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: 14-0189	Period: From 07/01/2016 To 06/30/2017	Worksheet S Parts I-III Date/Time Prepared: 11/16/2017 4:03 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 11/16/2017 Time: 4:03 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 SARAH BUSH LINCOLN HEALTH CENTER (14-0189) for the cost reporting period beginning 07/01/2016 and ending 06/30/2017 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

_____
Title

_____
Date

	Cost Center Description	Title V	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	-526,817	-79,967	0	0	1.00
2.00	Subprovider - IPF	0	41,876	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
8.00	NURSING FACILITY	0				0	8.00
9.00	HOME HEALTH AGENCY I	0	0	-1		0	9.00
10.00	RURAL HEALTH CLINIC I	0		1,386		0	10.00
10.01	RURAL HEALTH CLINIC II	0		2,680		0	10.01
10.02	RURAL HEALTH CLINIC III	0		2,638		0	10.02
10.03	RURAL HEALTH CLINIC IV	0		2,629		0	10.03
10.04	RURAL HEALTH CLINIC V	0		4,208		0	10.04
200.00	Total	0	-484,941	-66,427	0	0	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-0189 | Period: From 07/01/2016 To 06/30/2017 | Worksheet S-2 Part I Date/Time Prepared: 11/16/2017 3:52 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 1000 HEALTH CENTER DRIVE	PO Box: 372			1.00
2.00	City: MATTOON	State: IL	Zip Code: 61920-	County: COLES	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	SARAH BUSH LINCOLN HEALTH CENTER	140189	99914	1	05/01/1977	N	P	O	3.00
4.00	Subprovider - IPF	SARAH BUSH LINCOLN HEALTH CENTER	14S189	99914	4	01/01/1990	N	P	O	4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA	LINCOLNLAND HOME CARE OF SBLHS	147594	99914		06/18/1996	N	P	N	12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice	LINCOLNLAND HOSPICE OF SBLHS	141599	99914		08/10/1999				14.00
15.00	Hospital-Based Health Clinic - RHC	CASEY RHC	143978	99914		06/15/1992	N	O	N	15.00
15.01	Hospital-Based Health Clinic - RHC II	SULLIVAN RHC	143998	99914		01/13/1995	N	O	N	15.01
15.02	Hospital-Based Health Clinic - RHC III	NEOGA RHC	143435	99914		05/31/1997	N	O	N	15.02
15.03	Hospital-Based Health Clinic - RHC IV	NEWTON RHC	148541	99914		07/01/2014	N	O	N	15.03
15.04	Hospital-Based Health Clinic - RHC V	MARTINSVILLE RHC	148555	99914		07/01/2015	N	O	N	15.04
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)	07/01/2016	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.	1	N	23.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-0189 | Period: From 07/01/2016 To 06/30/2017 | Worksheet S-2 Part I | Date/Time Prepared: 11/16/2017 3:52 pm

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
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.	3,864	0	0	0	0	0	24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0		25.00

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

		Beginning:	Ending:	
		1.00	2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.	07/01/2016	06/30/2017	36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.	0		37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)	N		37.01
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.			38.00

		Y/N	Y/N	
		1.00	2.00	
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 “Y” for yes or “N” for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	N	N	39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	N	Y	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.				57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.				58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59.00
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N			60.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-0189 | Period: From 07/01/2016 To 06/30/2017 | Worksheet S-2 Part I | Date/Time Prepared: 11/16/2017 3:52 pm

		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00	0.00			61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)		0.00	0.00			61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)		0.00	0.00			61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).		0.00	0.00			61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)		0.00	0.00			61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)		0.00	0.00			61.06

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-0189 | Period: From 07/01/2016 To 06/30/2017 | Worksheet S-2 Part I | Date/Time Prepared: 11/16/2017 3:52 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	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
76.00	If line 75 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0	76.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-0189 | Period: From 07/01/2016 To 06/30/2017 | Worksheet S-2 Part I Date/Time Prepared: 11/16/2017 3:52 pm

		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.	Y	N	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	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.	N	N	N	N	109.00

		1.00	
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (410A Demo)for the current cost reporting period? Enter "Y" for yes or "N" for no.	N	110.00

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

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	5,134,346	0	0	118.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-0189 | Period: From 07/01/2016 To 06/30/2017 | Worksheet S-2 Part I Date/Time Prepared: 11/16/2017 3:52 pm

		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
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)	N		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:	Contractor's Name:	Contractor's Number:	141.00
142.00	Street:	PO Box:		142.00
143.00	City:	State:	Zip Code:	143.00

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

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

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

		Part A	Part B	Title V	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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-0189 | Period: From 07/01/2016 To 06/30/2017 | Worksheet S-2 Part I Date/Time Prepared: 11/16/2017 3:52 pm

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

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

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

		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	07/01/2016	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: 14-0189 | Period: From 07/01/2016 To 06/30/2017 | Worksheet S-2 Part II | Date/Time Prepared: 11/16/2017 3:52 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)	N			3.00

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

		Y/N	Legal Oper.	
		1.00	2.00	
	Approved Educational Activities			
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	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)	Y	09/30/2017	Y	09/30/2017	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 14-0189 | Period: From 07/01/2016 To 06/30/2017 | Worksheet S-2 Part II Date/Time Prepared: 11/16/2017 3:52 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				Y	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				N	31.00
	Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				N	33.00
	Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				Y	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.	BARB		IPPOLITO		41.00
42.00	Enter the employer/company name of the cost report preparer.	SARAH BUSH LINCOLN HEALTH CENTER				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	217-258-2509		BIPPOLITO@SBLHS.ORG		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 14-0189	Period: From 07/01/2016 To 06/30/2017	Worksheet S-2 Part II Date/Time Prepared: 11/16/2017 3:52 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.	REIMB. ACCOUNTANT		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: 14-0189 | Period: From 07/01/2016 To 06/30/2017 | Worksheet S-3 Part I | Date/Time Prepared: 11/16/2017 3:52 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	79	28,835	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)		79	28,835	0.00	0	7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT	32.00	9	3,285	0.00	0	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)		88	32,120	0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF	40.00	20	7,300		0	16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						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	101.00				0	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	116.00	0	0			24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	88.00				0	26.00
26.01	RURAL HEALTH CLINIC II	88.01				0	26.01
26.02	RURAL HEALTH CLINIC III	88.02				0	26.02
26.03	RURAL HEALTH CLINIC IV	88.03				0	26.03
26.04	RURAL HEALTH CLINIC V	88.04				0	26.04
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		108				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: 14-0189 | Period: From 07/01/2016 To 06/30/2017 | Worksheet S-3 Part I | Date/Time Prepared: 11/16/2017 3:52 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)	9,932	2,624	18,311			1.00
2.00	HMO and other (see instructions)	2,187	0				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	9,932	2,624	18,311			7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT	1,078	358	2,074			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		687	1,243			13.00
14.00	Total (see instructions)	11,010	3,669	21,628	0.00	1,820.55	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF	970	1,634	3,305	0.00	26.66	16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						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	20,538	0	31,348	0.00	59.80	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	0	0	0	0.00	28.80	24.00
24.10	HOSPICE (non-distinct part)	0	0	0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	651	0	2,528	0.00	4.68	26.00
26.01	RURAL HEALTH CLINIC II	811	0	3,734	0.00	6.06	26.01
26.02	RURAL HEALTH CLINIC III	1,718	0	6,095	0.00	7.62	26.02
26.03	RURAL HEALTH CLINIC IV	1,183	0	6,106	0.00	8.18	26.03
26.04	RURAL HEALTH CLINIC V	3,623	0	17,793	0.00	13.06	26.04
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	1,975.41	27.00
28.00	Observation Bed Days		1,095	4,387			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	195	413			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: 14-0189 | Period: From 07/01/2016 To 06/30/2017 | Worksheet S-3 Part I | Date/Time Prepared: 11/16/2017 3:52 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	2,961	1,291	6,619	1.00
2.00	HMO and other (see instructions)			559	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	2,961	1,291	6,619	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF	0.00	0	176	372	719	16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY	0.00					20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0.00					22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	0.00					24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	0.00					26.00
26.01	RURAL HEALTH CLINIC II	0.00					26.01
26.02	RURAL HEALTH CLINIC III	0.00					26.02
26.03	RURAL HEALTH CLINIC IV	0.00					26.03
26.04	RURAL HEALTH CLINIC V	0.00					26.04
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: 14-0189 | Period: From 07/01/2016 To 06/30/2017 | Worksheet S-3 Part II | Date/Time Prepared: 11/16/2017 3:52 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	142,741,515	0	142,741,515	4,108,905.00	34.74	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		1,901,586	0	1,901,586	20,459.00	92.95	3.00
4.00	Physician-Part A - Administrative		250,837	0	250,837	1,099.00	228.24	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		17,312,919	0	17,312,919	66,873.00	258.89	5.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		971,052	0	971,052	15,457.00	62.82	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)		46,605,400	0	46,605,400	1,154,967.00	40.35	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		0	0	0	0.00	0.00	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		0	0	0	0.00	0.00	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		0	0	0	0.00	0.00	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)		24,600,268	0	24,600,268			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		8,145,587	0	8,145,587			19.00
20.00	Non-physician anesthetist Part A		491,231	0	491,231			20.00
21.00	Non-physician anesthetist Part B		0	0	0			21.00
22.00	Physician Part A - Administrative		52,292	0	52,292			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		2,309,611	0	2,309,611			23.00
24.00	Wage-related costs (RHC/FQHC)		141,185	0	141,185			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
25.50	Home office wage-related		0	0	0			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
	OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	774,075	0	774,075	22,331.00	34.66	26.00
27.00	Administrative & General	5.00	16,659,733	0	16,659,733	436,942.00	38.13	27.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 14-0189 | Period: From 07/01/2016 To 06/30/2017 | Worksheet S-3 Part II Date/Time Prepared: 11/16/2017 3:52 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	
28.00	Administrative & General under contract (see inst.)		491,121	0	491,121	1,559.00	315.02	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	1,228,730	0	1,228,730	72,206.00	17.02	30.00
31.00	Laundry & Linen Service	8.00	28,571	0	28,571	2,075.00	13.77	31.00
32.00	Housekeeping	9.00	1,617,019	0	1,617,019	111,666.00	14.48	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	1,458,821	-1,080,840	377,981	25,022.00	15.11	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	1,080,840	1,080,840	71,552.00	15.11	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	1,849,286	0	1,849,286	56,640.00	32.65	38.00
39.00	Central Services and Supply	14.00	595,216	0	595,216	35,137.00	16.94	39.00
40.00	Pharmacy	15.00	1,662,558	0	1,662,558	44,362.00	37.48	40.00
41.00	Medical Records & Medical Records Library	16.00	1,817,813	0	1,817,813	138,220.00	13.15	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: 14-0189 | Period: From 07/01/2016 To 06/30/2017 | Worksheet S-3 Part III Date/Time Prepared: 11/16/2017 3:52 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)		123,047,079	0	123,047,079	4,007,675.00	30.70	1.00
2.00	Excluded area salaries (see instructions)		46,605,400	0	46,605,400	1,154,967.00	40.35	2.00
3.00	Subtotal salaries (line 1 minus line 2)		76,441,679	0	76,441,679	2,852,708.00	26.80	3.00
4.00	Subtotal other wages & related costs (see inst.)		0	0	0	0.00	0.00	4.00
5.00	Subtotal wage-related costs (see inst.)		24,652,560	0	24,652,560	0.00	32.25	5.00
6.00	Total (sum of lines 3 thru 5)		101,094,239	0	101,094,239	2,852,708.00	35.44	6.00
7.00	Total overhead cost (see instructions)		28,182,943	0	28,182,943	1,017,712.00	27.69	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 14-0189 | Period: From 07/01/2016 To 06/30/2017 | Worksheet S-3 Part IV Date/Time Prepared: 11/16/2017 3:52 pm

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	5,825,396	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	289,614	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	18,077,483	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	0	9.00
10.00	Dental, Hearing and Vision Plan	801,639	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	314,572	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	31,712	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	326,071	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	1,738,575	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	0	16.00
	TAXES		
17.00	FICA-Employers Portion Only	7,935,189	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	78,652	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
	OTHER		
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	321,271	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	35,740,174	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: 14-0189 | Period: From 07/01/2016 To 06/30/2017 | Worksheet S-3 Part V Date/Time Prepared: 11/16/2017 3:52 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	0	35,740,174	1.00
2.00	Hospital	0	24,600,268	2.00
3.00	Subprovider - IPF	0	847,477	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			8.00
9.00	Hospital-Based NF	0	0	9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA	0	998,375	11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice	0	410,956	13.00
14.00	Hospital-Based Health Clinic RHC	0	0	14.00
14.01	Hospital-Based Health Clinic RHC 1	0	0	14.01
14.02	Hospital-Based Health Clinic RHC 2	0	51,762	14.02
14.03	Hospital-Based Health Clinic RHC 3	0	0	14.03
14.04	Hospital-Based Health Clinic RHC 4	0	89,423	14.04
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	8,741,913	18.00

HOME HEALTH AGENCY STATISTICAL DATA | Provider CCN: 14-0189 | Component CCN: 14-7594 | Period: From 07/01/2016 To 06/30/2017 | Worksheet S-4 | Date/Time Prepared: 11/16/2017 3:52 pm

Home Health Agency I | PPS

		1.00	
0.00	County		0.00

		Title V	Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	5.00	
	HOME HEALTH AGENCY STATISTICAL DATA						
1.00	Home Health Aide Hours	0	0	0	0	0	1.00
2.00	Unduplicated Census Count (see instructions)	0.00	0.00	0.00	0.00	0.00	2.00

		Enter the number of hours in your normal work week	Number of Employees (Full Time Equivalent)			
			Staff	Contract	Total	
		0	1.00	2.00	3.00	
	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES					
3.00	Administrator and Assistant Administrator(s)	0.00	0.87	0.00	0.87	3.00
4.00	Director(s) and Assistant Director(s)		2.01	0.00	2.01	4.00
5.00	Other Administrative Personnel		14.33	0.00	14.33	5.00
6.00	Direct Nursing Service		29.06	0.00	29.06	6.00
7.00	Nursing Supervisor		0.00	0.00	0.00	7.00
8.00	Physical Therapy Service		6.39	0.00	6.39	8.00
9.00	Physical Therapy Supervisor		0.00	0.00	0.00	9.00
10.00	Occupational Therapy Service		2.88	0.00	2.88	10.00
11.00	Occupational Therapy Supervisor		0.00	0.00	0.00	11.00
12.00	Speech Pathology Service		0.32	0.00	0.32	12.00
13.00	Speech Pathology Supervisor		0.00	0.00	0.00	13.00
14.00	Medical Social Service		0.63	0.00	0.63	14.00
15.00	Medical Social Service Supervisor		0.00	0.00	0.00	15.00
16.00	Home Health Aide		3.30	0.00	3.30	16.00
17.00	Home Health Aide Supervisor		0.00	0.00	0.00	17.00
18.00	Other (specify)		0.00	0.00	0.00	18.00
	HOME HEALTH AGENCY CBSA CODES					
19.00	Enter in column 1 the number of CBSAs where you provided services during the cost reporting period.		1			19.00
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).		99914			20.00

		Full Episodes					
		Without Outliers	With Outliers	LUPA Episodes	PEP Only Episodes	Total (cols. 1-4)	
		1.00	2.00	3.00	4.00	5.00	
	PPS ACTIVITY DATA						
21.00	Skilled Nursing Visits	9,098	2,679	308	290	12,375	21.00
22.00	Skilled Nursing Visit Charges	1,629,048	479,063	60,806	52,958	2,221,875	22.00
23.00	Physical Therapy Visits	3,475	285	66	137	3,963	23.00
24.00	Physical Therapy Visit Charges	646,175	51,931	12,378	25,544	736,028	24.00
25.00	Occupational Therapy Visits	1,493	171	17	76	1,757	25.00
26.00	Occupational Therapy Visit Charges	274,655	31,183	3,155	14,076	323,069	26.00
27.00	Speech Pathology Visits	132	15	3	0	150	27.00
28.00	Speech Pathology Visit Charges	24,085	2,730	546	0	27,361	28.00
29.00	Medical Social Service Visits	172	24	2	9	207	29.00
30.00	Medical Social Service Visit Charges	38,356	5,352	446	2,007	46,161	30.00
31.00	Home Health Aide Visits	1,483	565	1	37	2,086	31.00
32.00	Home Health Aide Visit Charges	115,674	44,070	78	2,886	162,708	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	15,853	3,739	397	549	20,538	33.00
34.00	Other Charges	194,491	120,422	12,928	3,020	330,861	34.00
35.00	Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)	2,922,484	734,751	90,337	100,491	3,848,063	35.00
36.00	Total Number of Episodes (standard/non outlier)	1,143		141	37	1,321	36.00
37.00	Total Number of Outlier Episodes		115		8	123	37.00
38.00	Total Non-Routine Medical Supply Charges	0	0	0	0	0	38.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 14-0189 | Component CCN: 14-3978 | Period: From 07/01/2016 To 06/30/2017 | Worksheet S-8 | Date/Time Prepared: 11/16/2017 3:52 pm

RHC I | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			412 NW 3RD		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	CASEY		IL	62420	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?						12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.				N	0	13.00
				Provider name		CCN number
				1.00		2.00	
14.00	RHC/FQHC name, CCN number						14.00
		Y/N	V	XVIII	XIX	Total Visits	
		1.00	2.00	3.00	4.00	5.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)						15.00
			County				
			4.00				
2.00	City, State, ZIP Code, County		CLARK				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

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-0189
Component CCN: 14-3978

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

Worksheet S-8
Date/Time Prepared:
11/16/2017 3:52 pm

RHC I | Cost

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	Clinic	08:00	17:00				11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 14-0189 | Component CCN: 14-3998 | Period: From 07/01/2016 To 06/30/2017 | Worksheet S-8 | Date/Time Prepared: 11/16/2017 3:52 pm

RHC II | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			7 HAWTHORNE LANE		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	SULLIVAN		IL	61951	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?						12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.				N	0	13.00
				Provider name		CCN number
				1.00		2.00	
14.00	RHC/FQHC name, CCN number						14.00
		Y/N	V	XVIII	XIX	Total Visits	
		1.00	2.00	3.00	4.00	5.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)						15.00
			County				
			4.00				
2.00	City, State, ZIP Code, County		MOULTRIE				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

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-0189
Component CCN: 14-3998

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

Worksheet S-8

Date/Time Prepared:
11/16/2017 3:52 pm

RHC II

Cost

		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				11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 14-0189 | Component CCN: 14-3435 | Period: From 07/01/2016 To 06/30/2017 | Worksheet S-8 | Date/Time Prepared: 11/16/2017 3:52 pm

RHC III | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			650 OAK AVENUE		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	NEOGA		IL	62447	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?				12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.	N	0		13.00

				Provider name		CCN number	
				1.00		2.00	
14.00	RHC/FQHC name, CCN number						14.00
		Y/N	V	XVIII	XIX	Total Visits	
		1.00	2.00	3.00	4.00	5.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)						15.00

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

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-0189
Component CCN: 14-3435

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

Worksheet S-8

Date/Time Prepared:
11/16/2017 3:52 pm

RHC III

Cost

		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				11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 14-0189 | Component CCN: 14-8541 | Period: From 07/01/2016 To 06/30/2017 | Worksheet S-8 | Date/Time Prepared: 11/16/2017 3:52 pm

RHC IV | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			910 SOUTH VAN BUREN ST		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	NEWTON		IL	62448	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?						12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.				N	0	13.00
				Provider name		CCN number
				1.00		2.00	
14.00	RHC/FQHC name, CCN number						14.00
		Y/N	V	XVIII	XIX	Total Visits	
		1.00	2.00	3.00	4.00	5.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)						15.00
			County				
			4.00				
2.00	City, State, ZIP Code, County		JASPER				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

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-0189
Component CCN: 14-8541

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

Worksheet S-8

Date/Time Prepared:
11/16/2017 3:52 pm

RHC IV

Cost

		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				11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 14-0189 | Component CCN: 14-8555 | Period: From 07/01/2016 To 06/30/2017 | Worksheet S-8 | Date/Time Prepared: 11/16/2017 3:52 pm

RHC V | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			890 E RIDGELAWN RD		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	MARTINSVILLE		IL	62442	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?						12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.				N	0	13.00
				Provider name		CCN number
				1.00		2.00	
14.00	RHC/FQHC name, CCN number						14.00
		Y/N	V	XVIII	XIX	Total Visits	
		1.00	2.00	3.00	4.00	5.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)						15.00
			County				
			4.00				
2.00	City, State, ZIP Code, County		CLARK				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

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-0189
Component CCN: 14-8555

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

Worksheet S-8
Date/Time Prepared:
11/16/2017 3:52 pm

RHC V | Cost

		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				11.00

HOSPITAL-BASED HOSPICE IDENTIFICATION DATA

Provider CCN: 14-0189
Hospice CCN: 14-1599

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

Worksheet S-9 PARTS I THROUGH IV Date/Time Prepared: 11/16/2017 3:52 pm

Hospice I

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

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

		Title XVIII	Title XIX	Other	Total (sum of cols. 1 through 3)	
		1.00	2.00	3.00	4.00	
	PART III - ENROLLMENT DAYS FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2015					
10.00	Hospice Continuous Home Care	0	0	0	0	10.00
11.00	Hospice Routine Home Care	17,955	732	853	19,540	11.00
12.00	Hospice Inpatient Respite Care	41	5	0	46	12.00
13.00	Hospice General Inpatient Care	66	9	7	82	13.00
14.00	Total Hospice Days	18,062	746	860	19,668	14.00
	PART IV - CONTRACTED STATISTICAL DATA FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2015					
15.00	Hospice Inpatient Respite Care	0	0	0	0	15.00
16.00	Hospice General Inpatient Care	0	0	0	0	16.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 14-0189 | Period: From 07/01/2016 To 06/30/2017 | Worksheet S-10 | Date/Time Prepared: 11/16/2017 3:52 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)	0.256509	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	23,603,359	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH or supplemental payments from Medicaid?	N	4.00
5.00	If line 4 is no, then enter DSH or supplemental payments from Medicaid	2,741,761	5.00
6.00	Medicaid charges	147,331,442	6.00
7.00	Medicaid cost (line 1 times line 6)	37,791,841	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)	11,446,721	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)	11,446,721	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
	Uncompensated Care (see instructions for each line)				
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	2,621,755	11,541,289	14,163,044	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	672,504	11,541,289	12,213,793	21.00
22.00	Payments received from patients for amounts previously written off as charity care	68,619	2,477,641	2,546,260	22.00
23.00	Cost of charity care (line 21 minus line 22)	603,885	9,063,648	9,667,533	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)	6,730,245	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	850,887	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	1,309,056	27.01
28.00	Non-Medicare bad debt expense (line 26 minus line 27.01)	5,421,189	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	1,848,753	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	11,516,286	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	22,963,007	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-0189 | Period: From 07/01/2016 To 06/30/2017 | Worksheet A | Date/Time Prepared: 11/16/2017 3:52 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		0	0	7,731,565	7,731,565	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		0	0	11,809,525	11,809,525	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	774,075	27,886,633	28,660,708	209,562	28,870,270	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	16,659,733	43,345,727	60,005,460	-21,066,402	38,939,058	5.00
7.00	00700	OPERATION OF PLANT	1,228,730	3,650,953	4,879,683	-29,265	4,850,418	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	28,571	568,479	597,050	0	597,050	8.00
9.00	00900	HOUSEKEEPING	1,617,019	481,354	2,098,373	0	2,098,373	9.00
10.00	01000	DIETARY	1,458,821	1,601,905	3,060,726	-2,267,691	793,035	10.00
11.00	01100	CAFETERIA	0	0	0	2,267,691	2,267,691	11.00
13.00	01300	NURSING ADMINISTRATION	1,849,286	522,330	2,371,616	-5,967	2,365,649	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	595,216	962,075	1,557,291	-34,432	1,522,859	14.00
15.00	01500	PHARMACY	1,662,558	15,862,473	17,525,031	-15,537,605	1,987,426	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,817,813	892,075	2,709,888	-8,368	2,701,520	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	17,646,460	3,474,020	21,120,480	-1,185,215	19,935,265	30.00
32.00	03200	CORONARY CARE UNIT	1,786,735	1,090,010	2,876,745	-1,331	2,875,414	32.00
40.00	04000	SUBPROVIDER - IPF	3,564,052	275,980	3,840,032	54,064	3,894,096	40.00
43.00	04300	NURSERY	0	31,166	31,166	525,678	556,844	43.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,552,182	2,604,560	8,156,742	-73,480	8,083,262	50.00
51.00	05100	RECOVERY ROOM	1,360,106	274,124	1,634,230	-9,778	1,624,452	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	84,442	84,442	797,748	882,190	52.00
53.00	05300	ANESTHESIOLOGY	5,681,558	874,106	6,555,664	118,764	6,674,428	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,962,219	1,421,809	7,384,028	-298,422	7,085,606	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	2,455,935	604,374	3,060,309	42,310	3,102,619	55.00
56.00	05600	RADIOISOTOPE	1,163,113	1,398,637	2,561,750	208,874	2,770,624	56.00
57.00	05700	CT SCAN	476,302	765,869	1,242,171	81,747	1,323,918	57.00
58.00	05800	MRI	367,993	545,731	913,724	68,942	982,666	58.00
59.00	05900	CARDIAC CATHETERIZATION	571,085	449,592	1,020,677	-9,925	1,010,752	59.00
60.00	06000	LABORATORY	4,986,340	5,205,494	10,191,834	41,496	10,233,330	60.00
65.00	06500	RESPIRATORY THERAPY	1,184,095	441,910	1,626,005	-1,335	1,624,670	65.00
66.00	06600	PHYSICAL THERAPY	2,015,608	1,002,961	3,018,569	-17,682	3,000,887	66.00
67.00	06700	OCCUPATIONAL THERAPY	520,499	65,790	586,289	0	586,289	67.00
68.00	06800	SPEECH PATHOLOGY	814,777	540,472	1,355,249	-910	1,354,339	68.00
69.00	06900	ELECTROCARDIOLOGY	1,383,186	2,776,433	4,159,619	4,784	4,164,403	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,199,927	1,370,006	2,569,933	43,622	2,613,555	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	3,704,262	3,704,262	0	3,704,262	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	6,502,047	6,502,047	0	6,502,047	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	15,365,196	15,365,196	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	606,749	58,408	665,157	-21,231	643,926	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	283,068	125,122	408,190	10,352	418,542	88.00
88.01	08801	RURAL HEALTH CLINIC II	359,488	140,047	499,535	21,714	521,249	88.01
88.02	08802	RURAL HEALTH CLINIC III	715,345	128,998	844,343	25,570	869,913	88.02
88.03	08803	RURAL HEALTH CLINIC IV	482,631	172,161	654,792	21,923	676,715	88.03
88.04	08805	RURAL HEALTH CLINIC V	1,241,644	243,625	1,485,269	6,147	1,491,416	88.04
91.00	09100	EMERGENCY	9,627,248	2,466,865	12,094,113	371,143	12,465,256	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	3,744,214	811,174	4,555,388	-9,496	4,545,892	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	1,541,852	964,815	2,506,667	-2,766	2,503,901	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	104,986,233	136,389,014	241,375,247	-752,884	240,622,363	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	33,632,525	8,535,950	42,168,475	966,370	43,134,845	192.00
194.00	07950	WELLNESS	719,112	439,200	1,158,312	-7,788	1,150,524	194.00
194.01	07953	OTHER NONREIMB PROGRAM: PEACE MEAL	1,290,597	1,745,865	3,036,462	-3,200	3,033,262	194.01
194.02	07951	LIFELINE	13,162	111,221	124,383	0	124,383	194.02
194.03	07952	OCCUPATIONAL HEALTH	593,633	205,883	799,516	-199,521	599,995	194.03
194.05	07954	MISC. NONREIMBURSABLE	1,506,253	572,217	2,078,470	-2,977	2,075,493	194.05
200.00		TOTAL (SUM OF LINES 118-199)	142,741,515	147,999,350	290,740,865	0	290,740,865	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-0189 | Period: From 07/01/2016 To 06/30/2017 | Worksheet A | Date/Time Prepared: 11/16/2017 3:52 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	-1,631,940	6,099,625		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	11,809,525		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-384,085	28,486,185		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-5,740,273	33,198,785		5.00
7.00	00700	OPERATION OF PLANT	-250	4,850,168		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	597,050		8.00
9.00	00900	HOUSEKEEPING	-151	2,098,222		9.00
10.00	01000	DIETARY	-1,150	791,885		10.00
11.00	01100	CAFETERIA	-998,177	1,269,514		11.00
13.00	01300	NURSING ADMINISTRATION	0	2,365,649		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,522,859		14.00
15.00	01500	PHARMACY	0	1,987,426		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-82,143	2,619,377		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-4,519,679	15,415,586		30.00
32.00	03200	CORONARY CARE UNIT	0	2,875,414		32.00
40.00	04000	SUBPROVIDER - IPF	-2,161,742	1,732,354		40.00
43.00	04300	NURSERY	0	556,844		43.00
45.00	04500	NURSING FACILITY	0	0		45.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	8,083,262		50.00
51.00	05100	RECOVERY ROOM	0	1,624,452		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	882,190		52.00
53.00	05300	ANESTHESIOLOGY	-6,117,234	557,194		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-3,495,781	3,589,825		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	-1,493,449	1,609,170		55.00
56.00	05600	RADIOISOTOPE	0	2,770,624		56.00
57.00	05700	CT SCAN	0	1,323,918		57.00
58.00	05800	MRI	0	982,666		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	1,010,752		59.00
60.00	06000	LABORATORY	-645,824	9,587,506		60.00
65.00	06500	RESPIRATORY THERAPY	-146,942	1,477,728		65.00
66.00	06600	PHYSICAL THERAPY	-2,885	2,998,002		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	586,289		67.00
68.00	06800	SPEECH PATHOLOGY	-779,519	574,820		68.00
69.00	06900	ELECTROCARDIOLOGY	-2,636,180	1,528,223		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	-662,370	1,951,185		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	3,704,262		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	6,502,047		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	15,365,196		73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0		75.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	643,926		76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	418,542		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	521,249		88.01
88.02	08802	RURAL HEALTH CLINIC III	0	869,913		88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	676,715		88.03
88.04	08805	RURAL HEALTH CLINIC V	0	1,491,416		88.04
91.00	09100	EMERGENCY	-6,460,746	6,004,510		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
		OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY	0	4,545,892		101.00
		SPECIAL PURPOSE COST CENTERS				
116.00	11600	HOSPICE	0	2,503,901		116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-37,960,520	202,661,843		118.00
		NONREIMBURSABLE COST CENTERS				
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	43,134,845		192.00
194.00	07950	WELLNESS	0	1,150,524		194.00
194.01	07953	OTHER NONREIMB PROGRAM: PEACE MEAL	0	3,033,262		194.01
194.02	07951	LIFELINE	0	124,383		194.02
194.03	07952	OCCUPATIONAL HEALTH	0	599,995		194.03
194.05	07954	MISC. NONREIMBURSABLE	0	2,075,493		194.05
200.00		TOTAL (SUM OF LINES 118-199)	-37,960,520	252,780,345		200.00

