2016 To 09/30/2017 | Worksheet O-5 | Date/Time Prepared: 2/28/2018 10:40 am

Hospice I

	Descriptions	HOSPICE DIRECT EXPENSES (see instructions)	GENERAL SERVICE EXPENSES FROM WKST B PART I (see instructions)	TOTAL EXPENSES (sum of cols. 1 + 2)	
		1.00	2.00	3.00	
	GENERAL SERVICE COST CENTERS				
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	72,676	72,676	2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	0	114,548	114,548	3.00
4.00	ADMINISTRATIVE & GENERAL	340,278	795,430	1,135,708	4.00
5.00	PLANT OPERATION & MAINTENANCE	0	0	0	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0	6.00
7.00	HOUSEKEEPING	0	0	0	7.00
8.00	DIETARY	0	0	0	8.00
9.00	NURSING ADMINISTRATION	0	340,926	340,926	9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	0	0	10.00
11.00	MEDICAL RECORDS	0	0	0	11.00
12.00	STAFF TRANSPORTATION	99,271		99,271	12.00
13.00	VOLUNTEER SERVICE COORDINATION	143,306		143,306	13.00
14.00	PHARMACY	0	0	0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0		0	15.00
16.00	OTHER GENERAL SERVICE	0	45,109	45,109	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES		0	0	17.00
	LEVEL OF CARE				
50.00	HOSPICE CONTINUOUS HOME CARE	0		0	50.00
51.00	HOSPICE ROUTINE HOME CARE	1,278,019		1,278,019	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	3,295		3,295	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	152,567		152,567	53.00
	NONREIMBURSABLE COST CENTERS				
60.00	BEREAVEMENT PROGRAM	0		0	60.00
61.00	VOLUNTEER PROGRAM	0		0	61.00
62.00	FUNDRAISING	0		0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0		0	63.00
64.00	PALLIATIVE CARE PROGRAM	75,602		75,602	64.00
65.00	OTHER PHYSICIAN SERVICES	0		0	65.00
66.00	RESIDENTIAL CARE	0		0	66.00
67.00	ADVERTISING	0		0	67.00
68.00	TELEHEALTH/TELEMONITORING	0		0	68.00
69.00	THRIFT STORE	0		0	69.00
70.00	NURSING FACILITY ROOM & BOARD	0		0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0		0	71.00
99.00	NEGATIVE COST CENTER	0		0	99.00
100.00	TOTAL	2,092,338	1,368,689	3,461,027	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN: 14-0015 | Hospice CCN: 14-1501 | Period: From 10/01/2016 To 09/30/2017 | Worksheet O-6 Part I | Date/Time Prepared: 2/28/2018 10:40 am

Hospice I

	Descriptions	TOTAL EXPENSES	CAP REL BLDG & FIX	CAP REL MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	SUBTOTAL	
		0	1.00	2.00	3.00	3A	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	72,676		72,676			2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	114,548	0	0	114,548		3.00
4.00	ADMINISTRATIVE & GENERAL	1,135,708	0	72,676	20,409	1,228,793	4.00
5.00	PLANT OPERATION & MAINTENANCE	0	0	0	0	0	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0	0	0	6.00
7.00	HOUSEKEEPING	0	0	0	0	0	7.00
8.00	DIETARY	0	0	0	0	0	8.00
9.00	NURSING ADMINISTRATION	340,926	0	0	0	340,926	9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	0	0	0	0	10.00
11.00	MEDICAL RECORDS	0	0	0	0	0	11.00
12.00	STAFF TRANSPORTATION	99,271	0	0	0	99,271	12.00
13.00	VOLUNTEER SERVICE COORDINATION	143,306	0	0	1,404	144,710	13.00
14.00	PHARMACY	0	0	0	0	0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0	0	0	0	15.00
16.00	OTHER GENERAL SERVICE	45,109	0	0	0	45,109	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES		0	0		0	17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0			0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	1,278,019			83,441	1,361,460	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	3,295	0	0	84	3,379	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	152,567	0	0	3,155	155,722	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0	0	0	0	0	60.00
61.00	VOLUNTEER PROGRAM	0	0	0	0	0	61.00
62.00	FUNDRAISING	0	0	0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0	0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	75,602	0	0	6,055	81,657	64.00
65.00	OTHER PHYSICIAN SERVICES	0	0	0	0	0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0	0	0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING	0	0	0	0	0	68.00
69.00	THRIFT STORE	0	0	0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD	0				0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER	0	0	0	0		99.00
100.00	TOTAL	3,461,027	0	72,676	114,548	3,461,027	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS | Provider CCN: 14-0015 | Hospice CCN: 14-1501 | Period: From 10/01/2016 To 09/30/2017 | Worksheet O-6 Part I | Date/Time Prepared: 2/28/2018 10:40 am

