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: 14-0137	Period: From 01/01/2017 To 06/30/2017	Worksheet S Parts I-III Date/Time Prepared: 11/22/2017 4:48 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 11/22/2017 Time: 4:48 pm
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by GREENVILLE REGIONAL HOSPITAL (14-0137) for the cost reporting period beginning 01/01/2017 and ending 06/30/2017 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

_____
Title

_____
Date

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	81,120	-5,650	0	0	1.00
2.00	Subprovider - IPF	0	-1	0		0	2.00
3.00	Subprovider - IRF	0	0	0		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	0	0		0	7.00
8.00	NURSING FACILITY	0				0	8.00
10.00	RURAL HEALTH CLINIC I	0		149,973		0	10.00
200.00	Total	0	81,119	144,323	0	0	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-0137 | Period: From 01/01/2017 To 06/30/2017 | Worksheet S-2 Part I | Date/Time Prepared: 11/22/2017 4:46 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 200 HEALTHCARE DRIVE	PO Box:			1.00
2.00	City: GREENVILLE	State: IL	Zip Code: 62246-1156	County: BOND	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	GREENVILLE REGIONAL HOSPITAL	140137	41180	1	07/01/1966	N	P	N	3.00
4.00	Subprovider - IPF	GREENVILLE I/P PSYCH UNIT	14S137	41180	4	01/01/2005	N	P	N	4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	GREENVILLE REGIONAL HOSP- SWING BED	14U137	41180		10/03/2001	N	P	N	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC	GREENVILLE FAMILY WELLNESS	143491	41180		07/24/2007	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: 1.00	To: 2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	01/01/2017	06/30/2017	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)	Y	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.	347	0	0	0	199	0	24.00

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

		Urban/Rural S	Date of Geogr	
		1.00	2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	1		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.	1		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0		35.00

		Beginning:	Ending:	
		1.00	2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.			36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.	0		37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)	N		37.01
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.			38.00

		Y/N	Y/N	
		1.00	2.00	
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 “Y” for yes or “N” for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	Y	Y	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)	Y	N	40.00

		V	XVIII	XIX	
		1.00	2.00	3.00	
	Prospective Payment System (PPS)-Capital				
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y for yes or "N" for no.	N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00
	Teaching Hospitals				
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N			56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.	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
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N			60.00

		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00	0.00			61.01

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		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)		0.00	0.00			61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)		0.00	0.00			61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).		0.00	0.00			61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)		0.00	0.00			61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)		0.00	0.00			61.06

		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1.00	2.00	3.00	4.00	
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column 4, direct GME FTE unweighted count.			0.00	0.00	61.10
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column 4, direct GME FTE unweighted count.			0.00	0.00	61.20

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

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

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-0137 | Period: From 01/01/2017 To 06/30/2017 | Worksheet S-2 Part I Date/Time Prepared: 11/22/2017 4:46 pm

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

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

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

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

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		1.00	2.00	3.00	
76.00	If line 75 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0	76.00

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

		V	XIX	
		1.00	2.00	
	Title V and XIX Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
	Rural Providers			
105.00	Does this hospital qualify as a critical access hospital (CAH)?	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)	N		106.00
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II.	N		107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	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 Demo)for the current cost reporting period? Enter "Y" for yes or "N" for no.	N	110.00

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

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		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	0	0	114,685	118.01

		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain state health or similar taxes? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N		122.00
	Transplant Center Information			
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
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	148005	140.00

	1.00	2.00	3.00	
	If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.			
141.00	Name: HOSPITAL SISTERS HEALTH SYSTEM	Contractor's Name: NATIONAL GOVERNMENT SERVICES	Contractor's Number: 00131	141.00
142.00	Street: 4936 LAVERNA ROAD	PO Box:		142.00
143.00	City: SPRINGFIELD	State: IL	Zip Code: 62794	143.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-0137 | Period: From 01/01/2017 To 06/30/2017 | Worksheet S-2 Part I Date/Time Prepared: 11/22/2017 4:46 pm

						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)					41180	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)						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)				01/01/2017	06/30/2017	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: 14-0137 | Period: From 01/01/2017 To 06/30/2017 | Worksheet S-2 Part II | Date/Time Prepared: 11/22/2017 4:46 pm

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

		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	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.	Y			5.00

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

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

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	N		N		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	09/22/2017	Y	09/22/2017	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: 14-0137 | Period: From 01/01/2017 To 06/30/2017 | Worksheet S-2 Part II Date/Time Prepared: 11/22/2017 4:46 pm

		Description		Y/N	Y/N	
		0		1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00

		1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)		
	Capital Related Cost		
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions	N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.	N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions	N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.	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.	N	35.00

		Y/N	Date	
		1.00	2.00	
	Home Office Costs			
36.00	Were home office costs claimed on the cost report?	N		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.	N		37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.	N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.	N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.	N		40.00

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	PATRICIA	RACHELL	41.00
42.00	Enter the employer/company name of the cost report preparer.	BKD, LLP		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	314-231-5544	PRACHELL@BKD.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 14-0137	Period: From 01/01/2017 To 06/30/2017	Worksheet S-2 Part II Date/Time Prepared: 11/22/2017 4:46 pm

		3.00		
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	DIRECTOR		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: 14-0137 | Period: From 01/01/2017 To 06/30/2017 | Worksheet S-3 Part I Date/Time Prepared: 11/22/2017 4:46 pm

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	32	5,792	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)		32	5,792	0.00	0	7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		32	5,792	0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF	40.00	10	1,810		0	16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	44.00	0	0		0	19.00
20.00	NURSING FACILITY	45.00	0	0		0	20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RHC (CONSOLIDATED)	88.00				0	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		42				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 14-0137 | Period: From 01/01/2017 To 06/30/2017 | Worksheet S-3 Part I | Date/Time Prepared: 11/22/2017 4:46 pm

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	404	253	1,059			1.00
2.00	HMO and other (see instructions)	49	199				2.00
3.00	HMO IPF Subprovider	38	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	322	0	322			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	125			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	726	253	1,506			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		84	146			13.00
14.00	Total (see instructions)	726	337	1,652	0.00	185.00	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF	648	20	837	0.00	14.40	16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	0	0	0	0.00	0.00	19.00
20.00	NURSING FACILITY		0	0	0.00	0.00	20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	0	0	0			24.10
25.00	CMHC - CMHC						25.00
26.00	RHC (CONSOLIDATED)	2,486	0	8,896	0.00	5.71	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	205.11	27.00
28.00	Observation Bed Days		21	91			28.00
29.00	Ambulance Trips	347					29.00
30.00	Employee discount days (see instruction)			9			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	10	26			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 14-0137 | Period: From 01/01/2017 To 06/30/2017 | Worksheet S-3 Part I | Date/Time Prepared: 11/22/2017 4:46 pm

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	155	109	456	1.00
2.00	HMO and other (see instructions)			22	0		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				0		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	155	109	456	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF	0.00	0	69	2	93	16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	0.00					19.00
20.00	NURSING FACILITY	0.00					20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RHC (CONSOLIDATED)	0.00					26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 14-0137 | Period: From 01/01/2017 To 06/30/2017 | Worksheet S-3 Part II Date/Time Prepared: 11/22/2017 4:46 pm

		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 II - WAGE DATA							
	SALARIES							
1.00	Total salaries (see instructions)	200.00	5,507,408	0	5,507,408	207,643.99	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	207,737	207,737	2,080.00	99.87	3.00
4.00	Physician-Part A - Administrative		3,000	0	3,000	29.50	101.69	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		267,486	0	267,486	1,955.20	136.81	5.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		627,487	0	627,487	27,477.10	22.84	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	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	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		864,549	0	864,549	33,212.29	26.03	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		879,151	0	879,151	14,819.69	59.32	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		35,516	0	35,516	385.35	92.17	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		246,531	0	246,531	3,472.00	71.01	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)		936,838	0	936,838			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		221,053	0	221,053			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		25,740	0	25,740			21.00
22.00	Physician Part A - Administrative		369	0	369			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		29,788	0	29,788			23.00
24.00	Wage-related costs (RHC/FQHC)		176,083	0	176,083			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
25.50	Home office wage-related		50,527	0	50,527			25.50
25.51	Related orgainzation wage-related		0	0	0			25.51
25.52	Home office: Physician Part A - Administrative - wage-related		0	0	0			25.52
25.53	Home office & Contract Physicians Part A - Teaching - wage-related		0	0	0			25.53

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 14-0137 | Period: From 01/01/2017 To 06/30/2017 | Worksheet S-3 Part II Date/Time Prepared: 11/22/2017 4:46 pm

		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	
	OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	83,172	0	83,172	1,696.80	49.02	26.00
27.00	Administrative & General	5.00	691,410	0	691,410	25,732.45	26.87	27.00
28.00	Administrative & General under contract (see inst.)		29,388	0	29,388	1,537.00	19.12	28.00
29.00	Maintenance & Repairs	6.00	142,445	0	142,445	5,450.75	26.13	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	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	191,306	0	191,306	15,606.47	12.26	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	209,048	-140,182	68,866	4,509.11	15.27	34.00
35.00	Dietary under contract (see instructions)		9,137	0	9,137	1,051.45	8.69	35.00
36.00	Cafeteria	11.00	0	140,182	140,182	9,491.00	14.77	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	351,822	0	351,822	10,825.11	32.50	38.00
39.00	Central Services and Supply	14.00	51,597	0	51,597	2,580.00	20.00	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	113,206	0	113,206	5,540.81	20.43	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: 14-0137 | Period: From 01/01/2017 To 06/30/2017 | Worksheet S-3 Part III Date/Time Prepared: 11/22/2017 4:46 pm

		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)		4,650,960	-207,737	4,443,223	178,720.14	24.86	1.00
2.00	Excluded area salaries (see instructions)		864,549	0	864,549	33,212.29	26.03	2.00
3.00	Subtotal salaries (line 1 minus line 2)		3,786,411	-207,737	3,578,674	145,507.85	24.59	3.00
4.00	Subtotal other wages & related costs (see inst.)		1,161,198	0	1,161,198	18,677.04	62.17	4.00
5.00	Subtotal wage-related costs (see inst.)		987,734	0	987,734	0.00	27.60	5.00
6.00	Total (sum of lines 3 thru 5)		5,935,343	-207,737	5,727,606	164,184.89	34.89	6.00
7.00	Total overhead cost (see instructions)		1,872,531	0	1,872,531	84,020.95	22.29	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 14-0137 | Period: From 01/01/2017 To 06/30/2017 | Worksheet S-3 Part IV Date/Time Prepared: 11/22/2017 4:46 pm

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	55,930	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)	0	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	2,726	7.00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	882,781	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)	0	8.02
8.03	Health Insurance (Purchased)	0	8.03
9.00	Prescription Drug Plan	763	9.00
10.00	Dental, Hearing and Vision Plan	21,277	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	18,539	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)	0	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	46,332	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	272,150	17.00
18.00	Medicare Taxes - Employers Portion Only	79,844	18.00
19.00	Unemployment Insurance	0	19.00
20.00	State or Federal Unemployment Taxes	6	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	9,522	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	1,389,870	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: 14-0137 | Period: From 01/01/2017 To 06/30/2017 | Worksheet S-3 Part V Date/Time Prepared: 11/22/2017 4:46 pm

	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	2,171,326	0	1.00
2.00	Hospital	879,151	0	2.00
3.00	Subprovider - IPF	68,229	0	3.00
4.00	Subprovider - IRF			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	0	0	8.00
9.00	Hospital-Based NF	0	0	9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC	1,223,946	0	14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis			17.00
18.00	Other	0	0	18.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA | Provider CCN: 14-0137 | Period: From 01/01/2017 To 06/30/2017 | Worksheet S-7 | Date/Time Prepared: 11/22/2017 4:46 pm

		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	28	28	5.00
6.00		RVL	0	26	26	6.00
7.00		RHX	0	0	0	7.00
8.00		RHL	0	15	15	8.00
9.00		RMX	0	0	0	9.00
10.00		RML	0	0	0	10.00
11.00		RLX	0	0	0	11.00
12.00		RUC	0	0	0	12.00
13.00		RUB	0	0	0	13.00
14.00		RUA	0	41	41	14.00
15.00		RVC	0	0	0	15.00
16.00		RVB	0	28	28	16.00
17.00		RVA	0	102	102	17.00
18.00		RHC	0	0	0	18.00
19.00		RHB	0	28	28	19.00
20.00		RHA	0	35	35	20.00
21.00		RMC	0	0	0	21.00
22.00		RMB	0	0	0	22.00
23.00		RMA	0	0	0	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	0	0	0	27.00
28.00		ES1	0	0	0	28.00
29.00		HE2	0	0	0	29.00
30.00		HE1	0	0	0	30.00
31.00		HD2	0	0	0	31.00
32.00		HD1	0	0	0	32.00
33.00		HC2	0	0	0	33.00
34.00		HC1	0	0	0	34.00
35.00		HB2	0	0	0	35.00
36.00		HB1	0	3	3	36.00
37.00		LE2	0	0	0	37.00
38.00		LE1	0	0	0	38.00
39.00		LD2	0	0	0	39.00
40.00		LD1	0	0	0	40.00
41.00		LC2	0	0	0	41.00
42.00		LC1	0	4	4	42.00
43.00		LB2	0	0	0	43.00
44.00		LB1	0	0	0	44.00
45.00		CE2	0	0	0	45.00
46.00		CE1	0	0	0	46.00
47.00		CD2	0	0	0	47.00
48.00		CD1	0	0	0	48.00
49.00		CC2	0	0	0	49.00
50.00		CC1	0	2	2	50.00
51.00		CB2	0	0	0	51.00
52.00		CB1	0	0	0	52.00
53.00		CA2	0	3	3	53.00
54.00		CA1	0	4	4	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	0	0	0	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: 14-0137 | Period: From 01/01/2017 To 06/30/2017 | Worksheet S-7 | Date/Time Prepared: 11/22/2017 4:46 pm

