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: 14-0210	Period: From 07/01/2016 To 06/30/2017	Worksheet S Parts I-III Date/Time Prepared: 11/29/2017 2:18 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 11/29/2017 Time: 2:18 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 HARRISBURG MEDICAL CENTER, INC. (14-0210) 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	-7,694	13,992	0	0	1.00
2.00	Subprovider - IPF	0	-15,026	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
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
10.00	RHC I	0		82,816		0	10.00
10.01	RHC II	0		14,405		0	10.01
10.02	RHC III	0		47,614		0	10.02
200.00	Total	0	-22,720	158,827	0	0	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-0210 | Period: From 07/01/2016 To 06/30/2017 | Worksheet S-2 Part I | Date/Time Prepared: 11/29/2017 1:19 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 100 DR WARREN TUTTLE DRIVE	PO Box:			1.00
2.00	City: HARRISBURG	State: IL	Zip Code: 62946	County: SALINE	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	HARRISBURG MEDICAL CENTER, INC.	140210	99914	1	07/01/1966	N	P	O	3.00
4.00	Subprovider - IPF	HARRISBURG MEDICAL CENTER, INC.	14S210	99914	4	06/19/1989	N	P	O	4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	HARRISBURG MEDICAL CENTER, INC.	14U210	99914		11/03/1988	N	P	N	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA	HARRISBURG MEDICAL CENTER, INC.	147419	99914		08/15/1985	N	P	N	12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC	ELDORADO PRIMARY CARE	143473	99914		12/31/2001	N	O	N	15.00
15.01	Hospital-Based Health Clinic - RHC II	EQUALITY FAMILY PRACTICE	148518	99914		09/27/2011	N	O	N	15.01
15.02	Hospital-Based Health Clinic - RHC III	GALATIA PRIMARY CARE	148560	99914		05/10/2016	N	O	N	15.02
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	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.	3	N	23.00

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	662	85	1	0	2	0	24.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-0210 | Period: From 07/01/2016 To 06/30/2017 | Worksheet S-2 Part I | Date/Time Prepared: 11/29/2017 1:19 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	
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)	Y	Y	39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	N	N	40.00

		V	XVIII	XIX	
		1.00	2.00	3.00	
	Prospective Payment System (PPS)-Capital				
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y for yes or "N" for no.	N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00
	Teaching Hospitals				
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N			56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.	N			57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.	N			58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59.00
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N			60.00

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

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-0210 | Period: From 07/01/2016 To 06/30/2017 | Worksheet S-2 Part I | Date/Time Prepared: 11/29/2017 1:19 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)	N	N	0	76.00

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

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

		Physical	Occupational	Speech	Respiratory	
		1.00	2.00	3.00	4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	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.	2			118.00

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	637,318	5,536	0	118.01

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		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: 14-0210	Period: From 07/01/2016 To 06/30/2017	Worksheet S-2 Part I Date/Time Prepared: 11/29/2017 1:19 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)			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: 14-0210 | Period: From 07/01/2016 To 06/30/2017 | Worksheet S-2 Part II | Date/Time Prepared: 11/29/2017 1:19 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	10/13/2017	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	Y			5.00

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

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

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	N		N		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	10/27/2017	Y	10/27/2017	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 14-0210 | Period: From 07/01/2016 To 06/30/2017 | Worksheet S-2 Part II Date/Time Prepared: 11/29/2017 1:19 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				Y	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				Y	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				N	27.00
	Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				Y	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				Y	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.				N	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				N	35.00
				Y/N	Date	
				1.00	2.00	
	Home Office Costs					
36.00	Were home office costs claimed on the cost report?			N		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			N		37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.			N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			N		40.00
		1.00		2.00		
	Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	KEVIN		WELLEN		41.00
42.00	Enter the employer/company name of the cost report preparer.	CLIFTONLARSENALLEN LLP				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	314-925-4446		KEVIN.WELLEN@CLACONNECT.COM		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 14-0210	Period: From 07/01/2016 To 06/30/2017	Worksheet S-2 Part II Date/Time Prepared: 11/29/2017 1:19 pm

		3.00		
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	DIRECTOR		41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 14-0210 | Period: From 07/01/2016 To 06/30/2017 | Worksheet S-3 Part I | Date/Time Prepared: 11/29/2017 1:19 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	46	16,790	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)		46	16,790	0.00	0	7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)		46	16,790	0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF	40.00	30	10,950		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						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						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RHC I	88.00				0	26.00
26.01	RHC II	88.01				0	26.01
26.02	RHC III	88.02				0	26.02
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		76				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: 14-0210 | Period: From 07/01/2016 To 06/30/2017 | Worksheet S-3 Part I | Date/Time Prepared: 11/29/2017 1:19 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)	3,110	662	4,713			1.00
2.00	HMO and other (see instructions)	374	88				2.00
3.00	HMO IPF Subprovider	169	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	62	0	76			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)	3,172	662	4,789			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)	3,172	662	4,789	0.00	399.41	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF	2,946	5,127	9,716	0.00	61.04	16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	1,924	0	3,723	0.00	10.19	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	0	0	0			24.10
25.00	CMHC - CMHC						25.00
26.00	RHC I	4,619	0	18,908	0.00	26.39	26.00
26.01	RHC II	427	0	2,352	0.00	3.35	26.01
26.02	RHC III	362	0	2,251	0.00	3.67	26.02
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	504.05	27.00
28.00	Observation Bed Days		0	2,113			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 14-0210 | Period: From 07/01/2016 To 06/30/2017 | Worksheet S-3 Part I | Date/Time Prepared: 11/29/2017 1:19 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	1,069	294	1,720	1.00
2.00	HMO and other (see instructions)			122	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	1,069	294	1,720	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF	0.00	0	331	728	1,306	16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0.00					22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RHC I	0.00					26.00
26.01	RHC II	0.00					26.01
26.02	RHC III	0.00					26.02
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: 14-0210 | Period: From 07/01/2016 To 06/30/2017 | Worksheet S-3 Part II Date/Time Prepared: 11/29/2017 1:19 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	23,876,754	0	23,876,754	1,048,422.00	22.77	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		684,373	0	684,373	6,365.00	107.52	3.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00	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		3,359,736	0	3,359,736	37,921.00	88.60	5.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		1,024,353	0	1,024,353	47,780.00	21.44	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)		3,599,977	-102,700	3,497,277	175,314.00	19.95	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		531,809	0	531,809	5,610.00	94.80	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)		6,468,096	0	6,468,096			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		1,462,249	0	1,462,249			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		109,705	0	109,705			21.00
22.00	Physician Part A - Administrative		0	0	0			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		539,199	0	539,199			23.00
24.00	Wage-related costs (RHC/FQHC)		223,365	0	223,365			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	150,157	0	150,157	4,470.00	33.59	26.00
27.00	Administrative & General	5.00	3,348,987	54,802	3,403,789	140,183.00	24.28	27.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 14-0210 | Period: From 07/01/2016 To 06/30/2017 | Worksheet S-3 Part II Date/Time Prepared: 11/29/2017 1:19 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.)		75,296	0	75,296	1,606.00	46.88	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	476,573	0	476,573	29,467.00	16.17	30.00
31.00	Laundry & Linen Service	8.00	43,925	0	43,925	4,010.00	10.95	31.00
32.00	Housekeeping	9.00	579,826	0	579,826	45,631.00	12.71	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	610,502	0	610,502	49,459.00	12.34	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	0	0	0.00	0.00	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	121,024	0	121,024	4,464.00	27.11	38.00
39.00	Central Services and Supply	14.00	229,621	0	229,621	15,225.00	15.08	39.00
40.00	Pharmacy	15.00	596,554	0	596,554	13,532.00	44.08	40.00
41.00	Medical Records & Medical Records Library	16.00	554,899	0	554,899	34,460.00	16.10	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: 14-0210 | Period: From 07/01/2016 To 06/30/2017 | Worksheet S-3 Part III Date/Time Prepared: 11/29/2017 1:19 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)		18,883,588	0	18,883,588	957,962.00	19.71	1.00
2.00	Excluded area salaries (see instructions)		3,599,977	-102,700	3,497,277	175,314.00	19.95	2.00
3.00	Subtotal salaries (line 1 minus line 2)		15,283,611	102,700	15,386,311	782,648.00	19.66	3.00
4.00	Subtotal other wages & related costs (see inst.)		531,809	0	531,809	5,610.00	94.80	4.00
5.00	Subtotal wage-related costs (see inst.)		6,468,096	0	6,468,096	0.00	42.04	5.00
6.00	Total (sum of lines 3 thru 5)		22,283,516	102,700	22,386,216	788,258.00	28.40	6.00
7.00	Total overhead cost (see instructions)		6,787,364	54,802	6,842,166	342,507.00	19.98	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 14-0210 | Period: From 07/01/2016 To 06/30/2017 | Worksheet S-3 Part IV | Date/Time Prepared: 11/29/2017 1:19 pm