Hospice I

	Descriptions	ADMINISTRATIVE & GENERAL	PLANT OPERATION & MAINTENANCE	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		4.00	5.00	6.00	7.00	8.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL	1,228,793					4.00
5.00	PLANT OPERATION & MAINTENANCE	0	0				5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0			6.00
7.00	HOUSEKEEPING	0	0		0		7.00
8.00	DIETARY	0	0		0	0	8.00
9.00	NURSING ADMINISTRATION	187,672	0		0		9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	0		0		10.00
11.00	MEDICAL RECORDS	0	0		0		11.00
12.00	STAFF TRANSPORTATION	54,646	0		0		12.00
13.00	VOLUNTEER SERVICE COORDINATION	79,660	0		0		13.00
14.00	PHARMACY	0	0		0		14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0		0		15.00
16.00	OTHER GENERAL SERVICE	24,831	0		0		16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0	0		0		17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0					50.00
51.00	HOSPICE ROUTINE HOME CARE	749,453					51.00
52.00	HOSPICE INPATIENT RESPITE CARE	1,860	0	0	0	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	85,721	0	0	0	0	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0	0		0		60.00
61.00	VOLUNTEER PROGRAM	0	0		0		61.00
62.00	FUNDRAISING	0	0		0		62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0		0		63.00
64.00	PALLIATIVE CARE PROGRAM	44,950	0		0		64.00
65.00	OTHER PHYSICIAN SERVICES	0	0		0		65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0	0		0		67.00
68.00	TELEHEALTH/TELEMONITORING	0	0		0		68.00
69.00	THRIFT STORE	0	0		0		69.00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER	0	0	0	0	0	99.00
100.00	TOTAL	1,228,793	0	0	0	0	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN: 14-0015 | Hospice CCN: 14-1501 | Period: From 10/01/2016 To 09/30/2017 | Worksheet O-6 Part I | Date/Time Prepared: 2/28/2018 10:40 am

Hospice I

	Descriptions	NURSING ADMINISTRATION	ROUTINE MEDICAL SUPPLIES	MEDICAL RECORDS	STAFF TRANSPORTATION	VOLUNTEER SERVICE COORDINATION	
		9.00	10.00	11.00	12.00	13.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5.00
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPING						7.00
8.00	DIETARY						8.00
9.00	NURSING ADMINISTRATION	528,598					9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	0				10.00
11.00	MEDICAL RECORDS	0		0			11.00
12.00	STAFF TRANSPORTATION	0			153,917		12.00
13.00	VOLUNTEER SERVICE COORDINATION	0			0	224,370	13.00
14.00	PHARMACY	0			0	0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0			0	0	15.00
16.00	OTHER GENERAL SERVICE	0			0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES						17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0	0	0	0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	524,760	0	0	152,800	222,741	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	146	0	0	42	62	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	3,692	0	0	1,075	1,567	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0			0	0	60.00
61.00	VOLUNTEER PROGRAM	0			0	0	61.00
62.00	FUNDRAISING	0			0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0			0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0			0	0	64.00
65.00	OTHER PHYSICIAN SERVICES	0			0	0	65.00
66.00	RESIDENTIAL CARE	0			0	0	66.00
67.00	ADVERTISING	0			0	0	67.00
68.00	TELEHEALTH/TELEMONITORING	0			0	0	68.00
69.00	THRIFT STORE	0			0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0			0	0	71.00
99.00	NEGATIVE COST CENTER	0	0	0	0	0	99.00
100.00	TOTAL	528,598	0	0	153,917	224,370	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN: 14-0015 | Hospice CCN: 14-1501 | Period: From 10/01/2016 To 09/30/2017 | Worksheet O-6 Part I | Date/Time Prepared: 2/28/2018 10:40 am