RECLASSIFICATIONS | Provider CCN: 14-0189 | Period: From 07/01/2016 To 06/30/2017 | Worksheet A-6 | Date/Time Prepared: 11/16/2017 3:52 pm

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - DRUGS CHARGED TO PATIENTS				
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	15,365,196	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
	0		0	15,365,196	
	B - RADIOLOGY ADMIN EXPENSE ALLOCATION				
1.00	RADIOISOTOPE	56.00	171,370	37,732	1.00
2.00	CT SCAN	57.00	70,177	20,662	2.00
3.00	MRI	58.00	54,219	14,723	3.00
	0		295,766	73,117	
	C - CAP REL COSTS-MOVABLE EQUIP				
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	569,307	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
22.00		0.00	0	0	22.00
23.00		0.00	0	0	23.00
24.00		0.00	0	0	24.00
25.00		0.00	0	0	25.00
26.00		0.00	0	0	26.00
27.00		0.00	0	0	27.00
28.00		0.00	0	0	28.00
29.00		0.00	0	0	29.00
30.00		0.00	0	0	30.00
31.00		0.00	0	0	31.00
32.00		0.00	0	0	32.00
33.00		0.00	0	0	33.00
34.00		0.00	0	0	34.00
36.00		0.00	0	0	36.00
37.00		0.00	0	0	37.00
	0		0	569,307	
	D - DEPRECIATION				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	5,902,329	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	11,240,218	2.00
	0		0	17,142,547	
	E - CAFETERIA EXPENSE				
1.00	CAFETERIA	11.00	1,080,840	1,186,851	1.00
	0		1,080,840	1,186,851	
	F - EMPLOYEE PHYSICALS/BENF EXP				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	197,380	1.00
	0		0	197,380	
	G - EAP BENEFITS				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	18,925	1.00
	0		0	18,925	
	H - INTEREST EXPENSE				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1,829,236	1.00
	0		0	1,829,236	
	I - NURSRY/L&D EXP				
1.00	NURSERY	43.00	525,678	0	1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	797,748	0	2.00
	0		1,323,426	0	

RECLASSIFICATIONS | Provider CCN: 14-0189 | Period: From 07/01/2016 To 06/30/2017 | Worksheet A-6 | Date/Time Prepared: 11/16/2017 3:52 pm

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	J - PHYSN PROF LIAB EXP				
1.00	ADULTS & PEDIATRICS	30.00	0	168,673	1.00
2.00	SUBPROVIDER - IPF	40.00	0	58,272	2.00
3.00	ANESTHESIOLOGY	53.00	0	123,285	3.00
4.00	RADIOLOGY-THERAPEUTIC	55.00	0	45,389	4.00
5.00	LABORATORY	60.00	0	15,130	5.00
6.00	ELECTROCARDIOLOGY	69.00	0	11,259	6.00
7.00	EMERGENCY	91.00	0	376,591	7.00
8.00	RURAL HEALTH CLINIC	88.00	0	11,259	8.00
9.00	RURAL HEALTH CLINIC II	88.01	0	22,517	9.00
10.00	RURAL HEALTH CLINIC III	88.02	0	26,270	10.00
11.00	RURAL HEALTH CLINIC IV	88.03	0	22,517	11.00
12.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	1,010,257	12.00
13.00	RADIOLOGY-DIAGNOSTIC	54.00	0	73,402	13.00
14.00	ELECTROENCEPHALOGRAPHY	70.00	0	47,636	14.00
15.00	RURAL HEALTH CLINIC V	88.04	0	41,281	15.00
	0		0	2,053,738	
	K - RHC V-LAB STAFF EXPENSE				
1.00	LABORATORY	60.00	31,828	0	1.00
	0		31,828	0	
500.00	Grand Total: Increases		2,731,860	38,436,297	500.00

RECLASSIFICATIONS | Provider CCN: 14-0189 | Period: From 07/01/2016 To 06/30/2017 | Worksheet A-6 | Date/Time Prepared: 11/16/2017 3:52 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - DRUGS CHARGED TO PATIENTS						
1.00	PHARMACY	15.00	0	15,342,764	0		1.00
2.00	RECOVERY ROOM	51.00	0	8,426	0		2.00
3.00	ANESTHESIOLOGY	53.00	0	4,521	0		3.00
4.00	CT SCAN	57.00	0	9,092	0		4.00
5.00	OPERATING ROOM	50.00	0	155	0		5.00
6.00	RADIOISOTOPE	56.00	0	228	0		6.00
7.00	EMERGENCY	91.00	0	10	0		7.00
	0		0	15,365,196			
	B - RADIOLOGY ADMIN EXPENSE ALLOCATION						
1.00	RADIOLOGY-DIAGNOSTIC	54.00	295,766	73,117	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
	0		295,766	73,117			
	C - CAP REL COSTS-MOVABLE EQUIP						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	6,743	14		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	40,881	14		2.00
3.00	OPERATION OF PLANT	7.00	0	29,265	14		3.00
4.00	NURSING ADMINISTRATION	13.00	0	5,967	14		4.00
5.00	CENTRAL SERVICES & SUPPLY	14.00	0	34,432	14		5.00
6.00	PHARMACY	15.00	0	194,841	14		6.00
7.00	MEDICAL RECORDS & LIBRARY	16.00	0	8,368	14		7.00
8.00	ADULTS & PEDIATRICS	30.00	0	30,462	14		8.00
9.00	CORONARY CARE UNIT	32.00	0	1,331	14		9.00
10.00	SUBPROVIDER - IPF	40.00	0	4,208	14		10.00
12.00	OPERATING ROOM	50.00	0	73,325	14		12.00
13.00	RECOVERY ROOM	51.00	0	1,352	14		13.00
14.00	RURAL HEALTH CLINIC IV	88.03	0	594	14		14.00
15.00	RADIOLOGY-DIAGNOSTIC	54.00	0	2,941	14		15.00
16.00	RADIOLOGY-THERAPEUTIC	55.00	0	3,079	14		16.00
17.00	CARDIAC CATHETERIZATION	59.00	0	9,925	14		17.00
18.00	LABORATORY	60.00	0	5,462	14		18.00
19.00	RESPIRATORY THERAPY	65.00	0	1,335	14		19.00
20.00	PHYSICAL THERAPY	66.00	0	17,682	14		20.00
21.00	SPEECH PATHOLOGY	68.00	0	910	14		21.00
22.00	ELECTROCARDIOLOGY	69.00	0	6,475	14		22.00
23.00	ELECTROENCEPHALOGRAPHY	70.00	0	4,014	14		23.00
24.00	RURAL HEALTH CLINIC	88.00	0	907	14		24.00
25.00	RURAL HEALTH CLINIC II	88.01	0	803	14		25.00
26.00	RURAL HEALTH CLINIC III	88.02	0	700	14		26.00
27.00	EMERGENCY	91.00	0	5,438	14		27.00
28.00	HOME HEALTH AGENCY	101.00	0	9,496	14		28.00
29.00	HOSPICE	116.00	0	2,766	14		29.00
30.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	43,887	14		30.00
31.00	WELLNESS	194.00	0	7,788	14		31.00
32.00	OCCUPATIONAL HEALTH	194.03	0	2,141	14		32.00
33.00	MISC. NONREIMBURSABLE	194.05	0	2,977	14		33.00
34.00	OTHER NONREIMB PROGRAM: PEACE MEAL	194.01	0	3,200	14		34.00
36.00	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	76.00	0	2,306	14		36.00
37.00	RURAL HEALTH CLINIC V	88.04	0	3,306	14		37.00
	0		0	569,307			
	D - DEPRECIATION						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	17,142,547	9		1.00
2.00		0.00	0	0	9		2.00
	0		0	17,142,547			
	E - CAFETERIA EXPENSE						
1.00	DIETARY	10.00	1,080,840	1,186,851	0		1.00
	0		1,080,840	1,186,851			
	F - EMPLOYEE PHYSICALS/BENF EXP						
1.00	OCCUPATIONAL HEALTH	194.03	0	197,380	0		1.00
	0		0	197,380			
	G - EAP BENEFITS						
1.00	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	76.00	0	18,925	0		1.00
	0		0	18,925			
	H - INTEREST EXPENSE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	1,829,236	11		1.00
	0		0	1,829,236			
	I - NURSRY/L&D EXP						
1.00	ADULTS & PEDIATRICS	30.00	1,323,426	0	0		1.00
2.00		0.00	0	0	0		2.00
	0		1,323,426	0			

RECLASSIFICATIONS | Provider CCN: 14-0189 | Period: From 07/01/2016 To 06/30/2017 | Worksheet A-6 | Date/Time Prepared: 11/16/2017 3:52 pm

		Decreases				
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
	J - PHYSN PROF LIAB EXP					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	2,053,738	0	1.00
2.00		0.00	0	0	0	2.00
3.00		0.00	0	0	0	3.00
4.00		0.00	0	0	0	4.00
5.00		0.00	0	0	0	5.00
6.00		0.00	0	0	0	6.00
7.00		0.00	0	0	0	7.00
8.00		0.00	0	0	0	8.00
9.00		0.00	0	0	0	9.00
10.00		0.00	0	0	0	10.00
11.00		0.00	0	0	0	11.00
12.00		0.00	0	0	0	12.00
13.00		0.00	0	0	0	13.00
14.00		0.00	0	0	0	14.00
15.00		0.00	0	0	0	15.00
	0		0	2,053,738		
	K - RHC V-LAB STAFF EXPENSE					
1.00	RURAL HEALTH CLINIC V	88.04	31,828	0	0	1.00
	0		31,828	0		
500.00	Grand Total: Decreases		2,731,860	38,436,297		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-0189 | Period: From 07/01/2016 To 06/30/2017 | Worksheet A-7 Part I | Date/Time Prepared: 11/16/2017 3:52 pm

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	3,553,346	124,050	0	124,050	0	1.00
2.00	Land Improvements	8,721,929	3,690,963	0	3,690,963	49,990	2.00
3.00	Buildings and Fixtures	134,966,259	28,558,018	0	28,558,018	3,088,808	3.00
4.00	Building Improvements	543,828	0	0	0	2,048	4.00
5.00	Fixed Equipment	17,238,745	1,858,341	0	1,858,341	49,088	5.00
6.00	Movable Equipment	85,533,663	28,963,911	0	28,963,911	4,109,313	6.00
7.00	HIT designated Assets	684,552	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	251,242,322	63,195,283	0	63,195,283	7,299,247	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	251,242,322	63,195,283	0	63,195,283	7,299,247	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	3,677,396	0	1.00
2.00	Land Improvements	12,362,902	0	2.00
3.00	Buildings and Fixtures	160,435,469	0	3.00
4.00	Building Improvements	541,780	0	4.00
5.00	Fixed Equipment	19,047,998	0	5.00
6.00	Movable Equipment	110,388,261	0	6.00
7.00	HIT designated Assets	684,552	0	7.00
8.00	Subtotal (sum of lines 1-7)	307,138,358	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	307,138,358	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-0189 | Period: From 07/01/2016 To 06/30/2017 | Worksheet A-7 Part II | Date/Time Prepared: 11/16/2017 3:52 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	0	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL			
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)		
		14.00	15.00		
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2				
1.00	CAP REL COSTS-BLDG & FIXT	0	0		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0		2.00
3.00	Total (sum of lines 1-2)	0	0		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-0189 | Period: From 07/01/2016 To 06/30/2017 | Worksheet A-7 Part III Date/Time Prepared: 11/16/2017 3:52 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	5,902,328	0	5,902,328	0.344309	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	11,240,217	0	11,240,217	0.655691	0	2.00
3.00	Total (sum of lines 1-2)	17,142,545	0	17,142,545	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	5,902,329	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	11,240,218	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	17,142,547	0	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	197,296	0	0	0	6,099,625	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	569,307	11,809,525	2.00
3.00	Total (sum of lines 1-2)	197,296	0	0	569,307	17,909,150	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-0189 | Period: From 07/01/2016 To 06/30/2017 | Worksheet A-8 | Date/Time Prepared: 11/16/2017 3:52 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)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		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)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-26,163,454			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	0			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-948,303	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		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-82,143	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	-151	HOUSEKEEPING	9.00	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		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	INVESTMENT INCOME	B	-1,631,940	CAP REL COSTS-BLDG & FIXT	1.00	11	33.00
35.00	A&G OTHER INCOME	B	-510,277	ADMINISTRATIVE & GENERAL	5.00	0	35.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-0189 | Period: From 07/01/2016 To 06/30/2017 | Worksheet A-8 | Date/Time Prepared: 11/16/2017 3:52 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	
36.00	DIETARY OUTREACH REVENUE	B	-1,150	DIETARY	10.00	0	36.00
37.00	FACILITIES SVC OTHER REV	B	-250	OPERATION OF PLANT	7.00	0	37.00
38.00	W&C (BABY CLASSES), 4W MISC	B	-10,523	ADULTS & PEDIATRICS	30.00	0	38.00
38.01	XRAY OTHER REVENUE	B	-295	RADIOLOGY-DIAGNOSTIC	54.00	0	38.01
39.00	PHYSICAL THERAPY OTHER REV	B	-2,885	PHYSICAL THERAPY	66.00	0	39.00
39.01	MEDICAID ASSESSMENT TAX	A	-5,199,538	ADMINISTRATIVE & GENERAL	5.00	0	39.01
41.00	SPEECH/AUDIO OTHER REV	B	-779,519	SPEECH PATHOLOGY	68.00	0	41.00
42.00	EKG/CARDIOLOGY OTR REV	B	-55,016	ELECTROCARDIOLOGY	69.00	0	42.00
43.00	EMERGENCY (EMS)OTHER REV	B	-101,927	EMERGENCY	91.00	0	43.00
44.00	AHA/IIHA LOBBYING FEES	A	-30,458	ADMINISTRATIVE & GENERAL	5.00	0	44.00
45.00	CRNA S&W (EMPLYEES)	A	-2,008,732	ANESTHESIOLOGY	53.00	0	45.00
45.01	CRNA (BENEFIT EXP)	A	-384,085	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	45.01
45.02	CAFETERIA REV/OTHER	B	-49,874	CAFETERIA	11.00	0	45.02
45.03			0		0.00	0	45.03
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-37,960,520				50.00

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 14-0189 | Period: From 07/01/2016 To 06/30/2017 | Worksheet A-8-2 | Date/Time Prepared: 11/16/2017 3:52 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	AGGREGATE-ADULTS & PEDIATRICS	4,509,156	4,509,156	0	142,500	0	1.00
2.00	40.00	AGGREGATE-SUBPROVIDER - IPF	2,161,742	2,161,742	0	138,700	0	2.00
3.00	53.00	AGGREGATE-ANESTHESIOLOGY	4,108,502	4,108,502	0	167,500	0	3.00
4.00	54.00	AGGREGATE-RADIOLOGY-DIAGNOSTIC	3,495,486	3,495,486	0	167,500	0	4.00
5.00	55.00	AGGREGATE-RADIOLOGY-THERAPEUTIC	1,493,449	1,493,449	0	217,600	0	5.00
6.00	60.00	DR. A	652,225	633,778	18,447	208,000	59	6.00
7.00	65.00	AGGREGATE-RESPIRATORY THERAPY	146,942	146,942	0	159,800	0	7.00
8.00	69.00	AGGREGATE-ELECTROCARDIOLOGY	2,581,164	2,581,164	0	159,800	0	8.00
9.00	70.00	AGGREGATE-ELECTROENCEPHALOGRAPHY	662,370	662,370	0	159,800	0	9.00
10.00	91.00	DR. B	464,780	232,390	232,390	159,800	1,040	10.00
11.00	91.00	AGGREGATE-EMERGENCY	5,986,862	5,986,862	0	159,800	0	11.00
200.00			26,262,678	26,011,841	250,837		1,099	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	AGGREGATE-ADULTS & PEDIATRICS	0	0	58,537	0	168,673	1.00
2.00	40.00	AGGREGATE-SUBPROVIDER - IPF	0	0	11,679	0	58,272	2.00
3.00	53.00	AGGREGATE-ANESTHESIOLOGY	0	0	62,251	0	123,285	3.00
4.00	54.00	AGGREGATE-RADIOLOGY-DIAGNOSTIC	0	0	13,623	0	73,402	4.00
5.00	55.00	AGGREGATE-RADIOLOGY-THERAPEUTIC	0	0	0	0	45,389	5.00
6.00	60.00	DR. A	5,900	295	2,569	73	15,130	6.00
7.00	65.00	AGGREGATE-RESPIRATORY THERAPY	0	0	0	0	0	7.00
8.00	69.00	AGGREGATE-ELECTROCARDIOLOGY	0	0	0	0	0	8.00
9.00	70.00	AGGREGATE-ELECTROENCEPHALOGRAPHY	0	0	16,169	0	31,757	9.00
10.00	91.00	DR. B	79,900	3,995	3,205	1,603	22,640	10.00
11.00	91.00	AGGREGATE-EMERGENCY	0	0	50,564	0	353,951	11.00
200.00			85,800	4,290	218,597	1,676	892,499	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	30.00	AGGREGATE-ADULTS & PEDIATRICS	0	0	0	4,509,156		1.00
2.00	40.00	AGGREGATE-SUBPROVIDER - IPF	0	0	0	2,161,742		2.00
3.00	53.00	AGGREGATE-ANESTHESIOLOGY	0	0	0	4,108,502		3.00
4.00	54.00	AGGREGATE-RADIOLOGY-DIAGNOSTIC	0	0	0	3,495,486		4.00
5.00	55.00	AGGREGATE-RADIOLOGY-THERAPEUTIC	0	0	0	1,493,449		5.00
6.00	60.00	DR. A	428	6,401	12,046	645,824		6.00
7.00	65.00	AGGREGATE-RESPIRATORY THERAPY	0	0	0	146,942		7.00
8.00	69.00	AGGREGATE-ELECTROCARDIOLOGY	0	0	0	2,581,164		8.00
9.00	70.00	AGGREGATE-ELECTROENCEPHALOGRAPHY	0	0	0	662,370		9.00
10.00	91.00	DR. B	11,320	92,823	139,567	371,957		10.00
11.00	91.00	AGGREGATE-EMERGENCY	0	0	0	5,986,862		11.00
200.00			11,748	99,224	151,613	26,163,454		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0189 | Period: From 07/01/2016 To 06/30/2017 | Worksheet B Part I Date/Time Prepared: 11/16/2017 3:52 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	6,099,625	6,099,625				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	11,809,525		11,809,525			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	28,486,185	42,582	2,961	28,531,728		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	33,198,785	522,309	3,428,592	3,348,173	40,497,859	5.00
7.00	00700	OPERATION OF PLANT	4,850,168	392,922	745,803	246,943	6,235,836	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	597,050	12,362	0	5,742	615,154	8.00
9.00	00900	HOUSEKEEPING	2,098,222	11,687	21,578	324,979	2,456,466	9.00
10.00	01000	DIETARY	791,885	76,410	43,172	75,964	987,431	10.00
11.00	01100	CAFETERIA	1,269,514	46,249	17,479	217,221	1,550,463	11.00
13.00	01300	NURSING ADMINISTRATION	2,365,649	23,479	50,672	371,658	2,811,458	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,522,859	74,256	183,311	119,623	1,900,049	14.00
15.00	01500	PHARMACY	1,987,426	34,166	29,562	334,131	2,385,285	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,619,377	44,863	55,592	365,333	3,085,165	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	15,415,586	627,634	457,416	3,280,505	19,781,141	30.00
32.00	03200	CORONARY CARE UNIT	2,875,414	57,133	184,862	359,087	3,476,496	32.00
40.00	04000	SUBPROVIDER - IPF	1,732,354	101,472	24,231	716,282	2,574,339	40.00
43.00	04300	NURSERY	556,844	7,182	39,761	105,648	709,435	43.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	8,083,262	419,987	1,329,376	1,115,844	10,948,469	50.00
51.00	05100	RECOVERY ROOM	1,624,452	98,970	56,445	273,346	2,053,213	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	882,190	16,379	60,573	160,327	1,119,469	52.00
53.00	05300	ANESTHESIOLOGY	557,194	7,520	257,484	1,141,845	1,964,043	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,589,825	176,159	571,240	1,138,810	5,476,034	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	1,609,170	219,952	505,696	493,579	2,828,397	55.00
56.00	05600	RADIOISOTOPE	2,770,624	22,676	1,409,983	268,196	4,471,479	56.00
57.00	05700	CT SCAN	1,323,918	17,764	121,639	109,828	1,573,149	57.00
58.00	05800	MRI	982,666	23,782	311,074	84,854	1,402,376	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,010,752	33,083	250,771	114,773	1,409,379	59.00
60.00	06000	LABORATORY	9,587,506	142,972	405,824	1,008,521	11,144,823	60.00
65.00	06500	RESPIRATORY THERAPY	1,477,728	17,985	69,736	237,972	1,803,421	65.00
66.00	06600	PHYSICAL THERAPY	2,998,002	167,371	25,700	405,085	3,596,158	66.00
67.00	06700	OCCUPATIONAL THERAPY	586,289	4,912	4,348	104,607	700,156	67.00
68.00	06800	SPEECH PATHOLOGY	574,820	36,016	31,415	163,749	806,000	68.00
69.00	06900	ELECTROCARDIOLOGY	1,528,223	66,736	73,941	277,984	1,946,884	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,951,185	53,443	41,566	241,154	2,287,348	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,704,262	0	0	0	3,704,262	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	6,502,047	0	0	0	6,502,047	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	15,365,196	0	0	0	15,365,196	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	643,926	31,651	2,883	121,941	800,401	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	418,542	154,287	9,141	56,889	638,859	88.00
88.01	08801	RURAL HEALTH CLINIC II	521,249	76,980	5,883	72,248	676,360	88.01
88.02	08802	RURAL HEALTH CLINIC III	869,913	30,161	6,854	143,766	1,050,694	88.02
88.03	08803	RURAL HEALTH CLINIC IV	676,715	34,166	29,342	96,996	837,219	88.03
88.04	08805	RURAL HEALTH CLINIC V	1,491,416	98,434	34,163	243,142	1,867,155	88.04
91.00	09100	EMERGENCY	6,004,510	207,694	140,899	1,934,827	8,287,930	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	4,545,892	46,447	106,768	752,490	5,451,597	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	2,503,901	17,461	155	309,872	2,831,389	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	202,661,843	4,297,694	11,147,891	20,943,934	192,610,484	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	43,134,845	1,279,972	411,500	6,759,227	51,585,544	192.00
194.00	07950	WELLNESS	1,150,524	271,229	79,415	144,523	1,645,691	194.00
194.01	07953	OTHER NONREIMB PROGRAM: PEACE MEAL	3,033,262	0	97,848	259,376	3,390,486	194.01
194.02	07951	LIFELINE	124,383	2,794	0	2,645	129,822	194.02
194.03	07952	OCCUPATIONAL HEALTH	599,995	33,886	8,128	119,305	761,314	194.03
194.05	07954	MISC. NONREIMBURSABLE	2,075,493	214,050	64,743	302,718	2,657,004	194.05
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)	252,780,345	6,099,625	11,809,525	28,531,728	252,780,345	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0189 | Period: From 07/01/2016 To 06/30/2017 | Worksheet B Part I Date/Time Prepared: 11/16/2017 3:52 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	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	40,497,859					5.00
7.00	00700	OPERATION OF PLANT	1,189,629	7,425,465				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	117,355	17,853	750,362			8.00
9.00	00900	HOUSEKEEPING	468,627	16,878	38,893	2,980,864		9.00
10.00	01000	DIETARY	188,375	110,346	9,636	0	1,295,788	10.00
11.00	01100	CAFETERIA	295,786	66,789	0	98,825	0	11.00
13.00	01300	NURSING ADMINISTRATION	536,350	33,907	0	22,386	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	362,478	107,236	10,736	32,760	0	14.00
15.00	01500	PHARMACY	455,048	49,340	0	8,463	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	588,566	64,789	0	14,196	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,773,708	906,388	216,477	26,481	1,090,302	30.00
32.00	03200	CORONARY CARE UNIT	663,222	82,507	17,816	64,701	47,974	32.00
40.00	04000	SUBPROVIDER - IPF	491,114	146,540	14,422	88,451	117,903	40.00
43.00	04300	NURSERY	135,341	10,372	5,890	0	0	43.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,088,672	606,517	110,006	801,247	5,960	50.00
51.00	05100	RECOVERY ROOM	391,698	142,925	49,575	109,199	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	213,564	23,653	18,956	0	0	52.00
53.00	05300	ANESTHESIOLOGY	374,686	10,860	0	4,095	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,044,679	254,398	32,613	54,054	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	539,582	317,640	7,107	174,719	0	55.00
56.00	05600	RADIOISOTOPE	853,037	32,747	20,944	24,570	0	56.00
57.00	05700	CT SCAN	300,114	25,653	17,178	13,104	0	57.00
58.00	05800	MRI	267,535	34,344	7,054	5,460	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	268,871	47,776	11,484	27,300	0	59.00
60.00	06000	LABORATORY	2,126,131	206,470	152	125,852	0	60.00
65.00	06500	RESPIRATORY THERAPY	344,044	25,973	0	16,653	0	65.00
66.00	06600	PHYSICAL THERAPY	686,050	241,706	7,937	107,834	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	133,571	7,094	0	8,190	0	67.00
68.00	06800	SPEECH PATHOLOGY	153,763	52,013	84	12,285	0	68.00
69.00	06900	ELECTROCARDIOLOGY	371,413	96,376	6,494	102,101	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	436,364	77,178	127	37,128	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	706,673	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,240,415	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,931,265	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	152,695	45,709	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	121,877	222,810	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	129,031	111,170	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	200,444	43,557	0	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	159,719	49,340	0	0	0	88.03
88.04	08805	RURAL HEALTH CLINIC V	356,203	142,152	0	0	0	88.04
91.00	09100	EMERGENCY	1,581,113	299,938	146,537	307,942	33,649	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	1,040,018	67,075	0	18,564	0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	540,153	25,216	0	8,736	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	29,018,979	4,823,235	750,118	2,315,296	1,295,788	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	9,841,224	1,848,450	244	493,580	0	192.00
194.00	07950	WELLNESS	313,953	391,692	0	76,166	0	194.00
194.01	07953	OTHER NONREIMB PROGRAM: PEACE MEAL	646,813	0	0	0	0	194.01
194.02	07951	LIFELINE	24,767	4,035	0	0	0	194.02
194.03	07952	OCCUPATIONAL HEALTH	145,238	48,936	0	22,659	0	194.03
194.05	07954	MISC. NONREIMBURSABLE	506,885	309,117	0	73,163	0	194.05
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)	40,497,859	7,425,465	750,362	2,980,864	1,295,788	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0189 | Period: From 07/01/2016 To 06/30/2017 | Worksheet B Part I | Date/Time Prepared: 11/16/2017 3:52 pm