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	0	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	747,027	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	5,917,113	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	63,325	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	38,045	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	0	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	77,802	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	1,421,188	17.00
18.00	Medicare Taxes - Employers Portion Only	332,374	18.00
19.00	Unemployment Insurance	0	19.00
20.00	State or Federal Unemployment Taxes	175,897	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	29,844	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	8,802,615	24.00
	Part B - Other than Core Related Cost		
25.00	FRINGE BENEFITS	8,586	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST | Provider CCN: 14-0210 | Period: From 07/01/2016 To 06/30/2017 | Worksheet S-3 Part V Date/Time Prepared: 11/29/2017 1:19 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	531,809	8,802,615	1.00
2.00	Hospital	531,809	8,802,615	2.00
3.00	Subprovider - IPF	0	0	3.00
4.00	Subprovider - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA	0	0	11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			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	0	14.02
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis			17.00
18.00	Other	0	0	18.00

HOME HEALTH AGENCY STATISTICAL DATA | Provider CCN: 14-0210 | Component CCN: 14-7419 | Period: From 07/01/2016 To 06/30/2017 | Worksheet S-4 | Date/Time Prepared: 11/29/2017 1:19 pm

Home Health Agency I | PPS

						1.00	
0.00	County				SALINE		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)	158.00	0.00	0.00	0.00	158.00	2.00
				Number of Employees (Full Time Equivalent)			
		Enter the number of hours in your normal work week		Staff	Contract	Total	
		0		1.00	2.00	3.00	
	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES						
3.00	Administrator and Assistant Administrator(s)		40.00	0.00	0.00	0.00	3.00
4.00	Director(s) and Assistant Director(s)			0.00	0.00	0.00	4.00
5.00	Other Administrative Personnel			0.00	0.00	0.00	5.00
6.00	Direct Nursing Service			6.59	0.00	6.59	6.00
7.00	Nursing Supervisor			1.81	0.00	1.81	7.00
8.00	Physical Therapy Service			1.68	0.00	1.68	8.00
9.00	Physical Therapy Supervisor			0.00	0.00	0.00	9.00
10.00	Occupational Therapy Service			0.09	0.00	0.09	10.00
11.00	Occupational Therapy Supervisor			0.00	0.00	0.00	11.00
12.00	Speech Pathology Service			0.02	0.00	0.02	12.00
13.00	Speech Pathology Supervisor			0.00	0.00	0.00	13.00
14.00	Medical Social Service			0.00	0.00	0.00	14.00
15.00	Medical Social Service Supervisor			0.00	0.00	0.00	15.00
16.00	Home Health Aide			0.00	0.00	0.00	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	860	0	76	13	949	21.00
22.00	Skilled Nursing Visit Charges	201,582	0	17,832	3,055	222,469	22.00
23.00	Physical Therapy Visits	859	0	13	19	891	23.00
24.00	Physical Therapy Visit Charges	202,388	0	3,061	4,484	209,933	24.00
25.00	Occupational Therapy Visits	65	0	0	0	65	25.00
26.00	Occupational Therapy Visit Charges	16,559	0	0	0	16,559	26.00
27.00	Speech Pathology Visits	19	0	0	0	19	27.00
28.00	Speech Pathology Visit Charges	4,837	0	0	0	4,837	28.00
29.00	Medical Social Service Visits	0	0	0	0	0	29.00
30.00	Medical Social Service Visit Charges	0	0	0	0	0	30.00
31.00	Home Health Aide Visits	0	0	0	0	0	31.00
32.00	Home Health Aide Visit Charges	0	0	0	0	0	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	1,803	0	89	32	1,924	33.00
34.00	Other Charges	0	0	0	0	0	34.00
35.00	Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)	425,366	0	20,893	7,539	453,798	35.00
36.00	Total Number of Episodes (standard/non outlier)	140		33	2	175	36.00
37.00	Total Number of Outlier Episodes		0		0	0	37.00
38.00	Total Non-Routine Medical Supply Charges	12,818	0	2,133	213	15,164	38.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA | Provider CCN: 14-0210 | Period: From 07/01/2016 To 06/30/2017 | Worksheet S-7 | Date/Time Prepared: 11/29/2017 1:19 pm

		1.00	2.00	
1.00	If this facility contains a hospital-based SNF, were all patients under managed care or was there no Medicare utilization? Enter "Y" for yes in column 1 and do not complete the rest of this worksheet.	N		1.00
2.00	Does this hospital have an agreement under either section 1883 or section 1913 for swing beds? Enter "Y" for yes or "N" for no in column 1. If yes, enter the agreement date (mm/dd/yyyy) in column 2.	Y	11/03/1988	2.00

		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
		1.00	2.00	3.00	4.00	
3.00		RUX	0	0	0	3.00
4.00		RUL	0	0	0	4.00
5.00		RVX	0	0	0	5.00
6.00		RVL	0	0	0	6.00
7.00		RHX	0	0	0	7.00
8.00		RHL	0	0	0	8.00
9.00		RMX	0	0	0	9.00
10.00		RML	0	0	0	10.00
11.00		RLX	0	0	0	11.00
12.00		RUC	0	0	0	12.00
13.00		RUB	0	0	0	13.00
14.00		RUA	0	0	0	14.00
15.00		RVC	0	0	0	15.00
16.00		RVB	0	8	8	16.00
17.00		RVA	0	9	9	17.00
18.00		RHC	0	8	8	18.00
19.00		RHB	0	0	0	19.00
20.00		RHA	0	13	13	20.00
21.00		RMC	0	0	0	21.00
22.00		RMB	0	0	0	22.00
23.00		RMA	0	0	0	23.00
24.00		RLB	0	0	0	24.00
25.00		RLA	0	0	0	25.00
26.00		ES3	0	0	0	26.00
27.00		ES2	0	0	0	27.00
28.00		ES1	0	0	0	28.00
29.00		HE2	0	0	0	29.00
30.00		HE1	0	0	0	30.00
31.00		HD2	0	0	0	31.00
32.00		HD1	0	0	0	32.00
33.00		HC2	0	0	0	33.00
34.00		HC1	0	0	0	34.00
35.00		HB2	0	0	0	35.00
36.00		HB1	0	5	5	36.00
37.00		LE2	0	0	0	37.00
38.00		LE1	0	0	0	38.00
39.00		LD2	0	0	0	39.00
40.00		LD1	0	0	0	40.00
41.00		LC2	0	0	0	41.00
42.00		LC1	0	0	0	42.00
43.00		LB2	0	0	0	43.00
44.00		LB1	0	0	0	44.00
45.00		CE2	0	0	0	45.00
46.00		CE1	0	0	0	46.00
47.00		CD2	0	0	0	47.00
48.00		CD1	0	3	3	48.00
49.00		CC2	0	0	0	49.00
50.00		CC1	0	0	0	50.00
51.00		CB2	0	0	0	51.00
52.00		CB1	0	0	0	52.00
53.00		CA2	0	10	10	53.00
54.00		CA1	0	0	0	54.00
55.00		SE3	0	0	0	55.00
56.00		SE2	0	0	0	56.00
57.00		SE1	0	0	0	57.00
58.00		SSC	0	0	0	58.00
59.00		SSB	0	0	0	59.00
60.00		SSA	0	0	0	60.00
61.00		IB2	0	0	0	61.00
62.00		IB1	0	0	0	62.00
63.00		IA2	0	0	0	63.00
64.00		IA1	0	0	0	64.00
65.00		BB2	0	0	0	65.00
66.00		BB1	0	6	6	66.00
67.00		BA2	0	0	0	67.00
68.00		BA1	0	0	0	68.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA | Provider CCN: 14-0210 | Period: From 07/01/2016 To 06/30/2017 | Worksheet S-7 | Date/Time Prepared: 11/29/2017 1:19 pm

		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
		1.00	2.00	3.00	4.00	
69.00		PE2	0	0	0	69.00
70.00		PE1	0	0	0	70.00
71.00		PD2	0	0	0	71.00
72.00		PD1	0	0	0	72.00
73.00		PC2	0	0	0	73.00
74.00		PC1	0	0	0	74.00
75.00		PB2	0	0	0	75.00
76.00		PB1	0	0	0	76.00
77.00		PA2	0	0	0	77.00
78.00		PA1	0	0	0	78.00
199.00		AAA	0	0	0	199.00
200.00	TOTAL		0	62	62	200.00