Hospice I

	Descriptions	PHARMACY	PHYSICIAN ADMINISTRATIVE SERVICES	OTHER GENERAL SERVICE	PATIENT/ RESIDENTIAL CARE SERVICES	TOTAL	
		14.00	15.00	16.00	17.00	18.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5.00
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPING						7.00
8.00	DIETARY						8.00
9.00	NURSING ADMINISTRATION						9.00
10.00	ROUTINE MEDICAL SUPPLIES						10.00
11.00	MEDICAL RECORDS						11.00
12.00	STAFF TRANSPORTATION						12.00
13.00	VOLUNTEER SERVICE COORDINATION						13.00
14.00	PHARMACY	0					14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0				15.00
16.00	OTHER GENERAL SERVICE	0		69,940			16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES				0		17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0	0	0		0	50.00
51.00	HOSPICE ROUTINE HOME CARE	0	0	69,940		3,081,154	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0	0	0	5,489	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	0	0	247,777	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0		0		0	60.00
61.00	VOLUNTEER PROGRAM	0		0		0	61.00
62.00	FUNDRAISING	0		0		0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0		0		0	63.00
64.00	PALLIATIVE CARE PROGRAM	0		0		126,607	64.00
65.00	OTHER PHYSICIAN SERVICES	0		0		0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0		0		0	67.00
68.00	TELEHEALTH/TELEMONITORING	0		0		0	68.00
69.00	THRIFT STORE	0		0		0	69.00
70.00	NURSING FACILITY ROOM & BOARD					0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER	0	0	0	0	0	99.00
100.00	TOTAL	0	0	69,940	0	3,461,027	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS STATISTICAL BASIS

Provider CCN: 14-0015 | Hospice CCN: 14-1501 | Period: From 10/01/2016 To 09/30/2017 | Worksheet O-6 Part II | Date/Time Prepared: 2/28/2018 10:40 am

Hospice I

	Cost Center Descriptions	CAP REL BLDG & FIX (SQUARE FEET)	CAP REL MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	RECONCILIATION	ADMINISTRATIVE & GENERAL (ACCUMULATED COSTS)	
		1.00	2.00	3.00	4A	4.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0					1.00
2.00	CAP REL COSTS-MVBLE EQUIP		73,652				2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	0	0	1,430,115			3.00
4.00	ADMINISTRATIVE & GENERAL	0	73,652	254,805	-1,228,793	2,232,234	4.00
5.00	PLANT OPERATION & MAINTENANCE	0	0	0	0	0	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0	0	0	6.00
7.00	HOUSEKEEPING	0	0	0	0	0	7.00
8.00	DIETARY	0	0	0	0	0	8.00
9.00	NURSING ADMINISTRATION	0	0	0	0	340,926	9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	0	0	0	0	10.00
11.00	MEDICAL RECORDS	0	0	0	0	0	11.00
12.00	STAFF TRANSPORTATION	0	0	0	0	99,271	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0	0	17,527	0	144,710	13.00
14.00	PHARMACY	0	0	0	0	0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0	0	0	0	15.00
16.00	OTHER GENERAL SERVICE	0	0	0	0	45,109	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0	0		0	0	17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE			0	0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE			1,041,743	0	1,361,460	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0	1,051	0	3,379	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	39,387	0	155,722	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0	0	0	0	0	60.00
61.00	VOLUNTEER PROGRAM	0	0	0	0	0	61.00
62.00	FUNDRAISING	0	0	0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0	0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0	0	75,602	0	81,657	64.00
65.00	OTHER PHYSICIAN SERVICES	0	0	0	0	0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0	0	0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING	0	0	0	0	0	68.00
69.00	THRIFT STORE	0	0	0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD				0		70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER						99.00
100.00	COST TO BE ALLOCATED (per Wkst. O-6, Part I)	0	72,676	114,548		1,228,793	100.00
101.00	UNIT COST MULTIPLIER	0.000000	0.986748	0.080097		0.550477	101.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS STATISTICAL BASIS