		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	0	0	0	70.00
71.00		PD2	0	0	0	71.00
72.00		PD1	0	0	0	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	0	1	1	76.00
77.00		PA2	0	0	0	77.00
78.00		PA1	0	2	2	78.00
199.00		AAA	0	0	0	199.00
200.00	TOTAL		0	322	322	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).	41180	41180	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	0	0.00		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)	0			207.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 14-0137 | Component CCN: 14-3491 | Period: From 01/01/2017 To 06/30/2017 | Worksheet S-8 | Date/Time Prepared: 11/22/2017 4:46 pm

			RHC I	Cost
			1.00	
	Clinic Address and Identification			
1.00	Street		150 HEALTHCARE DRIVE	1.00
		City	State	ZIP Code
		1.00	2.00	3.00
2.00	City, State, ZIP Code, County	GREENVILLE	IL	62246 2.00
				1.00
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban			0 3.00

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

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

		Sunday		Monday		Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
	Facility hours of operations (1)						
11.00	Clinic			08:00	17:00	08:00	11.00

		1.00	2.00
12.00	Have you received an approval for an exception to the productivity standard?	N	12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.	Y	5 13.00

		Provider name	CCN number
		1.00	2.00
14.00	RHC/FQHC name, CCN number	GREENVILLE FAMILY WELLNESS	143491 14.00
14.01		MCCRACKEN DAWDY HALL FAMILY PRACTICE	148519 14.01
14.02		MCCRACKEN DAWDY HALL FAMILY PRACTICE	148520 14.02
14.03		GREENVILLE MEDICAL ASSOCIATES	148513 14.03
14.04		CONVENIENT CARE	148545 14.04

		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

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 14-0137 | Component CCN: 14-3491 | Period: From 01/01/2017 To 06/30/2017 | Worksheet S-8 | Date/Time Prepared: 11/22/2017 4:46 pm

RHC I | Cost

			County				
			4.00				
2.00	City, State, ZIP Code, County		BOND				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	08:00	17:00	11.00
		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	Clinic	08:00	17:00	08:00	12:00		11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 14-0137 | Period: From 01/01/2017 To 06/30/2017 | Worksheet S-10 | Date/Time Prepared: 11/22/2017 4:46 pm

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.388507	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	690,593	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH or supplemental payments from Medicaid?	N	4.00
5.00	If line 4 is no, then enter DSH or supplemental payments from Medicaid	1,995,928	5.00
6.00	Medicaid charges	5,819,880	6.00
7.00	Medicaid cost (line 1 times line 6)	2,261,064	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)	0	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)	0	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
	Uncompensated Care (see instructions for each line)				
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	184,179	201,856	386,035	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	71,555	201,856	273,411	21.00
22.00	Payments received from patients for amounts previously written off as charity care	405	1,733	2,138	22.00
23.00	Cost of charity care (line 21 minus line 22)	71,150	200,123	271,273	23.00

		1.00	
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	431,284	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	75,115	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	115,560	27.01
28.00	Non-Medicare bad debt expense (line 26 minus line 27.01)	315,724	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	163,106	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	434,379	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	434,379	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-0137 | Period: From 01/01/2017 To 06/30/2017 | Worksheet A | Date/Time Prepared: 11/22/2017 4:46 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		393,162	393,162	-173,488	219,674	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		308,663	308,663	251,053	559,716	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	83,172	1,417,881	1,501,053	0	1,501,053	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	691,410	1,821,352	2,512,762	-226,053	2,286,709	5.00
6.00	00600	MAINTENANCE & REPAIRS	142,445	409,078	551,523	0	551,523	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	46,424	46,424	0	46,424	8.00
9.00	00900	HOUSEKEEPING	191,306	35,157	226,463	0	226,463	9.00
10.00	01000	DIETARY	209,048	117,846	326,894	-218,843	108,051	10.00
11.00	01100	CAFETERIA	0	0	0	218,843	218,843	11.00
13.00	01300	NURSING ADMINISTRATION	351,822	76,925	428,747	0	428,747	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	51,597	26,719	78,316	0	78,316	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	113,206	66,528	179,734	0	179,734	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	270,603	270,603	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	689,815	717,290	1,407,105	-293,267	1,113,838	30.00
40.00	04000	SUBPROVIDER - IPF	440,734	96,979	537,713	0	537,713	40.00
43.00	04300	NURSERY	0	0	0	248,936	248,936	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	362,126	270,078	632,204	13,100	645,304	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	62	62	44,331	44,393	52.00
53.00	05300	ANESTHESIOLOGY	207,737	75,966	283,703	-283,703	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	301,720	282,173	583,893	0	583,893	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	295,682	353,426	649,108	0	649,108	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	149,314	11,835	161,149	-40,182	120,967	65.00
66.00	06600	PHYSICAL THERAPY	0	597,961	597,961	-166,950	431,011	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	123,844	123,844	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	43,106	43,106	68.00
69.00	06900	ELECTROCARDIOLOGY	0	24,128	24,128	40,182	64,310	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	132,388	132,388	0	132,388	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	35,320	35,320	0	35,320	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	287,065	414,445	701,510	0	701,510	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
75.01	07501	SNR DAY TREATMENT- WHITE OAKS	57,197	15,540	72,737	0	72,737	75.01
76.97	07697	CARDIAC REHABILITATION	-203	700	497	0	497	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	66,537	1,284,442	1,350,979	226,053	1,577,032	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	391,863	441,696	833,559	0	833,559	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	297,255	51,317	348,572	0	348,572	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		77,565	77,565	-77,565	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	5,380,848	9,603,046	14,983,894	0	14,983,894	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	83,623	138,089	221,712	0	221,712	192.00
193.00	19300	NONPAID WORKERS	-552	5,824	5,272	0	5,272	193.00
194.00	07950	EMERALD POINT	43,489	95,578	139,067	0	139,067	194.00
194.01	07951	CONVENIENT CARE PRE-RHC	0	0	0	0	0	194.01
200.00		TOTAL (SUM OF LINES 118-199)	5,507,408	9,842,537	15,349,945	0	15,349,945	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-0137 | Period: From 01/01/2017 To 06/30/2017 | Worksheet A | Date/Time Prepared: 11/22/2017 4:46 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	333,382	553,056		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-6,034	553,682		2.00
3.00	00300	OTHER CAP REL COSTS	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-249,447	1,251,606		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-1,121,835	1,164,874		5.00
6.00	00600	MAINTENANCE & REPAIRS	-6,677	544,846		6.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	46,424		8.00
9.00	00900	HOUSEKEEPING	0	226,463		9.00
10.00	01000	DIETARY	-605	107,446		10.00
11.00	01100	CAFETERIA	-65,274	153,569		11.00
13.00	01300	NURSING ADMINISTRATION	-140	428,607		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	-412	77,904		14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-1,593	178,141		16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	-270,603	0		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-370,936	742,902		30.00
40.00	04000	SUBPROVIDER - IPF	-83,789	453,924		40.00
43.00	04300	NURSERY	0	248,936		43.00
44.00	04400	SKILLED NURSING FACILITY	0	0		44.00
45.00	04500	NURSING FACILITY	0	0		45.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	645,304		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	44,393		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-3,993	579,900		54.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MRI	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	-17,584	631,524		60.00
60.01	06001	BLOOD LABORATORY	0	0		60.01
65.00	06500	RESPIRATORY THERAPY	0	120,967		65.00
66.00	06600	PHYSICAL THERAPY	0	431,011		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	123,844		67.00
68.00	06800	SPEECH PATHOLOGY	0	43,106		68.00
69.00	06900	ELECTROCARDIOLOGY	-18,603	45,707		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	-1,342	131,046		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	35,320		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-1,648	699,862		73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0		75.00
75.01	07501	SNR DAY TREATMENT- WHITE OAKS	-1	72,736		75.01
76.97	07697	CARDIAC REHABILITATION	0	497		76.97
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	132,801	1,709,833		88.00
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	-469,246	364,313		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT				92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	-29,156	319,416		95.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-2,252,735	12,731,159		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	0		190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	75,725	297,437		192.00
193.00	19300	NONPAID WORKERS	0	5,272		193.00
194.00	07950	EMERALD POINT	101,130	240,197		194.00
194.01	07951	CONVENIENT CARE PRE-RHC	0	0		194.01
200.00		TOTAL (SUM OF LINES 118-199)	-2,075,880	13,274,065		200.00

RECLASSIFICATIONS | Provider CCN: 14-0137 | Period: From 01/01/2017 To 06/30/2017 | Worksheet A-6 | Date/Time Prepared: 11/22/2017 4:46 pm

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - CRNA FEES				
1.00	NONPHYSICIAN ANESTHETISTS	19.00	207,737	62,866	1.00
2.00	OPERATING ROOM	50.00	0	13,100	2.00
	0		207,737	75,966	
	B - CAFETERIA EXPENSE				
1.00	CAFETERIA	11.00	140,182	78,661	1.00
	0		140,182	78,661	
	C - DEPRECIATION EXPENSE				
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	246,215	1.00
	0		0	246,215	
	D - EKG SALARIES				
1.00	ELECTROCARDIOLOGY	69.00	40,182	0	1.00
	0		40,182	0	
	E - OB EXPENSE				
1.00	NURSERY	43.00	133,579	115,357	1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	23,788	20,543	2.00
	0		157,367	135,900	
	F - CONTRACT THERAPY EXPENSE				
1.00	OCCUPATIONAL THERAPY	67.00	0	123,844	1.00
2.00	SPEECH PATHOLOGY	68.00	0	43,106	2.00
	0		0	166,950	
	G - PROPERTY INSURANCE				
1.00		0.00	0	0	1.00
	0		0	0	
	H - INTEREST EXPENSE				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	72,727	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	4,838	2.00
	0		0	77,565	
	I - TO RECLASSIFY ALLOWABLE PORTION OF M				
1.00	RURAL HEALTH CLINIC	88.00	0	226,053	1.00
	0		0	226,053	
500.00	Grand Total: Increases		545,468	1,007,310	500.00

RECLASSIFICATIONS | Provider CCN: 14-0137 | Period: From 01/01/2017 To 06/30/2017 | Worksheet A-6 | Date/Time Prepared: 11/22/2017 4:46 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - CRNA FEES						
1.00	ANESTHESIOLOGY	53.00	207,737	75,966	0		1.00
2.00		0.00	0	0	0		2.00
	0		207,737	75,966			
	B - CAFETERIA EXPENSE						
1.00	DIETARY	10.00	140,182	78,661	0		1.00
	0		140,182	78,661			
	C - DEPRECIATION EXPENSE						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	246,215	9		1.00
	0		0	246,215			
	D - EKG SALARIES						
1.00	RESPIRATORY THERAPY	65.00	40,182	0	0		1.00
	0		40,182	0			
	E - OB EXPENSE						
1.00	ADULTS & PEDIATRICS	30.00	157,367	135,900	0		1.00
2.00		0.00	0	0	0		2.00
	0		157,367	135,900			
	F - CONTRACT THERAPY EXPENSE						
1.00	PHYSICAL THERAPY	66.00	0	166,950	0		1.00
2.00		0.00	0	0	0		2.00
	0		0	166,950			
	G - PROPERTY INSURANCE						
1.00		0.00	0	0	0		1.00
	0		0	0			
	H - INTEREST EXPENSE						
1.00	INTEREST EXPENSE	113.00	0	77,565	11		1.00
2.00		0.00	0	0	11		2.00
	0		0	77,565			
	I - TO RECLASSIFY ALLOWABLE PORTION OF M						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	226,053	0		1.00
	0		0	226,053			
500.00	Grand Total: Decreases		545,468	1,007,310			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-0137 | Period: From 01/01/2017 To 06/30/2017 | Worksheet A-7 Part I | Date/Time Prepared: 11/22/2017 4:46 pm

		Beginning Balances	Acquisitions: Purchases	Acquisitions: Donation	Acquisitions: 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	1,540,441	0	0	0	0	1.00
2.00	Land Improvements	400,000	6,675	0	6,675	0	2.00
3.00	Buildings and Fixtures	6,194,481	75,058	0	75,058	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	1,326,167	0	0	0	353,951	6.00
7.00	HIT designated Assets	407,937	407,937	0	407,937	0	7.00
8.00	Subtotal (sum of lines 1-7)	9,869,026	489,670	0	489,670	353,951	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	9,869,026	489,670	0	489,670	353,951	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	1,540,441	0	1.00
2.00	Land Improvements	406,675	0	2.00
3.00	Buildings and Fixtures	6,269,539	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	972,216	0	6.00
7.00	HIT designated Assets	815,874	0	7.00
8.00	Subtotal (sum of lines 1-7)	10,004,745	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	10,004,745	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-0137 | Period: From 01/01/2017 To 06/30/2017 | Worksheet A-7 Part II | Date/Time Prepared: 11/22/2017 4:46 pm