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		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
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	2,011,863					11.00
13.00	01300	NURSING ADMINISTRATION	45,042	3,449,143				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	28,360	0	2,441,619			14.00
15.00	01500	PHARMACY	35,032	0	0	2,933,168		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	65,060	0	0	0	3,817,776	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	453,756	1,627,444	0	0	163,655	30.00
32.00	03200	CORONARY CARE UNIT	48,378	184,906	0	0	21,922	32.00
40.00	04000	SUBPROVIDER - IPF	45,042	137,290	0	0	23,509	40.00
43.00	04300	NURSERY	13,346	60,395	0	0	11,137	43.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	125,116	602,106	0	0	423,600	50.00
51.00	05100	RECOVERY ROOM	38,369	150,025	0	0	109,209	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	20,019	87,464	0	0	27,565	52.00
53.00	05300	ANESTHESIOLOGY	25,023	7,053	0	0	78,342	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	66,728	0	0	0	179,744	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	35,032	0	0	0	74,337	55.00
56.00	05600	RADIOISOTOPE	28,360	0	0	0	204,789	56.00
57.00	05700	CT SCAN	16,682	0	0	0	369,537	57.00
58.00	05800	MRI	10,009	0	0	0	154,819	58.00
59.00	05900	CARDIAC CATHETERIZATION	11,677	0	0	0	90,115	59.00
60.00	06000	LABORATORY	153,475	0	0	0	277,531	60.00
65.00	06500	RESPIRATORY THERAPY	35,032	0	0	0	72,653	65.00
66.00	06600	PHYSICAL THERAPY	48,378	0	0	0	106,974	66.00
67.00	06700	OCCUPATIONAL THERAPY	11,677	0	0	0	16,111	67.00
68.00	06800	SPEECH PATHOLOGY	18,350	0	0	0	16,552	68.00
69.00	06900	ELECTROCARDIOLOGY	43,373	0	0	0	45,103	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	18,350	0	0	0	40,521	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	878,983	0	152,052	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	1,562,636	0	158,772	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	2,933,168	618,557	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	25,023	0	0	0	1,161	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	1,765	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	2,680	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	4,485	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	0	0	4,155	88.03
88.04	08805	RURAL HEALTH CLINIC V	0	0	0	0	9,330	88.04
91.00	09100	EMERGENCY	146,803	592,460	0	0	293,858	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	23,355	0	0	0	32,545	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	10,009	0	0	0	30,691	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,644,856	3,449,143	2,441,619	2,933,168	3,817,776	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	311,956	0	0	0	0	192.00
194.00	07950	WELLNESS	28,360	0	0	0	0	194.00
194.01	07953	OTHER NONREIMB PROGRAM: PEACE MEAL	0	0	0	0	0	194.01
194.02	07951	LIFELINE	0	0	0	0	0	194.02
194.03	07952	OCCUPATIONAL HEALTH	16,682	0	0	0	0	194.03
194.05	07954	MISC. NONREIMBURSABLE	10,009	0	0	0	0	194.05
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)	2,011,863	3,449,143	2,441,619	2,933,168	3,817,776	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0189 | Period: From 07/01/2016 To 06/30/2017 | Worksheet B Part I | Date/Time Prepared: 11/16/2017 3:52 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
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	28,039,352	0	28,039,352		30.00
32.00	03200	CORONARY CARE UNIT	4,607,922	0	4,607,922		32.00
40.00	04000	SUBPROVIDER - IPF	3,638,610	0	3,638,610		40.00
43.00	04300	NURSERY	945,916	0	945,916		43.00
45.00	04500	NURSING FACILITY	0	0	0		45.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	15,711,693	0	15,711,693		50.00
51.00	05100	RECOVERY ROOM	3,044,213	0	3,044,213		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,510,690	0	1,510,690		52.00
53.00	05300	ANESTHESIOLOGY	2,464,102	0	2,464,102		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,108,250	0	7,108,250		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	3,976,814	0	3,976,814		55.00
56.00	05600	RADIOISOTOPE	5,635,926	0	5,635,926		56.00
57.00	05700	CT SCAN	2,315,417	0	2,315,417		57.00
58.00	05800	MRI	1,881,597	0	1,881,597		58.00
59.00	05900	CARDIAC CATHETERIZATION	1,866,602	0	1,866,602		59.00
60.00	06000	LABORATORY	14,034,434	0	14,034,434		60.00
65.00	06500	RESPIRATORY THERAPY	2,297,776	0	2,297,776		65.00
66.00	06600	PHYSICAL THERAPY	4,795,037	0	4,795,037		66.00
67.00	06700	OCCUPATIONAL THERAPY	876,799	0	876,799		67.00
68.00	06800	SPEECH PATHOLOGY	1,059,047	0	1,059,047		68.00
69.00	06900	ELECTROCARDIOLOGY	2,611,744	0	2,611,744		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	2,897,016	0	2,897,016		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	5,441,970	0	5,441,970		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	9,463,870	0	9,463,870		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	21,848,186	0	21,848,186		73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0		75.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	1,024,989	0	1,024,989		76.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	985,311	0	985,311		88.00
88.01	08801	RURAL HEALTH CLINIC II	919,241	0	919,241		88.01
88.02	08802	RURAL HEALTH CLINIC III	1,299,180	0	1,299,180		88.02
88.03	08803	RURAL HEALTH CLINIC IV	1,050,433	0	1,050,433		88.03
88.04	08805	RURAL HEALTH CLINIC V	2,374,840	0	2,374,840		88.04
91.00	09100	EMERGENCY	11,690,230	0	11,690,230		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0			92.00
		OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY	6,633,154	0	6,633,154		101.00
		SPECIAL PURPOSE COST CENTERS					
116.00	11600	HOSPICE	3,446,194	0	3,446,194		116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	177,496,555	0	177,496,555		118.00
		NONREIMBURSABLE COST CENTERS					
192.00	19200	PHYSICIANS' PRIVATE OFFICES	64,080,998	0	64,080,998		192.00
194.00	07950	WELLNESS	2,455,862	0	2,455,862		194.00
194.01	07953	OTHER NONREIMB PROGRAM: PEACE MEAL	4,037,299	0	4,037,299		194.01
194.02	07951	LIFELINE	158,624	0	158,624		194.02
194.03	07952	OCCUPATIONAL HEALTH	994,829	0	994,829		194.03
194.05	07954	MISC. NONREIMBURSABLE	3,556,178	0	3,556,178		194.05
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)	252,780,345	0	252,780,345		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0189 | Period: From 07/01/2016 To 06/30/2017 | Worksheet B Part II Date/Time Prepared: 11/16/2017 3:52 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	42,582	2,961	45,543	45,543	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	522,309	3,428,592	3,950,901	5,348	5.00
7.00	00700	OPERATION OF PLANT	0	392,922	745,803	1,138,725	394	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	12,362	0	12,362	9	8.00
9.00	00900	HOUSEKEEPING	0	11,687	21,578	33,265	519	9.00
10.00	01000	DIETARY	0	76,410	43,172	119,582	121	10.00
11.00	01100	CAFETERIA	0	46,249	17,479	63,728	347	11.00
13.00	01300	NURSING ADMINISTRATION	0	23,479	50,672	74,151	594	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	74,256	183,311	257,567	191	14.00
15.00	01500	PHARMACY	0	34,166	29,562	63,728	534	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	44,863	55,592	100,455	584	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	627,634	457,416	1,085,050	5,240	30.00
32.00	03200	CORONARY CARE UNIT	0	57,133	184,862	241,995	574	32.00
40.00	04000	SUBPROVIDER - IPF	0	101,472	24,231	125,703	1,144	40.00
43.00	04300	NURSERY	0	7,182	39,761	46,943	169	43.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	419,987	1,329,376	1,749,363	1,782	50.00
51.00	05100	RECOVERY ROOM	0	98,970	56,445	155,415	437	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	16,379	60,573	76,952	256	52.00
53.00	05300	ANESTHESIOLOGY	0	7,520	257,484	265,004	1,824	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	176,159	571,240	747,399	1,819	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	219,952	505,696	725,648	788	55.00
56.00	05600	RADIOISOTOPE	0	22,676	1,409,983	1,432,659	428	56.00
57.00	05700	CT SCAN	0	17,764	121,639	139,403	175	57.00
58.00	05800	MRI	0	23,782	311,074	334,856	136	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	33,083	250,771	283,854	183	59.00
60.00	06000	LABORATORY	0	142,972	405,824	548,796	1,611	60.00
65.00	06500	RESPIRATORY THERAPY	0	17,985	69,736	87,721	380	65.00
66.00	06600	PHYSICAL THERAPY	0	167,371	25,700	193,071	647	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	4,912	4,348	9,260	167	67.00
68.00	06800	SPEECH PATHOLOGY	0	36,016	31,415	67,431	262	68.00
69.00	06900	ELECTROCARDIOLOGY	0	66,736	73,941	140,677	444	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	53,443	41,566	95,009	385	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	31,651	2,883	34,534	195	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	154,287	9,141	163,428	91	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	76,980	5,883	82,863	115	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	30,161	6,854	37,015	230	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	34,166	29,342	63,508	155	88.03
88.04	08805	RURAL HEALTH CLINIC V	0	98,434	34,163	132,597	388	88.04
91.00	09100	EMERGENCY	0	207,694	140,899	348,593	3,090	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	46,447	106,768	153,215	1,202	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	17,461	155	17,616	495	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	4,297,694	11,147,891	15,445,585	33,453	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	1,279,972	411,500	1,691,472	10,766	192.00
194.00	07950	WELLNESS	0	271,229	79,415	350,644	231	194.00
194.01	07953	OTHER NONREIMB PROGRAM: PEACE MEAL	0	0	97,848	97,848	414	194.01
194.02	07951	LIFELINE	0	2,794	0	2,794	4	194.02
194.03	07952	OCCUPATIONAL HEALTH	0	33,886	8,128	42,014	191	194.03
194.05	07954	MISC. NONREIMBURSABLE	0	214,050	64,743	278,793	484	194.05
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)	0	6,099,625	11,809,525	17,909,150	45,543	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0189 | Period: From 07/01/2016 To 06/30/2017 | Worksheet B Part II Date/Time Prepared: 11/16/2017 3:52 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	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	3,956,249					5.00
7.00	00700	OPERATION OF PLANT	116,217	1,255,336				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	11,465	3,018	26,854			8.00
9.00	00900	HOUSEKEEPING	45,781	2,853	1,392	83,810		9.00
10.00	01000	DIETARY	18,403	18,655	345	0	157,106	10.00
11.00	01100	CAFETERIA	28,896	11,291	0	2,779	0	11.00
13.00	01300	NURSING ADMINISTRATION	52,397	5,732	0	629	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	35,411	18,129	384	921	0	14.00
15.00	01500	PHARMACY	44,455	8,341	0	238	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	57,498	10,953	0	399	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	368,661	153,232	7,748	745	132,191	30.00
32.00	03200	CORONARY CARE UNIT	64,791	13,949	638	1,819	5,817	32.00
40.00	04000	SUBPROVIDER - IPF	47,978	24,774	516	2,487	14,295	40.00
43.00	04300	NURSERY	13,222	1,754	211	0	0	43.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	204,047	102,537	3,937	22,528	723	50.00
51.00	05100	RECOVERY ROOM	38,266	24,163	1,774	3,070	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	20,864	3,999	678	0	0	52.00
53.00	05300	ANESTHESIOLOGY	36,604	1,836	0	115	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	102,057	43,008	1,167	1,520	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	52,713	53,700	254	4,912	0	55.00
56.00	05600	RADIOISOTOPE	83,335	5,536	750	691	0	56.00
57.00	05700	CT SCAN	29,319	4,337	615	368	0	57.00
58.00	05800	MRI	26,136	5,806	252	154	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	26,267	8,077	411	768	0	59.00
60.00	06000	LABORATORY	207,706	34,905	5	3,538	0	60.00
65.00	06500	RESPIRATORY THERAPY	33,610	4,391	0	468	0	65.00
66.00	06600	PHYSICAL THERAPY	67,022	40,862	284	3,032	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	13,049	1,199	0	230	0	67.00
68.00	06800	SPEECH PATHOLOGY	15,021	8,793	3	345	0	68.00
69.00	06900	ELECTROCARDIOLOGY	36,284	16,293	232	2,871	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	42,629	13,048	5	1,044	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	69,036	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	121,179	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	286,361	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	14,917	7,727	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	11,906	37,668	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	12,605	18,794	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	19,582	7,364	0	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	15,603	8,341	0	0	0	88.03
88.04	08805	RURAL HEALTH CLINIC V	34,798	24,032	0	0	0	88.04
91.00	09100	EMERGENCY	154,462	50,707	5,244	8,658	4,080	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	101,601	11,340	0	522	0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	52,769	4,263	0	246	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	2,834,923	815,407	26,845	65,097	157,106	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	961,340	312,496	9	13,878	0	192.00
194.00	07950	WELLNESS	30,671	66,219	0	2,141	0	194.00
194.01	07953	OTHER NONREIMB PROGRAM: PEACE MEAL	63,188	0	0	0	0	194.01
194.02	07951	LIFELINE	2,419	682	0	0	0	194.02
194.03	07952	OCCUPATIONAL HEALTH	14,189	8,273	0	637	0	194.03
194.05	07954	MISC. NONREIMBURSABLE	49,519	52,259	0	2,057	0	194.05
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)	3,956,249	1,255,336	26,854	83,810	157,106	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0189 | Period: From 07/01/2016 To 06/30/2017 | Worksheet B Part II | Date/Time Prepared: 11/16/2017 3:52 pm

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		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
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	107,041					11.00
13.00	01300	NURSING ADMINISTRATION	2,396	135,899				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,509	0	314,112			14.00
15.00	01500	PHARMACY	1,864	0	0	119,160		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,462	0	0	0	173,351	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	24,140	64,124	0	0	7,446	30.00
32.00	03200	CORONARY CARE UNIT	2,574	7,285	0	0	997	32.00
40.00	04000	SUBPROVIDER - IPF	2,396	5,409	0	0	1,070	40.00
43.00	04300	NURSERY	710	2,380	0	0	507	43.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,657	23,723	0	0	19,272	50.00
51.00	05100	RECOVERY ROOM	2,041	5,911	0	0	4,969	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,065	3,446	0	0	1,254	52.00
53.00	05300	ANESTHESIOLOGY	1,331	278	0	0	3,564	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,550	0	0	0	8,178	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	1,864	0	0	0	3,382	55.00
56.00	05600	RADIOISOTOPE	1,509	0	0	0	9,317	56.00
57.00	05700	CT SCAN	888	0	0	0	16,812	57.00
58.00	05800	MRI	533	0	0	0	7,044	58.00
59.00	05900	CARDIAC CATHETERIZATION	621	0	0	0	4,100	59.00
60.00	06000	LABORATORY	8,166	0	0	0	12,626	60.00
65.00	06500	RESPIRATORY THERAPY	1,864	0	0	0	3,305	65.00
66.00	06600	PHYSICAL THERAPY	2,574	0	0	0	4,867	66.00
67.00	06700	OCCUPATIONAL THERAPY	621	0	0	0	733	67.00
68.00	06800	SPEECH PATHOLOGY	976	0	0	0	753	68.00
69.00	06900	ELECTROCARDIOLOGY	2,308	0	0	0	2,052	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	976	0	0	0	1,844	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	113,080	0	6,918	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	201,032	0	7,223	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	119,160	27,800	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	1,331	0	0	0	53	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	80	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	122	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	204	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	0	0	189	88.03
88.04	08805	RURAL HEALTH CLINIC V	0	0	0	0	424	88.04
91.00	09100	EMERGENCY	7,811	23,343	0	0	13,369	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	1,243	0	0	0	1,481	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	533	0	0	0	1,396	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	87,513	135,899	314,112	119,160	173,351	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	16,598	0	0	0	0	192.00
194.00	07950	WELLNESS	1,509	0	0	0	0	194.00
194.01	07953	OTHER NONREIMB PROGRAM: PEACE MEAL	0	0	0	0	0	194.01
194.02	07951	LIFELINE	0	0	0	0	0	194.02
194.03	07952	OCCUPATIONAL HEALTH	888	0	0	0	0	194.03
194.05	07954	MISC. NONREIMBURSABLE	533	0	0	0	0	194.05
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)	107,041	135,899	314,112	119,160	173,351	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0189 | Period: From 07/01/2016 To 06/30/2017 | Worksheet B Part II | Date/Time Prepared: 11/16/2017 3:52 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
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	1,848,577	0	1,848,577		30.00
32.00	03200	CORONARY CARE UNIT	340,439	0	340,439		32.00
40.00	04000	SUBPROVIDER - IPF	225,772	0	225,772		40.00
43.00	04300	NURSERY	65,896	0	65,896		43.00
45.00	04500	NURSING FACILITY	0	0	0		45.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	2,134,569	0	2,134,569		50.00
51.00	05100	RECOVERY ROOM	236,046	0	236,046		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	108,514	0	108,514		52.00
53.00	05300	ANESTHESIOLOGY	310,556	0	310,556		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	908,698	0	908,698		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	843,261	0	843,261		55.00
56.00	05600	RADIOISOTOPE	1,534,225	0	1,534,225		56.00
57.00	05700	CT SCAN	191,917	0	191,917		57.00
58.00	05800	MRI	374,917	0	374,917		58.00
59.00	05900	CARDIAC CATHETERIZATION	324,281	0	324,281		59.00
60.00	06000	LABORATORY	817,353	0	817,353		60.00
65.00	06500	RESPIRATORY THERAPY	131,739	0	131,739		65.00
66.00	06600	PHYSICAL THERAPY	312,359	0	312,359		66.00
67.00	06700	OCCUPATIONAL THERAPY	25,259	0	25,259		67.00
68.00	06800	SPEECH PATHOLOGY	93,584	0	93,584		68.00
69.00	06900	ELECTROCARDIOLOGY	201,161	0	201,161		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	154,940	0	154,940		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	189,034	0	189,034		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	329,434	0	329,434		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	433,321	0	433,321		73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0		75.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	58,757	0	58,757		76.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	213,173	0	213,173		88.00
88.01	08801	RURAL HEALTH CLINIC II	114,499	0	114,499		88.01
88.02	08802	RURAL HEALTH CLINIC III	64,395	0	64,395		88.02
88.03	08803	RURAL HEALTH CLINIC IV	87,796	0	87,796		88.03
88.04	08805	RURAL HEALTH CLINIC V	192,239	0	192,239		88.04
91.00	09100	EMERGENCY	619,357	0	619,357		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0			92.00
		OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY	270,604	0	270,604		101.00
		SPECIAL PURPOSE COST CENTERS					
116.00	11600	HOSPICE	77,318	0	77,318		116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	13,833,990	0	13,833,990		118.00
		NONREIMBURSABLE COST CENTERS					
192.00	19200	PHYSICIANS' PRIVATE OFFICES	3,006,559	0	3,006,559		192.00
194.00	07950	WELLNESS	451,415	0	451,415		194.00
194.01	07953	OTHER NONREIMB PROGRAM: PEACE MEAL	161,450	0	161,450		194.01
194.02	07951	LIFELINE	5,899	0	5,899		194.02
194.03	07952	OCCUPATIONAL HEALTH	66,192	0	66,192		194.03
194.05	07954	MISC. NONREIMBURSABLE	383,645	0	383,645		194.05
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)	17,909,150	0	17,909,150		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0189 | Period: From 07/01/2016 To 06/30/2017 | Worksheet B-1 | Date/Time Prepared: 11/16/2017 3:52 pm

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	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	523,989					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		11,328,816				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	3,658	2,840	141,967,440			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	44,869	3,289,027	16,659,733	-40,497,859	212,282,486	5.00
7.00	00700	OPERATION OF PLANT	33,754	715,445	1,228,730	0	6,235,836	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,062	0	28,571	0	615,154	8.00
9.00	00900	HOUSEKEEPING	1,004	20,700	1,617,019	0	2,456,466	9.00
10.00	01000	DIETARY	6,564	41,415	377,981	0	987,431	10.00
11.00	01100	CAFETERIA	3,973	16,768	1,080,840	0	1,550,463	11.00
13.00	01300	NURSING ADMINISTRATION	2,017	48,609	1,849,286	0	2,811,458	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	6,379	175,849	595,216	0	1,900,049	14.00
15.00	01500	PHARMACY	2,935	28,359	1,662,558	0	2,385,285	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,854	53,329	1,817,813	0	3,085,165	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	53,917	438,797	16,323,034	0	19,781,141	30.00
32.00	03200	CORONARY CARE UNIT	4,908	177,337	1,786,735	0	3,476,496	32.00
40.00	04000	SUBPROVIDER - IPF	8,717	23,245	3,564,052	0	2,574,339	40.00
43.00	04300	NURSERY	617	38,143	525,678	0	709,435	43.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	36,079	1,275,264	5,552,182	0	10,948,469	50.00
51.00	05100	RECOVERY ROOM	8,502	54,147	1,360,106	0	2,053,213	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,407	58,107	797,748	0	1,119,469	52.00
53.00	05300	ANESTHESIOLOGY	646	247,003	5,681,558	0	1,964,043	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	15,133	547,988	5,666,453	0	5,476,034	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	18,895	485,112	2,455,935	0	2,828,397	55.00
56.00	05600	RADIOISOTOPE	1,948	1,352,590	1,334,483	0	4,471,479	56.00
57.00	05700	CT SCAN	1,526	116,688	546,479	0	1,573,149	57.00
58.00	05800	MRI	2,043	298,412	422,212	0	1,402,376	58.00
59.00	05900	CARDIAC CATHETERIZATION	2,842	240,563	571,085	0	1,409,379	59.00
60.00	06000	LABORATORY	12,282	389,305	5,018,168	0	11,144,823	60.00
65.00	06500	RESPIRATORY THERAPY	1,545	66,897	1,184,095	0	1,803,421	65.00
66.00	06600	PHYSICAL THERAPY	14,378	24,654	2,015,608	0	3,596,158	66.00
67.00	06700	OCCUPATIONAL THERAPY	422	4,171	520,499	0	700,156	67.00
68.00	06800	SPEECH PATHOLOGY	3,094	30,136	814,777	0	806,000	68.00
69.00	06900	ELECTROCARDIOLOGY	5,733	70,931	1,383,186	0	1,946,884	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	4,591	39,874	1,199,927	0	2,287,348	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	3,704,262	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	6,502,047	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	15,365,196	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	2,719	2,766	606,749	0	800,401	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	13,254	8,769	283,068	0	638,859	88.00
88.01	08801	RURAL HEALTH CLINIC II	6,613	5,644	359,488	0	676,360	88.01
88.02	08802	RURAL HEALTH CLINIC III	2,591	6,575	715,345	0	1,050,694	88.02
88.03	08803	RURAL HEALTH CLINIC IV	2,935	28,148	482,631	0	837,219	88.03
88.04	08805	RURAL HEALTH CLINIC V	8,456	32,772	1,209,816	0	1,867,155	88.04
91.00	09100	EMERGENCY	17,842	135,164	9,627,248	0	8,287,930	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	3,990	102,422	3,744,214	0	5,451,597	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	1,500	149	1,541,852	0	2,831,389	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	369,194	10,694,114	104,212,158	-40,497,859	152,112,625	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	109,956	394,750	33,632,525	0	51,585,544	192.00
194.00	07950	WELLNESS	23,300	76,182	719,112	0	1,645,691	194.00
194.01	07953	OTHER NONREIMB PROGRAM: PEACE MEAL	0	93,865	1,290,597	0	3,390,486	194.01
194.02	07951	LIFELINE	240	0	13,162	0	129,822	194.02
194.03	07952	OCCUPATIONAL HEALTH	2,911	7,797	593,633	0	761,314	194.03
194.05	07954	MISC. NONREIMBURSABLE	18,388	62,108	1,506,253	0	2,657,004	194.05
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)	6,099,625	11,809,525	28,531,728		40,497,859	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	11.640750	1.042432	0.200974		0.190773	203.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0189 | Period: From 07/01/2016 To 06/30/2017 | Worksheet B-1 | Date/Time Prepared: 11/16/2017 3:52 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
204.00		Cost to be allocated (per Wkst. B, Part II)			45,543		3,956,249	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000321		0.018637	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0189 | Period: From 07/01/2016 To 06/30/2017 | Worksheet B-1 | Date/Time Prepared: 11/16/2017 3:52 pm