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

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

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 14-0210 | Component CCN: 14-3473 | Period: From 07/01/2016 To 06/30/2017 | Worksheet S-8 | Date/Time Prepared: 11/29/2017 1:19 pm

		RHC I	Cost
		1.00	
	Clinic Address and Identification		
1.00	Street	1007 USE ROUTE 45	1.00

		City	State	ZIP Code	
		1.00	2.00	3.00	
2.00	City, State, ZIP Code, County	ELDORADO	IL	62930	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	20:00	08:00	11.00

		1.00	2.00	
12.00	Have you received an approval for an exception to the productivity standard?	N		12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.	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		SALINE				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	20:00	08:00	20:00	08:00	18:00	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-0210
Component CCN: 14-3473

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

Worksheet S-8
Date/Time Prepared:
11/29/2017 1:19 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: 14-0210 | Component CCN: 14-8518 | Period: From 07/01/2016 To 06/30/2017 | Worksheet S-8 | Date/Time Prepared: 11/29/2017 1:19 pm

RHC II | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			183 WEST LN ST		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	EQUALITY		IL	62934	2.00
					1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0	3.00
			Grant Award		Date	
			1.00		2.00	
	Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)					4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)					5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)					6.00
7.00	Appalachian Regional Commission					7.00
8.00	Look-Alikes					8.00
9.00	OTHER (SPECIFY)					9.00
				1.00	2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N	0	10.00

		Sunday		Monday		Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
	Facility hours of operations (1)						
11.00	Clinic			08:00	17:00	08:00	11.00
					1.00	2.00	
12.00	Have you received an approval for an exception to the productivity standard?				N		12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.				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		SALINE				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	19:00	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-0210
Component CCN: 14-8518

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

Worksheet S-8
Date/Time Prepared:
11/29/2017 1:19 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: 14-0210 | Component CCN: 14-8560 | Period: From 07/01/2016 To 06/30/2017 | Worksheet S-8 | Date/Time Prepared: 11/29/2017 1:19 pm

RHC III | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			124 E MAIN STREET		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	GALATIA		IL	62935	2.00
					1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0	3.00
			Grant Award		Date	
			1.00		2.00	
	Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)					4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)					5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)					6.00
7.00	Appalachian Regional Commission					7.00
8.00	Look-Alikes					8.00
9.00	OTHER (SPECIFY)					9.00
				1.00	2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N	0	10.00

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

				1.00	2.00	
12.00	Have you received an approval for an exception to the productivity standard?			N		12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.			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		SALINE				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: 14-0210
Component CCN: 14-8560

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

Worksheet S-8
Date/Time Prepared:
11/29/2017 1:19 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 UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 14-0210 | Period: From 07/01/2016 To 06/30/2017 | Worksheet S-10 | Date/Time Prepared: 11/29/2017 1:19 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)	0.314160	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	11,345,099	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?	Y	4.00
5.00	If line 4 is no, then enter DSH or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	41,610,529	6.00
7.00	Medicaid cost (line 1 times line 6)	13,072,364	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)	1,727,265	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)	1,727,265	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)	2,042,312	220,758	2,263,070	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	641,613	220,758	862,371	21.00
22.00	Payments received from patients for amounts previously written off as charity care	14,303	18,133	32,436	22.00
23.00	Cost of charity care (line 21 minus line 22)	627,310	202,625	829,935	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)	2,679,655	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	550,947	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	847,613	27.01
28.00	Non-Medicare bad debt expense (line 26 minus line 27.01)	1,832,042	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	872,220	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	1,702,155	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	3,429,420	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-0210 | Period: From 07/01/2016 To 06/30/2017 | Worksheet A | Date/Time Prepared: 11/29/2017 1:19 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		2,363,186	2,363,186	-1,170,074	1,193,112	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		0	0	1,615,803	1,615,803	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	150,157	8,882,888	9,033,045	0	9,033,045	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	3,348,987	5,730,639	9,079,626	-107,147	8,972,479	5.00
7.00	00700	OPERATION OF PLANT	476,573	653,981	1,130,554	0	1,130,554	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	43,925	108,775	152,700	0	152,700	8.00
9.00	00900	HOUSEKEEPING	579,826	95,328	675,154	0	675,154	9.00
10.00	01000	DIETARY	610,502	334,619	945,121	0	945,121	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	121,024	8,600	129,624	0	129,624	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	229,621	104,583	334,204	0	334,204	14.00
15.00	01500	PHARMACY	596,554	29,485	626,039	0	626,039	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	554,899	332,702	887,601	0	887,601	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	684,373	684,373	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,973,604	2,415,092	5,388,696	0	5,388,696	30.00
40.00	04000	SUBPROVIDER - IPF	2,436,556	1,038,819	3,475,375	0	3,475,375	40.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	773,680	622,639	1,396,319	0	1,396,319	50.00
53.00	05300	ANESTHESIOLOGY	947,480	55,562	1,003,042	-684,373	318,669	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	462,410	192,681	655,091	47,898	702,989	54.00
54.01	05401	ULTRASOUND	219,262	23,278	242,540	0	242,540	54.01
54.02	03440	MAMMOGRAPHY	65,539	60,340	125,879	0	125,879	54.02
56.00	05600	RADIOISOTOPE	171,909	306,132	478,041	0	478,041	56.00
57.00	05700	CT SCAN	193,040	57,517	250,557	0	250,557	57.00
60.00	06000	LABORATORY	803,217	1,632,932	2,436,149	33,741	2,469,890	60.00
64.00	06400	INTRAVENOUS THERAPY	24,862	69,330	94,192	0	94,192	64.00
65.00	06500	RESPIRATORY THERAPY	611,883	106,511	718,394	0	718,394	65.00
66.00	06600	PHYSICAL THERAPY	613,974	26,061	640,035	0	640,035	66.00
67.00	06700	OCCUPATIONAL THERAPY	192,466	5,314	197,780	0	197,780	67.00
68.00	06800	SPEECH PATHOLOGY	102,101	3,018	105,119	0	105,119	68.00
69.00	06900	ELECTROCARDIOLOGY	99,745	199,039	298,784	0	298,784	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2,845,243	2,845,243	-1,772,695	1,072,548	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1,772,695	1,772,695	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,450,537	2,450,537	0	2,450,537	73.00
75.00	07500	ASC (NON-DISTINCT PART)	615,962	114,646	730,608	0	730,608	75.00
76.00	03950	FAITH CENTER CHEMOTHERAPY	139,404	7,547	146,951	0	146,951	76.00
76.97	07697	CARDIAC REHABILITATION	89,442	26,403	115,845	0	115,845	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RHC I	1,719,189	297,025	2,016,214	118,939	2,135,153	88.00
88.01	08801	RHC II	204,328	66,177	270,505	0	270,505	88.01
88.02	08802	RHC III	233,224	66,503	299,727	4,536	304,263	88.02
91.00	09100	EMERGENCY	2,307,988	972,589	3,280,577	0	3,280,577	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	477,136	68,131	545,267	-54,802	490,465	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		454,814	454,814	-454,814	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	23,190,469	32,828,666	56,019,135	34,080	56,053,215	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	601,863	939,043	1,540,906	-34,080	1,506,826	192.00
194.00	07950	OTHER NRCC	0	0	0	0	0	194.00
194.01	07951	AUXILIARY	39,595	1,172	40,767	0	40,767	194.01
194.02	07952	FOUNDATION	44,827	140,918	185,745	0	185,745	194.02
200.00		TOTAL (SUM OF LINES 118-199)	23,876,754	33,909,799	57,786,553	0	57,786,553	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-0210 | Period: From 07/01/2016 To 06/30/2017 | Worksheet A | Date/Time Prepared: 11/29/2017 1:19 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	0	1,193,112		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	1,615,803		2.00
3.00	00300	OTHER CAP REL COSTS	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-1,289,127	7,743,918		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-2,247,881	6,724,598		5.00
7.00	00700	OPERATION OF PLANT	-23,767	1,106,787		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	152,700		8.00
9.00	00900	HOUSEKEEPING	-43,816	631,338		9.00
10.00	01000	DIETARY	-112,171	832,950		10.00
11.00	01100	CAFETERIA	0	0		11.00
13.00	01300	NURSING ADMINISTRATION	-9,967	119,657		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	-6,452	327,752		14.00
15.00	01500	PHARMACY	-32,452	593,587		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-359	887,242		16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	-684,373	0		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-2,056,703	3,331,993		30.00
40.00	04000	SUBPROVIDER - IPF	-250,875	3,224,500		40.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-74,312	1,322,007		50.00
53.00	05300	ANESTHESIOLOGY	-263,107	55,562		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	702,989		54.00
54.01	05401	ULTRASOUND	0	242,540		54.01
54.02	03440	MAMMOGRAPHY	0	125,879		54.02
56.00	05600	RADIOISOTOPE	0	478,041		56.00
57.00	05700	CT SCAN	26	250,583		57.00
60.00	06000	LABORATORY	0	2,469,890		60.00
64.00	06400	INTRAVENOUS THERAPY	0	94,192		64.00
65.00	06500	RESPIRATORY THERAPY	-7,500	710,894		65.00
66.00	06600	PHYSICAL THERAPY	272	640,307		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	197,780		67.00
68.00	06800	SPEECH PATHOLOGY	0	105,119		68.00
69.00	06900	ELECTROCARDIOLOGY	-159,157	139,627		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,072,548		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,772,695		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,450,537		73.00
75.00	07500	ASC (NON-DISTINCT PART)	184	730,792		75.00
76.00	03950	FAITH CENTER CHEMOTHERAPY	0	146,951		76.00
76.97	07697	CARDIAC REHABILITATION	-22,135	93,710		76.97
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RHC I	-18,337	2,116,816		88.00
88.01	08801	RHC II	0	270,505		88.01
88.02	08802	RHC III	0	304,263		88.02
91.00	09100	EMERGENCY	-2,102,378	1,178,199		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY	0	490,465		101.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-9,404,387	46,648,828		118.00
		NONREIMBURSABLE COST CENTERS				
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	1,506,826		192.00
194.00	07950	OTHER NRCC	0	0		194.00
194.01	07951	AUXILIARY	0	40,767		194.01
194.02	07952	FOUNDATION	0	185,745		194.02
200.00		TOTAL (SUM OF LINES 118-199)	-9,404,387	48,382,166		200.00