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	366,986	20,226	0	0	5,950	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	308,663	0	0	0	2.00
3.00	Total (sum of lines 1-2)	366,986	328,889	0	0	5,950	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	393,162	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	308,663	2.00
3.00	Total (sum of lines 1-2)	0	701,825	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-0137 | Period: From 01/01/2017 To 06/30/2017 | Worksheet A-7 Part III Date/Time Prepared: 11/22/2017 4:46 pm

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	COMPUTATION OF RATIOS: Capitalized Leases	COMPUTATION OF RATIOS: Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	ALLOCATION OF OTHER CAPITAL: 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	8,216,655	0	8,216,655	0.821276	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	1,788,090	0	1,788,090	0.178724	0	2.00
3.00	Total (sum of lines 1-2)	10,004,745	0	10,004,745	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	ALLOCATION OF OTHER CAPITAL: Other Capital-Related Costs	ALLOCATION OF OTHER CAPITAL: Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	SUMMARY OF CAPITAL: 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	517,967	20,226	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	243,540	308,663	2.00
3.00	Total (sum of lines 1-2)	0	0	0	761,507	328,889	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	SUMMARY OF CAPITAL: Insurance (see instructions)	SUMMARY OF CAPITAL: Taxes (see instructions)	SUMMARY OF CAPITAL: Other Capital-Related Costs (see instructions)	SUMMARY OF CAPITAL: 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	8,913	0	5,950	0	553,056	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	1,479	0	0	0	553,682	2.00
3.00	Total (sum of lines 1-2)	10,392	0	5,950	0	1,106,738	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-0137 | Period: From 01/01/2017 To 06/30/2017 | Worksheet A-8 | Date/Time Prepared: 11/22/2017 4:46 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-63,814	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)	B	-3,359	CAP REL COSTS-MVBLE EQUIP	2.00	11	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-1,020	ADMINISTRATIVE & GENERAL	5.00	0	7.00
8.00	Television and radio service (chapter 21)	B	-6,677	MAINTENANCE & REPAIRS	6.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-971,402			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	-181,840			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-65,274	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	B	-4	DRUGS CHARGED TO PATIENTS	73.00	0	17.00
18.00	Sale of medical records and abstracts	B	-1,593	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines	B	-490	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
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist	A	-270,603	NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-0137 | Period: From 01/01/2017 To 06/30/2017 | Worksheet A-8 | Date/Time Prepared: 11/22/2017 4:46 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	COUNTRY CLUB DUES	A	-200	ADMINISTRATIVE & GENERAL	5.00	0	33.00
33.01	CRNA RELATED BENEFITS	A	-10,328	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.01
33.02	LOBBYING EXPENSE	A	-5,478	ADMINISTRATIVE & GENERAL	5.00	0	33.02
33.03	ADVERTISING OFFSET	A	-20,513	ADMINISTRATIVE & GENERAL	5.00	0	33.03
33.04	MARKETING OUTREACH EXPENSE	A	-7,163	ADMINISTRATIVE & GENERAL	5.00	0	33.04
33.05	AMBULANCE REIMBURSEMENT	B	-29,101	AMBULANCE SERVICES	95.00	0	33.05
33.06	EDUCATION SEMINARS	B	-140	NURSING ADMINISTRATION	13.00	0	33.06
33.07	MARKETING OUTREACH EXPENSE	A	-55	AMBULANCE SERVICES	95.00	0	33.07
33.08			0		0.00	0	33.08
33.09	PROVIDER TAX	A	-512,231	ADMINISTRATIVE & GENERAL	5.00	0	33.09
33.10			0		0.00	0	33.10
33.11			0		0.00	0	33.11
33.12	MISC REVENUE	B	-160,529	ADMINISTRATIVE & GENERAL	5.00	0	33.12
33.13	SELF INSURANCE ADJUSTMENT	A	-239,119	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.13
33.14	RENT	B	-3,750	RADIOLOGY-DIAGNOSTIC	54.00	0	33.14
33.15			0		0.00	0	33.15
33.16			0		0.00	0	33.16
33.17	TELEPHONE SERVICE	A	-2,675	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.17
33.18	TELEPHONE SERVICE	A	-1,254	ADMINISTRATIVE & GENERAL	5.00	0	33.18
33.19	TELEPHONE SERVICE	A	-228	CAP REL COSTS-BLDG & FIXT	1.00	9	33.19
33.20	CATERING REVENUE	B	-115	DIETARY	10.00	0	33.20
33.21			0		0.00	0	33.21
33.22	MISC SUPPLY REVENUE	B	-1,644	DRUGS CHARGED TO PATIENTS	73.00	0	33.22
33.23	MISC SUPPLY REVENUE	B	-1,342	MEDICAL SUPPLIES CHARGED TO PAT	71.00	0	33.23
33.24	MANAGEMENT FEES	A	-53,919	ADMINISTRATIVE & GENERAL	5.00	0	33.24
33.25	REVALUED ASSETS DEPRECIATION	A	364,468	CAP REL COSTS-BLDG & FIXT	1.00	9	33.25
33.26	REVALUED ASSETS DEPRECIATION	A	75,725	PHYSICIANS PRIVATE OFFICES	192.00	0	33.26
33.27	REVALUED ASSETS DEPRECIATION	A	101,130	EMERALD POINT	194.00	0	33.27
33.28			0		0.00	0	33.28
33.29	LATE FEES	A	-412	CENTRAL SERVICES & SUPPLY	14.00	0	33.29
33.30			0		0.00	0	33.30
33.31	ALCHOLIC BEVERAGES	A	-460	ADMINISTRATIVE & GENERAL	5.00	0	33.31
33.32	FOOD COSTS FOR ADMINISTRATION	A	-471	ADMINISTRATIVE & GENERAL	5.00	0	33.32
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-2,075,880				50.00

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 14-0137 | Period: From 01/01/2017 To 06/30/2017 | Worksheet A-8-1 | Date/Time Prepared: 11/22/2017 4:46 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	1.00	CAP REL COSTS-BLDG & FIXT	GFW RHC LEASE EXPENSE	5,000	-7,500	1.00
2.00	1.00	CAP REL COSTS-BLDG & FIXT	GMA RHC LEASE EXPENSE	7,500	0	2.00
3.00	1.00	CAP REL COSTS-BLDG & FIXT	MDH RHC LEASE EXPENSE	10,000	0	3.00
4.00	1.00	CAP REL COSTS-BLDG & FIXT	MDH POKEY RHC LEASE EXPENSE	2,956	0	4.00
4.01	5.00	ADMINISTRATIVE & GENERAL	IT CONTRACT SERVICES ISC	360,437	708,034	4.01
4.02	88.00	RURAL HEALTH CLINIC	MGMT FEE	132,801	0	4.02
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			518,694	700,534	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		
	Symbol (1)	Name	Percentage of Ownership	Name	Percentage of Ownership	
	1.00	2.00	3.00	4.00	5.00	
	B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:					

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

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

6.00	B	GREENVILLE REGI	100.00		0.00	6.00
7.00			0.00		0.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	Provider CCN: 14-0137	Period: From 01/01/2017 To 06/30/2017	Worksheet A-8-1 Date/Time Prepared: 11/22/2017 4:46 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	12,500	9		1.00
2.00	7,500	9		2.00
3.00	10,000	9		3.00
4.00	2,956	9		4.00
4.01	-347,597	0		4.01
4.02	132,801	0		4.02
5.00	-181,840			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			6.00
7.00			7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 14-0137 | Period: From 01/01/2017 To 06/30/2017 | Worksheet A-8-2 | Date/Time Prepared: 11/22/2017 4:46 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	54.00	RADIOLOGY-DIAGNOSTIC	243	243	0	0	0	1.00
2.00	69.00	ELECTROCARDIOLOGY	18,603	18,603	0	0	0	2.00
3.00	91.00	EMERGENCY	469,246	469,246	0	0	0	3.00
4.00	60.00	LABORATORY	17,584	17,584	0	0	0	4.00
5.00	40.00	SUBPROVIDER - IPF	105,805	83,789	22,016	181,300	253	5.00
6.00	5.00	ADMINISTRATIVE & GENERAL	11,000	11,000	0	0	0	6.00
7.00	30.00	ADULTS & PEDIATRICS	370,936	370,936	0	0	0	7.00
8.00	75.01	SNR DAY TREATMENT- WHITE OAKS	6,000	0	6,000	211,500	59	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			999,417	971,401	28,016		312	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	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	1.00
2.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	2.00
3.00	91.00	EMERGENCY	0	0	0	0	0	3.00
4.00	60.00	LABORATORY	0	0	0	0	0	4.00
5.00	40.00	SUBPROVIDER - IPF	22,052	1,103	0	0	0	5.00
6.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	0	0	6.00
7.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	7.00
8.00	75.01	SNR DAY TREATMENT- WHITE OAKS	5,999	300	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			28,051	1,403	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	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	243		1.00
2.00	69.00	ELECTROCARDIOLOGY	0	0	0	18,603		2.00
3.00	91.00	EMERGENCY	0	0	0	469,246		3.00
4.00	60.00	LABORATORY	0	0	0	17,584		4.00
5.00	40.00	SUBPROVIDER - IPF	0	22,052	0	83,789		5.00
6.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	11,000		6.00
7.00	30.00	ADULTS & PEDIATRICS	0	0	0	370,936		7.00
8.00	75.01	SNR DAY TREATMENT- WHITE OAKS	0	5,999	1	1		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	28,051	1	971,402		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0137 | Period: From 01/01/2017 To 06/30/2017 | Worksheet B Part I Date/Time Prepared: 11/22/2017 4:46 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	553,056	553,056				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	553,682		553,682			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,251,606	1,140	1,141	1,253,887		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,164,874	138,559	138,714	165,956	1,608,103	5.00
6.00	00600	MAINTENANCE & REPAIRS	544,846	44,905	44,956	34,241	668,948	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	46,424	7,831	7,840	0	62,095	8.00
9.00	00900	HOUSEKEEPING	226,463	7,265	7,274	45,987	286,989	9.00
10.00	01000	DIETARY	107,446	13,670	13,685	50,251	185,052	10.00
11.00	01100	CAFETERIA	153,569	3,806	3,811	33,697	194,883	11.00
13.00	01300	NURSING ADMINISTRATION	428,607	8,187	8,196	50,874	495,864	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	77,904	25,303	25,332	12,403	140,942	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	178,141	11,682	11,695	27,213	228,731	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	742,902	38,723	38,767	127,991	948,383	30.00
40.00	04000	SUBPROVIDER - IPF	453,924	18,127	18,148	105,945	596,144	40.00
43.00	04300	NURSERY	248,936	966	967	32,110	282,979	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	645,304	34,270	34,309	87,049	800,932	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	44,393	4,089	4,094	5,718	58,294	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	579,900	23,643	23,669	72,528	699,740	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	631,524	10,256	10,267	71,077	723,124	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	120,967	6,393	6,400	26,233	159,993	65.00
66.00	06600	PHYSICAL THERAPY	431,011	18,281	18,301	0	467,593	66.00
67.00	06700	OCCUPATIONAL THERAPY	123,844	5,217	5,223	0	134,284	67.00
68.00	06800	SPEECH PATHOLOGY	43,106	1,814	1,816	0	46,736	68.00
69.00	06900	ELECTROCARDIOLOGY	45,707	517	518	9,659	56,401	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	131,046	0	0	0	131,046	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	35,320	0	0	0	35,320	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	699,862	6,639	6,647	69,005	782,153	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
75.01	07501	SNR DAY TREATMENT- WHITE OAKS	72,736	8,154	8,164	13,749	102,803	75.01
76.97	07697	CARDIAC REHABILITATION	497	1,600	1,602	0	3,699	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,709,833	75,955	76,041	15,994	1,877,823	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	364,313	9,229	9,240	94,197	476,979	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	319,416	8,344	8,354	71,455	407,569	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	12,731,159	534,565	535,171	1,223,332	12,663,602	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	297,437	16,252	16,270	20,101	350,060	192.00
193.00	19300	NONPAID WORKERS	5,272	2,239	2,241	0	9,752	193.00
194.00	07950	EMERALD POINT	240,197	0	0	10,454	250,651	194.00
194.01	07951	CONVENIENT CARE PRE-RHC	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	13,274,065	553,056	553,682	1,253,887	13,274,065	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0137 | Period: From 01/01/2017 To 06/30/2017 | Worksheet B Part I | Date/Time Prepared: 11/22/2017 4:46 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	6.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,608,103					5.00
6.00	00600	MAINTENANCE & REPAIRS	92,212	761,160				6.00
8.00	00800	LAUNDRY & LINEN SERVICE	8,560	16,178	86,833			8.00
9.00	00900	HOUSEKEEPING	39,560	15,009	494	342,052		9.00
10.00	01000	DIETARY	25,509	28,240	0	13,233	252,034	10.00
11.00	01100	CAFETERIA	26,864	7,863	0	3,685	0	11.00
13.00	01300	NURSING ADMINISTRATION	68,353	16,912	0	7,925	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	19,428	52,273	22	24,494	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	31,530	24,133	0	11,308	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	130,731	79,995	27,177	37,484	105,357	30.00
40.00	04000	SUBPROVIDER - IPF	82,176	37,447	17,961	17,547	35,789	40.00
43.00	04300	NURSERY	39,008	1,995	0	935	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	110,405	70,796	14,909	33,174	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	8,036	8,448	0	3,958	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	96,456	48,842	0	22,886	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	99,680	21,186	0	9,927	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	22,054	13,206	2,471	6,188	0	65.00
66.00	06600	PHYSICAL THERAPY	64,456	37,765	0	17,696	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	18,511	10,777	0	5,050	0	67.00
68.00	06800	SPEECH PATHOLOGY	6,442	3,748	0	1,756	0	68.00
69.00	06900	ELECTROCARDIOLOGY	7,775	1,068	0	501	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	18,064	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	4,869	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	107,817	13,715	0	6,427	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
75.01	07501	SNR DAY TREATMENT- WHITE OAKS	14,171	16,845	0	7,893	0	75.01
76.97	07697	CARDIAC REHABILITATION	510	3,306	6,081	1,549	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	258,845	156,910	803	73,526	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	65,750	19,066	13,479	8,934	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	56,182	17,238	3,003	8,077	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,523,954	722,961	86,400	324,153	141,146	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	48,254	33,574	427	15,732	0	192.00
193.00	19300	NONPAID WORKERS	1,344	4,625	0	2,167	0	193.00
194.00	07950	EMERALD POINT	34,551	0	6	0	110,888	194.00
194.01	07951	CONVENIENT CARE PRE-RHC	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	1,608,103	761,160	86,833	342,052	252,034	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0137 | Period: From 01/01/2017 To 06/30/2017 | Worksheet B Part I Date/Time Prepared: 11/22/2017 4:46 pm