Provider CCN: 14-0015 | Hospice CCN: 14-1501 | Period: From 10/01/2016 To 09/30/2017 | Worksheet O-6 Part II | Date/Time Prepared: 2/28/2018 10:40 am

Hospice I

	Cost Center Descriptions	PLANT OPERATION & MAINTENANCE (SQUARE FEET)	LAUNDRY & LINEN SERVICE (IN-FACILITY DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (IN-FACILITY DAYS)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	
		5.00	6.00	7.00	8.00	9.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE	0					5.00
6.00	LAUNDRY & LINEN SERVICE	0	0				6.00
7.00	HOUSEKEEPING	0		0			7.00
8.00	DIETARY	0		0	0		8.00
9.00	NURSING ADMINISTRATION	0		0		47,099	9.00
10.00	ROUTINE MEDICAL SUPPLIES	0		0		0	10.00
11.00	MEDICAL RECORDS	0		0		0	11.00
12.00	STAFF TRANSPORTATION	0		0		0	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0		0		0	13.00
14.00	PHARMACY	0		0		0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0		0		0	15.00
16.00	OTHER GENERAL SERVICE	0		0		0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0		0			17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE					0	50.00
51.00	HOSPICE ROUTINE HOME CARE					46,757	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0	0	0	13	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	0	0	329	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0		0		0	60.00
61.00	VOLUNTEER PROGRAM	0		0		0	61.00
62.00	FUNDRAISING	0		0		0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0		0		0	63.00
64.00	PALLIATIVE CARE PROGRAM	0		0		0	64.00
65.00	OTHER PHYSICIAN SERVICES	0		0		0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0		0		0	67.00
68.00	TELEHEALTH/TELEMONITORING	0		0		0	68.00
69.00	THRIFT STORE	0		0		0	69.00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER						99.00
100.00	COST TO BE ALLOCATED (per Wkst. O-6, Part I)	0	0	0	0	528,598	100.00
101.00	UNIT COST MULTIPLIER	0.000000	0.000000	0.000000	0.000000	11.223126	101.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS STATISTICAL BASIS

Provider CCN: 14-0015 | Hospice CCN: 14-1501 | Period: From 10/01/2016 To 09/30/2017 | Worksheet O-6 Part II | Date/Time Prepared: 2/28/2018 10:40 am

Hospice I

	Cost Center Descriptions	ROUTINE MEDICAL SUPPLIES (PATIENT DAYS)	MEDICAL RECORDS (PATIENT DAYS)	STAFF TRANSPORTATION (MILEAGE)	VOLUNTEER SERVICE COORDINATION (HOURS OF SERVICE)	PHARMACY (CHARGES)	
		10.00	11.00	12.00	13.00	14.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5.00
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPING						7.00
8.00	DIETARY						8.00
9.00	NURSING ADMINISTRATION						9.00
10.00	ROUTINE MEDICAL SUPPLIES	0					10.00
11.00	MEDICAL RECORDS		0				11.00
12.00	STAFF TRANSPORTATION			47,099			12.00
13.00	VOLUNTEER SERVICE COORDINATION			0	47,099		13.00
14.00	PHARMACY			0	0	0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES			0	0	0	15.00
16.00	OTHER GENERAL SERVICE			0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES						17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0	0	0	0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	0	0	46,757	46,757	0	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0	13	13	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	329	329	0	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM			0	0	0	60.00
61.00	VOLUNTEER PROGRAM			0	0	0	61.00
62.00	FUNDRAISING			0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS			0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM			0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES			0	0	0	65.00
66.00	RESIDENTIAL CARE			0	0	0	66.00
67.00	ADVERTISING			0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING			0	0	0	68.00
69.00	THRIFT STORE			0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)			0	0	0	71.00
99.00	NEGATIVE COST CENTER						99.00
100.00	COST TO BE ALLOCATED (per Wkst. O-6, Part I)	0	0	153,917	224,370	0	100.00
101.00	UNIT COST MULTIPLIER	0.000000	0.000000	3.267946	4.763795	0.000000	101.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS STATISTICAL BASIS