RECLASSIFICATIONS | Provider CCN: 14-0210 | Period: From 07/01/2016 To 06/30/2017 | Worksheet A-6 | Date/Time Prepared: 11/29/2017 1:19 pm

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - INTEREST EXP & BOND AMORT				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	453,014	1.00
2.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1,800	2.00
	0		0	454,814	
	B - MME DEPRECIATION				
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	1,552,879	1.00
	TOTALS		0	1,552,879	
	C - OFFSITE PROPERTY DEPRECIATION				
1.00	ADMINISTRATIVE & GENERAL	5.00	0	11,134	1.00
2.00	RHC I	88.00	0	152,680	2.00
3.00	RHC III	88.02	0	4,536	3.00
4.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	13,818	4.00
	TOTALS		0	182,168	
	D - PROPERTY INSURANCE				
1.00	OTHER CAP REL COSTS	3.00	0	173,083	1.00
	TOTALS		0	173,083	
	E - HOME HEALTH BILLERS				
1.00	ADMINISTRATIVE & GENERAL	5.00	54,802	0	1.00
	TOTALS		54,802	0	
	F - LAB TECHS				
1.00	LABORATORY	60.00	33,741	0	1.00
	TOTALS		33,741	0	
	G - RADIOLOGY TECHS				
1.00	RADIOLOGY-DIAGNOSTIC	54.00	47,898	0	1.00
	TOTALS		47,898	0	
	I - IMPLANTABLE DEVICES				
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	1,772,695	1.00
	TOTALS		0	1,772,695	
	J - CRNA SALARIES				
1.00	NONPHYSICIAN ANESTHETISTS	19.00	684,373	0	1.00
	TOTALS		684,373	0	
500.00	Grand Total: Increases		820,814	4,135,639	500.00

RECLASSIFICATIONS | Provider CCN: 14-0210 | Period: From 07/01/2016 To 06/30/2017 | Worksheet A-6 | Date/Time Prepared: 11/29/2017 1:19 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - INTEREST EXP & BOND AMORT						
1.00	INTEREST EXPENSE	113.00	0	454,814	11		1.00
2.00		0.00	0	0	14		2.00
	0		0	454,814			
	B - MME DEPRECIATION						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1,552,879	9		1.00
	TOTALS		0	1,552,879			
	C - OFFSITE PROPERTY DEPRECIATION						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	182,168	9		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
	TOTALS		0	182,168			
	D - PROPERTY INSURANCE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	173,083	12		1.00
	TOTALS		0	173,083			
	E - HOME HEALTH BILLERS						
1.00	HOME HEALTH AGENCY	101.00	54,802	0	0		1.00
	TOTALS		54,802	0			
	F - LAB TECHS						
1.00	RHC I	88.00	33,741	0	0		1.00
	TOTALS		33,741	0			
	G - RADIOLOGY TECHS						
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	47,898	0	0		1.00
	TOTALS		47,898	0			
	I - IMPLANTABLE DEVICES						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	1,772,695	0		1.00
	TOTALS		0	1,772,695			
	J - CRNA SALARIES						
1.00	ANESTHESIOLOGY	53.00	684,373	0	0		1.00
	TOTALS		684,373	0			
500.00	Grand Total: Decreases		820,814	4,135,639			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-0210 | Period: From 07/01/2016 To 06/30/2017 | Worksheet A-7 Part I | Date/Time Prepared: 11/29/2017 1:19 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	810,438	0	0	0	0	1.00
2.00	Land Improvements	833,408	17,694	0	17,694	0	2.00
3.00	Buildings and Fixtures	24,828,549	135,731	0	135,731	14,179	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	13,889,855	1,107,664	0	1,107,664	828,752	6.00
7.00	HIT designated Assets	1,032,011	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	41,394,261	1,261,089	0	1,261,089	842,931	8.00
9.00	Reconciling Items	-784,965	-4,825,199	0	-4,825,199	-503,877	9.00
10.00	Total (line 8 minus line 9)	42,179,226	6,086,288	0	6,086,288	1,346,808	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	810,438	0	1.00
2.00	Land Improvements	851,102	0	2.00
3.00	Buildings and Fixtures	24,950,101	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	14,168,767	0	6.00
7.00	HIT designated Assets	1,032,011	0	7.00
8.00	Subtotal (sum of lines 1-7)	41,812,419	0	8.00
9.00	Reconciling Items	-5,106,287	0	9.00
10.00	Total (line 8 minus line 9)	46,918,706	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-0210 | Period: From 07/01/2016 To 06/30/2017 | Worksheet A-7 Part II | Date/Time Prepared: 11/29/2017 1:19 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	2,363,186	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)	2,363,186	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	2,363,186		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0		2.00
3.00	Total (sum of lines 1-2)	0	2,363,186		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-0210 | Period: From 07/01/2016 To 06/30/2017 | Worksheet A-7 Part III | Date/Time Prepared: 11/29/2017 1:19 pm

	Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	26,611,641	0	26,611,641	0.636453	110,159	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	15,200,778	0	15,200,778	0.363547	62,924	2.00
3.00	Total (sum of lines 1-2)	41,812,419	0	41,812,419	1.000000	173,083	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	110,159	628,139	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	62,924	1,552,879	0	2.00
3.00	Total (sum of lines 1-2)	0	0	173,083	2,181,018	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	453,014	110,159	0	1,800	1,193,112	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	62,924	0	0	1,615,803	2.00
3.00	Total (sum of lines 1-2)	453,014	173,083	0	1,800	2,808,915	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-0210 | Period: From 07/01/2016 To 06/30/2017 | Worksheet A-8 | Date/Time Prepared: 11/29/2017 1:19 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)	B	-4,435	ADMINISTRATIVE & GENERAL	5.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-11,799	ADMINISTRATIVE & GENERAL	5.00	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	-4,931,591			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	-112,171	DIETARY	10.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		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	-359	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	-5,196	ADMINISTRATIVE & GENERAL	5.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist	A	-684,373	NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	MISC INCOME - A&G	B	-50,851	ADMINISTRATIVE & GENERAL	5.00	0	33.00
33.01	MISC INCOME - ER	B	-4,875	EMERGENCY	91.00	0	33.01