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	MEDICAL RECORDS & LIBRARY	NONPHYSICIAN ANESTHETISTS	
			11.00	13.00	14.00	16.00	19.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	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	233,295					11.00
13.00	01300	NURSING ADMINISTRATION	17,650	606,704				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	4,207	0	241,366			14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	9,035	0	251	304,988		16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	37,277	113,449	6,767	13,839	0	30.00
40.00	04000	SUBPROVIDER - IPF	24,363	74,147	1,663	8,449	0	40.00
43.00	04300	NURSERY	7,615	23,174	1,227	1,183	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	19,442	59,171	34,696	23,188	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,357	4,129	225	1,971	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	17,112	52,080	17,003	81,119	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	20,168	61,379	84,964	52,786	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	7,308	22,241	2,315	6,493	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	288	25,968	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	3,456	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	1,071	0	68.00
69.00	06900	ELECTROCARDIOLOGY	2,796	8,510	0	5,917	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	45,610	6,021	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	12,168	1,481	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	8,759	26,658	0	32,269	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
75.01	07501	SNR DAY TREATMENT- WHITE OAKS	4,792	14,584	135	1,859	0	75.01
76.97	07697	CARDIAC REHABILITATION	460	1,399	121	622	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	3,052	0	15,612	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	40,036	121,845	5,800	25,803	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	5,894	11,493	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	225,429	582,766	234,739	304,988	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	4,290	13,056	230	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	403	0	0	193.00
194.00	07950	EMERALD POINT	3,576	10,882	5,994	0	0	194.00
194.01	07951	CONVENIENT CARE PRE-RHC	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	233,295	606,704	241,366	304,988	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0137 | Period: From 01/01/2017 To 06/30/2017 | Worksheet B Part I | Date/Time Prepared: 11/22/2017 4:46 pm

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
6.00	00600	MAINTENANCE & REPAIRS					6.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS					19.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	1,500,459	0	1,500,459		30.00
40.00	04000	SUBPROVIDER - IPF	895,686	0	895,686		40.00
43.00	04300	NURSERY	358,116	0	358,116		43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0		44.00
45.00	04500	NURSING FACILITY	0	0	0		45.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	1,166,713	0	1,166,713		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	86,418	0	86,418		52.00
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,035,238	0	1,035,238		54.00
57.00	05700	CT SCAN	0	0	0		57.00
58.00	05800	MRI	0	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0		59.00
60.00	06000	LABORATORY	1,073,214	0	1,073,214		60.00
60.01	06001	BLOOD LABORATORY	0	0	0		60.01
65.00	06500	RESPIRATORY THERAPY	242,269	0	242,269		65.00
66.00	06600	PHYSICAL THERAPY	613,766	0	613,766		66.00
67.00	06700	OCCUPATIONAL THERAPY	172,078	0	172,078		67.00
68.00	06800	SPEECH PATHOLOGY	59,753	0	59,753		68.00
69.00	06900	ELECTROCARDIOLOGY	82,968	0	82,968		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	200,741	0	200,741		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	53,838	0	53,838		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	977,798	0	977,798		73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0		75.00
75.01	07501	SNR DAY TREATMENT- WHITE OAKS	163,082	0	163,082		75.01
76.97	07697	CARDIAC REHABILITATION	17,747	0	17,747		76.97
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	2,386,571	0	2,386,571		88.00
90.00	09000	CLINIC	0	0	0		90.00
91.00	09100	EMERGENCY	777,692	0	777,692		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT		0			92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	509,456	0	509,456		95.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	12,373,603	0	12,373,603		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	0	0		190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	465,623	0	465,623		192.00
193.00	19300	NONPAID WORKERS	18,291	0	18,291		193.00
194.00	07950	EMERALD POINT	416,548	0	416,548		194.00
194.01	07951	CONVENIENT CARE PRE-RHC	0	0	0		194.01
200.00		Cross Foot Adjustments	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0		201.00
202.00		TOTAL (sum lines 118-201)	13,274,065	0	13,274,065		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0137 | Period: From 01/01/2017 To 06/30/2017 | Worksheet B Part II | Date/Time Prepared: 11/22/2017 4:46 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	1,140	1,141	2,281	2,281	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	20,382	138,559	138,714	297,655	304	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	44,905	44,956	89,861	62	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	7,831	7,840	15,671	0	8.00
9.00	00900	HOUSEKEEPING	0	7,265	7,274	14,539	84	9.00
10.00	01000	DIETARY	0	13,670	13,685	27,355	91	10.00
11.00	01100	CAFETERIA	0	3,806	3,811	7,617	61	11.00
13.00	01300	NURSING ADMINISTRATION	0	8,187	8,196	16,383	92	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	25,303	25,332	50,635	23	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	11,682	11,695	23,377	49	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	38,723	38,767	77,490	233	30.00
40.00	04000	SUBPROVIDER - IPF	0	18,127	18,148	36,275	193	40.00
43.00	04300	NURSERY	0	966	967	1,933	58	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	34,270	34,309	68,579	158	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	4,089	4,094	8,183	10	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	23,643	23,669	47,312	132	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	10,256	10,267	20,523	129	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	6,393	6,400	12,793	48	65.00
66.00	06600	PHYSICAL THERAPY	0	18,281	18,301	36,582	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	5,217	5,223	10,440	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	1,814	1,816	3,630	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	517	518	1,035	18	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	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	6,639	6,647	13,286	125	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
75.01	07501	SNR DAY TREATMENT- WHITE OAKS	0	8,154	8,164	16,318	25	75.01
76.97	07697	CARDIAC REHABILITATION	0	1,600	1,602	3,202	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	75,955	76,041	151,996	29	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	9,229	9,240	18,469	171	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	8,344	8,354	16,698	130	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	20,382	534,565	535,171	1,090,118	2,225	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	16,252	16,270	32,522	37	192.00
193.00	19300	NONPAID WORKERS	0	2,239	2,241	4,480	0	193.00
194.00	07950	EMERALD POINT	38,900	0	0	38,900	19	194.00
194.01	07951	CONVENIENT CARE PRE-RHC	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	59,282	553,056	553,682	1,166,020	2,281	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0137 | Period: From 01/01/2017 To 06/30/2017 | Worksheet B Part II | Date/Time Prepared: 11/22/2017 4:46 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	6.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	297,959					5.00
6.00	00600	MAINTENANCE & REPAIRS	17,086	107,009				6.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,586	2,274	19,531			8.00
9.00	00900	HOUSEKEEPING	7,330	2,110	111	24,174		9.00
10.00	01000	DIETARY	4,726	3,970	0	935	37,077	10.00
11.00	01100	CAFETERIA	4,978	1,105	0	260	0	11.00
13.00	01300	NURSING ADMINISTRATION	12,665	2,378	0	560	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3,600	7,349	5	1,731	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	5,842	3,393	0	799	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	24,223	11,246	6,112	2,649	15,499	30.00
40.00	04000	SUBPROVIDER - IPF	15,226	5,265	4,040	1,240	5,265	40.00
43.00	04300	NURSERY	7,228	280	0	66	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	20,457	9,953	3,353	2,345	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,489	1,188	0	280	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	17,872	6,867	0	1,617	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	18,469	2,979	0	702	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	4,086	1,857	556	437	0	65.00
66.00	06600	PHYSICAL THERAPY	11,943	5,309	0	1,251	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	3,430	1,515	0	357	0	67.00
68.00	06800	SPEECH PATHOLOGY	1,194	527	0	124	0	68.00
69.00	06900	ELECTROCARDIOLOGY	1,441	150	0	35	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	3,347	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	902	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	19,977	1,928	0	454	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
75.01	07501	SNR DAY TREATMENT- WHITE OAKS	2,626	2,368	0	558	0	75.01
76.97	07697	CARDIAC REHABILITATION	94	465	1,368	109	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	47,957	22,060	181	5,198	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	12,183	2,680	3,032	631	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	10,410	2,423	676	571	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	282,367	101,639	19,434	22,909	20,764	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	8,941	4,720	96	1,112	0	192.00
193.00	19300	NONPAID WORKERS	249	650	0	153	0	193.00
194.00	07950	EMERALD POINT	6,402	0	1	0	16,313	194.00
194.01	07951	CONVENIENT CARE PRE-RHC	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	297,959	107,009	19,531	24,174	37,077	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0137 | Period: From 01/01/2017 To 06/30/2017 | Worksheet B Part II Date/Time Prepared: 11/22/2017 4:46 pm

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATIO N	CENTRAL SERVICES & SUPPLY	MEDICAL RECORDS & LIBRARY	NONPHYSICIAN ANESTHETISTS	
			11.00	13.00	14.00	16.00	19.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	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	14,021					11.00
13.00	01300	NURSING ADMINISTRATION	1,061	33,139				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	253	0	63,596			14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	543	0	66	34,069		16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,240	6,197	1,783	1,546		30.00
40.00	04000	SUBPROVIDER - IPF	1,464	4,050	438	944		40.00
43.00	04300	NURSERY	458	1,266	323	132		43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0		44.00
45.00	04500	NURSING FACILITY	0	0	0	0		45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,168	3,232	9,142	2,591		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	82	226	59	220		52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,028	2,845	4,480	9,056		54.00
57.00	05700	CT SCAN	0	0	0	0		57.00
58.00	05800	MRI	0	0	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0		59.00
60.00	06000	LABORATORY	1,212	3,353	22,388	5,898		60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0		60.01
65.00	06500	RESPIRATORY THERAPY	439	1,215	610	725		65.00
66.00	06600	PHYSICAL THERAPY	0	0	76	2,901		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	386		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	120		68.00
69.00	06900	ELECTROCARDIOLOGY	168	465	0	661		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	12,018	673		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	3,206	166		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	526	1,456	0	3,605		73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0		75.00
75.01	07501	SNR DAY TREATMENT- WHITE OAKS	288	797	35	208		75.01
76.97	07697	CARDIAC REHABILITATION	28	76	32	70		76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	183	0	4,113	0		88.00
90.00	09000	CLINIC	0	0	0	0		90.00
91.00	09100	EMERGENCY	2,407	6,654	1,528	2,883		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	1,553	1,284		95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	13,548	31,832	61,850	34,069	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	0	0	0		190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	258	713	61	0		192.00
193.00	19300	NONPAID WORKERS	0	0	106	0		193.00
194.00	07950	EMERALD POINT	215	594	1,579	0		194.00
194.01	07951	CONVENIENT CARE PRE-RHC	0	0	0	0		194.01
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	14,021	33,139	63,596	34,069	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0137 | Period: From 01/01/2017 To 06/30/2017 | Worksheet B Part II | Date/Time Prepared: 11/22/2017 4:46 pm