Provider CCN: 14-0015 | Hospice CCN: 14-1501 | Period: From 10/01/2016 To 09/30/2017 | Worksheet O-6 Part II | Date/Time Prepared: 2/28/2018 10:40 am

Hospice I

	Cost Center Descriptions	PHYSICIAN ADMINISTRATIVE SERVICES (PATIENT DAYS)	OTHER GENERAL SERVICE (SPECIFY BASIS)	PATIENT/ RESIDENTIAL CARE SERVICES (IN-FACILITY DAYS)		
		15.00	16.00	17.00		
	GENERAL SERVICE COST CENTERS					
1.00	CAP REL COSTS-BLDG & FIXT					1.00
2.00	CAP REL COSTS-MVBLE EQUIP					2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT					3.00
4.00	ADMINISTRATIVE & GENERAL					4.00
5.00	PLANT OPERATION & MAINTENANCE					5.00
6.00	LAUNDRY & LINEN SERVICE					6.00
7.00	HOUSEKEEPING					7.00
8.00	DIETARY					8.00
9.00	NURSING ADMINISTRATION					9.00
10.00	ROUTINE MEDICAL SUPPLIES					10.00
11.00	MEDICAL RECORDS					11.00
12.00	STAFF TRANSPORTATION					12.00
13.00	VOLUNTEER SERVICE COORDINATION					13.00
14.00	PHARMACY					14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0				15.00
16.00	OTHER GENERAL SERVICE		46,757			16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES			0		17.00
	LEVEL OF CARE					
50.00	HOSPICE CONTINUOUS HOME CARE	0	0			50.00
51.00	HOSPICE ROUTINE HOME CARE	0	46,757			51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0	0		52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	0		53.00
	NONREIMBURSABLE COST CENTERS					
60.00	BEREAVEMENT PROGRAM		0			60.00
61.00	VOLUNTEER PROGRAM		0			61.00
62.00	FUNDRAISING		0			62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS		0			63.00
64.00	PALLIATIVE CARE PROGRAM		0			64.00
65.00	OTHER PHYSICIAN SERVICES		0			65.00
66.00	RESIDENTIAL CARE	0	0	0		66.00
67.00	ADVERTISING		0			67.00
68.00	TELEHEALTH/TELEMONITORING		0			68.00
69.00	THRIFT STORE		0			69.00
70.00	NURSING FACILITY ROOM & BOARD					70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0		71.00
99.00	NEGATIVE COST CENTER					99.00
100.00	COST TO BE ALLOCATED (per Wkst. O-6, Part I)	0	69,940	0		100.00
101.00	UNIT COST MULTIPLIER	0.000000	1.495819	0.000000		101.00

APPORTIONMENT OF HOSPITAL-BASED HOSPICE SHARED SERVICE COSTS BY LEVEL OF CARE

Provider CCN: 14-0015 | Hospice CCN: 14-1501 | Period: From 10/01/2016 To 09/30/2017 | Worksheet O-7 | Date/Time Prepared: 2/28/2018 10:40 am