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-0210 | Period: From 07/01/2016 To 06/30/2017 | Worksheet A-8 | Date/Time Prepared: 11/29/2017 1:19 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	
34.00	RENTAL INCOME	B	-23,219	ADMINISTRATIVE & GENERAL	5.00	0	34.00
35.00	CRNA BENEFITS	A	-252,307	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	35.00
35.01	PHYSICIAN BENEFITS	A	-570,294	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	35.01
36.00	LLC OVERHEAD FRINGE BENEFIT	A	-465,571	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	36.00
36.01	LLC OVERHEAD A&G	A	-106,054	ADMINISTRATIVE & GENERAL	5.00	0	36.01
36.02	LLC OVERHEAD PLANT	A	-23,829	OPERATION OF PLANT	7.00	0	36.02
36.03	LLC OVERHEAD HOUSEKEEPING	A	-43,816	HOUSEKEEPING	9.00	0	36.03
36.04	LLC OVERHEAD NURSING ADMIN	A	-9,967	NURSING ADMINISTRATION	13.00	0	36.04
36.05	LLC OVERHEAD CENTRAL SUPPLY	A	-6,452	CENTRAL SERVICES & SUPPLY	14.00	0	36.05
36.06	LLC OVERHEAD PHARMACY	A	-32,452	PHARMACY	15.00	0	36.06
36.07	LLC OVERHEAD RHC I	A	-17,897	RHC I	88.00	0	36.07
37.00	CAPITALIZED INTEREST	A	62	OPERATION OF PLANT	7.00	0	37.00
37.01	CAPITALIZED INTEREST	A	138	OPERATING ROOM	50.00	0	37.01
37.02	CAPITALIZED INTEREST	A	26	CT SCAN	57.00	0	37.02
37.03	CAPITALIZED INTEREST	A	272	PHYSICAL THERAPY	66.00	0	37.03
37.04	CAPITALIZED INTEREST	A	184	ASC (NON-DISTINCT PART)	75.00	0	37.04
37.05	CAPITALIZED INTEREST	A	161	EMERGENCY	91.00	0	37.05
38.00	MEDICAID ASSESSMENT	A	-1,792,730	ADMINISTRATIVE & GENERAL	5.00	0	38.00
38.01	IHREF CONTRIBUTION EXPENSE	A	-8,712	ADMINISTRATIVE & GENERAL	5.00	0	38.01
38.02	INSURANCE SETTLEMENTS	A	-5,536	ADMINISTRATIVE & GENERAL	5.00	0	38.02
39.00	COMM RELATIONS	A	-346	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	39.00
39.01	COMM RELATIONS	A	-14,472	ADMINISTRATIVE & GENERAL	5.00	0	39.01
39.02	COMM RELATIONS	A	-440	RHC I	88.00	0	39.02
40.00	PHYSICIAN RECRUITMENT	A	-100,901	ADMINISTRATIVE & GENERAL	5.00	0	40.00
40.01	PHYSICIAN LOANS	A	-98,515	ADMINISTRATIVE & GENERAL	5.00	0	40.01
40.02	ALCOHOL	A	-44	ADMINISTRATIVE & GENERAL	5.00	0	40.02
40.03	LOBBYING DUES	A	-18,556	ADMINISTRATIVE & GENERAL	5.00	0	40.03
40.04	HR DUES	A	-609	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	40.04
40.05	ADMIN DUES	A	-2,690	ADMINISTRATIVE & GENERAL	5.00	0	40.05
40.06	BOARD MEMBER EXPENSE	A	-4,171	ADMINISTRATIVE & GENERAL	5.00	0	40.06
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-9,404,387				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: 14-0210 | Period: From 07/01/2016 To 06/30/2017 | Worksheet A-8-2 | Date/Time Prepared: 11/29/2017 1:19 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	ADULTS & PEDIATRICS	2,056,703	2,056,703	0	211,500	0	1.00
2.00	40.00	SUBPROVIDER - IPF	336,121	0	336,121	181,300	978	2.00
3.00	50.00	OPERATING ROOM	74,450	74,450	0	246,400	0	3.00
4.00	53.00	ANESTHESIOLOGY	263,107	263,107	0	239,400	0	4.00
5.00	60.00	LABORATORY	6,000	0	6,000	260,300	60	5.00
6.00	65.00	RESPIRATORY THERAPY	7,500	7,500	0	211,500	0	6.00
7.00	69.00	ELECTROCARDIOLOGY	159,157	159,157	0	211,500	0	7.00
8.00	76.97	CARDIAC REHABILITATION	22,135	22,135	0	211,500	0	8.00
9.00	91.00	EMERGENCY	2,130,711	2,090,711	40,000	211,500	325	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			5,055,884	4,673,763	382,121		1,363	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	ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	40.00	SUBPROVIDER - IPF	85,246	4,262	0	0	0	2.00
3.00	50.00	OPERATING ROOM	0	0	0	0	0	3.00
4.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	4.00
5.00	60.00	LABORATORY	7,509	375	0	0	0	5.00
6.00	65.00	RESPIRATORY THERAPY	0	0	0	0	0	6.00
7.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	7.00
8.00	76.97	CARDIAC REHABILITATION	0	0	0	0	0	8.00
9.00	91.00	EMERGENCY	33,047	1,652	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			125,802	6,289	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	2,056,703		1.00
2.00	40.00	SUBPROVIDER - IPF	0	85,246	250,875	250,875		2.00
3.00	50.00	OPERATING ROOM	0	0	0	74,450		3.00
4.00	53.00	ANESTHESIOLOGY	0	0	0	263,107		4.00
5.00	60.00	LABORATORY	0	7,509	0	0		5.00
6.00	65.00	RESPIRATORY THERAPY	0	0	0	7,500		6.00
7.00	69.00	ELECTROCARDIOLOGY	0	0	0	159,157		7.00
8.00	76.97	CARDIAC REHABILITATION	0	0	0	22,135		8.00
9.00	91.00	EMERGENCY	0	33,047	6,953	2,097,664		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	125,802	257,828	4,931,591		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0210 | Period: From 07/01/2016 To 06/30/2017 | Worksheet B Part I | Date/Time Prepared: 11/29/2017 1:19 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	1,193,112	1,193,112				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	1,615,803		1,615,803			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	7,743,918	9,784	10,828	7,764,530		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	6,724,598	218,623	459,203	1,204,684	8,607,108	5.00
7.00	00700	OPERATION OF PLANT	1,106,787	49,818	12,961	165,390	1,334,956	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	152,700	24,332	8,440	16,046	201,518	8.00
9.00	00900	HOUSEKEEPING	631,338	6,230	1,772	195,808	835,148	9.00
10.00	01000	DIETARY	832,950	44,523	7,445	223,020	1,107,938	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	119,657	0	140	40,570	160,367	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	327,752	10,902	5,592	81,525	425,771	14.00
15.00	01500	PHARMACY	593,587	21,345	56,257	206,070	877,259	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	887,242	14,896	30,290	202,708	1,135,136	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,331,993	183,718	105,518	1,086,275	4,707,504	30.00
40.00	04000	SUBPROVIDER - IPF	3,224,500	172,083	12,735	890,089	4,299,407	40.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,322,007	113,800	162,553	282,630	1,880,990	50.00
53.00	05300	ANESTHESIOLOGY	55,562	0	18,058	0	73,620	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	702,989	72,923	144,629	186,419	1,106,960	54.00
54.01	05401	ULTRASOUND	242,540	9,216	22,298	80,098	354,152	54.01
54.02	03440	MAMMOGRAPHY	125,879	5,552	39,692	23,942	195,065	54.02
56.00	05600	RADIOISOTOPE	478,041	7,127	60,283	62,799	608,250	56.00
57.00	05700	CT SCAN	250,583	8,318	113,539	70,519	442,959	57.00
60.00	06000	LABORATORY	2,469,890	42,599	46,951	305,746	2,865,186	60.00
64.00	06400	INTRAVENOUS THERAPY	94,192	0	0	9,082	103,274	64.00
65.00	06500	RESPIRATORY THERAPY	710,894	16,966	24,601	223,525	975,986	65.00
66.00	06600	PHYSICAL THERAPY	640,307	3,811	12,265	224,288	880,671	66.00
67.00	06700	OCCUPATIONAL THERAPY	197,780	0	1,918	70,309	270,007	67.00
68.00	06800	SPEECH PATHOLOGY	105,119	0	0	37,298	142,417	68.00
69.00	06900	ELECTROCARDIOLOGY	139,627	11,067	6,213	36,437	193,344	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,072,548	0	0	0	1,072,548	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,772,695	0	0	0	1,772,695	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,450,537	0	0	0	2,450,537	73.00
75.00	07500	ASC (NON-DISTINCT PART)	730,792	75,964	62,444	225,015	1,094,215	75.00
76.00	03950	FAITH CENTER CHEMOTHERAPY	146,951	17,095	3,115	50,925	218,086	76.00
76.97	07697	CARDIAC REHABILITATION	93,710	4,965	5,669	32,674	137,018	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RHC I	2,116,816	0	33,220	609,166	2,759,202	88.00
88.01	08801	RHC II	270,505	0	1,813	74,642	346,960	88.01
88.02	08802	RHC III	304,263	0	12,481	85,198	401,942	88.02
91.00	09100	EMERGENCY	1,178,199	35,619	15,775	374,145	1,603,738	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	490,465	0	6,592	154,281	651,338	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	46,648,828	1,181,276	1,505,290	7,531,323	46,293,272	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,506,826	0	109,577	202,367	1,818,770	192.00
194.00	07950	OTHER NRCC	0	0	0	0	0	194.00
194.01	07951	AUXILIARY	40,767	11,836	0	14,464	67,067	194.01
194.02	07952	FOUNDATION	185,745	0	936	16,376	203,057	194.02
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)	48,382,166	1,193,112	1,615,803	7,764,530	48,382,166	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0210 | Period: From 07/01/2016 To 06/30/2017 | Worksheet B Part I | Date/Time Prepared: 11/29/2017 1:19 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	8,607,108					5.00
7.00	00700	OPERATION OF PLANT	288,878	1,623,834				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	43,607	43,187	288,312			8.00
9.00	00900	HOUSEKEEPING	180,722	11,057	0	1,026,927		9.00
10.00	01000	DIETARY	239,752	79,024	0	0	1,426,714	10.00
11.00	01100	CAFETERIA	0	0	0	0	292,801	11.00
13.00	01300	NURSING ADMINISTRATION	34,703	0	0	10,056	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	92,135	19,350	0	0	0	14.00
15.00	01500	PHARMACY	189,834	37,886	0	16,759	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	245,638	26,439	0	0	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,018,664	326,081	81,796	375,408	285,778	30.00
40.00	04000	SUBPROVIDER - IPF	930,370	305,430	42,249	101,394	400,599	40.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	407,037	201,983	33,412	67,037	0	50.00
53.00	05300	ANESTHESIOLOGY	15,931	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	239,541	129,431	13,257	0	0	54.00
54.01	05401	ULTRASOUND	76,637	16,358	0	0	0	54.01
54.02	03440	MAMMOGRAPHY	42,211	9,854	0	0	0	54.02
56.00	05600	RADIOISOTOPE	131,622	12,650	0	0	0	56.00
57.00	05700	CT SCAN	95,854	14,764	0	0	0	57.00
60.00	06000	LABORATORY	620,012	75,610	0	15,502	0	60.00
64.00	06400	INTRAVENOUS THERAPY	22,348	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	211,198	30,114	9,823	8,799	0	65.00
66.00	06600	PHYSICAL THERAPY	190,573	6,764	9,982	9,637	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	58,428	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	30,818	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	41,839	19,642	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	232,094	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	383,602	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	530,284	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	236,783	134,829	43,381	73,741	0	75.00
76.00	03950	FAITH CENTER CHEMOTHERAPY	47,193	30,341	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	29,650	8,813	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RHC I	597,078	0	17,326	108,936	0	88.00
88.01	08801	RHC II	75,080	0	9,187	16,759	0	88.01
88.02	08802	RHC III	86,978	0	7,967	0	0	88.02
91.00	09100	EMERGENCY	347,041	63,219	19,932	189,380	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	140,946	0	0	33,519	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	8,155,081	1,602,826	288,312	1,026,927	979,178	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	393,573	0	0	0	447,536	192.00
194.00	07950	OTHER NRCC	0	0	0	0	0	194.00
194.01	07951	AUXILIARY	14,513	21,008	0	0	0	194.01
194.02	07952	FOUNDATION	43,941	0	0	0	0	194.02
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)	8,607,108	1,623,834	288,312	1,026,927	1,426,714	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0210 | Period: From 07/01/2016 To 06/30/2017 | Worksheet B Part I | Date/Time Prepared: 11/29/2017 1:19 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	292,801					11.00
13.00	01300	NURSING ADMINISTRATION	1,870	206,996				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	6,376	0	543,632			14.00
15.00	01500	PHARMACY	5,667	0	3,495	1,130,900		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	14,432	0	4,595	0	1,426,240	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	62,264	62,273	149,057	0	102,227	30.00
40.00	04000	SUBPROVIDER - IPF	53,176	53,185	27,787	0	121,459	40.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	23,293	23,297	139,687	0	61,929	50.00
53.00	05300	ANESTHESIOLOGY	0	0	7,760	0	41,545	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	11,178	0	2,170	0	47,401	54.00
54.01	05401	ULTRASOUND	5,075	0	2,320	0	44,848	54.01
54.02	03440	MAMMOGRAPHY	1,148	0	318	0	6,821	54.02
56.00	05600	RADIOISOTOPE	3,684	0	2,578	0	36,441	56.00
57.00	05700	CT SCAN	3,745	0	4,037	0	167,932	57.00
60.00	06000	LABORATORY	19,006	0	13,610	0	215,990	60.00
64.00	06400	INTRAVENOUS THERAPY	749	0	19,613	0	68,396	64.00
65.00	06500	RESPIRATORY THERAPY	11,910	0	5,319	0	83,014	65.00
66.00	06600	PHYSICAL THERAPY	9,368	0	2,303	0	27,433	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,880	0	436	0	10,548	67.00
68.00	06800	SPEECH PATHOLOGY	881	0	0	0	2,814	68.00
69.00	06900	ELECTROCARDIOLOGY	1,825	0	1,288	0	21,718	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	28,883	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	28,009	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,060,160	117,083	73.00
75.00	07500	ASC (NON-DISTINCT PART)	16,463	16,466	50,899	0	50,171	75.00
76.00	03950	FAITH CENTER CHEMOTHERAPY	1,971	1,972	9,337	0	824	76.00
76.97	07697	CARDIAC REHABILITATION	1,429	1,429	1,131	0	5,572	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RHC I	0	22,572	9,627	30,996	30,921	88.00
88.01	08801	RHC II	0	0	1,748	4,684	3,374	88.01
88.02	08802	RHC III	0	0	1,629	4,528	3,469	88.02
91.00	09100	EMERGENCY	16,917	16,920	70,757	0	88,882	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	8,880	8,882	4,520	0	8,536	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	284,187	206,996	536,021	1,100,368	1,426,240	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	5,688	0	6,688	30,532	0	192.00
194.00	07950	OTHER NRCC	0	0	0	0	0	194.00
194.01	07951	AUXILIARY	1,157	0	42	0	0	194.01
194.02	07952	FOUNDATION	1,769	0	881	0	0	194.02
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)	292,801	206,996	543,632	1,130,900	1,426,240	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0210 | Period: From 07/01/2016 To 06/30/2017 | Worksheet B Part I | Date/Time Prepared: 11/29/2017 1:19 pm