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDR)	HOUSEKEEPING (HOURS OF SERVIC)	DIETARY (MEALS SERVED)	CAFETERIA (MEALS SERVED)	
			7.00	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
7.00	00700	OPERATION OF PLANT	441,708					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,062	950,886				8.00
9.00	00900	HOUSEKEEPING	1,004	49,287	10,919			9.00
10.00	01000	DIETARY	6,564	12,211	0	160,007		10.00
11.00	01100	CAFETERIA	3,973	0	362	0	1,206	11.00
13.00	01300	NURSING ADMINISTRATION	2,017	0	82	0	27	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	6,379	13,605	120	0	17	14.00
15.00	01500	PHARMACY	2,935	0	31	0	21	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,854	0	52	0	39	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	53,917	274,329	97	134,633	272	30.00
32.00	03200	CORONARY CARE UNIT	4,908	22,577	237	5,924	29	32.00
40.00	04000	SUBPROVIDER - IPF	8,717	18,276	324	14,559	27	40.00
43.00	04300	NURSERY	617	7,464	0	0	8	43.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	36,079	139,404	2,935	736	75	50.00
51.00	05100	RECOVERY ROOM	8,502	62,823	400	0	23	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,407	24,022	0	0	12	52.00
53.00	05300	ANESTHESIOLOGY	646	0	15	0	15	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	15,133	41,328	198	0	40	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	18,895	9,006	640	0	21	55.00
56.00	05600	RADIOISOTOPE	1,948	26,541	90	0	17	56.00
57.00	05700	CT SCAN	1,526	21,768	48	0	10	57.00
58.00	05800	MRI	2,043	8,939	20	0	6	58.00
59.00	05900	CARDIAC CATHETERIZATION	2,842	14,553	100	0	7	59.00
60.00	06000	LABORATORY	12,282	192	461	0	92	60.00
65.00	06500	RESPIRATORY THERAPY	1,545	0	61	0	21	65.00
66.00	06600	PHYSICAL THERAPY	14,378	10,058	395	0	29	66.00
67.00	06700	OCCUPATIONAL THERAPY	422	0	30	0	7	67.00
68.00	06800	SPEECH PATHOLOGY	3,094	107	45	0	11	68.00
69.00	06900	ELECTROCARDIOLOGY	5,733	8,229	374	0	26	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	4,591	161	136	0	11	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	2,719	0	0	0	15	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	13,254	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	6,613	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	2,591	0	0	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	2,935	0	0	0	0	88.03
88.04	08805	RURAL HEALTH CLINIC V	8,456	0	0	0	0	88.04
91.00	09100	EMERGENCY	17,842	185,697	1,128	4,155	88	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	3,990	0	68	0	14	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	1,500	0	32	0	6	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	286,913	950,577	8,481	160,007	986	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	109,956	309	1,808	0	187	192.00
194.00	07950	WELLNESS	23,300	0	279	0	17	194.00
194.01	07953	OTHER NONREIMB PROGRAM: PEACE MEAL	0	0	0	0	0	194.01
194.02	07951	LIFELINE	240	0	0	0	0	194.02
194.03	07952	OCCUPATIONAL HEALTH	2,911	0	83	0	10	194.03
194.05	07954	MISC. NONREIMBURSABLE	18,388	0	268	0	6	194.05
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)	7,425,465	750,362	2,980,864	1,295,788	2,011,863	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	16.810800	0.789119	272.997894	8.098321	1,668.211443	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	1,255,336	26,854	83,810	157,106	107,041	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	2.842004	0.028241	7.675611	0.981870	88.757048	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0189 | Period: From 07/01/2016 To 06/30/2017 | Worksheet B-1 | Date/Time Prepared: 11/16/2017 3:52 pm

		Cost Center Description	NURSING ADMINISTRATION (DIRECT NRSING HR)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)		
			13.00	14.00	15.00	16.00		
		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
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	1,000,500					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	100				14.00
15.00	01500	PHARMACY	0	0	100			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	691,970,282		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	472,076	0	0	29,663,840		30.00
32.00	03200	CORONARY CARE UNIT	53,636	0	0	3,973,528		32.00
40.00	04000	SUBPROVIDER - IPF	39,824	0	0	4,261,270		40.00
43.00	04300	NURSERY	17,519	0	0	2,018,651		43.00
45.00	04500	NURSING FACILITY	0	0	0	0		45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	174,654	0	0	76,780,893		50.00
51.00	05100	RECOVERY ROOM	43,518	0	0	19,794,997		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	25,371	0	0	4,996,353		52.00
53.00	05300	ANESTHESIOLOGY	2,046	0	0	14,200,193		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	32,580,067		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	13,474,173		55.00
56.00	05600	RADIOISOTOPE	0	0	0	37,119,612		56.00
57.00	05700	CT SCAN	0	0	0	66,981,590		57.00
58.00	05800	MRI	0	0	0	28,062,092		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	16,334,070		59.00
60.00	06000	LABORATORY	0	0	0	50,304,677		60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	13,168,896		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	19,389,808		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	2,920,272		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	3,000,165		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	8,175,348		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	7,344,826		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	36	0	27,560,679		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	64	0	28,778,687		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	100	112,086,093		73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0		75.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	210,443		76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	319,994		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	485,789		88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	812,974		88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	0	753,162		88.03
88.04	08805	RURAL HEALTH CLINIC V	0	0	0	1,691,113		88.04
91.00	09100	EMERGENCY	171,856	0	0	53,264,023		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	5,899,086		101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	5,562,918		116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,000,500	100	100	691,970,282		118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192.00
194.00	07950	WELLNESS	0	0	0	0		194.00
194.01	07953	OTHER NONREIMB PROGRAM: PEACE MEAL	0	0	0	0		194.01
194.02	07951	LIFELINE	0	0	0	0		194.02
194.03	07952	OCCUPATIONAL HEALTH	0	0	0	0		194.03
194.05	07954	MISC. NONREIMBURSABLE	0	0	0	0		194.05
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	3,449,143	2,441,619	2,933,168	3,817,776		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	3.447419	24,416.190000	29,331.680000	0.005517		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	135,899	314,112	119,160	173,351		204.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0189 | Period: From 07/01/2016 To 06/30/2017 | Worksheet B-1 | Date/Time Prepared: 11/16/2017 3:52 pm

		Cost Center Description	NURSING ADMINISTRATION (DIRECT NRSING HR)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)		
			13.00	14.00	15.00	16.00		
205.00		Unit cost multiplier (Wkst. B, Part II)	0.135831	3,141.120000	1,191.600000	0.000251		205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0189 | Period: From 07/01/2016 To 06/30/2017 | Worksheet C Part I Date/Time Prepared: 11/16/2017 3:52 pm

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		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	28,039,352		28,039,352	0	28,039,352	30.00
32.00	03200	CORONARY CARE UNIT	4,607,922		4,607,922	0	4,607,922	32.00
40.00	04000	SUBPROVIDER - IPF	3,638,610		3,638,610	0	3,638,610	40.00
43.00	04300	NURSERY	945,916		945,916	0	945,916	43.00
45.00	04500	NURSING FACILITY	0		0	0	0	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	15,711,693		15,711,693	0	15,711,693	50.00
51.00	05100	RECOVERY ROOM	3,044,213		3,044,213	0	3,044,213	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,510,690		1,510,690	0	1,510,690	52.00
53.00	05300	ANESTHESIOLOGY	2,464,102		2,464,102	0	2,464,102	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,108,250		7,108,250	0	7,108,250	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	3,976,814		3,976,814	0	3,976,814	55.00
56.00	05600	RADIOISOTOPE	5,635,926		5,635,926	0	5,635,926	56.00
57.00	05700	CT SCAN	2,315,417		2,315,417	0	2,315,417	57.00
58.00	05800	MRI	1,881,597		1,881,597	0	1,881,597	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,866,602		1,866,602	0	1,866,602	59.00
60.00	06000	LABORATORY	14,034,434		14,034,434	12,046	14,046,480	60.00
65.00	06500	RESPIRATORY THERAPY	2,297,776	0	2,297,776	0	2,297,776	65.00
66.00	06600	PHYSICAL THERAPY	4,795,037	0	4,795,037	0	4,795,037	66.00
67.00	06700	OCCUPATIONAL THERAPY	876,799	0	876,799	0	876,799	67.00
68.00	06800	SPEECH PATHOLOGY	1,059,047	0	1,059,047	0	1,059,047	68.00
69.00	06900	ELECTROCARDIOLOGY	2,611,744		2,611,744	0	2,611,744	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	2,897,016		2,897,016	0	2,897,016	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	5,441,970		5,441,970	0	5,441,970	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	9,463,870		9,463,870	0	9,463,870	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	21,848,186		21,848,186	0	21,848,186	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0		0	0	0	75.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	1,024,989		1,024,989	0	1,024,989	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	985,311		985,311	0	985,311	88.00
88.01	08801	RURAL HEALTH CLINIC II	919,241		919,241	0	919,241	88.01
88.02	08802	RURAL HEALTH CLINIC III	1,299,180		1,299,180	0	1,299,180	88.02
88.03	08803	RURAL HEALTH CLINIC IV	1,050,433		1,050,433	0	1,050,433	88.03
88.04	08805	RURAL HEALTH CLINIC V	2,374,840		2,374,840	0	2,374,840	88.04
91.00	09100	EMERGENCY	11,690,230		11,690,230	139,567	11,829,797	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	5,419,349		5,419,349		5,419,349	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	6,633,154		6,633,154		6,633,154	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	3,446,194		3,446,194		3,446,194	116.00
200.00		Subtotal (see instructions)	182,915,904	0	182,915,904	151,613	183,067,517	200.00
201.00		Less Observation Beds	5,419,349		5,419,349		5,419,349	201.00
202.00		Total (see instructions)	177,496,555	0	177,496,555	151,613	177,648,168	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0189 | Period: From 07/01/2016 To 06/30/2017 | Worksheet C Part I Date/Time Prepared: 11/16/2017 3:52 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	24,452,719		24,452,719			30.00
32.00	03200	CORONARY CARE UNIT	3,973,528		3,973,528			32.00
40.00	04000	SUBPROVIDER - IPF	4,261,270		4,261,270			40.00
43.00	04300	NURSERY	2,018,651		2,018,651			43.00
45.00	04500	NURSING FACILITY	0		0			45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	17,094,876	59,686,017	76,780,893	0.204630	0.000000	50.00
51.00	05100	RECOVERY ROOM	4,084,185	15,710,812	19,794,997	0.153787	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,710,934	285,419	4,996,353	0.302359	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	5,010,911	9,189,282	14,200,193	0.173526	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,426,348	28,153,719	32,580,067	0.218178	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	128,254	13,345,919	13,474,173	0.295143	0.000000	55.00
56.00	05600	RADIOISOTOPE	6,002,731	31,116,881	37,119,612	0.151831	0.000000	56.00
57.00	05700	CT SCAN	11,701,130	55,280,460	66,981,590	0.034568	0.000000	57.00
58.00	05800	MRI	2,279,069	25,783,023	28,062,092	0.067051	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	5,468,533	10,865,537	16,334,070	0.114277	0.000000	59.00
60.00	06000	LABORATORY	9,063,979	41,240,698	50,304,677	0.278989	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	11,154,373	2,014,523	13,168,896	0.174485	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	1,950,614	17,439,194	19,389,808	0.247297	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	466,815	2,453,457	2,920,272	0.300246	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	293,468	2,706,697	3,000,165	0.352996	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	1,695,675	6,479,673	8,175,348	0.319466	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	119,427	7,225,399	7,344,826	0.394429	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	8,969,887	18,590,792	27,560,679	0.197454	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	21,393,486	7,385,201	28,778,687	0.328850	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	25,888,171	86,197,922	112,086,093	0.194923	0.000000	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0.000000	0.000000	75.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	210,443	210,443	4.870625	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	319,994	319,994			88.00
88.01	08801	RURAL HEALTH CLINIC II	0	485,789	485,789			88.01
88.02	08802	RURAL HEALTH CLINIC III	0	812,974	812,974			88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	753,162	753,162			88.03
88.04	08805	RURAL HEALTH CLINIC V	0	1,691,113	1,691,113			88.04
91.00	09100	EMERGENCY	11,074,223	42,189,800	53,264,023	0.219477	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	5,211,121	5,211,121	1.039958	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	5,899,086	5,899,086			101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	5,562,918	5,562,918			116.00
200.00		Subtotal (see instructions)	187,683,257	504,287,025	691,970,282			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	187,683,257	504,287,025	691,970,282			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0189 | Period: From 07/01/2016 To 06/30/2017 | Worksheet C Part I Date/Time Prepared: 11/16/2017 3:52 pm

Title XVIII | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
32.00	03200	CORONARY CARE UNIT		32.00
40.00	04000	SUBPROVIDER - IPF		40.00
43.00	04300	NURSERY		43.00
45.00	04500	NURSING FACILITY		45.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.204630	50.00
51.00	05100	RECOVERY ROOM	0.153787	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.302359	52.00
53.00	05300	ANESTHESIOLOGY	0.173526	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.218178	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.295143	55.00
56.00	05600	RADIOISOTOPE	0.151831	56.00
57.00	05700	CT SCAN	0.034568	57.00
58.00	05800	MRI	0.067051	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.114277	59.00
60.00	06000	LABORATORY	0.279228	60.00
65.00	06500	RESPIRATORY THERAPY	0.174485	65.00
66.00	06600	PHYSICAL THERAPY	0.247297	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.300246	67.00
68.00	06800	SPEECH PATHOLOGY	0.352996	68.00
69.00	06900	ELECTROCARDIOLOGY	0.319466	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.394429	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.197454	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.328850	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.194923	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	75.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	4.870625	76.00
		OUTPATIENT SERVICE COST CENTERS		
88.00	08800	RURAL HEALTH CLINIC		88.00
88.01	08801	RURAL HEALTH CLINIC II		88.01
88.02	08802	RURAL HEALTH CLINIC III		88.02
88.03	08803	RURAL HEALTH CLINIC IV		88.03
88.04	08805	RURAL HEALTH CLINIC V		88.04
91.00	09100	EMERGENCY	0.222097	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.039958	92.00
		OTHER REIMBURSABLE COST CENTERS		
101.00	10100	HOME HEALTH AGENCY		101.00
		SPECIAL PURPOSE COST CENTERS		
116.00	11600	HOSPICE		116.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0189 | Period: From 07/01/2016 To 06/30/2017 | Worksheet C Part I Date/Time Prepared: 11/16/2017 3:52 pm

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	28,039,352		28,039,352	0	28,039,352	30.00
32.00	03200	CORONARY CARE UNIT	4,607,922		4,607,922	0	4,607,922	32.00
40.00	04000	SUBPROVIDER - IPF	3,638,610		3,638,610	0	3,638,610	40.00
43.00	04300	NURSERY	945,916		945,916	0	945,916	43.00
45.00	04500	NURSING FACILITY	0		0	0	0	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	15,711,693		15,711,693	0	15,711,693	50.00
51.00	05100	RECOVERY ROOM	3,044,213		3,044,213	0	3,044,213	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,510,690		1,510,690	0	1,510,690	52.00
53.00	05300	ANESTHESIOLOGY	2,464,102		2,464,102	0	2,464,102	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,108,250		7,108,250	0	7,108,250	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	3,976,814		3,976,814	0	3,976,814	55.00
56.00	05600	RADIOISOTOPE	5,635,926		5,635,926	0	5,635,926	56.00
57.00	05700	CT SCAN	2,315,417		2,315,417	0	2,315,417	57.00
58.00	05800	MRI	1,881,597		1,881,597	0	1,881,597	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,866,602		1,866,602	0	1,866,602	59.00
60.00	06000	LABORATORY	14,034,434		14,034,434	12,046	14,046,480	60.00
65.00	06500	RESPIRATORY THERAPY	2,297,776	0	2,297,776	0	2,297,776	65.00
66.00	06600	PHYSICAL THERAPY	4,795,037	0	4,795,037	0	4,795,037	66.00
67.00	06700	OCCUPATIONAL THERAPY	876,799	0	876,799	0	876,799	67.00
68.00	06800	SPEECH PATHOLOGY	1,059,047	0	1,059,047	0	1,059,047	68.00
69.00	06900	ELECTROCARDIOLOGY	2,611,744		2,611,744	0	2,611,744	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	2,897,016		2,897,016	0	2,897,016	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	5,441,970		5,441,970	0	5,441,970	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	9,463,870		9,463,870	0	9,463,870	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	21,848,186		21,848,186	0	21,848,186	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0		0	0	0	75.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	1,024,989		1,024,989	0	1,024,989	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	985,311		985,311	0	985,311	88.00
88.01	08801	RURAL HEALTH CLINIC II	919,241		919,241	0	919,241	88.01
88.02	08802	RURAL HEALTH CLINIC III	1,299,180		1,299,180	0	1,299,180	88.02
88.03	08803	RURAL HEALTH CLINIC IV	1,050,433		1,050,433	0	1,050,433	88.03
88.04	08805	RURAL HEALTH CLINIC V	2,374,840		2,374,840	0	2,374,840	88.04
91.00	09100	EMERGENCY	11,690,230		11,690,230	139,567	11,829,797	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	5,419,349		5,419,349		5,419,349	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	6,633,154		6,633,154		6,633,154	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	3,446,194		3,446,194		3,446,194	116.00
200.00		Subtotal (see instructions)	182,915,904	0	182,915,904	151,613	183,067,517	200.00
201.00		Less Observation Beds	5,419,349		5,419,349		5,419,349	201.00
202.00		Total (see instructions)	177,496,555	0	177,496,555	151,613	177,648,168	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0189 | Period: From 07/01/2016 To 06/30/2017 | Worksheet C Part I Date/Time Prepared: 11/16/2017 3:52 pm

Title XIX | Hospital | Cost

		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	24,452,719		24,452,719			30.00
32.00	03200	CORONARY CARE UNIT	3,973,528		3,973,528			32.00
40.00	04000	SUBPROVIDER - IPF	4,261,270		4,261,270			40.00
43.00	04300	NURSERY	2,018,651		2,018,651			43.00
45.00	04500	NURSING FACILITY	0		0			45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	17,094,876	59,686,017	76,780,893	0.204630	0.000000	50.00
51.00	05100	RECOVERY ROOM	4,084,185	15,710,812	19,794,997	0.153787	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,710,934	285,419	4,996,353	0.302359	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	5,010,911	9,189,282	14,200,193	0.173526	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,426,348	28,153,719	32,580,067	0.218178	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	128,254	13,345,919	13,474,173	0.295143	0.000000	55.00
56.00	05600	RADIOISOTOPE	6,002,731	31,116,881	37,119,612	0.151831	0.000000	56.00
57.00	05700	CT SCAN	11,701,130	55,280,460	66,981,590	0.034568	0.000000	57.00
58.00	05800	MRI	2,279,069	25,783,023	28,062,092	0.067051	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	5,468,533	10,865,537	16,334,070	0.114277	0.000000	59.00
60.00	06000	LABORATORY	9,063,979	41,240,698	50,304,677	0.278989	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	11,154,373	2,014,523	13,168,896	0.174485	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	1,950,614	17,439,194	19,389,808	0.247297	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	466,815	2,453,457	2,920,272	0.300246	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	293,468	2,706,697	3,000,165	0.352996	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	1,695,675	6,479,673	8,175,348	0.319466	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	119,427	7,225,399	7,344,826	0.394429	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	8,969,887	18,590,792	27,560,679	0.197454	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	21,393,486	7,385,201	28,778,687	0.328850	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	25,888,171	86,197,922	112,086,093	0.194923	0.000000	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0.000000	0.000000	75.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	210,443	210,443	4.870625	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	319,994	319,994	3.079155	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	485,789	485,789	1.892264	0.000000	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	812,974	812,974	1.598058	0.000000	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	753,162	753,162	1.394697	0.000000	88.03
88.04	08805	RURAL HEALTH CLINIC V	0	1,691,113	1,691,113	1.404306	0.000000	88.04
91.00	09100	EMERGENCY	11,074,223	42,189,800	53,264,023	0.219477	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	5,211,121	5,211,121	1.039958	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	5,899,086	5,899,086			101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	5,562,918	5,562,918			116.00
200.00		Subtotal (see instructions)	187,683,257	504,287,025	691,970,282			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	187,683,257	504,287,025	691,970,282			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0189 | Period: From 07/01/2016 To 06/30/2017 | Worksheet C Part I Date/Time Prepared: 11/16/2017 3:52 pm

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
32.00	03200	CORONARY CARE UNIT			32.00
40.00	04000	SUBPROVIDER - IPF			40.00
43.00	04300	NURSERY			43.00
45.00	04500	NURSING FACILITY			45.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
51.00	05100	RECOVERY ROOM	0.000000		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000		55.00
56.00	05600	RADIOISOTOPE	0.000000		56.00
57.00	05700	CT SCAN	0.000000		57.00
58.00	05800	MRI	0.000000		58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000		59.00
60.00	06000	LABORATORY	0.000000		60.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000		75.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000		76.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	0.000000		88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000		88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000		88.02
88.03	08803	RURAL HEALTH CLINIC IV	0.000000		88.03
88.04	08805	RURAL HEALTH CLINIC V	0.000000		88.04
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
		OTHER REIMBURSABLE COST CENTERS			
101.00	10100	HOME HEALTH AGENCY			101.00
		SPECIAL PURPOSE COST CENTERS			
116.00	11600	HOSPICE			116.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 14-0189 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D Part I Date/Time Prepared: 11/16/2017 3:52 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	1,848,577	0	1,848,577	22,698	81.44	30.00
32.00	CORONARY CARE UNIT	340,439		340,439	2,074	164.15	32.00
40.00	SUBPROVIDER - IPF	225,772	0	225,772	3,305	68.31	40.00
43.00	NURSERY	65,896		65,896	1,243	53.01	43.00
45.00	NURSING FACILITY	0		0	0	0.00	45.00
200.00	Total (lines 30-199)	2,480,684		2,480,684	29,320		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	9,932	808,862	30.00
32.00	CORONARY CARE UNIT	1,078	176,954	32.00
40.00	SUBPROVIDER - IPF	970	66,261	40.00
43.00	NURSERY	0	0	43.00
45.00	NURSING FACILITY	0	0	45.00
200.00	Total (lines 30-199)	11,980	1,052,077	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 14-0189 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D Part II Date/Time Prepared: 11/16/2017 3:52 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,134,569	76,780,893	0.027801	8,745,209	243,126	50.00
51.00	05100	RECOVERY ROOM	236,046	19,794,997	0.011925	1,570,193	18,725	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	108,514	4,996,353	0.021719	9,788	213	52.00
53.00	05300	ANESTHESIOLOGY	310,556	14,200,193	0.021870	2,133,158	46,652	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	908,698	32,580,067	0.027891	2,294,847	64,006	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	843,261	13,474,173	0.062584	42,748	2,675	55.00
56.00	05600	RADIOISOTOPE	1,534,225	37,119,612	0.041332	3,432,499	141,872	56.00
57.00	05700	CT SCAN	191,917	66,981,590	0.002865	6,603,636	18,919	57.00
58.00	05800	MRI	374,917	28,062,092	0.013360	1,213,868	16,217	58.00
59.00	05900	CARDIAC CATHETERIZATION	324,281	16,334,070	0.019853	2,216,755	44,009	59.00
60.00	06000	LABORATORY	817,353	50,304,677	0.016248	4,946,637	80,373	60.00
65.00	06500	RESPIRATORY THERAPY	131,739	13,168,896	0.010004	5,644,010	56,463	65.00
66.00	06600	PHYSICAL THERAPY	312,359	19,389,808	0.016109	1,082,221	17,433	66.00
67.00	06700	OCCUPATIONAL THERAPY	25,259	2,920,272	0.008650	256,466	2,218	67.00
68.00	06800	SPEECH PATHOLOGY	93,584	3,000,165	0.031193	157,947	4,927	68.00
69.00	06900	ELECTROCARDIOLOGY	201,161	8,175,348	0.024606	973,615	23,957	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	154,940	7,344,826	0.021095	83,284	1,757	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	189,034	27,560,679	0.006859	4,594,450	31,513	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	329,434	28,778,687	0.011447	10,119,152	115,834	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	433,321	112,086,093	0.003866	13,204,702	51,049	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0.000000	0	0	75.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	58,757	210,443	0.279206	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	213,173	319,994	0.666178	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	114,499	485,789	0.235697	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	64,395	812,974	0.079209	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	87,796	753,162	0.116570	0	0	88.03
88.04	08805	RURAL HEALTH CLINIC V	192,239	1,691,113	0.113676	0	0	88.04
91.00	09100	EMERGENCY	619,357	53,264,023	0.011628	5,842,419	67,936	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	357,287	5,211,121	0.068562	0	0	92.00
200.00		Total (lines 50-199)	11,362,671	645,802,110		75,167,604	1,049,874	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 14-0189 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D Part III Date/Time Prepared: 11/16/2017 3:52 pm