Hospice I

	Cost Center Descriptions	From Wkst. C, Part I, Col. 9 line	Cost to Charge Ratio	Charges by LOC (from Provider Records)			
				HCHC	HRHC	HIRC	
		0	1.00	2.00	3.00	4.00	
	ANCILLARY SERVICE COST CENTERS						
1.00	PHYSICAL THERAPY	66.00	0.487420	0	0	0	1.00
2.00	OCCUPATIONAL THERAPY	67.00	0.330444	0	0	0	2.00
3.00	SPEECH PATHOLOGY	68.00	0.294284	0	0	0	3.00
4.00	DRUGS CHARGED TO PATIENTS	73.00	0.170393	0	0	0	4.00
5.00	DURABLE MEDICAL EQUIP-RENTED	96.00					5.00
6.00	LABORATORY	60.00	0.087199	0	0	0	6.00
7.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0.164857	0	0	0	7.00
8.00	OTHER OUTPATIENT SERVICE COST CENTER	93.00					8.00
9.00	RADIOLOGY-THERAPEUTIC	55.00	0.198427	0	0	0	9.00
10.00	OTHER ANCILLARY SERVICE COST CENTERS	76.00					10.00
11.00	Totals (sum of lines 1-11)						11.00

	Cost Center Descriptions	Charges by LOC (from Provider Records)	Shared Service Costs by LOC				
		HGIP	HCHC (col. 1 x col. 2)	HRHC (col. 1 x col. 3)	HIRC (col. 1 x col. 4)	HGIP (col. 1 x col. 5)	
		5.00	6.00	7.00	8.00	9.00	
	ANCILLARY SERVICE COST CENTERS						
1.00	PHYSICAL THERAPY	0	0	0	0	0	1.00
2.00	OCCUPATIONAL THERAPY	0	0	0	0	0	2.00
3.00	SPEECH PATHOLOGY	0	0	0	0	0	3.00
4.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	4.00
5.00	DURABLE MEDICAL EQUIP-RENTED						5.00
6.00	LABORATORY	0	0	0	0	0	6.00
7.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	7.00
8.00	OTHER OUTPATIENT SERVICE COST CENTER						8.00
9.00	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	9.00
10.00	OTHER ANCILLARY SERVICE COST CENTERS						10.00
11.00	Totals (sum of lines 1-11)		0	0	0	0	11.00

CALCULATION OF HOSPITAL-BASED HOSPICE PER DIEM COST

Provider CCN: 14-0015 | Hospice CCN: 14-1501 | Period: From 10/01/2016 To 09/30/2017 | Worksheet O-8 | Date/Time Prepared: 2/28/2018 10:40 am