		Cost Center Description	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			19.00	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
19.00	01900	NONPHYSICIAN ANESTHETISTS	0					19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	7,171,052	0	7,171,052		30.00
40.00	04000	SUBPROVIDER - IPF	0	6,335,056	0	6,335,056		40.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	2,838,665	0	2,838,665		50.00
53.00	05300	ANESTHESIOLOGY	0	138,856	0	138,856		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,549,938	0	1,549,938		54.00
54.01	05401	ULTRASOUND	0	499,390	0	499,390		54.01
54.02	03440	MAMMOGRAPHY	0	255,417	0	255,417		54.02
56.00	05600	RADIOISOTOPE	0	795,225	0	795,225		56.00
57.00	05700	CT SCAN	0	729,291	0	729,291		57.00
60.00	06000	LABORATORY	0	3,824,916	0	3,824,916		60.00
64.00	06400	INTRAVENOUS THERAPY	0	214,380	0	214,380		64.00
65.00	06500	RESPIRATORY THERAPY	0	1,336,163	0	1,336,163		65.00
66.00	06600	PHYSICAL THERAPY	0	1,136,731	0	1,136,731		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	342,299	0	342,299		67.00
68.00	06800	SPEECH PATHOLOGY	0	176,930	0	176,930		68.00
69.00	06900	ELECTROCARDIOLOGY	0	279,656	0	279,656		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,333,525	0	1,333,525		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	2,184,306	0	2,184,306		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	4,158,064	0	4,158,064		73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	1,716,948	0	1,716,948		75.00
76.00	03950	FAITH CENTER CHEMOTHERAPY	0	309,724	0	309,724		76.00
76.97	07697	CARDIAC REHABILITATION	0	185,042	0	185,042		76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RHC I	0	3,576,658	0	3,576,658		88.00
88.01	08801	RHC II	0	457,792	0	457,792		88.01
88.02	08802	RHC III	0	506,513	0	506,513		88.02
91.00	09100	EMERGENCY	0	2,416,786	0	2,416,786		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0			92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	856,621	0	856,621		101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	45,325,944	0	45,325,944		118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	2,702,787	0	2,702,787		192.00
194.00	07950	OTHER NRCC	0	0	0	0		194.00
194.01	07951	AUXILIARY	0	103,787	0	103,787		194.01
194.02	07952	FOUNDATION	0	249,648	0	249,648		194.02
200.00		Cross Foot Adjustments	0	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118-201)	0	48,382,166	0	48,382,166		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0210 | Period: From 07/01/2016 To 06/30/2017 | Worksheet B Part II Date/Time Prepared: 11/29/2017 1:19 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	9,784	10,828	20,612	20,612	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	11,134	218,623	459,203	688,960	3,195	5.00
7.00	00700	OPERATION OF PLANT	1,685	49,818	12,961	64,464	439	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	24,332	8,440	32,772	43	8.00
9.00	00900	HOUSEKEEPING	0	6,230	1,772	8,002	520	9.00
10.00	01000	DIETARY	50	44,523	7,445	52,018	592	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	140	140	108	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3,319	10,902	5,592	19,813	216	14.00
15.00	01500	PHARMACY	0	21,345	56,257	77,602	547	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	14,896	30,290	45,186	538	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	281	183,718	105,518	289,517	2,884	30.00
40.00	04000	SUBPROVIDER - IPF	850	172,083	12,735	185,668	2,363	40.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	157,385	113,800	162,553	433,738	750	50.00
53.00	05300	ANESTHESIOLOGY	1,952	0	18,058	20,010	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	72,923	144,629	217,552	495	54.00
54.01	05401	ULTRASOUND	0	9,216	22,298	31,514	213	54.01
54.02	03440	MAMMOGRAPHY	0	5,552	39,692	45,244	64	54.02
56.00	05600	RADIOISOTOPE	0	7,127	60,283	67,410	167	56.00
57.00	05700	CT SCAN	0	8,318	113,539	121,857	187	57.00
60.00	06000	LABORATORY	0	42,599	46,951	89,550	812	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	24	64.00
65.00	06500	RESPIRATORY THERAPY	21,874	16,966	24,601	63,441	594	65.00
66.00	06600	PHYSICAL THERAPY	0	3,811	12,265	16,076	596	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	1,918	1,918	187	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	99	68.00
69.00	06900	ELECTROCARDIOLOGY	34,465	11,067	6,213	51,745	97	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	75,964	62,444	138,408	597	75.00
76.00	03950	FAITH CENTER CHEMOTHERAPY	0	17,095	3,115	20,210	135	76.00
76.97	07697	CARDIAC REHABILITATION	0	4,965	5,669	10,634	87	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RHC I	153,804	0	33,220	187,024	1,618	88.00
88.01	08801	RHC II	0	0	1,813	1,813	198	88.01
88.02	08802	RHC III	4,536	0	12,481	17,017	226	88.02
91.00	09100	EMERGENCY	0	35,619	15,775	51,394	993	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	6,592	6,592	410	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	391,335	1,181,276	1,505,290	3,077,901	19,994	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	13,970	0	109,577	123,547	537	192.00
194.00	07950	OTHER NRCC	0	0	0	0	0	194.00
194.01	07951	AUXILIARY	0	11,836	0	11,836	38	194.01
194.02	07952	FOUNDATION	0	0	936	936	43	194.02
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)	405,305	1,193,112	1,615,803	3,214,220	20,612	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0210 | Period: From 07/01/2016 To 06/30/2017 | Worksheet B Part II | Date/Time Prepared: 11/29/2017 1:19 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	692,155					5.00
7.00	00700	OPERATION OF PLANT	23,231	88,134				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	3,507	2,344	38,666			8.00
9.00	00900	HOUSEKEEPING	14,533	600	0	23,655		9.00
10.00	01000	DIETARY	19,280	4,289	0	0	76,179	10.00
11.00	01100	CAFETERIA	0	0	0	0	15,634	11.00
13.00	01300	NURSING ADMINISTRATION	2,791	0	0	232	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	7,409	1,050	0	0	0	14.00
15.00	01500	PHARMACY	15,266	2,056	0	386	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	19,754	1,435	0	0	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	81,910	17,699	10,970	8,647	15,259	30.00
40.00	04000	SUBPROVIDER - IPF	74,818	16,577	5,666	2,336	21,390	40.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	32,733	10,963	4,481	1,544	0	50.00
53.00	05300	ANESTHESIOLOGY	1,281	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	19,263	7,025	1,778	0	0	54.00
54.01	05401	ULTRASOUND	6,163	888	0	0	0	54.01
54.02	03440	MAMMOGRAPHY	3,395	535	0	0	0	54.02
56.00	05600	RADIOISOTOPE	10,585	687	0	0	0	56.00
57.00	05700	CT SCAN	7,708	801	0	0	0	57.00
60.00	06000	LABORATORY	49,860	4,104	0	357	0	60.00
64.00	06400	INTRAVENOUS THERAPY	1,797	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	16,984	1,634	1,317	203	0	65.00
66.00	06600	PHYSICAL THERAPY	15,325	367	1,339	222	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	4,699	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	2,478	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	3,365	1,066	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	18,664	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	30,848	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	42,644	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	19,042	7,318	5,818	1,699	0	75.00
76.00	03950	FAITH CENTER CHEMOTHERAPY	3,795	1,647	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	2,384	478	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RHC I	48,016	0	2,324	2,509	0	88.00
88.01	08801	RHC II	6,038	0	1,232	386	0	88.01
88.02	08802	RHC III	6,995	0	1,068	0	0	88.02
91.00	09100	EMERGENCY	27,908	3,431	2,673	4,362	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	11,335	0	0	772	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	655,804	86,994	38,666	23,655	52,283	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	31,650	0	0	0	23,896	192.00
194.00	07950	OTHER NRCC	0	0	0	0	0	194.00
194.01	07951	AUXILIARY	1,167	1,140	0	0	0	194.01
194.02	07952	FOUNDATION	3,534	0	0	0	0	194.02
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)	692,155	88,134	38,666	23,655	76,179	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0210 | Period: From 07/01/2016 To 06/30/2017 | Worksheet B Part II | Date/Time Prepared: 11/29/2017 1:19 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	15,634					11.00
13.00	01300	NURSING ADMINISTRATION	100	3,371				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	340	0	28,828			14.00
15.00	01500	PHARMACY	303	0	185	96,345		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	771	0	244	0	67,928	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,325	1,014	7,904	0	4,871	30.00
40.00	04000	SUBPROVIDER - IPF	2,839	866	1,474	0	5,787	40.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,244	379	7,407	0	2,951	50.00
53.00	05300	ANESTHESIOLOGY	0	0	412	0	1,980	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	597	0	115	0	2,259	54.00
54.01	05401	ULTRASOUND	271	0	123	0	2,137	54.01
54.02	03440	MAMMOGRAPHY	61	0	17	0	325	54.02
56.00	05600	RADIOISOTOPE	197	0	137	0	1,736	56.00
57.00	05700	CT SCAN	200	0	214	0	8,002	57.00
60.00	06000	LABORATORY	1,015	0	722	0	10,260	60.00
64.00	06400	INTRAVENOUS THERAPY	40	0	1,040	0	3,259	64.00
65.00	06500	RESPIRATORY THERAPY	636	0	282	0	3,955	65.00
66.00	06600	PHYSICAL THERAPY	500	0	122	0	1,307	66.00
67.00	06700	OCCUPATIONAL THERAPY	154	0	23	0	503	67.00
68.00	06800	SPEECH PATHOLOGY	47	0	0	0	134	68.00
69.00	06900	ELECTROCARDIOLOGY	97	0	68	0	1,035	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	1,376	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	1,335	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	90,318	5,579	73.00
75.00	07500	ASC (NON-DISTINCT PART)	879	268	2,699	0	2,391	75.00
76.00	03950	FAITH CENTER CHEMOTHERAPY	105	32	495	0	39	76.00
76.97	07697	CARDIAC REHABILITATION	76	23	60	0	266	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RHC I	0	368	510	2,641	1,473	88.00
88.01	08801	RHC II	0	0	93	399	161	88.01
88.02	08802	RHC III	0	0	86	386	165	88.02
91.00	09100	EMERGENCY	903	276	3,752	0	4,235	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	474	145	240	0	407	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	15,174	3,371	28,424	93,744	67,928	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	304	0	355	2,601	0	192.00
194.00	07950	OTHER NRCC	0	0	0	0	0	194.00
194.01	07951	AUXILIARY	62	0	2	0	0	194.01
194.02	07952	FOUNDATION	94	0	47	0	0	194.02
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)	15,634	3,371	28,828	96,345	67,928	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0210 | Period: From 07/01/2016 To 06/30/2017 | Worksheet B Part II | Date/Time Prepared: 11/29/2017 1:19 pm