Title XVIII | Hospital | PPS

		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
32.00	03200	CORONARY CARE UNIT	0	0	0		0	32.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
43.00	04300	NURSERY	0	0	0		0	43.00
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	22,698	0.00	9,932	0		30.00
32.00	03200	CORONARY CARE UNIT	2,074	0.00	1,078	0		32.00
40.00	04000	SUBPROVIDER - IPF	3,305	0.00	970	0		40.00
43.00	04300	NURSERY	1,243	0.00	0	0		43.00
45.00	04500	NURSING FACILITY	0	0.00	0	0		45.00
200.00		Total (lines 30-199)	29,320		11,980	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0189 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D Part IV | Date/Time Prepared: 11/16/2017 3:52 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
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	0	0	0	88.03
88.04	08805	RURAL HEALTH CLINIC V	0	0	0	0	0	88.04
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0189 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D Part IV Date/Time Prepared: 11/16/2017 3:52 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	76,780,893	0.000000	0.000000	8,745,209	50.00
51.00	05100	RECOVERY ROOM	0	19,794,997	0.000000	0.000000	1,570,193	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	4,996,353	0.000000	0.000000	9,788	52.00
53.00	05300	ANESTHESIOLOGY	0	14,200,193	0.000000	0.000000	2,133,158	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	32,580,067	0.000000	0.000000	2,294,847	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	13,474,173	0.000000	0.000000	42,748	55.00
56.00	05600	RADIOISOTOPE	0	37,119,612	0.000000	0.000000	3,432,499	56.00
57.00	05700	CT SCAN	0	66,981,590	0.000000	0.000000	6,603,636	57.00
58.00	05800	MRI	0	28,062,092	0.000000	0.000000	1,213,868	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	16,334,070	0.000000	0.000000	2,216,755	59.00
60.00	06000	LABORATORY	0	50,304,677	0.000000	0.000000	4,946,637	60.00
65.00	06500	RESPIRATORY THERAPY	0	13,168,896	0.000000	0.000000	5,644,010	65.00
66.00	06600	PHYSICAL THERAPY	0	19,389,808	0.000000	0.000000	1,082,221	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	2,920,272	0.000000	0.000000	256,466	67.00
68.00	06800	SPEECH PATHOLOGY	0	3,000,165	0.000000	0.000000	157,947	68.00
69.00	06900	ELECTROCARDIOLOGY	0	8,175,348	0.000000	0.000000	973,615	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	7,344,826	0.000000	0.000000	83,284	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	27,560,679	0.000000	0.000000	4,594,450	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	28,778,687	0.000000	0.000000	10,119,152	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	112,086,093	0.000000	0.000000	13,204,702	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0.000000	0.000000	0	75.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	210,443	0.000000	0.000000	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	319,994	0.000000	0.000000	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	485,789	0.000000	0.000000	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	812,974	0.000000	0.000000	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	753,162	0.000000	0.000000	0	88.03
88.04	08805	RURAL HEALTH CLINIC V	0	1,691,113	0.000000	0.000000	0	88.04
91.00	09100	EMERGENCY	0	53,264,023	0.000000	0.000000	5,842,419	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	5,211,121	0.000000	0.000000	0	92.00
200.00		Total (lines 50-199)	0	645,802,110			75,167,604	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0189 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D Part IV Date/Time Prepared: 11/16/2017 3:52 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	19,679,666	0		50.00
51.00	05100	RECOVERY ROOM	0	2,524,775	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	2,312,782	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	10,796,252	0		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	4,081,141	0		55.00
56.00	05600	RADIOISOTOPE	0	7,332,393	0		56.00
57.00	05700	CT SCAN	0	16,551,741	0		57.00
58.00	05800	MRI	0	7,268,558	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	3,410,855	0		59.00
60.00	06000	LABORATORY	0	3,712,023	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	510,843	0		65.00
66.00	06600	PHYSICAL THERAPY	0	223,834	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	11,098	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	274,509	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,847,754	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	607,633	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	3,602,274	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	2,482,922	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	33,050,391	0		73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0		75.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0		76.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	0		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0		88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0		88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	0		88.03
88.04	08805	RURAL HEALTH CLINIC V	0	0	0		88.04
91.00	09100	EMERGENCY	0	10,443,722	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	1,918,200	0		92.00
200.00		Total (lines 50-199)	0	132,643,366	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-0189 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D Part V Date/Time Prepared: 11/16/2017 3:52 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	0.204630	19,679,666	0	0	4,027,050	50.00
51.00	05100	RECOVERY ROOM	0.153787	2,524,775	0	0	388,278	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.302359	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.173526	2,312,782	0	0	401,328	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.218178	10,796,252	0	0	2,355,505	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.295143	4,081,141	0	0	1,204,520	55.00
56.00	05600	RADIOISOTOPE	0.151831	7,332,393	0	0	1,113,285	56.00
57.00	05700	CT SCAN	0.034568	16,551,741	0	0	572,161	57.00
58.00	05800	MRI	0.067051	7,268,558	0	0	487,364	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.114277	3,410,855	0	0	389,782	59.00
60.00	06000	LABORATORY	0.278989	3,712,023	9,408	0	1,035,614	60.00
65.00	06500	RESPIRATORY THERAPY	0.174485	510,843	0	0	89,134	65.00
66.00	06600	PHYSICAL THERAPY	0.247297	223,834	0	0	55,353	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.300246	11,098	0	0	3,332	67.00
68.00	06800	SPEECH PATHOLOGY	0.352996	274,509	0	0	96,901	68.00
69.00	06900	ELECTROCARDIOLOGY	0.319466	1,847,754	0	0	590,295	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.394429	607,633	0	0	239,668	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.197454	3,602,274	0	0	711,283	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.328850	2,482,922	0	0	816,509	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.194923	33,050,391	0	42,854	6,442,281	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	0	0	0	75.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	4.870625	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000				0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000				0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0.000000				0	88.03
88.04	08805	RURAL HEALTH CLINIC V	0.000000				0	88.04
91.00	09100	EMERGENCY	0.219477	10,443,722	38	0	2,292,157	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.039958	1,918,200	0	0	1,994,847	92.00
200.00		Subtotal (see instructions)		132,643,366	9,446	42,854	25,306,647	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		132,643,366	9,446	42,854	25,306,647	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-0189 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D Part V Date/Time Prepared: 11/16/2017 3:52 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
51.00	05100	RECOVERY ROOM	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0		55.00
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MRI	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	2,625	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	8,353		73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0		75.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0		76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0		88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0		88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0		88.03
88.04	08805	RURAL HEALTH CLINIC V	0	0		88.04
91.00	09100	EMERGENCY	8	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
200.00		Subtotal (see instructions)	2,633	8,353		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	2,633	8,353		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0189 | Component CCN: 14-S189 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D Part II Date/Time Prepared: 11/16/2017 3:52 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	2,134,569	76,780,893	0.027801	6,711	187	50.00
51.00	05100	RECOVERY ROOM	236,046	19,794,997	0.011925	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	108,514	4,996,353	0.021719	0	0	52.00
53.00	05300	ANESTHESIOLOGY	310,556	14,200,193	0.021870	367	8	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	908,698	32,580,067	0.027891	20,606	575	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	843,261	13,474,173	0.062584	0	0	55.00
56.00	05600	RADIOISOTOPE	1,534,225	37,119,612	0.041332	17,378	718	56.00
57.00	05700	CT SCAN	191,917	66,981,590	0.002865	80,649	231	57.00
58.00	05800	MRI	374,917	28,062,092	0.013360	61,827	826	58.00
59.00	05900	CARDIAC CATHETERIZATION	324,281	16,334,070	0.019853	0	0	59.00
60.00	06000	LABORATORY	817,353	50,304,677	0.016248	158,097	2,569	60.00
65.00	06500	RESPIRATORY THERAPY	131,739	13,168,896	0.010004	138,596	1,387	65.00
66.00	06600	PHYSICAL THERAPY	312,359	19,389,808	0.016109	11,070	178	66.00
67.00	06700	OCCUPATIONAL THERAPY	25,259	2,920,272	0.008650	3,331	29	67.00
68.00	06800	SPEECH PATHOLOGY	93,584	3,000,165	0.031193	263	8	68.00
69.00	06900	ELECTROCARDIOLOGY	201,161	8,175,348	0.024606	16,244	400	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	154,940	7,344,826	0.021095	2,744	58	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	189,034	27,560,679	0.006859	13,145	90	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	329,434	28,778,687	0.011447	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	433,321	112,086,093	0.003866	190,026	735	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0.000000	0	0	75.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	58,757	210,443	0.279206	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	213,173	319,994	0.666178	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	114,499	485,789	0.235697	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	64,395	812,974	0.079209	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	87,796	753,162	0.116570	0	0	88.03
88.04	08805	RURAL HEALTH CLINIC V	192,239	1,691,113	0.113676	0	0	88.04
91.00	09100	EMERGENCY	619,357	53,264,023	0.011628	234,289	2,724	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	5,211,121	0.000000	0	0	92.00
200.00		Total (lines 50-199)	11,005,384	645,802,110		955,343	10,723	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0189 | Component CCN: 14-S189 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D Part IV Date/Time Prepared: 11/16/2017 3:52 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
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	0	0	0	88.03
88.04	08805	RURAL HEALTH CLINIC V	0	0	0	0	0	88.04
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0189 | Component CCN: 14-S189 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D Part IV Date/Time Prepared: 11/16/2017 3:52 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	76,780,893	0.000000	0.000000	6,711	50.00
51.00	05100	RECOVERY ROOM	0	19,794,997	0.000000	0.000000	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	4,996,353	0.000000	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0	14,200,193	0.000000	0.000000	367	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	32,580,067	0.000000	0.000000	20,606	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	13,474,173	0.000000	0.000000	0	55.00
56.00	05600	RADIOISOTOPE	0	37,119,612	0.000000	0.000000	17,378	56.00
57.00	05700	CT SCAN	0	66,981,590	0.000000	0.000000	80,649	57.00
58.00	05800	MRI	0	28,062,092	0.000000	0.000000	61,827	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	16,334,070	0.000000	0.000000	0	59.00
60.00	06000	LABORATORY	0	50,304,677	0.000000	0.000000	158,097	60.00
65.00	06500	RESPIRATORY THERAPY	0	13,168,896	0.000000	0.000000	138,596	65.00
66.00	06600	PHYSICAL THERAPY	0	19,389,808	0.000000	0.000000	11,070	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	2,920,272	0.000000	0.000000	3,331	67.00
68.00	06800	SPEECH PATHOLOGY	0	3,000,165	0.000000	0.000000	263	68.00
69.00	06900	ELECTROCARDIOLOGY	0	8,175,348	0.000000	0.000000	16,244	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	7,344,826	0.000000	0.000000	2,744	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	27,560,679	0.000000	0.000000	13,145	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	28,778,687	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	112,086,093	0.000000	0.000000	190,026	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0.000000	0.000000	0	75.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	210,443	0.000000	0.000000	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	319,994	0.000000	0.000000	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	485,789	0.000000	0.000000	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	812,974	0.000000	0.000000	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	753,162	0.000000	0.000000	0	88.03
88.04	08805	RURAL HEALTH CLINIC V	0	1,691,113	0.000000	0.000000	0	88.04
91.00	09100	EMERGENCY	0	53,264,023	0.000000	0.000000	234,289	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	5,211,121	0.000000	0.000000	0	92.00
200.00		Total (lines 50-199)	0	645,802,110			955,343	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0189 | Component CCN: 14-S189 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D Part IV | Date/Time Prepared: 11/16/2017 3:52 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
51.00	05100	RECOVERY ROOM	0	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0		55.00
56.00	05600	RADIOISOTOPE	0	0	0		56.00
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
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
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	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
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0		76.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	0		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0		88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0		88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	0		88.03
88.04	08805	RURAL HEALTH CLINIC V	0	0	0		88.04
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0		92.00
200.00		Total (lines 50-199)	0	0	0		200.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-0189 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D-1 | Date/Time Prepared: 11/16/2017 3:52 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)	22,698	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	22,698	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)	18,311	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)	9,932	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)	28,039,352	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)	28,039,352	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)	28,039,352	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)	1,235.32	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	12,269,198	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)	12,269,198	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-0189 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D-1 | Date/Time Prepared: 11/16/2017 3:52 pm

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	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	4,607,922	2,074	2,221.76	1,078	2,395,057	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)	15,218,245	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	29,882,500	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)	985,816	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	1,049,874	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	2,035,690	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	27,846,810	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)	4,387	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,235.32	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	5,419,349	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-0189 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D-1 | Date/Time Prepared: 11/16/2017 3:52 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	1,848,577	28,039,352	0.065928	5,419,349	357,287	90.00
91.00	Nursing School cost	0	28,039,352	0.000000	5,419,349	0	91.00
92.00	Allied health cost	0	28,039,352	0.000000	5,419,349	0	92.00
93.00	All other Medical Education	0	28,039,352	0.000000	5,419,349	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 14-0189 Component CCN: 14-S189	Period: From 07/01/2016 To 06/30/2017	Worksheet D-1 Date/Time Prepared: 11/16/2017 3:52 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)	3,305	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	3,305	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)	3,305	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)	970	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)	3,638,610	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)	3,638,610	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)	3,638,610	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)	1,100.94	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,067,912	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	1,067,912	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0189 | Component CCN: 14-S189 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D-1 | Date/Time Prepared: 11/16/2017 3:52 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	0	0	0.00	0	0	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)	185,607	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	1,253,519	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)	66,261	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	10,723	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	76,984	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	1,176,535	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: 14-0189 Component CCN: 14-S189	Period: From 07/01/2016 To 06/30/2017	Worksheet D-1 Date/Time Prepared: 11/16/2017 3:52 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	225,772	3,638,610	0.062049	0	0	90.00
91.00	Nursing School cost	0	3,638,610	0.000000	0	0	91.00
92.00	Allied health cost	0	3,638,610	0.000000	0	0	92.00
93.00	All other Medical Education	0	3,638,610	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 14-0189 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D-3 | Date/Time Prepared: 11/16/2017 3:52 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		11,571,919		30.00
32.00	03200	CORONARY CARE UNIT		2,017,474		32.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.204630	8,745,209	1,789,532	50.00
51.00	05100	RECOVERY ROOM	0.153787	1,570,193	241,475	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.302359	9,788	2,959	52.00
53.00	05300	ANESTHESIOLOGY	0.173526	2,133,158	370,158	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.218178	2,294,847	500,685	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.295143	42,748	12,617	55.00
56.00	05600	RADIOISOTOPE	0.151831	3,432,499	521,160	56.00
57.00	05700	CT SCAN	0.034568	6,603,636	228,274	57.00
58.00	05800	MRI	0.067051	1,213,868	81,391	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.114277	2,216,755	253,324	59.00
60.00	06000	LABORATORY	0.279228	4,946,637	1,381,240	60.00
65.00	06500	RESPIRATORY THERAPY	0.174485	5,644,010	984,795	65.00
66.00	06600	PHYSICAL THERAPY	0.247297	1,082,221	267,630	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.300246	256,466	77,003	67.00
68.00	06800	SPEECH PATHOLOGY	0.352996	157,947	55,755	68.00
69.00	06900	ELECTROCARDIOLOGY	0.319466	973,615	311,037	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.394429	83,284	32,850	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.197454	4,594,450	907,193	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.328850	10,119,152	3,327,683	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.194923	13,204,702	2,573,900	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	0	75.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	4.870625	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000		0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000		0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0.000000		0	88.03
88.04	08805	RURAL HEALTH CLINIC V	0.000000		0	88.04
91.00	09100	EMERGENCY	0.222097	5,842,419	1,297,584	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.039958	0	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		75,167,604	15,218,245	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)		75,167,604		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 14-0189 | Component CCN: 14-S189 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D-3 | Date/Time Prepared: 11/16/2017 3:52 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
32.00	03200	CORONARY CARE UNIT		0		32.00
40.00	04000	SUBPROVIDER - IPF		1,204,755		40.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.204630	6,711	1,373	50.00
51.00	05100	RECOVERY ROOM	0.153787	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.302359	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.173526	367	64	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.218178	20,606	4,496	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.295143	0	0	55.00
56.00	05600	RADIOISOTOPE	0.151831	17,378	2,639	56.00
57.00	05700	CT SCAN	0.034568	80,649	2,788	57.00
58.00	05800	MRI	0.067051	61,827	4,146	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.114277	0	0	59.00
60.00	06000	LABORATORY	0.279228	158,097	44,145	60.00
65.00	06500	RESPIRATORY THERAPY	0.174485	138,596	24,183	65.00
66.00	06600	PHYSICAL THERAPY	0.247297	11,070	2,738	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.300246	3,331	1,000	67.00
68.00	06800	SPEECH PATHOLOGY	0.352996	263	93	68.00
69.00	06900	ELECTROCARDIOLOGY	0.319466	16,244	5,189	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.394429	2,744	1,082	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.197454	13,145	2,596	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.328850	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.194923	190,026	37,040	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	0	75.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	4.870625	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000		0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000		0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0.000000		0	88.03
88.04	08805	RURAL HEALTH CLINIC V	0.000000		0	88.04
91.00	09100	EMERGENCY	0.222097	234,289	52,035	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.039958	0	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		955,343	185,607	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)		955,343		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0189	Period: From 07/01/2016 To 06/30/2017	Worksheet E Part A Date/Time Prepared: 11/16/2017 3:52 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)	4,967,409	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	14,662,980	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)	387,507	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	0	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)	75.98	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)	4.21	30.00
31.00	Percentage of Medicaid patient days (see instructions)	17.53	31.00
32.00	Sum of lines 30 and 31	21.74	32.00
33.00	Allowable disproportionate share percentage (see instructions)	7.15	33.00
34.00	Disproportionate share adjustment (see instructions)	350,894	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 14-0189 | Period: From 07/01/2016 To 06/30/2017 | Worksheet E Part A Date/Time Prepared: 11/16/2017 3:52 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)	6,406,145,534	5,977,483,147	35.00
35.01	Factor 3 (see instructions)	0.000100583	0.000107480	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	644,349	642,460	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	161,967	480,525	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	642,492		36.00
	Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)			
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)	0		40.00
		Before 1/1	On/After 1/1	
		1.00	1.01	
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0	0	41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0	0	41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)	0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)	0.00	0.00	45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)	0		46.00
47.00	Subtotal (see instructions)	21,011,282		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)	24,161,015		48.00
			Amount	
			1.00	
49.00	Total payment for inpatient operating costs (see instructions)		24,161,015	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		1,583,694	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		4,143	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)		25,748,852	59.00
60.00	Primary payer payments		6,547	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		25,742,305	61.00
62.00	Deductibles billed to program beneficiaries		2,708,216	62.00
63.00	Coinsurance billed to program beneficiaries		12,460	63.00
64.00	Allowable bad debts (see instructions)		536,544	64.00
65.00	Adjusted reimbursable bad debts (see instructions)		348,754	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		536,544	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		23,370,383	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)		10,803	70.93
70.94	HRR adjustment amount (see instructions)		-275,333	70.94
70.95	Recovery of accelerated depreciation		0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0189	Period: From 07/01/2016 To 06/30/2017	Worksheet E Part A Date/Time Prepared: 11/16/2017 3:52 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)	0	0	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0	70.97
70.98	Low Volume Payment-3		0	70.98
70.99	HAC adjustment amount (see instructions)		194,195	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		22,911,658	71.00
71.01	Sequestration adjustment (see instructions)		458,233	71.01
72.00	Interim payments		22,980,242	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)		-526,817	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

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0189	Period: From 07/01/2016 To 06/30/2017	Worksheet E Part B Date/Time Prepared: 11/16/2017 3:52 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	10,986	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	25,306,647	2.00
3.00	PPS payments	20,530,246	3.00
4.00	Outlier payment (see instructions)	90,321	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)	10,986	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	52,300	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)	52,300	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)	52,300	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	41,314	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)	10,986	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)	20,620,567	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)	4,169,795	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)	16,461,758	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)	16,461,758	30.00
31.00	Primary payer payments	25	31.00
32.00	Subtotal (line 30 minus line 31)	16,461,733	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)	706,863	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	459,461	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	706,863	36.00
37.00	Subtotal (see instructions)	16,921,194	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)	16,921,194	40.00
40.01	Sequestration adjustment (see instructions)	338,424	40.01
41.00	Interim payments	16,662,737	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	-79,967	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: 14-0189 | Period: From 07/01/2016 To 06/30/2017 | Worksheet E-1 Part I | Date/Time Prepared: 11/16/2017 3:52 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		22,932,862		16,634,324	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	01/19/2017	47,380	01/19/2017	28,413	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)		47,380		28,413	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)		22,980,242		16,662,737	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		526,817		79,967	6.02
7.00	Total Medicare program liability (see instructions)		22,453,425		16,582,770	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: 14-0189 | Component CCN: 14-S189 | Period: From 07/01/2016 To 06/30/2017 | Worksheet E-1 Part I | Date/Time Prepared: 11/16/2017 3:52 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		745,142		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)		745,142		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		41,876		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		787,018		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	Provider CCN: 14-0189 Component CCN: 14-S189	Period: From 07/01/2016 To 06/30/2017	Worksheet E-3 Part II Date/Time Prepared: 11/16/2017 3:52 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)	898,654	1.00
2.00	Net IPF PPS Outlier Payments	6,620	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)	9.054795	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)	905,274	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)	905,274	16.00
17.00	Primary payer payments	4,243	17.00
18.00	Subtotal (line 16 less line 17).	901,031	18.00
19.00	Deductibles	129,248	19.00
20.00	Subtotal (line 18 minus line 19)	771,783	20.00
21.00	Coinsurance	11,375	21.00
22.00	Subtotal (line 20 minus line 21)	760,408	22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	65,649	23.00
24.00	Adjusted reimbursable bad debts (see instructions)	42,672	24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	65,649	25.00
26.00	Subtotal (sum of lines 22 and 24)	803,080	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 (NET MSP PYMTS)	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)	803,080	31.00
31.01	Sequestration adjustment (see instructions)	16,062	31.01
32.00	Interim payments	745,142	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)	41,876	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	6,620	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: 14-0189 | Period: From 07/01/2016 To 06/30/2017 | Worksheet G | Date/Time Prepared: 11/16/2017 3:52 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	19,357,580	0	0	0	1.00
2.00	Temporary investments	30,287,280	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	169,950,490	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-102,882,895	0	0	0	6.00
7.00	Inventory	4,280,642	0	0	0	7.00
8.00	Prepaid expenses	4,757,238	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	125,750,335	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	3,677,396	0	0	0	12.00
13.00	Land improvements	12,311,403	0	0	0	13.00
14.00	Accumulated depreciation	-5,047,869	0	0	0	14.00
15.00	Buildings	175,721,817	0	0	0	15.00
16.00	Accumulated depreciation	-51,384,945	0	0	0	16.00
17.00	Leasehold improvements	541,780	0	0	0	17.00
18.00	Accumulated depreciation	-465,652	0	0	0	18.00
19.00	Fixed equipment	18,432,825	0	0	0	19.00
20.00	Accumulated depreciation	-12,527,663	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	111,743,461	0	0	0	23.00
24.00	Accumulated depreciation	-64,576,119	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	188,426,434	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	166,560,340	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	66,757,330	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	233,317,670	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	547,494,439	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	12,305,230	0	0	0	37.00
38.00	Salaries, wages, and fees payable	22,881,328	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	5,730,729	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	16,030,116	0	0	0	43.00
44.00	Other current liabilities	0	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	56,947,403	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	126,845,068	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	126,845,068	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	183,792,471	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	363,701,968				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)	363,701,968	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	547,494,439	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 14-0189 | Period: From 07/01/2016 To 06/30/2017 | Worksheet G-1 | Date/Time Prepared: 11/16/2017 3:52 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		322,031,251		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		41,670,717				2.00
3.00	Total (sum of line 1 and line 2)		363,701,968		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)		363,701,968		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)		363,701,968		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: 14-0189 | Period: From 07/01/2016 To 06/30/2017 | Worksheet G-2 Parts I & II | Date/Time Prepared: 11/16/2017 3:52 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	23,452,719		23,452,719	1.00
2.00	SUBPROVIDER - IPF	4,261,270		4,261,270	2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				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)	27,713,989		27,713,989	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT	3,973,528		3,973,528	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)	3,973,528		3,973,528	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	31,687,517		31,687,517	17.00
18.00	Ancillary services	152,988,721	446,361,818	599,350,539	18.00
19.00	Outpatient services	0	42,400,243	42,400,243	19.00
20.00	RURAL HEALTH CLINIC	0	319,994	319,994	20.00
20.01	RURAL HEALTH CLINIC II	0	485,789	485,789	20.01
20.02	RURAL HEALTH CLINIC III	0	812,974	812,974	20.02
20.03	RURAL HEALTH CLINIC IV	0	753,162	753,162	20.03
20.04	RURAL HEALTH CLINIC V	0	1,691,113	1,691,113	20.04
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		5,899,086	5,899,086	22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE	0	5,562,918	5,562,918	26.00
27.00	OTHER: NURS IP, HMKRS, ACCRL,OCC HLT	1,903,286	1,632,822	3,536,108	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	186,579,524	505,919,919	692,499,443	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		290,740,865		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)		290,740,865		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 14-0189	Period: From 07/01/2016 To 06/30/2017	Worksheet G-3 Date/Time Prepared: 11/16/2017 3:52 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	692,499,443	1.00
2.00	Less contractual allowances and discounts on patients' accounts	441,773,635	2.00
3.00	Net patient revenues (line 1 minus line 2)	250,725,808	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	290,740,865	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-40,015,057	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	2,356,607	6.00
7.00	Income from investments	20,824,293	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	198,748	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	948,303	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	84,485	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	22,368	21.00
22.00	Rental of hospital space	376,065	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER: PHYSN REV, GRANTS, MISC OTR	56,874,905	24.00
25.00	Total other income (sum of lines 6-24)	81,685,774	25.00
26.00	Total (line 5 plus line 25)	41,670,717	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)	41,670,717	29.00

ANALYSIS OF HOSPITAL-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 14-0189 | HHA CCN: 14-7594 | Period: From 07/01/2016 To 06/30/2017 | Worksheet H | Date/Time Prepared: 11/16/2017 3:52 pm

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		Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased Services	Other Costs	Total (sum of cols. 1 thru 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures			0		0	0	1.00
2.00	Capital Related - Movable Equipment			0		0	0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0	0	0	3.00
4.00	Transportation	0	0	0	0	0	0	4.00
5.00	Administrative and General	1,043,324	269,100	64,574	100,697	367,307	1,845,002	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	1,829,236	0	0	0	0	1,829,236	6.00
7.00	Physical Therapy	484,807	0	0	0	0	484,807	7.00
8.00	Occupational Therapy	228,414	0	0	0	0	228,414	8.00
9.00	Speech Pathology	22,449	0	0	0	0	22,449	9.00
10.00	Medical Social Services	39,861	0	0	0	0	39,861	10.00
11.00	Home Health Aide	96,123	0	0	0	0	96,123	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	3,744,214	269,100	64,574	100,697	367,307	4,545,892	24.00

		Reclassification	Reclassified Trial Balance (col. 6 + col.7)	Adjustments	Net Expenses for Allocation (col. 8 + col. 9)			
		7.00	8.00	9.00	10.00			
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0	0	0			1.00
2.00	Capital Related - Movable Equipment	0	0	0	0			2.00
3.00	Plant Operation & Maintenance	0	0	0	0			3.00
4.00	Transportation	0	0	0	0			4.00
5.00	Administrative and General	0	1,845,002	0	1,845,002			5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	1,829,236	0	1,829,236			6.00
7.00	Physical Therapy	0	484,807	0	484,807			7.00
8.00	Occupational Therapy	0	228,414	0	228,414			8.00
9.00	Speech Pathology	0	22,449	0	22,449			9.00
10.00	Medical Social Services	0	39,861	0	39,861			10.00
11.00	Home Health Aide	0	96,123	0	96,123			11.00
12.00	Supplies (see instructions)	0	0	0	0			12.00
13.00	Drugs	0	0	0	0			13.00
14.00	DME	0	0	0	0			14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0			15.00
16.00	Respiratory Therapy	0	0	0	0			16.00
17.00	Private Duty Nursing	0	0	0	0			17.00
18.00	Clinic	0	0	0	0			18.00
19.00	Health Promotion Activities	0	0	0	0			19.00
20.00	Day Care Program	0	0	0	0			20.00
21.00	Home Delivered Meals Program	0	0	0	0			21.00
22.00	Homemaker Service	0	0	0	0			22.00
23.00	All Others (specify)	0	0	0	0			23.00
23.50	Telemedicine	0	0	0	0			23.50
24.00	Total (sum of lines 1-23)	0	4,545,892	0	4,545,892			24.00