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
6.00	00600	MAINTENANCE & REPAIRS					6.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS					19.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	149,218	0	149,218		30.00
40.00	04000	SUBPROVIDER - IPF	74,400	0	74,400		40.00
43.00	04300	NURSERY	11,744	0	11,744		43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0		44.00
45.00	04500	NURSING FACILITY	0	0	0		45.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	120,978	0	120,978		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	11,737	0	11,737		52.00
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	91,209	0	91,209		54.00
57.00	05700	CT SCAN	0	0	0		57.00
58.00	05800	MRI	0	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0		59.00
60.00	06000	LABORATORY	75,653	0	75,653		60.00
60.01	06001	BLOOD LABORATORY	0	0	0		60.01
65.00	06500	RESPIRATORY THERAPY	22,766	0	22,766		65.00
66.00	06600	PHYSICAL THERAPY	58,062	0	58,062		66.00
67.00	06700	OCCUPATIONAL THERAPY	16,128	0	16,128		67.00
68.00	06800	SPEECH PATHOLOGY	5,595	0	5,595		68.00
69.00	06900	ELECTROCARDIOLOGY	3,973	0	3,973		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	16,038	0	16,038		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	4,274	0	4,274		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	41,357	0	41,357		73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0		75.00
75.01	07501	SNR DAY TREATMENT- WHITE OAKS	23,223	0	23,223		75.01
76.97	07697	CARDIAC REHABILITATION	5,444	0	5,444		76.97
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	231,717	0	231,717		88.00
90.00	09000	CLINIC	0	0	0		90.00
91.00	09100	EMERGENCY	50,638	0	50,638		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT		0			92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	33,745	0	33,745		95.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,047,899	0	1,047,899		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	0	0		190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	48,460	0	48,460		192.00
193.00	19300	NONPAID WORKERS	5,638	0	5,638		193.00
194.00	07950	EMERALD POINT	64,023	0	64,023		194.00
194.01	07951	CONVENIENT CARE PRE-RHC	0	0	0		194.01
200.00		Cross Foot Adjustments	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0		201.00
202.00		TOTAL (sum lines 118-201)	1,166,020	0	1,166,020		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0137 | Period: From 01/01/2017 To 06/30/2017 | Worksheet B-1 | Date/Time Prepared: 11/22/2017 4:46 pm

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIE)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	136,868					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		136,868				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	282	282	5,216,234			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	34,290	34,290	690,390	-1,608,103	11,665,962	5.00
6.00	00600	MAINTENANCE & REPAIRS	11,113	11,113	142,445	0	668,948	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,938	1,938	0	0	62,095	8.00
9.00	00900	HOUSEKEEPING	1,798	1,798	191,306	0	286,989	9.00
10.00	01000	DIETARY	3,383	3,383	209,048	0	185,052	10.00
11.00	01100	CAFETERIA	942	942	140,182	0	194,883	11.00
13.00	01300	NURSING ADMINISTRATION	2,026	2,026	211,640	0	495,864	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	6,262	6,262	51,597	0	140,942	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,891	2,891	113,206	0	228,731	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	9,583	9,583	532,448	0	948,383	30.00
40.00	04000	SUBPROVIDER - IPF	4,486	4,486	440,734	0	596,144	40.00
43.00	04300	NURSERY	239	239	133,579	0	282,979	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	8,481	8,481	362,126	0	800,932	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,012	1,012	23,788	0	58,294	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,851	5,851	301,720	0	699,740	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	2,538	2,538	295,682	0	723,124	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	1,582	1,582	109,132	0	159,993	65.00
66.00	06600	PHYSICAL THERAPY	4,524	4,524	0	0	467,593	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,291	1,291	0	0	134,284	67.00
68.00	06800	SPEECH PATHOLOGY	449	449	0	0	46,736	68.00
69.00	06900	ELECTROCARDIOLOGY	128	128	40,182	0	56,401	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	0	131,046	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	35,320	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,643	1,643	287,065	0	782,153	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
75.01	07501	SNR DAY TREATMENT- WHITE OAKS	2,018	2,018	57,197	0	102,803	75.01
76.97	07697	CARDIAC REHABILITATION	396	396	0	0	3,699	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	18,797	18,797	66,537	0	1,877,823	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	2,284	2,284	391,863	0	476,979	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	2,065	2,065	297,255	0	407,569	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	132,292	132,292	5,089,122	-1,608,103	11,055,499	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	4,022	4,022	83,623	0	350,060	192.00
193.00	19300	NONPAID WORKERS	554	554	0	0	9,752	193.00
194.00	07950	EMERALD POINT	0	0	43,489	0	250,651	194.00
194.01	07951	CONVENIENT CARE PRE-RHC	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	553,056	553,682	1,253,887		1,608,103	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	4.040798	4.045372	0.240382		0.137846	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			2,281		297,959	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000437		0.025541	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0137 | Period: From 01/01/2017 To 06/30/2017 | Worksheet B-1 | Date/Time Prepared: 11/22/2017 4:46 pm

		Cost Center Description	MAINTENANCE & REPAIRS (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (HOURS OF SERVICE)	
			6.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS	91,183					6.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,938	105,790				8.00
9.00	00900	HOUSEKEEPING	1,798	602	87,447			9.00
10.00	01000	DIETARY	3,383	0	3,383	17,683		10.00
11.00	01100	CAFETERIA	942	0	942	0	143,080	11.00
13.00	01300	NURSING ADMINISTRATION	2,026	0	2,026	0	10,825	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	6,262	27	6,262	0	2,580	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,891	0	2,891	0	5,541	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	9,583	33,109	9,583	7,392	22,862	30.00
40.00	04000	SUBPROVIDER - IPF	4,486	21,882	4,486	2,511	14,942	40.00
43.00	04300	NURSERY	239	0	239	0	4,670	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	8,481	18,164	8,481	0	11,924	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,012	0	1,012	0	832	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,851	0	5,851	0	10,495	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	2,538	0	2,538	0	12,369	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	1,582	3,011	1,582	0	4,482	65.00
66.00	06600	PHYSICAL THERAPY	4,524	0	4,524	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,291	0	1,291	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	449	0	449	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	128	0	128	0	1,715	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	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	1,643	0	1,643	0	5,372	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
75.01	07501	SNR DAY TREATMENT- WHITE OAKS	2,018	0	2,018	0	2,939	75.01
76.97	07697	CARDIAC REHABILITATION	396	7,409	396	0	282	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	18,797	978	18,797	0	1,872	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	2,284	16,422	2,284	0	24,554	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	2,065	3,659	2,065	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	86,607	105,263	82,871	9,903	138,256	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	4,022	520	4,022	0	2,631	192.00
193.00	19300	NONPAID WORKERS	554	0	554	0	0	193.00
194.00	07950	EMERALD POINT	0	7	0	7,780	2,193	194.00
194.01	07951	CONVENIENT CARE PRE-RHC	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	761,160	86,833	342,052	252,034	233,295	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	8.347609	0.820805	3.911535	14.252898	1.630521	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	107,009	19,531	24,174	37,077	14,021	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	1.173563	0.184620	0.276442	2.096760	0.097994	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0137 | Period: From 01/01/2017 To 06/30/2017 | Worksheet B-1 | Date/Time Prepared: 11/22/2017 4:46 pm

		Cost Center Description	NURSING ADMINISTRATION (DIRECT NRSING)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS REVENUE)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)		
			13.00	14.00	16.00	19.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	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	122,262					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	700,592				14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	730	30,754,099			16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	22,862	19,643	1,395,487	0		30.00
40.00	04000	SUBPROVIDER - IPF	14,942	4,828	851,935	0		40.00
43.00	04300	NURSERY	4,670	3,561	119,293	0		43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0		44.00
45.00	04500	NURSING FACILITY	0	0	0	0		45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	11,924	100,710	2,338,242	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	832	652	198,766	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	10,495	49,352	8,179,633	0		54.00
57.00	05700	CT SCAN	0	0	0	0		57.00
58.00	05800	MRI	0	0	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0		59.00
60.00	06000	LABORATORY	12,369	246,614	5,322,822	0		60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0		60.01
65.00	06500	RESPIRATORY THERAPY	4,482	6,720	654,750	0		65.00
66.00	06600	PHYSICAL THERAPY	0	836	2,618,533	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	348,447	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	108,014	0		68.00
69.00	06900	ELECTROCARDIOLOGY	1,715	0	596,675	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	132,388	607,167	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	35,320	149,387	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,372	0	3,253,898	0		73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0		75.00
75.01	07501	SNR DAY TREATMENT- WHITE OAKS	2,939	391	187,479	0		75.01
76.97	07697	CARDIAC REHABILITATION	282	351	62,757	0		76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	45,315	0	0		88.00
90.00	09000	CLINIC	0	0	0	0		90.00
91.00	09100	EMERGENCY	24,554	16,836	2,601,931	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	17,109	1,158,883	0		95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	117,438	681,356	30,754,099	0		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	0	0	0		190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	2,631	668	0	0		192.00
193.00	19300	NONPAID WORKERS	0	1,170	0	0		193.00
194.00	07950	EMERALD POINT	2,193	17,398	0	0		194.00
194.01	07951	CONVENIENT CARE PRE-RHC	0	0	0	0		194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	606,704	241,366	304,988	0		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	4.962327	0.344517	0.009917	0.000000		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	33,139	63,596	34,069	0		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.271049	0.090775	0.001108	0.000000		205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0137 | Period: From 01/01/2017 To 06/30/2017 | Worksheet C Part I Date/Time Prepared: 11/22/2017 4:46 pm

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		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	1,500,459		1,500,459	0	1,500,459	30.00
40.00	04000	SUBPROVIDER - IPF	895,686		895,686	0	895,686	40.00
43.00	04300	NURSERY	358,116		358,116	0	358,116	43.00
44.00	04400	SKILLED NURSING FACILITY	0		0	0	0	44.00
45.00	04500	NURSING FACILITY	0		0	0	0	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,166,713		1,166,713	0	1,166,713	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	86,418		86,418	0	86,418	52.00
53.00	05300	ANESTHESIOLOGY	0		0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,035,238		1,035,238	0	1,035,238	54.00
57.00	05700	CT SCAN	0		0	0	0	57.00
58.00	05800	MRI	0		0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0		0	0	0	59.00
60.00	06000	LABORATORY	1,073,214		1,073,214	0	1,073,214	60.00
60.01	06001	BLOOD LABORATORY	0		0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	242,269	0	242,269	0	242,269	65.00
66.00	06600	PHYSICAL THERAPY	613,766	0	613,766	0	613,766	66.00
67.00	06700	OCCUPATIONAL THERAPY	172,078	0	172,078	0	172,078	67.00
68.00	06800	SPEECH PATHOLOGY	59,753	0	59,753	0	59,753	68.00
69.00	06900	ELECTROCARDIOLOGY	82,968		82,968	0	82,968	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	200,741		200,741	0	200,741	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	53,838		53,838	0	53,838	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	977,798		977,798	0	977,798	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0		0	0	0	75.00
75.01	07501	SNR DAY TREATMENT- WHITE OAKS	163,082		163,082	1	163,083	75.01
76.97	07697	CARDIAC REHABILITATION	17,747		17,747	0	17,747	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	2,386,571		2,386,571	0	2,386,571	88.00
90.00	09000	CLINIC	0		0	0	0	90.00
91.00	09100	EMERGENCY	777,692		777,692	0	777,692	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	111,639		111,639		111,639	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	509,456		509,456	0	509,456	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	12,485,242	0	12,485,242	1	12,485,243	200.00
201.00		Less Observation Beds	111,639		111,639		111,639	201.00
202.00		Total (see instructions)	12,373,603	0	12,373,603	1	12,373,604	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0137 | Period: From 01/01/2017 To 06/30/2017 | Worksheet C Part I Date/Time Prepared: 11/22/2017 4:46 pm

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		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,332,998		1,332,998			30.00
40.00	04000	SUBPROVIDER - IPF	813,741		813,741			40.00
43.00	04300	NURSERY	113,945		113,945			43.00
44.00	04400	SKILLED NURSING FACILITY	0		0			44.00
45.00	04500	NURSING FACILITY	0		0			45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	193,145	2,145,097	2,338,242	0.498970	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	134,837	63,929	198,766	0.434773	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	358,151	7,821,482	8,179,633	0.126563	0.000000	54.00
57.00	05700	CT SCAN	0	0	0	0.000000	0.000000	57.00
58.00	05800	MRI	0	0	0	0.000000	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	0.000000	59.00
60.00	06000	LABORATORY	880,220	4,442,602	5,322,822	0.201625	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	0.000000	60.01
65.00	06500	RESPIRATORY THERAPY	262,905	391,845	654,750	0.370018	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	188,480	2,430,053	2,618,533	0.234393	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	142,005	206,442	348,447	0.493843	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	44,557	63,457	108,014	0.553197	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	60,155	536,520	596,675	0.139051	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	199,858	407,309	607,167	0.330619	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,170	148,217	149,387	0.360393	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	887,129	2,366,768	3,253,897	0.300501	0.000000	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0.000000	0.000000	75.00
75.01	07501	SNR DAY TREATMENT- WHITE OAKS	0	187,479	187,479	0.869868	0.000000	75.01
76.97	07697	CARDIAC REHABILITATION	0	62,757	62,757	0.282789	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	1,094,950	1,094,950			88.00
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
91.00	09100	EMERGENCY	297,810	2,304,121	2,601,931	0.298890	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	17,898	88,208	106,106	1.052146	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	136,548	1,022,335	1,158,883	0.439610	0.000000	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	6,065,552	25,783,571	31,849,123			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	6,065,552	25,783,571	31,849,123			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0137 | Period: From 01/01/2017 To 06/30/2017 | Worksheet C Part I Date/Time Prepared: 11/22/2017 4:46 pm