		Cost Center Description	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			19.00	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
19.00	01900	NONPHYSICIAN ANESTHETISTS	0					19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS		444,000	0	444,000		30.00
40.00	04000	SUBPROVIDER - IPF		319,784	0	319,784		40.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM		496,190	0	496,190		50.00
53.00	05300	ANESTHESIOLOGY		23,683	0	23,683		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		249,084	0	249,084		54.00
54.01	05401	ULTRASOUND		41,309	0	41,309		54.01
54.02	03440	MAMMOGRAPHY		49,641	0	49,641		54.02
56.00	05600	RADIOISOTOPE		80,919	0	80,919		56.00
57.00	05700	CT SCAN		138,969	0	138,969		57.00
60.00	06000	LABORATORY		156,680	0	156,680		60.00
64.00	06400	INTRAVENOUS THERAPY		6,160	0	6,160		64.00
65.00	06500	RESPIRATORY THERAPY		89,046	0	89,046		65.00
66.00	06600	PHYSICAL THERAPY		35,854	0	35,854		66.00
67.00	06700	OCCUPATIONAL THERAPY		7,484	0	7,484		67.00
68.00	06800	SPEECH PATHOLOGY		2,758	0	2,758		68.00
69.00	06900	ELECTROCARDIOLOGY		57,473	0	57,473		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS		20,040	0	20,040		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		32,183	0	32,183		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		138,541	0	138,541		73.00
75.00	07500	ASC (NON-DISTINCT PART)		179,119	0	179,119		75.00
76.00	03950	FAITH CENTER CHEMOTHERAPY		26,458	0	26,458		76.00
76.97	07697	CARDIAC REHABILITATION		14,008	0	14,008		76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RHC I		246,483	0	246,483		88.00
88.01	08801	RHC II		10,320	0	10,320		88.01
88.02	08802	RHC III		25,943	0	25,943		88.02
91.00	09100	EMERGENCY		99,927	0	99,927		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0			92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY		20,375	0	20,375		101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	3,012,431	0	3,012,431		118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES		182,890	0	182,890		192.00
194.00	07950	OTHER NRCC		0	0	0		194.00
194.01	07951	AUXILIARY		14,245	0	14,245		194.01
194.02	07952	FOUNDATION		4,654	0	4,654		194.02
200.00		Cross Foot Adjustments	0	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118-201)	0	3,214,220	0	3,214,220		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0210 | Period: From 07/01/2016 To 06/30/2017 | Worksheet B-1 | Date/Time Prepared: 11/29/2017 1:19 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	65,118					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		1,552,879				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	534	10,406	21,254,857			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	11,932	441,322	3,297,735	-8,607,108	39,775,058	5.00
7.00	00700	OPERATION OF PLANT	2,719	12,456	452,744	0	1,334,956	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,328	8,111	43,925	0	201,518	8.00
9.00	00900	HOUSEKEEPING	340	1,703	536,010	0	835,148	9.00
10.00	01000	DIETARY	2,430	7,155	610,502	0	1,107,938	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	135	111,057	0	160,367	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	595	5,374	223,169	0	425,771	14.00
15.00	01500	PHARMACY	1,165	54,066	564,102	0	877,259	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	813	29,110	554,899	0	1,135,136	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	10,027	101,409	2,973,604	0	4,707,504	30.00
40.00	04000	SUBPROVIDER - IPF	9,392	12,239	2,436,556	0	4,299,407	40.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,211	156,223	773,680	0	1,880,990	50.00
53.00	05300	ANESTHESIOLOGY	0	17,355	0	0	73,620	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,980	138,997	510,308	0	1,106,960	54.00
54.01	05401	ULTRASOUND	503	21,430	219,262	0	354,152	54.01
54.02	03440	MAMMOGRAPHY	303	38,146	65,539	0	195,065	54.02
56.00	05600	RADIOISOTOPE	389	57,935	171,909	0	608,250	56.00
57.00	05700	CT SCAN	454	109,117	193,040	0	442,959	57.00
60.00	06000	LABORATORY	2,325	45,123	836,958	0	2,865,186	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	24,862	0	103,274	64.00
65.00	06500	RESPIRATORY THERAPY	926	23,643	611,883	0	975,986	65.00
66.00	06600	PHYSICAL THERAPY	208	11,787	613,974	0	880,671	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,843	192,466	0	270,007	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	102,101	0	142,417	68.00
69.00	06900	ELECTROCARDIOLOGY	604	5,971	99,745	0	193,344	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	1,072,548	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	1,772,695	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	2,450,537	73.00
75.00	07500	ASC (NON-DISTINCT PART)	4,146	60,012	615,962	0	1,094,215	75.00
76.00	03950	FAITH CENTER CHEMOTHERAPY	933	2,994	139,404	0	218,086	76.00
76.97	07697	CARDIAC REHABILITATION	271	5,448	89,442	0	137,018	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RHC I	0	31,926	1,667,551	0	2,759,202	88.00
88.01	08801	RHC II	0	1,742	204,328	0	346,960	88.01
88.02	08802	RHC III	0	11,995	233,224	0	401,942	88.02
91.00	09100	EMERGENCY	1,944	15,161	1,024,195	0	1,603,738	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	6,335	422,334	0	651,338	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	64,472	1,446,669	20,616,470	-8,607,108	37,686,164	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	105,310	553,965	0	1,818,770	192.00
194.00	07950	OTHER NRCC	0	0	0	0	0	194.00
194.01	07951	AUXILIARY	646	0	39,595	0	67,067	194.01
194.02	07952	FOUNDATION	0	900	44,827	0	203,057	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,193,112	1,615,803	7,764,530		8,607,108	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	18.322307	1.040521	0.365306		0.216395	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			20,612		692,155	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000970		0.017402	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0210 | Period: From 07/01/2016 To 06/30/2017 | Worksheet B-1 | Date/Time Prepared: 11/29/2017 1:19 pm