Hospice I

		TITLE XVIII MEDICARE	TITLE XIX MEDICAID	TOTAL	
		1.00	2.00	3.00	
	HOSPICE CONTINUOUS HOME CARE				
1.00	Total cost (Wkst. O-6, Part I, col. 18, line 50 plus Wkst. O-7, col. 6, line 11)			0	1.00
2.00	Total unduplicated days (Wkst. S-9, col. 4, line 10)			0	2.00
3.00	Total average cost per diem (line 1 divided by line 2)			0.00	3.00
4.00	Unduplicated program days (Wkst. S-9 col. as appropriate, line 10)	0	0		4.00
5.00	Program cost (line 3 times line 4)	0	0		5.00
	HOSPICE ROUTINE HOME CARE				
6.00	Total cost (Wkst. O-6, Part I, col. 18, line 51 plus Wkst. O-7, col. 7, line 11)			3,081,154	6.00
7.00	Total unduplicated days (Wkst. S-9, col. 4, line 11)			13,251	7.00
8.00	Total average cost per diem (line 6 divided by line 7)			232.52	8.00
9.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 11)	12,064	309		9.00
10.00	Program cost (line 8 times line 9)	2,805,121	71,849		10.00
	HOSPICE INPATIENT RESPITE CARE				
11.00	Total cost (Wkst. O-6, Part I, col. 18, line 52 plus Wkst. O-7, col. 8, line 11)			5,489	11.00
12.00	Total unduplicated days (Wkst. S-9, col. 4, line 12)			13	12.00
13.00	Total average cost per diem (line 11 divided by line 12)			422.23	13.00
14.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 12)	13	0		14.00
15.00	Program cost (line 13 times line 14)	5,489	0		15.00
	HOSPICE GENERAL INPATIENT CARE				
16.00	Total cost (Wkst. O-6, Part I, col. 18, line 53 plus Wkst. O-7, col. 9, line 11)			247,777	16.00
17.00	Total unduplicated days (Wkst. S-9, col. 4, line 13)			329	17.00
18.00	Total average cost per diem (line 16 divided by line 17)			753.12	18.00
19.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 13)	279	12		19.00
20.00	Program cost (line 18 times line 19)	210,120	9,037		20.00
	TOTAL HOSPICE CARE				
21.00	Total cost (sum of line 1 + line 6 + line 11 + line 16)			3,334,420	21.00
22.00	Total unduplicated days (Wkst. S-9, col. 4, line 14)			13,593	22.00
23.00	Average cost per diem (line 21 divided by line 22)			245.30	23.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 14-0015	Period: From 10/01/2016 To 09/30/2017	Worksheet L Parts I-III Date/Time Prepared: 2/28/2018 10:40 am
	Title XVIII	Hospital	PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	3,906,307	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	175,955	2.00
2.01	Model 4 BPCI Capital DRG outlier payments	0	2.01
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)	126.39	3.00
4.00	Number of interns & residents (see instructions)	15.86	4.00
5.00	Indirect medical education percentage (see instructions)	3.60	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)	140,627	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)	0.00	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)	0.00	8.00
9.00	Sum of lines 7 and 8	0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)	0.00	10.00
11.00	Disproportionate share adjustment (see instructions)	0	11.00
12.00	Total prospective capital payments (see instructions)	4,222,889	12.00

		1.00	
	PART II - PAYMENT UNDER REASONABLE COST		
1.00	Program inpatient routine capital cost (see instructions)	0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)	0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)	0	3.00
4.00	Capital cost payment factor (see instructions)	0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)	0	5.00

		1.00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS		
1.00	Program inpatient capital costs (see instructions)	0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)	0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)	0	3.00
4.00	Applicable exception percentage (see instructions)	0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)	0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)	0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)	0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)	0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)	0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)	0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)	0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)	0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)	0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)	0	14.00
15.00	Current year allowable operating and capital payment (see instructions)	0	15.00
16.00	Current year operating and capital costs (see instructions)	0	16.00
17.00	Current year exception offset amount (see instructions)	0	17.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-0015 | Period: From 10/01/2016 To 09/30/2017 | Worksheet M-1

Component CCN: 14-3422 | Date/Time Prepared: 2/28/2018 10:40 am

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	55,309	0	55,309	0	55,309	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	118,161	0	118,161	0	118,161	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	165,723	0	165,723	0	165,723	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)	339,193	0	339,193	0	339,193	10.00
11.00	Physician Services Under Agreement	0	351,612	351,612	0	351,612	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	19,912	19,912	0	19,912	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	371,524	371,524	0	371,524	14.00
15.00	Medical Supplies	0	0	0	0	0	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	61,462	61,462	-974	60,488	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	61,462	61,462	-974	60,488	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	339,193	432,986	772,179	-974	771,205	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
25.01	Telehealth	0	0	0	0	0	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	89,458	89,458	0	89,458	29.00
30.00	Administrative Costs	90,417	25,642	116,059	0	116,059	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	90,417	115,100	205,517	0	205,517	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	429,610	548,086	977,696	-974	976,722	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-0015 | Period: From 10/01/2016 To 09/30/2017 | Worksheet M-1