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		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
40.00	04000	SUBPROVIDER - IPF			40.00
43.00	04300	NURSERY			43.00
44.00	04400	SKILLED NURSING FACILITY			44.00
45.00	04500	NURSING FACILITY			45.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.498970		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.434773		52.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.126563		54.00
57.00	05700	CT SCAN	0.000000		57.00
58.00	05800	MRI	0.000000		58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000		59.00
60.00	06000	LABORATORY	0.201625		60.00
60.01	06001	BLOOD LABORATORY	0.000000		60.01
65.00	06500	RESPIRATORY THERAPY	0.370018		65.00
66.00	06600	PHYSICAL THERAPY	0.234393		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.493843		67.00
68.00	06800	SPEECH PATHOLOGY	0.553197		68.00
69.00	06900	ELECTROCARDIOLOGY	0.139051		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0.330619		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.360393		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.300501		73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000		75.00
75.01	07501	SNR DAY TREATMENT- WHITE OAKS	0.869873		75.01
76.97	07697	CARDIAC REHABILITATION	0.282789		76.97
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC			88.00
90.00	09000	CLINIC	0.000000		90.00
91.00	09100	EMERGENCY	0.298890		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	1.052146		92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0.439610		95.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 14-0137 | Period: From 01/01/2017 To 06/30/2017 | Worksheet D Part I Date/Time Prepared: 11/22/2017 4:46 pm

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	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	149,218	8,915	140,303	1,150	122.00	30.00
40.00	SUBPROVIDER - IPF	74,400	0	74,400	837	88.89	40.00
43.00	NURSERY	11,744		11,744	146	80.44	43.00
44.00	SKILLED NURSING FACILITY	0		0	0	0.00	44.00
45.00	NURSING FACILITY	0		0	0	0.00	45.00
200.00	Total (lines 30-199)	235,362		226,447	2,133		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	404	49,288				30.00
40.00	SUBPROVIDER - IPF	648	57,601				40.00
43.00	NURSERY	0	0				43.00
44.00	SKILLED NURSING FACILITY	0	0				44.00
45.00	NURSING FACILITY	0	0				45.00
200.00	Total (lines 30-199)	1,052	106,889				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 14-0137 | Period: From 01/01/2017 To 06/30/2017 | Worksheet D Part II Date/Time Prepared: 11/22/2017 4:46 pm

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		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	120,978	2,338,242	0.051739	25,932	1,342	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	11,737	198,766	0.059049	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	91,209	8,179,633	0.011151	239,298	2,668	54.00
57.00	05700	CT SCAN	0	0	0.000000	0	0	57.00
58.00	05800	MRI	0	0	0.000000	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	06000	LABORATORY	75,653	5,322,822	0.014213	406,864	5,783	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	22,766	654,750	0.034771	134,698	4,684	65.00
66.00	06600	PHYSICAL THERAPY	58,062	2,618,533	0.022173	42,962	953	66.00
67.00	06700	OCCUPATIONAL THERAPY	16,128	348,447	0.046285	14,212	658	67.00
68.00	06800	SPEECH PATHOLOGY	5,595	108,014	0.051799	9,097	471	68.00
69.00	06900	ELECTROCARDIOLOGY	3,973	596,675	0.006659	44,906	299	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	16,038	607,167	0.026414	71,036	1,876	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	4,274	149,387	0.028610	1,170	33	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	41,357	3,253,897	0.012710	295,289	3,753	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0.000000	0	0	75.00
75.01	07501	SNR DAY TREATMENT- WHITE OAKS	23,223	187,479	0.123870	0	0	75.01
76.97	07697	CARDIAC REHABILITATION	5,444	62,757	0.086747	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	231,717	1,094,950	0.211623	0	0	88.00
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
91.00	09100	EMERGENCY	50,638	2,601,931	0.019462	187,960	3,658	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	11,102	106,106	0.104631	10,156	1,063	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	789,894	28,429,556		1,483,580	27,241	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 14-0137 | Period: From 01/01/2017 To 06/30/2017 | Worksheet D Part III Date/Time Prepared: 11/22/2017 4:46 pm

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		Cost Center Description	Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
43.00	04300	NURSERY	0	0	0		0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0			0	44.00
45.00	04500	NURSING FACILITY	0	0			0	45.00
200.00		Total (lines 30-199)	0	0	0		0	200.00

		Cost Center Description	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)		
			6.00	7.00	8.00	9.00		
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,150	0.00	404	0		30.00
40.00	04000	SUBPROVIDER - IPF	837	0.00	648	0		40.00
43.00	04300	NURSERY	146	0.00	0	0		43.00
44.00	04400	SKILLED NURSING FACILITY	0	0.00	0	0		44.00
45.00	04500	NURSING FACILITY	0	0.00	0	0		45.00
200.00		Total (lines 30-199)	2,133		1,052	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0137 | Period: From 01/01/2017 To 06/30/2017 | Worksheet D Part IV | Date/Time Prepared: 11/22/2017 4:46 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	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
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
75.01	07501	SNR DAY TREATMENT- WHITE OAKS	0	0	0	0	0	75.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0137 | Period: From 01/01/2017 To 06/30/2017 | Worksheet D Part IV | Date/Time Prepared: 11/22/2017 4:46 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	2,338,242	0.000000	0.000000	25,932	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	198,766	0.000000	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	8,179,633	0.000000	0.000000	239,298	54.00
57.00	05700	CT SCAN	0	0	0.000000	0.000000	0	57.00
58.00	05800	MRI	0	0	0.000000	0.000000	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0.000000	0	59.00
60.00	06000	LABORATORY	0	5,322,822	0.000000	0.000000	406,864	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0.000000	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	654,750	0.000000	0.000000	134,698	65.00
66.00	06600	PHYSICAL THERAPY	0	2,618,533	0.000000	0.000000	42,962	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	348,447	0.000000	0.000000	14,212	67.00
68.00	06800	SPEECH PATHOLOGY	0	108,014	0.000000	0.000000	9,097	68.00
69.00	06900	ELECTROCARDIOLOGY	0	596,675	0.000000	0.000000	44,906	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	607,167	0.000000	0.000000	71,036	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	149,387	0.000000	0.000000	1,170	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,253,897	0.000000	0.000000	295,289	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0.000000	0.000000	0	75.00
75.01	07501	SNR DAY TREATMENT- WHITE OAKS	0	187,479	0.000000	0.000000	0	75.01
76.97	07697	CARDIAC REHABILITATION	0	62,757	0.000000	0.000000	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	1,094,950	0.000000	0.000000	0	88.00
90.00	09000	CLINIC	0	0	0.000000	0.000000	0	90.00
91.00	09100	EMERGENCY	0	2,601,931	0.000000	0.000000	187,960	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0	106,106	0.000000	0.000000	10,156	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	28,429,556			1,483,580	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0137 | Period: From 01/01/2017 To 06/30/2017 | Worksheet D Part IV Date/Time Prepared: 11/22/2017 4:46 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	813,313	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,775,158	0		54.00
57.00	05700	CT SCAN	0	0	0		57.00
58.00	05800	MRI	0	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0		59.00
60.00	06000	LABORATORY	0	694,948	0		60.00
60.01	06001	BLOOD LABORATORY	0	0	0		60.01
65.00	06500	RESPIRATORY THERAPY	0	67,485	0		65.00
66.00	06600	PHYSICAL THERAPY	0	7,949	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	1,068	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	228,976	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	113,690	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	59,182	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,043,253	0		73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0		75.00
75.01	07501	SNR DAY TREATMENT- WHITE OAKS	0	171,761	0		75.01
76.97	07697	CARDIAC REHABILITATION	0	31,464	0		76.97
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	0		88.00
90.00	09000	CLINIC	0	0	0		90.00
91.00	09100	EMERGENCY	0	626,839	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0	58,769	0		92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES					95.00
200.00		Total (lines 50-199)	0	6,693,855	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-0137 | Period: From 01/01/2017 To 06/30/2017 | Worksheet D Part V Date/Time Prepared: 11/22/2017 4:46 pm

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	0.498970	813,313	0	0	405,819	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.434773	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.126563	2,775,158	0	0	351,232	54.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MRI	0.000000	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY	0.201625	694,948	0	0	140,119	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0.370018	67,485	0	0	24,971	65.00
66.00	06600	PHYSICAL THERAPY	0.234393	7,949	0	0	1,863	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.493843	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.553197	1,068	0	0	591	68.00
69.00	06900	ELECTROCARDIOLOGY	0.139051	228,976	0	0	31,839	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0.330619	113,690	0	0	37,588	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.360393	59,182	0	0	21,329	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.300501	1,043,253	0	9,241	313,499	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	0	0	0	75.00
75.01	07501	SNR DAY TREATMENT- WHITE OAKS	0.869868	171,761	0	0	149,409	75.01
76.97	07697	CARDIAC REHABILITATION	0.282789	31,464	0	0	8,898	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.298890	626,839	0	0	187,356	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	1.052146	58,769	0	0	61,834	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.439610		0			95.00
200.00		Subtotal (see instructions)		6,693,855	0	9,241	1,736,347	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		6,693,855	0	9,241	1,736,347	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-0137 | Period: From 01/01/2017 To 06/30/2017 | Worksheet D Part V Date/Time Prepared: 11/22/2017 4:46 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MRI	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	0	0		60.00
60.01	06001	BLOOD LABORATORY	0	0		60.01
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,777		73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0		75.00
75.01	07501	SNR DAY TREATMENT- WHITE OAKS	0	0		75.01
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0	0		92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	0	2,777		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	0	2,777		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0137 | Component CCN: 14-S137 | Period: From 01/01/2017 To 06/30/2017 | Worksheet D Part II | Date/Time Prepared: 11/22/2017 4:46 pm

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	120,978	2,338,242	0.051739	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	11,737	198,766	0.059049	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	91,209	8,179,633	0.011151	25,744	287	54.00
57.00	05700	CT SCAN	0	0	0.000000	0	0	57.00
58.00	05800	MRI	0	0	0.000000	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	06000	LABORATORY	75,653	5,322,822	0.014213	116,991	1,663	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	22,766	654,750	0.034771	757	26	65.00
66.00	06600	PHYSICAL THERAPY	58,062	2,618,533	0.022173	20,723	459	66.00
67.00	06700	OCCUPATIONAL THERAPY	16,128	348,447	0.046285	2,826	131	67.00
68.00	06800	SPEECH PATHOLOGY	5,595	108,014	0.051799	3,317	172	68.00
69.00	06900	ELECTROCARDIOLOGY	3,973	596,675	0.006659	13,000	87	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	16,038	607,167	0.026414	1,838	49	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	4,274	149,387	0.028610	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	41,357	3,253,897	0.012710	171,244	2,177	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0.000000	0	0	75.00
75.01	07501	SNR DAY TREATMENT- WHITE OAKS	23,223	187,479	0.123870	0	0	75.01
76.97	07697	CARDIAC REHABILITATION	5,444	62,757	0.086747	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	231,717	1,094,950	0.211623	0	0	88.00
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
91.00	09100	EMERGENCY	50,638	2,601,931	0.019462	32,814	639	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0	106,106	0.000000	1,758	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	778,792	28,429,556		391,012	5,690	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0137 | Component CCN: 14-S137 | Period: From 01/01/2017 To 06/30/2017 | Worksheet D Part IV | Date/Time Prepared: 11/22/2017 4:46 pm

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	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
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
75.01	07501	SNR DAY TREATMENT- WHITE OAKS	0	0	0	0	0	75.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0137 | Component CCN: 14-S137 | Period: From 01/01/2017 To 06/30/2017 | Worksheet D Part IV | Date/Time Prepared: 11/22/2017 4:46 pm

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	2,338,242	0.000000	0.000000	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	198,766	0.000000	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	8,179,633	0.000000	0.000000	25,744	54.00
57.00	05700	CT SCAN	0	0	0.000000	0.000000	0	57.00
58.00	05800	MRI	0	0	0.000000	0.000000	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0.000000	0	59.00
60.00	06000	LABORATORY	0	5,322,822	0.000000	0.000000	116,991	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0.000000	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	654,750	0.000000	0.000000	757	65.00
66.00	06600	PHYSICAL THERAPY	0	2,618,533	0.000000	0.000000	20,723	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	348,447	0.000000	0.000000	2,826	67.00
68.00	06800	SPEECH PATHOLOGY	0	108,014	0.000000	0.000000	3,317	68.00
69.00	06900	ELECTROCARDIOLOGY	0	596,675	0.000000	0.000000	13,000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	607,167	0.000000	0.000000	1,838	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	149,387	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,253,897	0.000000	0.000000	171,244	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0.000000	0.000000	0	75.00
75.01	07501	SNR DAY TREATMENT- WHITE OAKS	0	187,479	0.000000	0.000000	0	75.01
76.97	07697	CARDIAC REHABILITATION	0	62,757	0.000000	0.000000	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	1,094,950	0.000000	0.000000	0	88.00
90.00	09000	CLINIC	0	0	0.000000	0.000000	0	90.00
91.00	09100	EMERGENCY	0	2,601,931	0.000000	0.000000	32,814	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0	106,106	0.000000	0.000000	1,758	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	28,429,556			391,012	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0137 | Component CCN: 14-S137 | Period: From 01/01/2017 To 06/30/2017 | Worksheet D Part IV | Date/Time Prepared: 11/22/2017 4:46 pm