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

COST ALLOCATION - HHA GENERAL SERVICE COST

Provider CCN: 14-0189 HHA CCN: 14-7594

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

Worksheet H-1 Part I Date/Time Prepared: 11/16/2017 3:52 pm

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		Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Capital Related Costs: Bldgs & Fixtures	Capital Related Costs: Movable Equipment	Plant Operation & Maintenance	Transportation	Subtotal (cols. 0-4)	
		0	1.00	2.00	3.00	4.00	4A.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0				0	1.00
2.00	Capital Related - Movable Equipment	0		0			0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0		0	3.00
4.00	Transportation	0	0	0	0	0		4.00
5.00	Administrative and General	1,845,002	0	0	0	0	1,845,002	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	1,829,236	0	0	0	0	1,829,236	6.00
7.00	Physical Therapy	484,807	0	0	0	0	484,807	7.00
8.00	Occupational Therapy	228,414	0	0	0	0	228,414	8.00
9.00	Speech Pathology	22,449	0	0	0	0	22,449	9.00
10.00	Medical Social Services	39,861	0	0	0	0	39,861	10.00
11.00	Home Health Aide	96,123	0	0	0	0	96,123	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0		0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	4,545,892	0	0	0	0	4,545,892	24.00

		Administrative & General	Total (cols. 4A + 5)		
		5.00	6.00		
	GENERAL SERVICE COST CENTERS				
1.00	Capital Related - Bldg. & Fixtures				1.00
2.00	Capital Related - Movable Equipment				2.00
3.00	Plant Operation & Maintenance				3.00
4.00	Transportation				4.00
5.00	Administrative and General	1,845,002			5.00
	HHA REIMBURSABLE SERVICES				
6.00	Skilled Nursing Care	1,249,568	3,078,804		6.00
7.00	Physical Therapy	331,176	815,983		7.00
8.00	Occupational Therapy	156,032	384,446		8.00
9.00	Speech Pathology	15,335	37,784		9.00
10.00	Medical Social Services	27,229	67,090		10.00
11.00	Home Health Aide	65,662	161,785		11.00
12.00	Supplies (see instructions)	0	0		12.00
13.00	Drugs	0	0		13.00
14.00	DME	0	0		14.00
	HHA NONREIMBURSABLE SERVICES				
15.00	Home Dialysis Aide Services	0	0		15.00
16.00	Respiratory Therapy	0	0		16.00
17.00	Private Duty Nursing	0	0		17.00
18.00	Clinic	0	0		18.00
19.00	Health Promotion Activities	0	0		19.00
20.00	Day Care Program	0	0		20.00
21.00	Home Delivered Meals Program	0	0		21.00
22.00	Homemaker Service	0	0		22.00
23.00	All Others (specify)	0	0		23.00
23.50	Telemedicine	0	0		23.50
24.00	Total (sum of lines 1-23)		4,545,892		24.00

COST ALLOCATION - HHA STATISTICAL BASIS | Provider CCN: 14-0189 | HHA CCN: 14-7594 | Period: From 07/01/2016 To 06/30/2017 | Worksheet H-1 Part II Date/Time Prepared: 11/16/2017 3:52 pm

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		Capital Related Costs						
		Bldgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)	Plant Operation & Maintenance (SQUARE FEET)	Transportation (MILEAGE)	Reconciliation	Administrative & General (ACCUM. COST)	
		1.00	2.00	3.00	4.00	5A.00	5.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0				0		1.00
2.00	Capital Related - Movable Equipment		0			0		2.00
3.00	Plant Operation & Maintenance	0	0	0		0		3.00
4.00	Transportation (see instructions)	0	0	0	0			4.00
5.00	Administrative and General	0	0	0	0	-1,845,002	2,700,890	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	0	1,829,236	6.00
7.00	Physical Therapy	0	0	0	0	0	484,807	7.00
8.00	Occupational Therapy	0	0	0	0	0	228,414	8.00
9.00	Speech Pathology	0	0	0	0	0	22,449	9.00
10.00	Medical Social Services	0	0	0	0	0	39,861	10.00
11.00	Home Health Aide	0	0	0	0	0	96,123	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	0	12.00
13.00	Drugs	0	0	0		0	0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	0	0	0	0	-1,845,002	2,700,890	24.00
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0	0		1,845,002	25.00
26.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000		0.683109	26.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 14-0189 HHA CCN: 14-7594

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

Worksheet H-2 Part I Date/Time Prepared: 11/16/2017 3:52 pm

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	Cost Center Description	HHA Trial Balance (1)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	
		0	1.00	2.00	4.00	4A	5.00	
1.00	Administrative and General	0	46,447	106,768	752,490	905,705	172,784	1.00
2.00	Skilled Nursing Care	3,078,804	0	0	0	3,078,804	587,353	2.00
3.00	Physical Therapy	815,983	0	0	0	815,983	155,668	3.00
4.00	Occupational Therapy	384,446	0	0	0	384,446	73,342	4.00
5.00	Speech Pathology	37,784	0	0	0	37,784	7,208	5.00
6.00	Medical Social Services	67,090	0	0	0	67,090	12,799	6.00
7.00	Home Health Aide	161,785	0	0	0	161,785	30,864	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	4,545,892	46,447	106,768	752,490	5,451,597	1,040,018	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.					0.000000		21.00

	Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
		7.00	8.00	9.00	10.00	11.00	13.00	
1.00	Administrative and General	67,075	0	18,564	0	23,355	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	67,075	0	18,564	0	23,355	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 14-0189 HHA CCN: 14-7594 | Period: From 07/01/2016 To 06/30/2017 | Worksheet H-2 Part I Date/Time Prepared: 11/16/2017 3:52 pm

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	Cost Center Description	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	
		14.00	15.00	16.00	24.00	25.00	26.00	
1.00	Administrative and General	0	0	32,545	1,220,028	0	1,220,028	1.00
2.00	Skilled Nursing Care	0	0	0	3,666,157	0	3,666,157	2.00
3.00	Physical Therapy	0	0	0	971,651	0	971,651	3.00
4.00	Occupational Therapy	0	0	0	457,788	0	457,788	4.00
5.00	Speech Pathology	0	0	0	44,992	0	44,992	5.00
6.00	Medical Social Services	0	0	0	79,889	0	79,889	6.00
7.00	Home Health Aide	0	0	0	192,649	0	192,649	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	0	0	32,545	6,633,154	0	6,633,154	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

	Cost Center Description	Allocated HHA A&G (see Part II)	Total HHA Costs					
		27.00	28.00					
1.00	Administrative and General							1.00
2.00	Skilled Nursing Care	826,290	4,492,447					2.00
3.00	Physical Therapy	218,994	1,190,645					3.00
4.00	Occupational Therapy	103,178	560,966					4.00
5.00	Speech Pathology	10,140	55,132					5.00
6.00	Medical Social Services	18,006	97,895					6.00
7.00	Home Health Aide	43,420	236,069					7.00
8.00	Supplies (see instructions)	0	0					8.00
9.00	Drugs	0	0					9.00
10.00	DME	0	0					10.00
11.00	Home Dialysis Aide Services	0	0					11.00
12.00	Respiratory Therapy	0	0					12.00
13.00	Private Duty Nursing	0	0					13.00
14.00	Clinic	0	0					14.00
15.00	Health Promotion Activities	0	0					15.00
16.00	Day Care Program	0	0					16.00
17.00	Home Delivered Meals Program	0	0					17.00
18.00	Homemaker Service	0	0					18.00
19.00	All Others (specify)	0	0					19.00
19.50	Telemedicine	0	0					19.50
20.00	Total (sum of lines 1-19) (2)	1,220,028	6,633,154					20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.	0.225383						21.00

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 14-0189 HHA CCN: 14-7594

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

Worksheet H-2 Part II Date/Time Prepared: 11/16/2017 3:52 pm

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	Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
		1.00	2.00	4.00	5A	5.00	7.00	
1.00	Administrative and General	3,990	102,422	3,744,214	0	905,705	3,990	1.00
2.00	Skilled Nursing Care	0	0	0	0	3,078,804	0	2.00
3.00	Physical Therapy	0	0	0	0	815,983	0	3.00
4.00	Occupational Therapy	0	0	0	0	384,446	0	4.00
5.00	Speech Pathology	0	0	0	0	37,784	0	5.00
6.00	Medical Social Services	0	0	0	0	67,090	0	6.00
7.00	Home Health Aide	0	0	0	0	161,785	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	3,990	102,422	3,744,214		5,451,597	3,990	20.00
21.00	Total cost to be allocated	46,447	106,768	752,490		1,040,018	67,075	21.00
22.00	Unit cost multiplier	11.640852	1.042432	0.200974		0.190773	16.810777	22.00

	Cost Center Description	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDR)	HOUSEKEEPING (HOURS OF SERVIC)	DIETARY (MEALS SERVED)	CAFETERIA (MEALS SERVED)	NURSING ADMINISTRATION (DIRECT NRSING HR)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	
		8.00	9.00	10.00	11.00	13.00	14.00	
1.00	Administrative and General	0	68	0	14	0	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	0	68	0	14	0	0	20.00
21.00	Total cost to be allocated	0	18,564	0	23,355	0	0	21.00
22.00	Unit cost multiplier	0.000000	273.000000	0.000000	1,668.214286	0.000000	0.000000	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 14-0189
HHA CCN: 14-7594

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

Worksheet H-2
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	Cost Center Description	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)			
		15.00	16.00			
1.00	Administrative and General	0	5,899,086			1.00
2.00	Skilled Nursing Care	0	0			2.00
3.00	Physical Therapy	0	0			3.00
4.00	Occupational Therapy	0	0			4.00
5.00	Speech Pathology	0	0			5.00
6.00	Medical Social Services	0	0			6.00
7.00	Home Health Aide	0	0			7.00
8.00	Supplies (see instructions)	0	0			8.00
9.00	Drugs	0	0			9.00
10.00	DME	0	0			10.00
11.00	Home Dialysis Aide Services	0	0			11.00
12.00	Respiratory Therapy	0	0			12.00
13.00	Private Duty Nursing	0	0			13.00
14.00	Clinic	0	0			14.00
15.00	Health Promotion Activities	0	0			15.00
16.00	Day Care Program	0	0			16.00
17.00	Home Delivered Meals Program	0	0			17.00
18.00	Homemaker Service	0	0			18.00
19.00	All Others (specify)	0	0			19.00
19.50	Telemedicine	0	0			19.50
20.00	Total (sum of lines 1-19)	0	5,899,086			20.00
21.00	Total cost to be allocated	0	32,545			21.00
22.00	Unit cost multiplier	0.000000	0.005517			22.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 14-0189 | HHA CCN: 14-7594 | Period: From 07/01/2016 To 06/30/2017 | Worksheet H-3 Part I | Date/Time Prepared: 11/16/2017 3:52 pm

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	Cost Center Description	From, Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Visits	Average Cost Per Visit (col. 3 ÷ col. 4)	
		0	1.00	2.00	3.00	4.00	5.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	2.00	4,492,447		4,492,447	19,337	232.32	1.00
2.00	Physical Therapy	3.00	1,190,645	0	1,190,645	6,215	191.58	2.00
3.00	Occupational Therapy	4.00	560,966	0	560,966	2,583	217.18	3.00
4.00	Speech Pathology	5.00	55,132	0	55,132	218	252.90	4.00
5.00	Medical Social Services	6.00	97,895		97,895	254	385.41	5.00
6.00	Home Health Aide	7.00	236,069		236,069	2,741	86.13	6.00
7.00	Total (sum of lines 1-6)		6,633,154	0	6,633,154	31,348		7.00

	Cost Center Description	Cost Limits	CBSA No. (1)	Part A	Program Visits Part B Not Subject to Deductibles & Coinsurance	Program Visits Part B Subject to Deductibles		
		0	1.00	2.00	3.00	4.00	5.00	
	Limitation Cost Computation							
8.00	Skilled Nursing Care		99914	0	12,375			8.00
9.00	Physical Therapy		99914	0	3,963			9.00
10.00	Occupational Therapy		99914	0	1,757			10.00
11.00	Speech Pathology		99914	0	150			11.00
12.00	Medical Social Services		99914	0	207			12.00
13.00	Home Health Aide		99914	0	2,086			13.00
14.00	Total (sum of lines 8-13)			0	20,538			14.00

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

	Cost Center Description	Program Visits Part A	Program Visits Part B Not Subject to Deductibles & Coinsurance	Program Visits Part B Subject to Deductibles & Coinsurance	Cost of Services Part A	Cost of Services Part B Not Subject to Deductibles & Coinsurance	Cost of Services Part B Subject to Deductibles & Coinsurance	
		6.00	7.00	8.00	9.00	10.00	11.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	0	12,375		0	2,874,960		1.00
2.00	Physical Therapy	0	3,963		0	759,232		2.00
3.00	Occupational Therapy	0	1,757		0	381,585		3.00
4.00	Speech Pathology	0	150		0	37,935		4.00
5.00	Medical Social Services	0	207		0	79,780		5.00
6.00	Home Health Aide	0	2,086		0	179,667		6.00
7.00	Total (sum of lines 1-6)	0	20,538		0	4,313,159		7.00

	Cost Center Description							
		6.00	7.00	8.00	9.00	10.00	11.00	
	Limitation Cost Computation							
8.00	Skilled Nursing Care							8.00
9.00	Physical Therapy							9.00
10.00	Occupational Therapy							10.00
11.00	Speech Pathology							11.00
12.00	Medical Social Services							12.00
13.00	Home Health Aide							13.00
14.00	Total (sum of lines 8-13)							14.00

APPORTIONMENT OF PATIENT SERVICE COSTS | Provider CCN: 14-0189 HHA CCN: 14-7594 | Period: From 07/01/2016 To 06/30/2017 | Worksheet H-3 Part I Date/Time Prepared: 11/16/2017 3:52 pm

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

	Cost Center Description	Total Program Cost (sum of cols. 9-10)	
		12.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION		
	Cost Per Visit Computation		
1.00	Skilled Nursing Care	2,874,960	1.00
2.00	Physical Therapy	759,232	2.00
3.00	Occupational Therapy	381,585	3.00
4.00	Speech Pathology	37,935	4.00
5.00	Medical Social Services	79,780	5.00
6.00	Home Health Aide	179,667	6.00
7.00	Total (sum of lines 1-6)	4,313,159	7.00

	Cost Center Description		
		12.00	
	Limitation Cost Computation		
8.00	Skilled Nursing Care		8.00
9.00	Physical Therapy		9.00
10.00	Occupational Therapy		10.00
11.00	Speech Pathology		11.00
12.00	Medical Social Services		12.00
13.00	Home Health Aide		13.00
14.00	Total (sum of lines 8-13)		14.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 14-0189 HHA CCN: 14-7594 | Period: From 07/01/2016 To 06/30/2017 | Worksheet H-3 Part II Date/Time Prepared: 11/16/2017 3:52 pm

Title XVIII | Home Health Agency I | PPS

	Cost Center Description	From Wkst. C, Part I, col. 9, line	Cost to Charge Ratio	Total HHA Charge (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)	Transfer to Part I as Indicated		
		0	1.00	2.00	3.00	4.00		
	PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS							
1.00	Physical Therapy	66.00	0.247297	0	0	col. 2, line 2.00		1.00
2.00	Occupational Therapy	67.00	0.300246	0	0	col. 2, line 3.00		2.00
3.00	Speech Pathology	68.00	0.352996	0	0	col. 2, line 4.00		3.00
4.00	Cost of Medical Supplies	71.00	0.197454	0	0	col. 2, line 15.00		4.00
5.00	Cost of Drugs	73.00	0.194923	0	0	col. 2, line 16.00		5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT

Provider CCN: 14-0189 | HHA CCN: 14-7594 | Period: From 07/01/2016 To 06/30/2017 | Worksheet H-4 Part I-II | Date/Time Prepared: 11/16/2017 3:52 pm

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		Part A	Part B Not Subject to Deductibles & Coinsurance	Part B Subject to Deductibles & Coinsurance	
		1.00	2.00	3.00	
	PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES				
	Reasonable Cost of Part A & Part B Services				
1.00	Reasonable cost of services (see instructions)	0	0	0	1.00
2.00	Total charges	0	0	0	2.00
	Customary Charges				
3.00	Amount actually collected from patients liable for payment for services on a charge basis (from your records)	0	0	0	3.00
4.00	Amount that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(b)	0	0	0	4.00
5.00	Ratio of line 3 to line 4 (not to exceed 1.000000)	0.000000	0.000000	0.000000	5.00
6.00	Total customary charges (see instructions)	0	0	0	6.00
7.00	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)	0	0	0	7.00
8.00	Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6)	0	0	0	8.00
9.00	Primary payer amounts	0	0	0	9.00

		Part A Services	Part B Services	
		1.00	2.00	
	PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT			
10.00	Total reasonable cost (see instructions)	0	0	10.00
11.00	Total PPS Reimbursement - Full Episodes without Outliers	0	2,819,892	11.00
12.00	Total PPS Reimbursement - Full Episodes with Outliers	0	286,544	12.00
13.00	Total PPS Reimbursement - LUPA Episodes	0	58,854	13.00
14.00	Total PPS Reimbursement - PEP Episodes	0	39,546	14.00
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers	0	119,304	15.00
16.00	Total PPS Outlier Reimbursement - PEP Episodes	0	1,589	16.00
17.00	Total Other Payments	0	-66,547	17.00
18.00	DME Payments	0	0	18.00
19.00	Oxygen Payments	0	0	19.00
20.00	Prosthetic and Orthotic Payments	0	0	20.00
21.00	Part B deductibles billed to Medicare patients (exclude coinsurance)		0	21.00
22.00	Subtotal (sum of lines 10 thru 20 minus line 21)	0	3,259,182	22.00
23.00	Excess reasonable cost (from line 8)	0	0	23.00
24.00	Subtotal (line 22 minus line 23)	0	3,259,182	24.00
25.00	Coinsurance billed to program patients (from your records)		0	25.00
26.00	Net cost (line 24 minus line 25)	0	3,259,182	26.00
27.00	Reimbursable bad debts (from your records)			27.00
28.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)			28.00
29.00	Total costs - current cost reporting period (line 26 plus line 27)	0	3,259,182	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	0	30.50
31.00	Subtotal (see instructions)	0	3,259,182	31.00
31.01	Sequestration adjustment (see instructions)	0	0	31.01
32.00	Interim payments (see instructions)	0	3,259,183	32.00
33.00	Tentative settlement (for contractor use only)	0	0	33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 32, and 33)	0	-1	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	35.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED HHAs FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES

Provider CCN: 14-0189 HHA CCN: 14-7594

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

Worksheet H-5

Date/Time Prepared: 11/16/2017 3:52 pm

Home Health Agency I

PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		0		3,259,183	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01			0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50			0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate, line 32)		0		3,259,183	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01			0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50			0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		1	6.02
7.00	Total Medicare program liability (see instructions)		0		3,259,182	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS

Provider CCN: 14-0189 | Hospice CCN: 14-1599 | Period: From 07/01/2016 To 06/30/2017 | Worksheet O | Date/Time Prepared: 11/16/2017 3:52 pm

Hospice I

		SALARIES	OTHER	SUBTOTAL (col. 1 plus col. 2)	RECLASSIFI-CATIONS	SUBTOTAL	
		1.00	2.00	3.00	4.00	5.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT*		0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP*		0	0	0	0	2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT*	0	0	0	0	0	3.00
4.00	ADMINISTRATIVE & GENERAL*	98,205	207,009	305,214	0	305,214	4.00
5.00	PLANT OPERATION & MAINTENANCE*	0	114	114	0	114	5.00
6.00	LAUNDRY & LINEN SERVICE*	0	0	0	0	0	6.00
7.00	HOUSEKEEPING*	0	0	0	0	0	7.00
8.00	DIETARY*	0	0	0	0	0	8.00
9.00	NURSING ADMINISTRATION*	220,411	0	220,411	0	220,411	9.00
10.00	ROUTINE MEDICAL SUPPLIES*	0	19,821	19,821	0	19,821	10.00
11.00	MEDICAL RECORDS*	0	0	0	0	0	11.00
12.00	STAFF TRANSPORTATION*	0	75,351	75,351	0	75,351	12.00
13.00	VOLUNTEER SERVICE COORDINATION*	34,319	0	34,319	0	34,319	13.00
14.00	PHARMACY*	0	314,335	314,335	0	314,335	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES*	0	57,060	57,060	0	57,060	15.00
16.00	OTHER GENERAL SERVICE*	0	0	0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES						17.00
	DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED**	0	0	0	0	0	25.00
26.00	PHYSICIAN SERVICES**	0	0	0	0	0	26.00
27.00	NURSE PRACTITIONER**	0	0	0	0	0	27.00
28.00	REGISTERED NURSE**	665,487	0	665,487	0	665,487	28.00
29.00	LPN/LVN**	31,136	0	31,136	0	31,136	29.00
30.00	PHYSICAL THERAPY**	0	0	0	0	0	30.00
31.00	OCCUPATIONAL THERAPY**	0	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY**	116	0	116	0	116	32.00
33.00	MEDICAL SOCIAL SERVICES**	89,133	0	89,133	0	89,133	33.00
34.00	SPIRITUAL COUNSELING**	10,634	1,350	11,984	0	11,984	34.00
35.00	DIETARY COUNSELING**	0	0	0	0	0	35.00
36.00	COUNSELING - OTHER**	0	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES**	107,482	0	107,482	0	107,482	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN**	0	192,443	192,443	0	192,443	38.00
39.00	PATIENT TRANSPORTATION**	0	4,946	4,946	0	4,946	39.00
40.00	IMAGING SERVICES**	0	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS**	0	0	0	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE**	0	0	0	0	0	42.00
43.00	OUTPATIENT SERVICES**	0	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY**	0	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY**	0	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)**	0	58,138	58,138	0	58,138	46.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM *	48,263	0	48,263	0	48,263	60.00
61.00	VOLUNTEER PROGRAM *	0	0	0	0	0	61.00
62.00	FUNDRAISING*	0	0	0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS*	0	0	0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM*	236,666	31,482	268,148	0	268,148	64.00
65.00	OTHER PHYSICIAN SERVICES*	0	0	0	0	0	65.00
66.00	RESIDENTIAL CARE*	0	0	0	0	0	66.00
67.00	ADVERTISING*	0	0	0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING*	0	0	0	0	0	68.00
69.00	THRIFT STORE*	0	0	0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD*	0	0	0	0	0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)*	0	0	0	0	0	71.00
100.00	TOTAL	1,541,852	962,049	2,503,901	0	2,503,901	100.00

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

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS

Provider CCN: 14-0189 | Hospice CCN: 14-1599 | Period: From 07/01/2016 To 06/30/2017 | Worksheet O | Date/Time Prepared: 11/16/2017 3:52 pm

Hospice I

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)		
		6.00	7.00		
	GENERAL SERVICE COST CENTERS				
1.00	CAP REL COSTS-BLDG & FIXT*	0	0		1.00
2.00	CAP REL COSTS-MVBLE EQUIP*	0	0		2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT*	0	0		3.00
4.00	ADMINISTRATIVE & GENERAL*	0	305,214		4.00
5.00	PLANT OPERATION & MAINTENANCE*	0	114		5.00
6.00	LAUNDRY & LINEN SERVICE*	0	0		6.00
7.00	HOUSEKEEPING*	0	0		7.00
8.00	DIETARY*	0	0		8.00
9.00	NURSING ADMINISTRATION*	0	220,411		9.00
10.00	ROUTINE MEDICAL SUPPLIES*	0	19,821		10.00
11.00	MEDICAL RECORDS*	0	0		11.00
12.00	STAFF TRANSPORTATION*	0	75,351		12.00
13.00	VOLUNTEER SERVICE COORDINATION*	0	34,319		13.00
14.00	PHARMACY*	0	314,335		14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES*	0	57,060		15.00
16.00	OTHER GENERAL SERVICE*	0	0		16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES				17.00
	DIRECT PATIENT CARE SERVICE COST CENTERS				
25.00	INPATIENT CARE-CONTRACTED**	0	0		25.00
26.00	PHYSICIAN SERVICES**	0	0		26.00
27.00	NURSE PRACTITIONER**	0	0		27.00
28.00	REGISTERED NURSE**	0	665,487		28.00
29.00	LPN/LVN**	0	31,136		29.00
30.00	PHYSICAL THERAPY**	0	0		30.00
31.00	OCCUPATIONAL THERAPY**	0	0		31.00
32.00	SPEECH/LANGUAGE PATHOLOGY**	0	116		32.00
33.00	MEDICAL SOCIAL SERVICES**	0	89,133		33.00
34.00	SPIRITUAL COUNSELING**	0	11,984		34.00
35.00	DIETARY COUNSELING**	0	0		35.00
36.00	COUNSELING - OTHER**	0	0		36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES**	0	107,482		37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN**	0	192,443		38.00
39.00	PATIENT TRANSPORTATION**	0	4,946		39.00
40.00	IMAGING SERVICES**	0	0		40.00
41.00	LABS & DIAGNOSTICS**	0	0		41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE**	0	0		42.00
43.00	OUTPATIENT SERVICES**	0	0		43.00
44.00	PALLIATIVE RADIATION THERAPY**	0	0		44.00
45.00	PALLIATIVE CHEMOTHERAPY**	0	0		45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)**	0	58,138		46.00
	NONREIMBURSABLE COST CENTERS				
60.00	BEREAVEMENT PROGRAM *	0	48,263		60.00
61.00	VOLUNTEER PROGRAM *	0	0		61.00
62.00	FUNDRAISING*	0	0		62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS*	0	0		63.00
64.00	PALLIATIVE CARE PROGRAM*	0	268,148		64.00
65.00	OTHER PHYSICIAN SERVICES*	0	0		65.00
66.00	RESIDENTIAL CARE*	0	0		66.00
67.00	ADVERTISING*	0	0		67.00
68.00	TELEHEALTH/TELEMONITORING*	0	0		68.00
69.00	THRIFT STORE*	0	0		69.00
70.00	NURSING FACILITY ROOM & BOARD*	0	0		70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)*	0	0		71.00
100.00	TOTAL	0	2,503,901		100.00