Component CCN: 14-3422 | Date/Time Prepared: 2/28/2018 10:40 am

RHC I | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
		6.00	7.00	
	FACILITY HEALTH CARE STAFF COSTS			
1.00	Physician	0	55,309	1.00
2.00	Physician Assistant	0	0	2.00
3.00	Nurse Practitioner	0	118,161	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	165,723	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	339,193	10.00
11.00	Physician Services Under Agreement	0	351,612	11.00
12.00	Physician Supervision Under Agreement	0	0	12.00
13.00	Other Costs Under Agreement	10,157	30,069	13.00
14.00	Subtotal (sum of lines 11 through 13)	10,157	381,681	14.00
15.00	Medical Supplies	0	0	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	60,488	19.00
20.00	Allowable GME Costs			20.00
21.00	Subtotal (sum of lines 15 through 20)	0	60,488	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	10,157	781,362	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	-46,129	43,329	29.00
30.00	Administrative Costs	-421	115,638	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-46,550	158,967	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-36,393	940,329	32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-0015 | Period: From 10/01/2016 To 09/30/2017 | Worksheet M-2

Component CCN: 14-3422 | Date/Time Prepared: 2/28/2018 10:40 am

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	1.07	2,032	4,200	4,494		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	0.93	4,708	2,100	1,953		3.00
4.00	Subtotal (sum of lines 1 through 3)	2.00	6,740		6,447	6,740	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	54			54	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)	2.00	6,794			6,794	8.00
9.00	Physician Services Under Agreements		0			0	9.00

		1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES		
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)	781,362	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)	781,362	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)	158,967	14.00
15.00	Parent provider overhead allocated to facility (see instructions)	374,535	15.00
16.00	Total overhead (sum of lines 14 and 15)	533,502	16.00
17.00	Allowable GME overhead (see instructions)	0	17.00
18.00	Enter the amount from line 16	533,502	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)	533,502	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)	1,314,864	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 14-0015 Component CCN: 14-3422	Period: From 10/01/2016 To 09/30/2017	Worksheet M-3 Date/Time Prepared: 2/28/2018 10:40 am
	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)		1,314,864	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)		40,482	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		1,274,382	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		6,794	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)		0	5.00
6.00	Total adjusted visits (line 4 plus line 5)		6,794	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		187.57	7.00
		Calculation of Limit (1)		
		Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	81.32	82.30	8.00
9.00	Rate for Program covered visits (see instructions)	81.32	82.30	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	605	1,514	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	49,199	124,602	11.00
12.00	Program covered visits for mental health services (from contractor records)	1	3	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	81	247	13.00
14.00	Limit adjustment for mental health services (see instructions)	81	247	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	174,129	16.00
16.01	Total program charges (see instructions)(from contractor's records)		455,100	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		533	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		204	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.)		108,638	16.04
16.05	Total program cost (see instructions)	0	108,842	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		38,127	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		83,288	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		108,842	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		24,938	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		133,780	22.00
23.00	Allowable bad debts (see instructions)		0	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		0	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	25.50
25.99	Demonstration payment adjustment amount before sequestration		0	25.99
26.00	Net reimbursable amount (see instructions)		133,780	26.00
26.01	Sequestration adjustment (see instructions)		2,676	26.01
26.02	Demonstration payment adjustment amount after sequestration		0	26.02
27.00	Interim payments		106,263	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, 26.02, 27, and 28)		24,841	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0	30.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA VACCINE COST	Provider CCN: 14-0015 Component CCN: 14-3422	Period: From 10/01/2016 To 09/30/2017	Worksheet M-4 Date/Time Prepared: 2/28/2018 10:40 am
	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)	339,193	339,193	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000334	0.006206	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	113	2,105	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	14,705	7,134	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	14,818	9,239	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	781,362	781,362	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	533,502	533,502	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.018964	0.011824	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	10,117	6,308	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	24,935	15,547	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	101	501	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	246.88	31.03	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	76	199	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	18,763	6,175	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)		40,482	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)		24,938	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 14-0015 Component CCN: 14-3422	Period: From 10/01/2016 To 09/30/2017	Worksheet M-5 Date/Time Prepared: 2/28/2018 10:40 am
		RHC I	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		102,803	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		07/13/2017	3,460	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)		3,460	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		106,263	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		24,841	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		131,104	7.00

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