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
57.00	05700	CT SCAN	0	0	0		57.00
58.00	05800	MRI	0	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0		59.00
60.00	06000	LABORATORY	0	0	0		60.00
60.01	06001	BLOOD LABORATORY	0	0	0		60.01
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0		75.00
75.01	07501	SNR DAY TREATMENT- WHITE OAKS	0	0	0		75.01
76.97	07697	CARDIAC REHABILITATION	0	0	0		76.97
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	0		88.00
90.00	09000	CLINIC	0	0	0		90.00
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0	0	0		92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES					95.00
200.00		Total (lines 50-199)	0	0	0		200.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-0137 | Period: From 01/01/2017 To 06/30/2017 | Worksheet D-1 | Date/Time Prepared: 11/22/2017 4:46 pm

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)	1,597	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,150	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	1,059	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	322	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	125	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)	404	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)	322	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	218.85	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	153.39	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)	1,500,459	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)	70,470	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)	19,174	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)	89,644	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	1,410,815	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	1,410,815	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,226.80	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	495,627	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)	495,627	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-0137 | Period: From 01/01/2017 To 06/30/2017 | Worksheet D-1 | Date/Time Prepared: 11/22/2017 4:46 pm

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						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)	382,972	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	878,599	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)	49,288	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	27,241	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	76,529	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	802,070	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)	70,470	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)	70,470	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)	91	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,226.80	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	111,639	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-0137 | Period: From 01/01/2017 To 06/30/2017 | Worksheet D-1 | Date/Time Prepared: 11/22/2017 4:46 pm

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	149,218	1,500,459	0.099448	111,639	11,102	90.00
91.00	Nursing School cost	0	1,500,459	0.000000	111,639	0	91.00
92.00	Allied health cost	0	1,500,459	0.000000	111,639	0	92.00
93.00	All other Medical Education	0	1,500,459	0.000000	111,639	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 14-0137 Component CCN: 14-S137	Period: From 01/01/2017 To 06/30/2017	Worksheet D-1 Date/Time Prepared: 11/22/2017 4:46 pm
	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)	837	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	837	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)	837	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)	648	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)	895,686	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)	895,686	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)	895,686	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)	1,070.11	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	693,431	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)	693,431	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0137 | Component CCN: 14-S137 | Period: From 01/01/2017 To 06/30/2017 | Worksheet D-1 | Date/Time Prepared: 11/22/2017 4:46 pm

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						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)	100,747	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	794,178	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)	57,601	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	5,690	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	63,291	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	730,887	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: 14-0137 | Component CCN: 14-S137 | Period: From 01/01/2017 To 06/30/2017 | Worksheet D-1 | Date/Time Prepared: 11/22/2017 4:46 pm

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	74,400	895,686	0.083065	0	0	90.00
91.00	Nursing School cost	0	895,686	0.000000	0	0	91.00
92.00	Allied health cost	0	895,686	0.000000	0	0	92.00
93.00	All other Medical Education	0	895,686	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 14-0137 | Period: From 01/01/2017 To 06/30/2017 | Worksheet D-3 | Date/Time Prepared: 11/22/2017 4:46 pm

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		381,175		30.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.498970	25,932	12,939	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.434773	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.126563	239,298	30,286	54.00
57.00	05700	CT SCAN	0.000000	0	0	57.00
58.00	05800	MRI	0.000000	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	06000	LABORATORY	0.201625	406,864	82,034	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0.370018	134,698	49,841	65.00
66.00	06600	PHYSICAL THERAPY	0.234393	42,962	10,070	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.493843	14,212	7,018	67.00
68.00	06800	SPEECH PATHOLOGY	0.553197	9,097	5,032	68.00
69.00	06900	ELECTROCARDIOLOGY	0.139051	44,906	6,244	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0.330619	71,036	23,486	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.360393	1,170	422	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.300501	295,289	88,735	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	0	75.00
75.01	07501	SNR DAY TREATMENT- WHITE OAKS	0.869873	0	0	75.01
76.97	07697	CARDIAC REHABILITATION	0.282789	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000	CLINIC	0.000000	0	0	90.00
91.00	09100	EMERGENCY	0.298890	187,960	56,179	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	1.052146	10,156	10,686	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		1,483,580	382,972	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		1,483,580		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 14-0137 | Period: From 01/01/2017 To 06/30/2017 | Worksheet D-3

Component CCN: 14-S137 | Date/Time Prepared: 11/22/2017 4:46 pm

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
40.00	04000	SUBPROVIDER - IPF		623,268		40.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.498970	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.434773	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.126563	25,744	3,258	54.00
57.00	05700	CT SCAN	0.000000	0	0	57.00
58.00	05800	MRI	0.000000	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	06000	LABORATORY	0.201625	116,991	23,588	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0.370018	757	280	65.00
66.00	06600	PHYSICAL THERAPY	0.234393	20,723	4,857	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.493843	2,826	1,396	67.00
68.00	06800	SPEECH PATHOLOGY	0.553197	3,317	1,835	68.00
69.00	06900	ELECTROCARDIOLOGY	0.139051	13,000	1,808	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0.330619	1,838	608	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.360393	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.300501	171,244	51,459	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	0	75.00
75.01	07501	SNR DAY TREATMENT- WHITE OAKS	0.869873	0	0	75.01
76.97	07697	CARDIAC REHABILITATION	0.282789	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000	CLINIC	0.000000	0	0	90.00
91.00	09100	EMERGENCY	0.298890	32,814	9,808	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	1.052146	1,758	1,850	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		391,012	100,747	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)		391,012		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 14-0137 | Component CCN: 14-U137 | Period: From 01/01/2017 To 06/30/2017 | Worksheet D-3 | Date/Time Prepared: 11/22/2017 4:46 pm

Title XVIII | Swing Beds - SNF | 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
40.00	04000	SUBPROVIDER - IPF		0		40.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.498970	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.434773	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.126563	12,777	1,617	54.00
57.00	05700	CT SCAN	0.000000	0	0	57.00
58.00	05800	MRI	0.000000	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	06000	LABORATORY	0.201625	61,586	12,417	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0.370018	83,440	30,874	65.00
66.00	06600	PHYSICAL THERAPY	0.234393	77,386	18,139	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.493843	86,007	42,474	67.00
68.00	06800	SPEECH PATHOLOGY	0.553197	15,487	8,567	68.00
69.00	06900	ELECTROCARDIOLOGY	0.139051	2,249	313	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0.330619	31,741	10,494	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.360393	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.300501	124,008	37,265	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	0	75.00
75.01	07501	SNR DAY TREATMENT- WHITE OAKS	0.869868	0	0	75.01
76.97	07697	CARDIAC REHABILITATION	0.282789	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000	CLINIC	0.000000	0	0	90.00
91.00	09100	EMERGENCY	0.298890	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	1.052146	169	178	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		494,850	162,338	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)		494,850		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0137	Period: From 01/01/2017 To 06/30/2017	Worksheet E Part A Date/Time Prepared: 11/22/2017 4:46 pm
	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)	865,818	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	0	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)	0	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	10,567	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)	29.03	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)	0.00	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 Section 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 section 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 section 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)	0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records	0.00	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)	0.00	12.00
13.00	Total allowable FTE count for the prior year.	0.00	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.	0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.	0.00	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	0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).	0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)	0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)	0.000000	21.00
22.00	IME payment adjustment (see instructions)	0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)	0	22.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA		
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 (f)(1)(iv)(C).	0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)	0.00	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)	0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)	0	29.01
	Disproportionate Share Adjustment		
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	4.32	30.00
31.00	Percentage of Medicaid patient days (see instructions)	44.03	31.00
32.00	Sum of lines 30 and 31	48.35	32.00
33.00	Allowable disproportionate share percentage (see instructions)	35.00	33.00
34.00	Disproportionate share adjustment (see instructions)	75,759	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0137	Period: From 01/01/2017 To 06/30/2017	Worksheet E Part A Date/Time Prepared: 11/22/2017 4:46 pm
	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	0	35.00
35.01	Factor 3 (see instructions)	0.000000000	0.000000000	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	175,086	0	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	86,823	0	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	86,823		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
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0		41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	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		45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)	0		46.00
47.00	Subtotal (see instructions)	1,028,400		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)	0		48.00

		Amount	
		1.00	
49.00	Total payment for inpatient operating costs (see instructions)	1,028,400	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)	69,552	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).	0	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).	0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)	0	58.00
59.00	Total (sum of amounts on lines 49 through 58)	1,097,952	59.00
60.00	Primary payer payments	0	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)	1,097,952	61.00
62.00	Deductibles billed to program beneficiaries	130,284	62.00
63.00	Coinsurance billed to program beneficiaries	1,316	63.00
64.00	Allowable bad debts (see instructions)	53,040	64.00
65.00	Adjusted reimbursable bad debts (see instructions)	34,476	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	53,040	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	1,000,828	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 DEMONSTRATION PROJECT	0	70.50
70.88	SCH or MDH volume decrease adjustment	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)	-1,693	70.93
70.94	HRR adjustment amount (see instructions)	0	70.94
70.95	Recovery of accelerated depreciation	0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0137	Period: From 01/01/2017 To 06/30/2017	Worksheet E Part A Date/Time Prepared: 11/22/2017 4:46 pm
	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)	2017	241,353	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)		13,376	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		1,227,112	71.00
71.01	Sequestration adjustment (see instructions)		24,542	71.01
72.00	Interim payments		1,121,450	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, 72, and 73)		81,120	74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	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	0	100.00
	HVBP Adjustment for HSP Bonus Payment			
101.00	HVBP adjustment factor (see instructions)	0.0000000000	0.0000000000	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)	0	0	102.00
	HRR Adjustment for HSP Bonus Payment			
103.00	HRR adjustment factor (see instructions)	0.0000	0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)	0	0	104.00

LOW VOLUME CALCULATION EXHIBIT 4 | Provider CCN: 14-0137 | Period: From 01/01/2017 To 06/30/2017 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 11/22/2017 4:46 pm

Title XVIII | Hospital | PPS

		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	865,818	0	865,818		865,818	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	0	0		0	0	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00	0	0	0	0	0	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0	2.01
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	10,567	0	10,567	0	10,567	4.00
	Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	0	6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	0	9.01
	Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.3500	0.3500	0.3500	0.3500		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	75,759	0	75,759	0	75,759	11.00
11.01	Uncompensated care payments	36.00	86,823	0	86,823	0	86,823	11.01
	Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	1,028,400	0	1,028,400	0	1,028,400	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	1,028,400	0	1,028,400	0	1,028,400	15.00
16.00	Payment for inpatient program capital	50.00	69,552	0	69,552	0	69,552	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	0	17.00
17.01	Net organ aquisition cost							17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0	17.02

LOW VOLUME CALCULATION EXHIBIT 4 | Provider CCN: 14-0137 | Period: From 01/01/2017 To 06/30/2017 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 11/22/2017 4:46 pm

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		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0	18.00
19.00	SUBTOTAL			0	1,097,952	0	1,097,952	19.00
		W/S L, line	(Amounts from L)					
		0	1.00	2.00	3.00	4.00	5.00	
20.00	Capital DRG other than outlier	1.00	69,552	0	69,552	0	69,552	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	0	0	0	0	0	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	69,552	0	69,552	0	69,552	26.00
		W/S E, Part A line	(Amounts to E, Part A)					
		0	1.00	2.00	3.00	4.00	5.00	
27.00	Low volume adjustment factor				0.219821	0.000000		27.00
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			241,353		241,353	28.00
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				0	0	29.00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 | Provider CCN: 14-0137 | Period: From 01/01/2017 To 06/30/2017 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 11/22/2017 4:46 pm

Title XVIII | Hospital | PPS

		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	1.00	2.00	3.00	4.00	
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	865,818	865,818		865,818	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	0		0	0	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00	0	0	0	0	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	2.01
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	10,567	10,567	0	10,567	4.00
	Indirect Medical Education Adjustment						
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA						
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	9.01
	Disproportionate Share Adjustment						
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.3500	0.3500	0.3500		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	75,759	75,759	0	75,759	11.00
11.01	Uncompensated care payments	36.00	86,823	86,823	0	86,823	11.01
	Additional payment for high percentage of ESRD beneficiary discharges						
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	1,028,400	1,028,400	0	1,028,400	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	1,028,400	1,028,400	0	1,028,400	15.00
16.00	Payment for inpatient program capital	50.00	69,552	69,552	0	69,552	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	17.00
17.01	Net organ acquisition cost						17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	18.00
19.00	SUBTOTAL			1,097,952	0	1,097,952	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 | Provider CCN: 14-0137 | Period: From 01/01/2017 To 06/30/2017 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 11/22/2017 4:46 pm