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

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

Provider CCN: 14-0189 Hospice CCN: 14-1599

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

Worksheet O-2

Date/Time Prepared: 11/16/2017 3:52 pm

Hospice I

		SALARIES	OTHER	SUBTOTAL (col. 1 + col. 2)	RECLASSIFI-CATIONS	SUBTOTAL	
		1.00	2.00	3.00	4.00	5.00	
	DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED						25.00
26.00	PHYSICIAN SERVICES	0	0	0	0	0	26.00
27.00	NURSE PRACTITIONER	0	0	0	0	0	27.00
28.00	REGISTERED NURSE	612,597	0	612,597	0	612,597	28.00
29.00	LPN/LVN	30,097	0	30,097	0	30,097	29.00
30.00	PHYSICAL THERAPY	0	0	0	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	116	0	116	0	116	32.00
33.00	MEDICAL SOCIAL SERVICES	78,090	0	78,090	0	78,090	33.00
34.00	SPIRITUAL COUNSELING	10,011	1,350	11,361	0	11,361	34.00
35.00	DIETARY COUNSELING	0	0	0	0	0	35.00
36.00	COUNSELING - OTHER	0	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	107,105	0	107,105	0	107,105	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	192,443	192,443	0	192,443	38.00
39.00	PATIENT TRANSPORTATION	0	2,854	2,854	0	2,854	39.00
40.00	IMAGING SERVICES	0	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	0	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	0	0	0	42.00
43.00	OUTPATIENT SERVICES	0	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	5,614	5,614	0	5,614	46.00
100.00	TOTAL *	838,016	202,261	1,040,277	0	1,040,277	100.00

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

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)		
		6.00	7.00		
	DIRECT PATIENT CARE SERVICE COST CENTERS				
25.00	INPATIENT CARE-CONTRACTED				25.00
26.00	PHYSICIAN SERVICES	0	0		26.00
27.00	NURSE PRACTITIONER	0	0		27.00
28.00	REGISTERED NURSE	0	612,597		28.00
29.00	LPN/LVN	0	30,097		29.00
30.00	PHYSICAL THERAPY	0	0		30.00
31.00	OCCUPATIONAL THERAPY	0	0		31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	116		32.00
33.00	MEDICAL SOCIAL SERVICES	0	78,090		33.00
34.00	SPIRITUAL COUNSELING	0	11,361		34.00
35.00	DIETARY COUNSELING	0	0		35.00
36.00	COUNSELING - OTHER	0	0		36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	107,105		37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	192,443		38.00
39.00	PATIENT TRANSPORTATION	0	2,854		39.00
40.00	IMAGING SERVICES	0	0		40.00
41.00	LABS & DIAGNOSTICS	0	0		41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0		42.00
43.00	OUTPATIENT SERVICES	0	0		43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0		44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0		45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	5,614		46.00
100.00	TOTAL *	0	1,040,277		100.00

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

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

Provider CCN: 14-0189 Hospice CCN: 14-1599

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

Worksheet O-3 Date/Time Prepared: 11/16/2017 3:52 pm

Hospice I

		SALARIES	OTHER	SUBTOTAL (col. 1 + col. 2)	RECLASSIFI-CATIONS	SUBTOTAL	
		1.00	2.00	3.00	4.00	5.00	
	DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED	0	0	0	0	0	25.00
26.00	PHYSICIAN SERVICES	0	0	0	0	0	26.00
27.00	NURSE PRACTITIONER	0	0	0	0	0	27.00
28.00	REGISTERED NURSE	22,222	0	22,222	0	22,222	28.00
29.00	LPN/LVN	566	0	566	0	566	29.00
30.00	PHYSICAL THERAPY	0	0	0	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	5,237	0	5,237	0	5,237	33.00
34.00	SPIRITUAL COUNSELING	280	0	280	0	280	34.00
35.00	DIETARY COUNSELING	0	0	0	0	0	35.00
36.00	COUNSELING - OTHER	0	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	334	0	334	0	334	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN						38.00
39.00	PATIENT TRANSPORTATION	0	1,042	1,042	0	1,042	39.00
40.00	IMAGING SERVICES	0	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	0	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	0	0	0	42.00
43.00	OUTPATIENT SERVICES	0	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	4,273	4,273	0	4,273	46.00
100.00	TOTAL *	28,639	5,315	33,954	0	33,954	100.00

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

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)		
		6.00	7.00		
	DIRECT PATIENT CARE SERVICE COST CENTERS				
25.00	INPATIENT CARE-CONTRACTED	0	0		25.00
26.00	PHYSICIAN SERVICES	0	0		26.00
27.00	NURSE PRACTITIONER	0	0		27.00
28.00	REGISTERED NURSE	0	22,222		28.00
29.00	LPN/LVN	0	566		29.00
30.00	PHYSICAL THERAPY	0	0		30.00
31.00	OCCUPATIONAL THERAPY	0	0		31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0		32.00
33.00	MEDICAL SOCIAL SERVICES	0	5,237		33.00
34.00	SPIRITUAL COUNSELING	0	280		34.00
35.00	DIETARY COUNSELING	0	0		35.00
36.00	COUNSELING - OTHER	0	0		36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	334		37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN				38.00
39.00	PATIENT TRANSPORTATION	0	1,042		39.00
40.00	IMAGING SERVICES	0	0		40.00
41.00	LABS & DIAGNOSTICS	0	0		41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0		42.00
43.00	OUTPATIENT SERVICES	0	0		43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0		44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0		45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	4,273		46.00
100.00	TOTAL *	0	33,954		100.00

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

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

Provider CCN: 14-0189 Hospice CCN: 14-1599

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

Worksheet O-4 Date/Time Prepared: 11/16/2017 3:52 pm

Hospice I

		SALARIES	OTHER	SUBTOTAL (col. 1 + col. 2)	RECLASSIFI-CATIONS	SUBTOTAL	
		1.00	2.00	3.00	4.00	5.00	
	DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED	0	0	0	0	0	25.00
26.00	PHYSICIAN SERVICES	0	0	0	0	0	26.00
27.00	NURSE PRACTITIONER	0	0	0	0	0	27.00
28.00	REGISTERED NURSE	30,668	0	30,668	0	30,668	28.00
29.00	LPN/LVN	473	0	473	0	473	29.00
30.00	PHYSICAL THERAPY	0	0	0	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	5,806	0	5,806	0	5,806	33.00
34.00	SPIRITUAL COUNSELING	343	0	343	0	343	34.00
35.00	DIETARY COUNSELING	0	0	0	0	0	35.00
36.00	COUNSELING - OTHER	0	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	43	0	43	0	43	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN						38.00
39.00	PATIENT TRANSPORTATION	0	1,050	1,050	0	1,050	39.00
40.00	IMAGING SERVICES	0	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	0	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	0	0	0	42.00
43.00	OUTPATIENT SERVICES	0	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	48,251	48,251	0	48,251	46.00
100.00	TOTAL *	37,333	49,301	86,634	0	86,634	100.00

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

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)		
		6.00	7.00		
	DIRECT PATIENT CARE SERVICE COST CENTERS				
25.00	INPATIENT CARE-CONTRACTED	0	0		25.00
26.00	PHYSICIAN SERVICES	0	0		26.00
27.00	NURSE PRACTITIONER	0	0		27.00
28.00	REGISTERED NURSE	0	30,668		28.00
29.00	LPN/LVN	0	473		29.00
30.00	PHYSICAL THERAPY	0	0		30.00
31.00	OCCUPATIONAL THERAPY	0	0		31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0		32.00
33.00	MEDICAL SOCIAL SERVICES	0	5,806		33.00
34.00	SPIRITUAL COUNSELING	0	343		34.00
35.00	DIETARY COUNSELING	0	0		35.00
36.00	COUNSELING - OTHER	0	0		36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	43		37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN				38.00
39.00	PATIENT TRANSPORTATION	0	1,050		39.00
40.00	IMAGING SERVICES	0	0		40.00
41.00	LABS & DIAGNOSTICS	0	0		41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0		42.00
43.00	OUTPATIENT SERVICES	0	0		43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0		44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0		45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	48,251		46.00
100.00	TOTAL *	0	86,634		100.00

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

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

Provider CCN: 14-0189 Hospice CCN: 14-1599

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

Worksheet O-5

Date/Time Prepared: 11/16/2017 3:52 pm

Hospice I

	Descriptions	HOSPICE DIRECT EXPENSES (see instructions)	GENERAL SERVICE EXPENSES FROM WKST B PART I (see instructions)	TOTAL EXPENSES (sum of cols. 1 + 2)	
		1.00	2.00	3.00	
	GENERAL SERVICE COST CENTERS				
1.00	CAP REL COSTS-BLDG & FIXT	0	17,461	17,461	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	155	155	2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	0	309,872	309,872	3.00
4.00	ADMINISTRATIVE & GENERAL	305,214	550,162	855,376	4.00
5.00	PLANT OPERATION & MAINTENANCE	114	25,216	25,330	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0	6.00
7.00	HOUSEKEEPING	0	8,736	8,736	7.00
8.00	DIETARY	0	0	0	8.00
9.00	NURSING ADMINISTRATION	220,411	0	220,411	9.00
10.00	ROUTINE MEDICAL SUPPLIES	19,821	0	19,821	10.00
11.00	MEDICAL RECORDS	0	30,691	30,691	11.00
12.00	STAFF TRANSPORTATION	75,351		75,351	12.00
13.00	VOLUNTEER SERVICE COORDINATION	34,319		34,319	13.00
14.00	PHARMACY	314,335	0	314,335	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	57,060		57,060	15.00
16.00	OTHER GENERAL SERVICE	0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES		0	0	17.00
	LEVEL OF CARE				
50.00	HOSPICE CONTINUOUS HOME CARE	0		0	50.00
51.00	HOSPICE ROUTINE HOME CARE	1,040,277		1,040,277	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	33,954		33,954	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	86,634		86,634	53.00
	NONREIMBURSABLE COST CENTERS				
60.00	BEREAVEMENT PROGRAM	48,263		48,263	60.00
61.00	VOLUNTEER PROGRAM	0		0	61.00
62.00	FUNDRAISING	0		0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0		0	63.00
64.00	PALLIATIVE CARE PROGRAM	268,148		268,148	64.00
65.00	OTHER PHYSICIAN SERVICES	0		0	65.00
66.00	RESIDENTIAL CARE	0		0	66.00
67.00	ADVERTISING	0		0	67.00
68.00	TELEHEALTH/TELEMONITORING	0		0	68.00
69.00	THRIFT STORE	0		0	69.00
70.00	NURSING FACILITY ROOM & BOARD	0		0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0		0	71.00
99.00	NEGATIVE COST CENTER	0		0	99.00
100.00	TOTAL	2,503,901	942,293	3,446,194	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN: 14-0189
Hospice CCN: 14-1599

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

Worksheet O-6 Part I
Date/Time Prepared: 11/16/2017 3:52 pm

Hospice I

	Descriptions	TOTAL EXPENSES	CAP REL BLDG & FIX	CAP REL MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	SUBTOTAL	
		0	1.00	2.00	3.00	3A	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	17,461	17,461				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	155		155			2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	309,872	0	0	309,872		3.00
4.00	ADMINISTRATIVE & GENERAL	855,376	17,461	155	19,737	892,729	4.00
5.00	PLANT OPERATION & MAINTENANCE	25,330	0	0	0	25,330	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0	0	0	6.00
7.00	HOUSEKEEPING	8,736	0	0	0	8,736	7.00
8.00	DIETARY	0	0	0	0	0	8.00
9.00	NURSING ADMINISTRATION	220,411	0	0	44,030	264,441	9.00
10.00	ROUTINE MEDICAL SUPPLIES	19,821	0	0	0	19,821	10.00
11.00	MEDICAL RECORDS	30,691	0	0	0	30,691	11.00
12.00	STAFF TRANSPORTATION	75,351	0	0	0	75,351	12.00
13.00	VOLUNTEER SERVICE COORDINATION	34,319	0	0	6,897	41,216	13.00
14.00	PHARMACY	314,335	0	0	0	314,335	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	57,060	0	0	0	57,060	15.00
16.00	OTHER GENERAL SERVICE	0	0	0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES		0	0		0	17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0			0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	1,040,277			168,613	1,208,890	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	33,954	0	0	5,792	39,746	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	86,634	0	0	7,539	94,173	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	48,263	0	0	9,700	57,963	60.00
61.00	VOLUNTEER PROGRAM	0	0	0	0	0	61.00
62.00	FUNDRAISING	0	0	0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0	0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	268,148	0	0	47,564	315,712	64.00
65.00	OTHER PHYSICIAN SERVICES	0	0	0	0	0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0	0	0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING	0	0	0	0	0	68.00
69.00	THRIFT STORE	0	0	0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD	0				0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER	0	0	0	0		99.00
100.00	TOTAL	3,446,194	17,461	155	309,872	3,446,194	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN: 14-0189
Hospice CCN: 14-1599

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

Worksheet O-6 Part I
Date/Time Prepared: 11/16/2017 3:52 pm

Hospice I

	Descriptions	ADMINISTRATIVE & GENERAL	PLANT OPERATION & MAINTENANCE	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		4.00	5.00	6.00	7.00	8.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL	892,729					4.00
5.00	PLANT OPERATION & MAINTENANCE	8,856	34,186				5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0			6.00
7.00	HOUSEKEEPING	3,054	0		11,790		7.00
8.00	DIETARY	0	0		0	0	8.00
9.00	NURSING ADMINISTRATION	92,453	34,186		11,790		9.00
10.00	ROUTINE MEDICAL SUPPLIES	6,930	0		0		10.00
11.00	MEDICAL RECORDS	10,730	0		0		11.00
12.00	STAFF TRANSPORTATION	26,344	0		0		12.00
13.00	VOLUNTEER SERVICE COORDINATION	14,410	0		0		13.00
14.00	PHARMACY	109,896	0		0		14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	19,949	0		0		15.00
16.00	OTHER GENERAL SERVICE	0	0		0		16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0	0		0		17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0					50.00
51.00	HOSPICE ROUTINE HOME CARE	422,644					51.00
52.00	HOSPICE INPATIENT RESPITE CARE	13,896	0	0	0	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	32,924	0	0	0	0	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	20,265	0		0		60.00
61.00	VOLUNTEER PROGRAM	0	0		0		61.00
62.00	FUNDRAISING	0	0		0		62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0		0		63.00
64.00	PALLIATIVE CARE PROGRAM	110,378	0		0		64.00
65.00	OTHER PHYSICIAN SERVICES	0	0		0		65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0	0		0		67.00
68.00	TELEHEALTH/TELEMONITORING	0	0		0		68.00
69.00	THRIFT STORE	0	0		0		69.00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER	0	0	0	0	0	99.00
100.00	TOTAL	892,729	34,186	0	11,790	0	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS | Provider CCN: 14-0189 Hospice CCN: 14-1599 | Period: From 07/01/2016 To 06/30/2017 | Worksheet O-6 Part I Date/Time Prepared: 11/16/2017 3:52 pm

Hospice I

	Descriptions	NURSING ADMINISTRATION	ROUTINE MEDICAL SUPPLIES	MEDICAL RECORDS	STAFF TRANSPORTATION	VOLUNTEER SERVICE COORDINATION	
		9.00	10.00	11.00	12.00	13.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5.00
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPING						7.00
8.00	DIETARY						8.00
9.00	NURSING ADMINISTRATION	402,870					9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	26,751				10.00
11.00	MEDICAL RECORDS	0		41,421			11.00
12.00	STAFF TRANSPORTATION	0			101,695		12.00
13.00	VOLUNTEER SERVICE COORDINATION	0			0	55,626	13.00
14.00	PHARMACY	0			0	0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0			0	0	15.00
16.00	OTHER GENERAL SERVICE	0			0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES						17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0	0	0	0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	349,516	26,576	41,151	101,033	55,222	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	9,714	63	97	238	162	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	12,476	112	173	424	242	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	31,164			0	0	60.00
61.00	VOLUNTEER PROGRAM	0			0	0	61.00
62.00	FUNDRAISING	0			0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0			0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0			0	0	64.00
65.00	OTHER PHYSICIAN SERVICES	0			0	0	65.00
66.00	RESIDENTIAL CARE	0			0	0	66.00
67.00	ADVERTISING	0			0	0	67.00
68.00	TELEHEALTH/TELEMONITORING	0			0	0	68.00
69.00	THRIFT STORE	0			0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0			0	0	71.00
99.00	NEGATIVE COST CENTER	0	0	0	0	0	99.00
100.00	TOTAL	402,870	26,751	41,421	101,695	55,626	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN: 14-0189
Hospice CCN: 14-1599

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

Worksheet O-6 Part I
Date/Time Prepared: 11/16/2017 3:52 pm

Hospice I

	Descriptions	PHARMACY	PHYSICIAN ADMINISTRATIVE SERVICES	OTHER GENERAL SERVICE	PATIENT/ RESIDENTIAL CARE SERVICES	TOTAL	
		14.00	15.00	16.00	17.00	18.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5.00
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPING						7.00
8.00	DIETARY						8.00
9.00	NURSING ADMINISTRATION						9.00
10.00	ROUTINE MEDICAL SUPPLIES						10.00
11.00	MEDICAL RECORDS						11.00
12.00	STAFF TRANSPORTATION						12.00
13.00	VOLUNTEER SERVICE COORDINATION						13.00
14.00	PHARMACY	424,231					14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	77,009				15.00
16.00	OTHER GENERAL SERVICE	0		0			16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES				0		17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0	0	0		0	50.00
51.00	HOSPICE ROUTINE HOME CARE	421,470	76,508	0		2,703,010	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	992	180	0	0	65,088	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	1,769	321	0	0	142,614	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0		0		109,392	60.00
61.00	VOLUNTEER PROGRAM	0		0		0	61.00
62.00	FUNDRAISING	0		0		0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0		0		0	63.00
64.00	PALLIATIVE CARE PROGRAM	0		0		426,090	64.00
65.00	OTHER PHYSICIAN SERVICES	0		0		0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0		0		0	67.00
68.00	TELEHEALTH/TELEMONITORING	0		0		0	68.00
69.00	THRIFT STORE	0		0		0	69.00
70.00	NURSING FACILITY ROOM & BOARD					0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER	0	0	0	0	0	99.00
100.00	TOTAL	424,231	77,009	0	0	3,446,194	100.00

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

Provider CCN: 14-0189
Hospice CCN: 14-1599

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

Worksheet O-6 Part II
Date/Time Prepared: 11/16/2017 3:52 pm

Hospice I

	Cost Center Descriptions	CAP REL BLDG & FIX (SQUARE FEET)	CAP REL MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	RECONCILIATION	ADMINISTRATIVE & GENERAL (ACCUMULATED COSTS)	
		1.00	2.00	3.00	4A	4.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	1,500					1.00
2.00	CAP REL COSTS-MVBLE EQUIP		149				2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	0	0	1,541,852			3.00
4.00	ADMINISTRATIVE & GENERAL	1,500	149	98,205	-892,729	2,553,465	4.00
5.00	PLANT OPERATION & MAINTENANCE	0	0	0	0	25,330	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0	0	0	6.00
7.00	HOUSEKEEPING	0	0	0	0	8,736	7.00
8.00	DIETARY	0	0	0	0	0	8.00
9.00	NURSING ADMINISTRATION	0	0	219,081	0	264,441	9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	0	0	0	19,821	10.00
11.00	MEDICAL RECORDS	0	0	0	0	30,691	11.00
12.00	STAFF TRANSPORTATION	0	0	0	0	75,351	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0	0	34,319	0	41,216	13.00
14.00	PHARMACY	0	0	0	0	314,335	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0	0	0	57,060	15.00
16.00	OTHER GENERAL SERVICE	0	0	0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0	0		0	0	17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE			0	0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE			838,984	0	1,208,890	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0	28,820	0	39,746	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	37,514	0	94,173	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0	0	48,263	0	57,963	60.00
61.00	VOLUNTEER PROGRAM	0	0	0	0	0	61.00
62.00	FUNDRAISING	0	0	0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0	0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0	0	236,666	0	315,712	64.00
65.00	OTHER PHYSICIAN SERVICES	0	0	0	0	0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0	0	0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING	0	0	0	0	0	68.00
69.00	THRIFT STORE	0	0	0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD				0		70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER						99.00
100.00	COST TO BE ALLOCATED (per Wkst. O-6, Part I)	17,461	155	309,872		892,729	100.00
101.00	UNIT COST MULTIPLIER	11.640667	1.040268	0.200974		0.349615	101.00

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

Provider CCN: 14-0189
Hospice CCN: 14-1599

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

Worksheet O-6
Part II
Date/Time Prepared:
11/16/2017 3:52 pm

Hospice I

	Cost Center Descriptions	PLANT OPERATION & MAINTENANCE (SQUARE FEET)	LAUNDRY & LINEN SERVICE (IN-FACILITY DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (IN-FACILITY DAYS)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	
		5.00	6.00	7.00	8.00	9.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE	1,500					5.00
6.00	LAUNDRY & LINEN SERVICE	0	0				6.00
7.00	HOUSEKEEPING	0		1,500			7.00
8.00	DIETARY	0		0	0		8.00
9.00	NURSING ADMINISTRATION	1,500		1,500		24,510	9.00
10.00	ROUTINE MEDICAL SUPPLIES	0		0		0	10.00
11.00	MEDICAL RECORDS	0		0		0	11.00
12.00	STAFF TRANSPORTATION	0		0		0	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0		0		0	13.00
14.00	PHARMACY	0		0		0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0		0		0	15.00
16.00	OTHER GENERAL SERVICE	0		0		0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0		0			17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE					0	50.00
51.00	HOSPICE ROUTINE HOME CARE					21,264	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0	0	0	591	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	0	0	759	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0		0		1,896	60.00
61.00	VOLUNTEER PROGRAM	0		0		0	61.00
62.00	FUNDRAISING	0		0		0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0		0		0	63.00
64.00	PALLIATIVE CARE PROGRAM	0		0		0	64.00
65.00	OTHER PHYSICIAN SERVICES	0		0		0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0		0		0	67.00
68.00	TELEHEALTH/TELEMONITORING	0		0		0	68.00
69.00	THRIFT STORE	0		0		0	69.00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER						99.00
100.00	COST TO BE ALLOCATED (per Wkst. O-6, Part I)	34,186	0	11,790	0	402,870	100.00
101.00	UNIT COST MULTIPLIER	22.790667	0.000000	7.860000	0.000000	16.436965	101.00

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

Provider CCN: 14-0189
Hospice CCN: 14-1599

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

Worksheet O-6
Part II
Date/Time Prepared:
11/16/2017 3:52 pm

Hospice I

	Cost Center Descriptions	ROUTINE MEDICAL SUPPLIES (PATIENT DAYS)	MEDICAL RECORDS (PATIENT DAYS)	STAFF TRANSPORTATION (MILEAGE)	VOLUNTEER SERVICE COORDINATION (HOURS OF SERVICE)	PHARMACY (CHARGES)	
		10.00	11.00	12.00	13.00	14.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5.00
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPING						7.00
8.00	DIETARY						8.00
9.00	NURSING ADMINISTRATION						9.00
10.00	ROUTINE MEDICAL SUPPLIES	19,668					10.00
11.00	MEDICAL RECORDS		19,668				11.00
12.00	STAFF TRANSPORTATION			19,668			12.00
13.00	VOLUNTEER SERVICE COORDINATION			0	2,065		13.00
14.00	PHARMACY			0	0	19,668	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES			0	0	0	15.00
16.00	OTHER GENERAL SERVICE			0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES						17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0	0	0	0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	19,540	19,540	19,540	2,050	19,540	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	46	46	46	6	46	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	82	82	82	9	82	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM			0	0	0	60.00
61.00	VOLUNTEER PROGRAM			0	0	0	61.00
62.00	FUNDRAISING			0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS			0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM			0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES			0	0	0	65.00
66.00	RESIDENTIAL CARE			0	0	0	66.00
67.00	ADVERTISING			0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING			0	0	0	68.00
69.00	THRIFT STORE			0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)			0	0	0	71.00
99.00	NEGATIVE COST CENTER						99.00
100.00	COST TO BE ALLOCATED (per Wkst. O-6, Part I)	26,751	41,421	101,695	55,626	424,231	100.00
101.00	UNIT COST MULTIPLIER	1.360128	2.106010	5.170582	26.937530	21.569605	101.00

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

Provider CCN: 14-0189
Hospice CCN: 14-1599

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

Worksheet O-6
Part II
Date/Time Prepared:
11/16/2017 3:52 pm

Hospice I

	Cost Center Descriptions	PHYSICIAN ADMINISTRATIVE SERVICES (PATIENT DAYS)	OTHER GENERAL SERVICE (SPECIFY BASIS)	PATIENT/ RESIDENTIAL CARE SERVICES (IN-FACILITY DAYS)		
		15.00	16.00	17.00		
	GENERAL SERVICE COST CENTERS					
1.00	CAP REL COSTS-BLDG & FIXT					1.00
2.00	CAP REL COSTS-MVBLE EQUIP					2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT					3.00
4.00	ADMINISTRATIVE & GENERAL					4.00
5.00	PLANT OPERATION & MAINTENANCE					5.00
6.00	LAUNDRY & LINEN SERVICE					6.00
7.00	HOUSEKEEPING					7.00
8.00	DIETARY					8.00
9.00	NURSING ADMINISTRATION					9.00
10.00	ROUTINE MEDICAL SUPPLIES					10.00
11.00	MEDICAL RECORDS					11.00
12.00	STAFF TRANSPORTATION					12.00
13.00	VOLUNTEER SERVICE COORDINATION					13.00
14.00	PHARMACY					14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	19,668				15.00
16.00	OTHER GENERAL SERVICE		0			16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES			0		17.00
	LEVEL OF CARE					
50.00	HOSPICE CONTINUOUS HOME CARE	0	0			50.00
51.00	HOSPICE ROUTINE HOME CARE	19,540	0			51.00
52.00	HOSPICE INPATIENT RESPITE CARE	46	0	0		52.00
53.00	HOSPICE GENERAL INPATIENT CARE	82	0	0		53.00
	NONREIMBURSABLE COST CENTERS					
60.00	BEREAVEMENT PROGRAM		0			60.00
61.00	VOLUNTEER PROGRAM		0			61.00
62.00	FUNDRAISING		0			62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS		0			63.00
64.00	PALLIATIVE CARE PROGRAM		0			64.00
65.00	OTHER PHYSICIAN SERVICES		0			65.00
66.00	RESIDENTIAL CARE	0	0	0		66.00
67.00	ADVERTISING		0			67.00
68.00	TELEHEALTH/TELEMONITORING		0			68.00
69.00	THRIFT STORE		0			69.00
70.00	NURSING FACILITY ROOM & BOARD					70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0		71.00
99.00	NEGATIVE COST CENTER					99.00
100.00	COST TO BE ALLOCATED (per Wkst. O-6, Part I)	77,009	0	0		100.00
101.00	UNIT COST MULTIPLIER	3.915446	0.000000	0.000000		101.00