Title XVIII | Hospital | PPS

		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	69,552	69,552	0	69,552	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	0	0	0	0	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	69,552	69,552	0	69,552	26.00
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
		0	1.00	2.00	3.00	4.00	
27.00							27.00
28.00	Low volume adjustment prior to October 1	70.96	241,353	241,353		241,353	28.00
29.00	Low volume adjustment on or after October 1	70.97	0		0	0	29.00
30.00	HVBP payment adjustment (see instructions)	70.93	-1,693	-1,693	0	-1,693	30.00
30.01	HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	0	0	0	0	30.01
31.00	HRR adjustment (see instructions)	70.94	0	0	0	0	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	0	0	0	0	31.01
						(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3.00	4.00	
32.00	HAC Reduction Program adjustment (see instructions)	70.99		13,376	0	13,376	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		Y				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0137	Period: From 01/01/2017 To 06/30/2017	Worksheet E Part B Date/Time Prepared: 11/22/2017 4:46 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	2,777	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	1,736,347	2.00
3.00	PPS payments	1,237,220	3.00
4.00	Outlier payment (see instructions)	0	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	2,777	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	9,241	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)	9,241	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)	9,241	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	6,464	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)	2,777	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)	1,237,220	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)	250,419	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)	989,578	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)	989,578	30.00
31.00	Primary payer payments	0	31.00
32.00	Subtotal (line 30 minus line 31)	989,578	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)	42,410	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	27,567	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	42,410	36.00
37.00	Subtotal (see instructions)	1,017,145	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	39.50
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	1,017,145	40.00
40.01	Sequestration adjustment (see instructions)	20,343	40.01
41.00	Interim payments	1,002,452	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	-5,650	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED | Provider CCN: 14-0137 | Period: From 01/01/2017 To 06/30/2017 | Worksheet E-1 Part I | Date/Time Prepared: 11/22/2017 4:46 pm

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		1,121,450		1,002,452	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)		1,121,450		1,002,452	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		81,120		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		5,650	6.02
7.00	Total Medicare program liability (see instructions)		1,202,570		996,802	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: 14-0137 | Component CCN: 14-S137 | Period: From 01/01/2017 To 06/30/2017 | Worksheet E-1 Part I | Date/Time Prepared: 11/22/2017 4:46 pm

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		526,531		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		526,531		0	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		1		0	6.02
7.00	Total Medicare program liability (see instructions)		526,530		0	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: 14-0137 | Component CCN: 14-U137 | Period: From 01/01/2017 To 06/30/2017 | Worksheet E-1 Part I | Date/Time Prepared: 11/22/2017 4:46 pm

Title XVIII | Swing Beds - SNF | 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		137,802		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		137,802		0	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		137,802		0	7.00

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

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 14-0137	Period: From 01/01/2017 To 06/30/2017	Worksheet E-1 Part II Date/Time Prepared: 11/22/2017 4:46 pm
	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 - SWING BEDS	Provider CCN: 14-0137 Component CCN: 14-U137	Period: From 01/01/2017 To 06/30/2017	Worksheet E-2 Date/Time Prepared: 11/22/2017 4:46 pm
	Title XVIII	Swing Beds - SNF	PPS

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	146,207	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)			2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202, for Part B) (For CAH, see instructions)			3.00
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)		0.00	4.00
5.00	Program days	322	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)		0	6.00
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	146,207	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	146,207	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0	0	11.00
12.00	Subtotal (line 10 minus line 11)	146,207	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	5,593	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)	140,614	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	0	16.50
16.55	410A RURAL DEMONSTRATION PROJECT	0		16.55
17.00	Allowable bad debts (see instructions)	0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (see instructions)	140,614	0	19.00
19.01	Sequestration adjustment (see instructions)	2,812	0	19.01
20.00	Interim payments	137,802	0	20.00
21.00	Tentative settlement (for contractor use only)	0	0	21.00
22.00	Balance due provider/program (line 19 minus lines 19.01, 20, and 21)	0	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	23.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0137 Component CCN: 14-S137	Period: From 01/01/2017 To 06/30/2017	Worksheet E-3 Part II Date/Time Prepared: 11/22/2017 4:46 pm
	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)	592,408	1.00
2.00	Net IPF PPS Outlier Payments	0	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)	4.624309	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)	592,408	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)	592,408	16.00
17.00	Primary payer payments	0	17.00
18.00	Subtotal (line 16 less line 17).	592,408	18.00
19.00	Deductibles	49,868	19.00
20.00	Subtotal (line 18 minus line 19)	542,540	20.00
21.00	Coinsurance	5,264	21.00
22.00	Subtotal (line 20 minus line 21)	537,276	22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	0	23.00
24.00	Adjusted reimbursable bad debts (see instructions)	0	24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	25.00
26.00	Subtotal (sum of lines 22 and 24)	537,276	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)	0	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	Recovery of Accelerated Depreciation	0	30.99
31.00	Total amount payable to the provider (see instructions)	537,276	31.00
31.01	Sequestration adjustment (see instructions)	10,746	31.01
32.00	Interim payments	526,531	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, 32 and 33)	-1	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	0	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

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 14-0137 | Period: From 01/01/2017 To 06/30/2017 | Worksheet G | Date/Time Prepared: 11/22/2017 4:46 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	311,067	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	13,143,015	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-8,762,655	0	0	0	6.00
7.00	Inventory	618,630	0	0	0	7.00
8.00	Prepaid expenses	553,518	0	0	0	8.00
9.00	Other current assets	637,736	0	0	0	9.00
10.00	Due from other funds	258,085	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	6,759,396	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	1,540,441	0	0	0	12.00
13.00	Land improvements	406,675	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	6,269,539	0	0	0	15.00
16.00	Accumulated depreciation	-785,631	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	1,788,090	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	0	0	0	0	23.00
24.00	Accumulated depreciation	0	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	68,310	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	9,287,424	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	1,468,127	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	1,468,127	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	17,514,947	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	968,958	0	0	0	37.00
38.00	Salaries, wages, and fees payable	772,402	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	680,438	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	1,124,439	0	0	0	43.00
44.00	Other current liabilities	636,174	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	4,182,411	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	10,199,521	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	1,598,750	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	11,798,271	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	15,980,682	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	1,534,265				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)	1,534,265	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	17,514,947	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 14-0137 | Period: From 01/01/2017 To 06/30/2017 | Worksheet G-1 | Date/Time Prepared: 11/22/2017 4:46 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		-336,617		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		1,870,882				2.00
3.00	Total (sum of line 1 and line 2)		1,534,265		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		1,534,265		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		1,534,265		0		19.00

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

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 14-0137 | Period: From 01/01/2017 To 06/30/2017 | Worksheet G-2 Parts I & II | Date/Time Prepared: 11/22/2017 4:46 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	1,273,926		1,273,926	1.00
2.00	SUBPROVIDER - IPF	813,741		813,741	2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	134,483		134,483	5.00
6.00	Swing bed - NF	52,206		52,206	6.00
7.00	SKILLED NURSING FACILITY	0		0	7.00
8.00	NURSING FACILITY	0		0	8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	2,274,356		2,274,356	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	2,274,356		2,274,356	17.00
18.00	Ancillary services	3,416,280	21,540,903	24,957,183	18.00
19.00	Outpatient services	318,229	2,409,575	2,727,804	19.00
20.00	RURAL HEALTH CLINIC	0	1,094,950	1,094,950	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES	142,451	1,028,033	1,170,484	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PROFESSIONAL SERVICES	153,214	887,040	1,040,254	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	6,304,530	26,960,501	33,265,031	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		15,349,945		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)		15,349,945		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 14-0137	Period: From 01/01/2017 To 06/30/2017	Worksheet G-3 Date/Time Prepared: 11/22/2017 4:46 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	33,265,031	1.00
2.00	Less contractual allowances and discounts on patients' accounts	16,751,372	2.00
3.00	Net patient revenues (line 1 minus line 2)	16,513,659	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	15,349,945	4.00
5.00	Net income from service to patients (line 3 minus line 4)	1,163,714	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	15,001	6.00
7.00	Income from investments	-12,474	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	66,172	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	1,342	16.00
17.00	Revenue from sale of drugs to other than patients	1,648	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	490	21.00
22.00	Rental of hospital space	195,663	22.00
23.00	Governmental appropriations	29,101	23.00
24.00	MISC REVENUE	259,226	24.00
24.01	GAIN/LOSS DISPOSAL FIXED ASSET	-27,779	24.01
24.02	AUX REVENUE	178,778	24.02
25.00	Total other income (sum of lines 6-24)	707,168	25.00
26.00	Total (line 5 plus line 25)	1,870,882	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	1,870,882	29.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 14-0137	Period: From 01/01/2017 To 06/30/2017	Worksheet L Parts I-III Date/Time Prepared: 11/22/2017 4:46 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	69,552	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	0	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)	6.04	3.00
4.00	Number of interns & residents (see instructions)	0.00	4.00
5.00	Indirect medical education percentage (see instructions)	0.00	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)	0	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)	69,552	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: 14-0137 | Component CCN: 14-3491 | Period: From 01/01/2017 To 06/30/2017 | Worksheet M-1 | Date/Time Prepared: 11/22/2017 4:46 pm

RHC I | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	0	267,486	267,486	0	267,486	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	0	277,494	277,494	0	277,494	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	0	123,460	123,460	0	123,460	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)	0	668,440	668,440	0	668,440	10.00
11.00	Physician Services Under Agreement	0	7,500	7,500	0	7,500	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	7,500	7,500	0	7,500	14.00
15.00	Medical Supplies	0	34,515	34,515	0	34,515	15.00
16.00	Transportation (Health Care Staff)	0	708	708	0	708	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	1,179	1,179	0	1,179	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	36,402	36,402	0	36,402	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	712,342	712,342	0	712,342	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	3,268	3,268	0	3,268	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	3,268	3,268	0	3,268	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	3,273	3,273	0	3,273	29.00
30.00	Administrative Costs	66,537	565,559	632,096	0	632,096	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	66,537	568,832	635,369	0	635,369	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	66,537	1,284,442	1,350,979	0	1,350,979	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-0137 | Component CCN: 14-3491 | Period: From 01/01/2017 To 06/30/2017 | Worksheet M-1 | Date/Time Prepared: 11/22/2017 4:46 pm

RHC I | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	267,486		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	277,494		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	123,460		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	668,440		10.00
11.00	Physician Services Under Agreement	0	7,500		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	0		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	7,500		14.00
15.00	Medical Supplies	0	34,515		15.00
16.00	Transportation (Health Care Staff)	0	708		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	1,179		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	36,402		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	712,342		22.00
	COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	3,268		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	3,268		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	3,273		29.00
30.00	Administrative Costs	358,854	990,950		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	358,854	994,223		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	358,854	1,709,833		32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-0137 Component CCN: 14-3491

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

Worksheet M-2

Date/Time Prepared: 11/22/2017 4:46 pm

RHC I

Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	0.94	3,324	4,200	3,948		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	1.92	5,572	2,100	4,032		3.00
4.00	Subtotal (sum of lines 1 through 3)	2.86	8,896		7,980	8,896	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	2.86	8,896			8,896	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)					712,342	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					3,268	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					715,610	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					0.995433	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					994,223	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					676,738	15.00
16.00	Total overhead (sum of lines 14 and 15)					1,670,961	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					1,670,961	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					1,663,330	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					2,375,672	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 14-0137 Component CCN: 14-3491	Period: From 01/01/2017 To 06/30/2017	Worksheet M-3 Date/Time Prepared: 11/22/2017 4:46 pm
	Title XVIII	RHC I	Cost

				1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES				
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			2,375,672	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			2,748	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			2,372,924	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			8,896	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)			8,896	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			266.74	7.00
		Calculation of Limit (1)			
		Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)		
		1.00	2.00		
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	0.00	82.30		8.00
9.00	Rate for Program covered visits (see instructions)	266.74	266.74		9.00
	CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	0	2,486		10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	663,116		11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0		12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0		13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0		14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)				15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *	0	663,116		16.00
16.01	Total program charges (see instructions)(from contractor's records)		360,685		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		0		16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		0		16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)		463,429		16.04
16.05	Total program cost (see instructions)	0	463,429		16.05
17.00	Primary payer amounts		0		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		83,830		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		55,198		19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		463,429		20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		2,748		21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		466,177		22.00
23.00	Allowable bad debts (see instructions)		20,110		23.00
23.01	Adjusted reimbursable bad debts (see instructions)		13,072		23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		20,110		24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0		25.50
26.00	Net reimbursable amount (see instructions)		479,249		26.00
26.01	Sequestration adjustment (see instructions)		9,585		26.01
27.00	Interim payments		319,691		27.00
28.00	Tentative settlement (for contractor use only)		0		28.00
29.00	Balance due component/program (line 26 minus lines 26.01, 27, and 28)		149,973		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: 14-0137 Component CCN: 14-3491	Period: From 01/01/2017 To 06/30/2017	Worksheet M-4 Date/Time Prepared: 11/22/2017 4:46 pm
	Title XVIII	RHC I	Cost

		Pneumococcal	Influenza	
		1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	668,440	668,440	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000098	0.000098	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	66	66	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	583	109	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	649	175	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	712,342	712,342	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	1,663,330	1,663,330	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.000911	0.000246	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	1,515	409	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	2,164	584	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	7	7	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	309.14	83.43	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	7	7	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	2,164	584	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)		2,748	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)		2,748	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 14-0137 Component CCN: 14-3491	Period: From 01/01/2017 To 06/30/2017	Worksheet M-5 Date/Time Prepared: 11/22/2017 4:46 pm
		RHC I	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		319,691	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00
	Program to Provider			
3.01			0	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
	Provider to Program			
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		319,691	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		149,973	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		469,664	7.00

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