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

Provider CCN: 14-0189 Hospice CCN: 14-1599

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

Worksheet O-7

Date/Time Prepared: 11/16/2017 3:52 pm

Hospice I

	Cost Center Descriptions	From Wkst. C, Part I, Col. 9 line	Cost to Charge Ratio	Charges by LOC (from Provider Records) HCHC	HRHC	HIRC	
		0	1.00	2.00	3.00	4.00	
	ANCILLARY SERVICE COST CENTERS						
1.00	PHYSICAL THERAPY	66.00	0.247297	0	0	0	1.00
2.00	OCCUPATIONAL THERAPY	67.00	0.300246	0	0	0	2.00
3.00	SPEECH PATHOLOGY	68.00	0.352996	0	0	0	3.00
4.00	DRUGS CHARGED TO PATIENTS	73.00	0.194923	0	0	0	4.00
5.00	DURABLE MEDICAL EQUIP-RENTED	96.00					5.00
6.00	LABORATORY	60.00	0.278989	0	0	0	6.00
7.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0.197454	0	0	0	7.00
8.00	OTHER OUTPATIENT SERVICE COST CENTER	93.00					8.00
9.00	RADIOLOGY-THERAPEUTIC	55.00	0.295143	0	0	0	9.00
10.00	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	76.00	4.870625	0	0	0	10.00
11.00	Totals (sum of lines 1-11)						11.00

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

CALCULATION OF HOSPITAL-BASED HOSPICE PER DIEM COST

Provider CCN: 14-0189 Hospice CCN: 14-1599

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

Worksheet O-8

Date/Time Prepared: 11/16/2017 3:52 pm

Hospice I

		TITLE XVIII MEDICARE	TITLE XIX MEDICAID	TOTAL	
		1.00	2.00	3.00	
	HOSPICE CONTINUOUS HOME CARE				
1.00	Total cost (Wkst. O-6, Part I, col. 18, line 50 plus Wkst. O-7, col. 6, line 11)			0	1.00
2.00	Total unduplicated days (Wkst. S-9, col. 4, line 10)			0	2.00
3.00	Total average cost per diem (line 1 divided by line 2)			0.00	3.00
4.00	Unduplicated program days (Wkst. S-9 col. as appropriate, line 10)	0	0		4.00
5.00	Program cost (line 3 times line 4)	0	0		5.00
	HOSPICE ROUTINE HOME CARE				
6.00	Total cost (Wkst. O-6, Part I, col. 18, line 51 plus Wkst. O-7, col. 7, line 11)			2,703,010	6.00
7.00	Total unduplicated days (Wkst. S-9, col. 4, line 11)			19,540	7.00
8.00	Total average cost per diem (line 6 divided by line 7)			138.33	8.00
9.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 11)	17,955	732		9.00
10.00	Program cost (line 8 times line 9)	2,483,715	101,258		10.00
	HOSPICE INPATIENT RESPITE CARE				
11.00	Total cost (Wkst. O-6, Part I, col. 18, line 52 plus Wkst. O-7, col. 8, line 11)			65,088	11.00
12.00	Total unduplicated days (Wkst. S-9, col. 4, line 12)			46	12.00
13.00	Total average cost per diem (line 11 divided by line 12)			1,414.96	13.00
14.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 12)	41	5		14.00
15.00	Program cost (line 13 times line 14)	58,013	7,075		15.00
	HOSPICE GENERAL INPATIENT CARE				
16.00	Total cost (Wkst. O-6, Part I, col. 18, line 53 plus Wkst. O-7, col. 9, line 11)			142,614	16.00
17.00	Total unduplicated days (Wkst. S-9, col. 4, line 13)			82	17.00
18.00	Total average cost per diem (line 16 divided by line 17)			1,739.20	18.00
19.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 13)	66	9		19.00
20.00	Program cost (line 18 times line 19)	114,787	15,653		20.00
	TOTAL HOSPICE CARE				
21.00	Total cost (sum of line 1 + line 6 + line 11 + line 16)			2,910,712	21.00
22.00	Total unduplicated days (Wkst. S-9, col. 4, line 14)			19,668	22.00
23.00	Average cost per diem (line 21 divided by line 22)			147.99	23.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 14-0189	Period: From 07/01/2016 To 06/30/2017	Worksheet L Parts I-III Date/Time Prepared: 11/16/2017 3:52 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	1,563,457	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	20,237	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)	56.98	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)	1,583,694	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: 14-0189 | Component CCN: 14-3978 | Period: From 07/01/2016 To 06/30/2017 | Worksheet M-1 | Date/Time Prepared: 11/16/2017 3:52 pm

RHC I | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	0	0	0	0	0	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	129,017	10,276	139,293	0	139,293	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	0	0	0	0	0	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	109,768	7,897	117,665	0	117,665	9.00
10.00	Subtotal (sum of lines 1 through 9)	238,785	18,173	256,958	0	256,958	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	24,847	24,847	0	24,847	15.00
16.00	Transportation (Health Care Staff)	0	840	840	0	840	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	11,259	11,259	0	11,259	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	36,946	36,946	0	36,946	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	238,785	55,119	293,904	0	293,904	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
25.01	Telehealth	0	0	0	0	0	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	71,135	71,135	0	71,135	29.00
30.00	Administrative Costs	44,283	9,220	53,503	0	53,503	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	44,283	80,355	124,638	0	124,638	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	283,068	135,474	418,542	0	418,542	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-0189 | Component CCN: 14-3978 | Period: From 07/01/2016 To 06/30/2017 | Worksheet M-1 | Date/Time Prepared: 11/16/2017 3:52 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	0		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	139,293		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	0		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	117,665		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	256,958		10.00
11.00	Physician Services Under Agreement	0	0		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	0		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0		14.00
15.00	Medical Supplies	0	24,847		15.00
16.00	Transportation (Health Care Staff)	0	840		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	11,259		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	36,946		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	293,904		22.00
	COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
25.01	Telehealth	0	0		25.01
25.02	Chronic Care Management	0	0		25.02
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs				27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	71,135		29.00
30.00	Administrative Costs	0	53,503		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	124,638		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	418,542		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-0189 | Component CCN: 14-3998 | Period: From 07/01/2016 To 06/30/2017 | Worksheet M-1 | Date/Time Prepared: 11/16/2017 3:52 pm

RHC II | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	0	0	0	0	0	1.00
2.00	Physician Assistant	61,880	5,531	67,411	0	67,411	2.00
3.00	Nurse Practitioner	134,514	15,981	150,495	0	150,495	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	0	0	0	0	0	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	90,613	5,688	96,301	0	96,301	9.00
10.00	Subtotal (sum of lines 1 through 9)	287,007	27,200	314,207	0	314,207	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	35,839	35,839	0	35,839	15.00
16.00	Transportation (Health Care Staff)	0	1,022	1,022	0	1,022	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	22,517	22,517	0	22,517	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	59,378	59,378	0	59,378	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	287,007	86,578	373,585	0	373,585	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
25.01	Telehealth	0	0	0	0	0	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	62,174	62,174	0	62,174	29.00
30.00	Administrative Costs	72,481	13,009	85,490	0	85,490	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	72,481	75,183	147,664	0	147,664	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	359,488	161,761	521,249	0	521,249	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-0189 | Component CCN: 14-3998 | Period: From 07/01/2016 To 06/30/2017 | Worksheet M-1 | Date/Time Prepared: 11/16/2017 3:52 pm

RHC II | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	0		1.00
2.00	Physician Assistant	0	67,411		2.00
3.00	Nurse Practitioner	0	150,495		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	0		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	96,301		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	314,207		10.00
11.00	Physician Services Under Agreement	0	0		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	0		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0		14.00
15.00	Medical Supplies	0	35,839		15.00
16.00	Transportation (Health Care Staff)	0	1,022		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	22,517		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	59,378		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	373,585		22.00
	COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
25.01	Telehealth	0	0		25.01
25.02	Chronic Care Management	0	0		25.02
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs				27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	62,174		29.00
30.00	Administrative Costs	0	85,490		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	147,664		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	521,249		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-0189 | Component CCN: 14-3435 | Period: From 07/01/2016 To 06/30/2017 | Worksheet M-1 | Date/Time Prepared: 11/16/2017 3:52 pm

RHC III | 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	202,101	20,457	222,558	0	222,558	1.00
2.00	Physician Assistant	303,982	11,407	315,389	0	315,389	2.00
3.00	Nurse Practitioner	0	0	0	0	0	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	0	0	0	0	0	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	135,523	7,926	143,449	0	143,449	9.00
10.00	Subtotal (sum of lines 1 through 9)	641,606	39,790	681,396	0	681,396	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	34,618	34,618	0	34,618	15.00
16.00	Transportation (Health Care Staff)	0	1,407	1,407	0	1,407	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	26,270	26,270	0	26,270	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	62,295	62,295	0	62,295	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	641,606	102,085	743,691	0	743,691	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
25.01	Telehealth	0	0	0	0	0	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	45,928	45,928	0	45,928	29.00
30.00	Administrative Costs	73,739	6,555	80,294	0	80,294	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	73,739	52,483	126,222	0	126,222	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	715,345	154,568	869,913	0	869,913	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-0189 | Component CCN: 14-3435 | Period: From 07/01/2016 To 06/30/2017 | Worksheet M-1 | Date/Time Prepared: 11/16/2017 3:52 pm

RHC III | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	222,558		1.00
2.00	Physician Assistant	0	315,389		2.00
3.00	Nurse Practitioner	0	0		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	0		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	143,449		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	681,396		10.00
11.00	Physician Services Under Agreement	0	0		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	0		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0		14.00
15.00	Medical Supplies	0	34,618		15.00
16.00	Transportation (Health Care Staff)	0	1,407		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	26,270		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	62,295		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	743,691		22.00
	COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
25.01	Telehealth	0	0		25.01
25.02	Chronic Care Management	0	0		25.02
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs				27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	45,928		29.00
30.00	Administrative Costs	0	80,294		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	126,222		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	869,913		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-0189 | Component CCN: 14-8541 | Period: From 07/01/2016 To 06/30/2017 | Worksheet M-1 | Date/Time Prepared: 11/16/2017 3:52 pm

RHC IV | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	0	0	0	0	0	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	247,664	25,437	273,101	0	273,101	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	0	0	0	0	0	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	161,378	10,945	172,323	0	172,323	9.00
10.00	Subtotal (sum of lines 1 through 9)	409,042	36,382	445,424	0	445,424	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	77,472	77,472	0	77,472	15.00
16.00	Transportation (Health Care Staff)	0	1,725	1,725	0	1,725	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	22,517	22,517	0	22,517	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	101,714	101,714	0	101,714	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	409,042	138,096	547,138	0	547,138	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
25.01	Telehealth	0	0	0	0	0	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	48,042	48,042	0	48,042	29.00
30.00	Administrative Costs	73,589	7,946	81,535	0	81,535	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	73,589	55,988	129,577	0	129,577	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	482,631	194,084	676,715	0	676,715	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-0189 | Component CCN: 14-8541 | Period: From 07/01/2016 To 06/30/2017 | Worksheet M-1 | Date/Time Prepared: 11/16/2017 3:52 pm

RHC IV | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	0		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	273,101		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	0		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	172,323		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	445,424		10.00
11.00	Physician Services Under Agreement	0	0		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	0		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0		14.00
15.00	Medical Supplies	0	77,472		15.00
16.00	Transportation (Health Care Staff)	0	1,725		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	22,517		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	101,714		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	547,138		22.00
	COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
25.01	Telehealth	0	0		25.01
25.02	Chronic Care Management	0	0		25.02
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs				27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	48,042		29.00
30.00	Administrative Costs	0	81,535		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	129,577		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	676,715		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS | Provider CCN: 14-0189 | Component CCN: 14-8555 | Period: From 07/01/2016 To 06/30/2017 | Worksheet M-1 | Date/Time Prepared: 11/16/2017 3:52 pm

RHC V | 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	755,472	34,927	790,399	0	790,399	1.00
2.00	Physician Assistant	93,995	8,477	102,472	0	102,472	2.00
3.00	Nurse Practitioner	0	0	0	0	0	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	0	0	0	0	0	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	144,394	5,928	150,322	0	150,322	9.00
10.00	Subtotal (sum of lines 1 through 9)	993,861	49,332	1,043,193	0	1,043,193	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	92,032	92,032	0	92,032	15.00
16.00	Transportation (Health Care Staff)	0	2,416	2,416	0	2,416	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	41,281	41,281	0	41,281	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	135,729	135,729	0	135,729	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	993,861	185,061	1,178,922	0	1,178,922	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
25.01	Telehealth	0	0	0	0	0	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	63,063	63,063	0	63,063	29.00
30.00	Administrative Costs	215,954	33,477	249,431	0	249,431	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	215,954	96,540	312,494	0	312,494	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	1,209,815	281,601	1,491,416	0	1,491,416	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-0189 | Component CCN: 14-8555 | Period: From 07/01/2016 To 06/30/2017 | Worksheet M-1 | Date/Time Prepared: 11/16/2017 3:52 pm

RHC V | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	790,399		1.00
2.00	Physician Assistant	0	102,472		2.00
3.00	Nurse Practitioner	0	0		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	0		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	150,322		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	1,043,193		10.00
11.00	Physician Services Under Agreement	0	0		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	0		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0		14.00
15.00	Medical Supplies	0	92,032		15.00
16.00	Transportation (Health Care Staff)	0	2,416		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	41,281		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	135,729		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	1,178,922		22.00
	COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
25.01	Telehealth	0	0		25.01
25.02	Chronic Care Management	0	0		25.02
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs				27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	63,063		29.00
30.00	Administrative Costs	0	249,431		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	312,494		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	1,491,416		32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-0189 | Component CCN: 14-3978 | Period: From 07/01/2016 To 06/30/2017 | Worksheet M-2 | Date/Time Prepared: 11/16/2017 3:52 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	0.00	0	0	0		1.00
2.00	Physician Assistant	0.00	0	0	0		2.00
3.00	Nurse Practitioner	0.88	2,528	2,100	1,848		3.00
4.00	Subtotal (sum of lines 1 through 3)	0.88	2,528		1,848	2,528	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)	0.88	2,528			2,528	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)					293,904	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					293,904	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					1.000000	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					124,638	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					566,769	15.00
16.00	Total overhead (sum of lines 14 and 15)					691,407	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					691,407	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					691,407	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					985,311	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-0189 | Component CCN: 14-3998 | Period: From 07/01/2016 To 06/30/2017 | Worksheet M-2 | Date/Time Prepared: 11/16/2017 3:52 pm

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	RHC II Minimum Visits (col. 1 x col. 3)	Cost Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	0.00	0	0	0		1.00
2.00	Physician Assistant	0.00	0	0	0		2.00
3.00	Nurse Practitioner	1.81	3,734	2,100	3,801		3.00
4.00	Subtotal (sum of lines 1 through 3)	1.81	3,734		3,801	3,801	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)	1.81	3,734			3,801	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)					373,585	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					373,585	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					1.000000	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					147,664	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					397,992	15.00
16.00	Total overhead (sum of lines 14 and 15)					545,656	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					545,656	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					545,656	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					919,241	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-0189 | Component CCN: 14-3435 | Period: From 07/01/2016 To 06/30/2017 | Worksheet M-2 | Date/Time Prepared: 11/16/2017 3:52 pm

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	RHC III Minimum Visits (col. 1 x col. 3)	Cost Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	0.78	2,125	4,200	3,276		1.00
2.00	Physician Assistant	0.70	3,970	2,100	1,470		2.00
3.00	Nurse Practitioner	0.00	0	0	0		3.00
4.00	Subtotal (sum of lines 1 through 3)	1.48	6,095		4,746	6,095	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)	1.48	6,095			6,095	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)					743,691	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					743,691	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					1.000000	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					126,222	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					429,267	15.00
16.00	Total overhead (sum of lines 14 and 15)					555,489	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					555,489	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					555,489	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					1,299,180	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-0189 | Component CCN: 14-8541 | Period: From 07/01/2016 To 06/30/2017 | Worksheet M-2 | Date/Time Prepared: 11/16/2017 3:52 pm

RHC IV | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	0.00	0	0	0		1.00
2.00	Physician Assistant	0.00	0	0	0		2.00
3.00	Nurse Practitioner	1.61	6,106	2,100	3,381		3.00
4.00	Subtotal (sum of lines 1 through 3)	1.61	6,106		3,381	6,106	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)	1.61	6,106			6,106	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)					547,138	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					547,138	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					1.000000	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					129,577	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					373,718	15.00
16.00	Total overhead (sum of lines 14 and 15)					503,295	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					503,295	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					503,295	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					1,050,433	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-0189 | Component CCN: 14-8555 | Period: From 07/01/2016 To 06/30/2017 | Worksheet M-2 | Date/Time Prepared: 11/16/2017 3:52 pm

RHC V | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	1.70	13,899	4,200	7,140		1.00
2.00	Physician Assistant	0.74	3,894	2,100	1,554		2.00
3.00	Nurse Practitioner	0.00	0	0	0		3.00
4.00	Subtotal (sum of lines 1 through 3)	2.44	17,793		8,694	17,793	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)	2.44	17,793			17,793	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)					1,178,922	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					1,178,922	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					1.000000	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					312,494	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					883,424	15.00
16.00	Total overhead (sum of lines 14 and 15)					1,195,918	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					1,195,918	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					1,195,918	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					2,374,840	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 14-0189 Component CCN: 14-3978	Period: From 07/01/2016 To 06/30/2017	Worksheet M-3 Date/Time Prepared: 11/16/2017 3:52 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)			985,311	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			1,830	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			983,481	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			2,528	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)			2,528	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			389.04	7.00
		Calculation of Limit (1)			
		Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)		
		1.00	2.00		
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	81.32	82.30		8.00
9.00	Rate for Program covered visits (see instructions)	81.32	82.30		9.00
	CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	333	318		10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	27,080	26,171		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	53,251		16.00
16.01	Total program charges (see instructions)(from contractor's records)		84,419		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.)		32,150		16.04
16.05	Total program cost (see instructions)	0	32,150		16.05
17.00	Primary payer amounts		0		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		13,064		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		14,271		19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		32,150		20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		587		21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		32,737		22.00
23.00	Allowable bad debts (see instructions)		0		23.00
23.01	Adjusted reimbursable bad debts (see instructions)		0		23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0		24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0		25.50
26.00	Net reimbursable amount (see instructions)		32,737		26.00
26.01	Sequestration adjustment (see instructions)		655		26.01
27.00	Interim payments		30,696		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)		1,386		29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0		30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 14-0189 Component CCN: 14-3998	Period: From 07/01/2016 To 06/30/2017	Worksheet M-3 Date/Time Prepared: 11/16/2017 3:52 pm
	Title XVIII	RHC II	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)		919,241	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)		10,003	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		909,238	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		3,801	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)		3,801	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		239.21	7.00
		Calculation of Limit (1)		
		Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	81.32	82.30	8.00
9.00	Rate for Program covered visits (see instructions)	81.32	82.30	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	466	345	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	37,895	28,394	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	66,289	16.00
16.01	Total program charges (see instructions)(from contractor's records)		108,643	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.)		39,710	16.04
16.05	Total program cost (see instructions)	0	39,710	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		16,652	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		18,398	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		39,710	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		1,842	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		41,552	22.00
23.00	Allowable bad debts (see instructions)		0	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		0	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	25.50
26.00	Net reimbursable amount (see instructions)		41,552	26.00
26.01	Sequestration adjustment (see instructions)		831	26.01
27.00	Interim payments		38,041	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)		2,680	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0	30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 14-0189 Component CCN: 14-3435	Period: From 07/01/2016 To 06/30/2017	Worksheet M-3 Date/Time Prepared: 11/16/2017 3:52 pm
	Title XVIII	RHC III	Cost

			1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES			
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)		1,299,180	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)		3,960	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		1,295,220	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		6,095	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)		0	5.00
6.00	Total adjusted visits (line 4 plus line 5)		6,095	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		212.51	7.00
		Calculation of Limit (1)		
		Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	81.32	82.30	8.00
9.00	Rate for Program covered visits (see instructions)	81.32	82.30	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	916	802	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	74,489	66,005	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	140,494	16.00
16.01	Total program charges (see instructions)(from contractor's records)		251,178	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.)		89,809	16.04
16.05	Total program cost (see instructions)	0	89,809	16.05
17.00	Primary payer amounts		494	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		28,233	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		44,589	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		89,315	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		743	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		90,058	22.00
23.00	Allowable bad debts (see instructions)		0	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		0	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	25.50
26.00	Net reimbursable amount (see instructions)		90,058	26.00
26.01	Sequestration adjustment (see instructions)		1,801	26.01
27.00	Interim payments		85,619	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)		2,638	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0	30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 14-0189 Component CCN: 14-8541	Period: From 07/01/2016 To 06/30/2017	Worksheet M-3 Date/Time Prepared: 11/16/2017 3:52 pm
	Title XVIII	RHC IV	Cost

			1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES			
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)		1,050,433	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)		12,412	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		1,038,021	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		6,106	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)		0	5.00
6.00	Total adjusted visits (line 4 plus line 5)		6,106	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		170.00	7.00
		Calculation of Limit (1)		
		Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	81.32	82.30	8.00
9.00	Rate for Program covered visits (see instructions)	81.32	82.30	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	633	550	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	51,476	45,265	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	96,741	16.00
16.01	Total program charges (see instructions)(from contractor's records)		144,913	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.)		61,516	16.04
16.05	Total program cost (see instructions)	0	61,516	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		19,846	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		25,013	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		61,516	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		1,752	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		63,268	22.00
23.00	Allowable bad debts (see instructions)		0	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		0	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	25.50
26.00	Net reimbursable amount (see instructions)		63,268	26.00
26.01	Sequestration adjustment (see instructions)		1,265	26.01
27.00	Interim payments		59,374	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)		2,629	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0	30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 14-0189 Component CCN: 14-8555	Period: From 07/01/2016 To 06/30/2017	Worksheet M-3 Date/Time Prepared: 11/16/2017 3:52 pm
	Title XVIII	RHC V	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)		2,374,840	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)		14,246	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		2,360,594	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		17,793	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)		17,793	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		132.67	7.00
		Calculation of Limit (1)		
		Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	81.32	82.30	8.00
9.00	Rate for Program covered visits (see instructions)	81.32	82.30	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	1,896	1,727	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	154,183	142,132	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	296,315	16.00
16.01	Total program charges (see instructions)(from contractor's records)		446,327	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.)		196,422	16.04
16.05	Total program cost (see instructions)	0	196,422	16.05
17.00	Primary payer amounts		53	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		50,787	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		79,108	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		196,369	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		2,159	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		198,528	22.00
23.00	Allowable bad debts (see instructions)		0	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		0	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	25.50
26.00	Net reimbursable amount (see instructions)		198,528	26.00
26.01	Sequestration adjustment (see instructions)		3,971	26.01
27.00	Interim payments		190,349	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)		4,208	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: 14-0189 | Component CCN: 14-3978 | Period: From 07/01/2016 To 06/30/2017 | Worksheet M-4 | Date/Time Prepared: 11/16/2017 3:52 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)	256,958	256,958	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000000	0.000000	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	0	0	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	55	491	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	55	491	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	293,904	293,904	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	691,407	691,407	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.000187	0.001671	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	129	1,155	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	184	1,646	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	1	49	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	184.00	33.59	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	1	12	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	184	403	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)		1,830	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)		587	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA VACCINE COST

Provider CCN: 14-0189 | Component CCN: 14-3998 | Period: From 07/01/2016 To 06/30/2017 | Worksheet M-4 | Date/Time Prepared: 11/16/2017 3:52 pm

Title XVIII | RHC II | Cost

		Pneumococcal	Influenza	
		1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	314,207	314,207	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000000	0.000000	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	0	0	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	1,760	2,305	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	1,760	2,305	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	373,585	373,585	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	545,656	545,656	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.004711	0.006170	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	2,571	3,367	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	4,331	5,672	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	32	191	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	135.34	29.70	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	9	21	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	1,218	624	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)		10,003	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)		1,842	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA VACCINE COST

Provider CCN: 14-0189 | Component CCN: 14-3435 | Period: From 07/01/2016 To 06/30/2017 | Worksheet M-4 | Date/Time Prepared: 11/16/2017 3:52 pm

Title XVIII | RHC III | Cost

		Pneumococcal	Influenza	
		1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	681,396	681,396	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000000	0.000000	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	0	0	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	770	1,497	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	770	1,497	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	743,691	743,691	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	555,489	555,489	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.001035	0.002013	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	575	1,118	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	1,345	2,615	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	14	124	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	96.07	21.09	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	4	17	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	384	359	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)		3,960	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)		743	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA VACCINE COST

Provider CCN: 14-0189 | Component CCN: 14-8541 | Period: From 07/01/2016 To 06/30/2017 | Worksheet M-4 | Date/Time Prepared: 11/16/2017 3:52 pm

Title XVIII | RHC IV | Cost

		Pneumococcal	Influenza	
		1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	445,424	445,424	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000000	0.000000	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	0	0	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	2,310	4,155	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	2,310	4,155	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	547,138	547,138	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	503,295	503,295	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.004222	0.007594	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	2,125	3,822	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	4,435	7,977	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	42	344	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	105.60	23.19	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	10	30	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	1,056	696	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)		12,412	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)		1,752	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA VACCINE COST

Provider CCN: 14-0189 | Component CCN: 14-8555 | Period: From 07/01/2016 To 06/30/2017 | Worksheet M-4 | Date/Time Prepared: 11/16/2017 3:52 pm

Title XVIII | RHC V | Cost

		Pneumococcal	Influenza	
		1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	1,043,193	1,043,193	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000000	0.000000	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	0	0	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	2,365	4,707	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	2,365	4,707	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	1,178,922	1,178,922	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	1,195,918	1,195,918	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.002006	0.003993	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	2,399	4,775	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	4,764	9,482	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	43	390	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	110.79	24.31	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	14	25	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	1,551	608	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)		14,246	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)		2,159	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 14-0189 Component CCN: 14-3978	Period: From 07/01/2016 To 06/30/2017	Worksheet M-5 Date/Time Prepared: 11/16/2017 3:52 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		30,696	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)		30,696	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		1,386	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		32,082	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 HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 14-0189 Component CCN: 14-3998	Period: From 07/01/2016 To 06/30/2017	Worksheet M-5 Date/Time Prepared: 11/16/2017 3:52 pm
		RHC II	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		38,041	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)		38,041	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		2,680	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		40,721	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 HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 14-0189 Component CCN: 14-3435	Period: From 07/01/2016 To 06/30/2017	Worksheet M-5 Date/Time Prepared: 11/16/2017 3:52 pm
		RHC III	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		85,619	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)		85,619	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		2,638	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		88,257	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 HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 14-0189 Component CCN: 14-8541	Period: From 07/01/2016 To 06/30/2017	Worksheet M-5 Date/Time Prepared: 11/16/2017 3:52 pm
		RHC IV	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		59,374	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)		59,374	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		2,629	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		62,003	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 HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 14-0189 Component CCN: 14-8555	Period: From 07/01/2016 To 06/30/2017	Worksheet M-5 Date/Time Prepared: 11/16/2017 3:52 pm
		RHC V	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		190,349	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)		190,349	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		4,208	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		194,557	7.00

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