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (TIME SPENT)	DIETARY (MEALS SERVED)	CAFETERIA (ASSIGNED TIME)	
			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	49,933					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,328	45,346				8.00
9.00	00900	HOUSEKEEPING	340	0	2,451			9.00
10.00	01000	DIETARY	2,430	0	0	240,124		10.00
11.00	01100	CAFETERIA	0	0	0	49,280	699,128	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	24	0	4,464	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	595	0	0	0	15,225	14.00
15.00	01500	PHARMACY	1,165	0	40	0	13,532	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	813	0	0	0	34,460	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	10,027	12,865	896	48,098	148,671	30.00
40.00	04000	SUBPROVIDER - IPF	9,392	6,645	242	67,423	126,970	40.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,211	5,255	160	0	55,617	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,980	2,085	0	0	26,689	54.00
54.01	05401	ULTRASOUND	503	0	0	0	12,118	54.01
54.02	03440	MAMMOGRAPHY	303	0	0	0	2,742	54.02
56.00	05600	RADIOISOTOPE	389	0	0	0	8,796	56.00
57.00	05700	CT SCAN	454	0	0	0	8,941	57.00
60.00	06000	LABORATORY	2,325	0	37	0	45,380	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	1,789	64.00
65.00	06500	RESPIRATORY THERAPY	926	1,545	21	0	28,437	65.00
66.00	06600	PHYSICAL THERAPY	208	1,570	23	0	22,368	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	6,877	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	2,103	68.00
69.00	06900	ELECTROCARDIOLOGY	604	0	0	0	4,357	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	4,146	6,823	176	0	39,309	75.00
76.00	03950	FAITH CENTER CHEMOTHERAPY	933	0	0	0	4,707	76.00
76.97	07697	CARDIAC REHABILITATION	271	0	0	0	3,411	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RHC I	0	2,725	260	0	0	88.00
88.01	08801	RHC II	0	1,445	40	0	0	88.01
88.02	08802	RHC III	0	1,253	0	0	0	88.02
91.00	09100	EMERGENCY	1,944	3,135	452	0	40,394	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	80	0	21,204	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	49,287	45,346	2,451	164,801	678,561	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	75,323	13,581	192.00
194.00	07950	OTHER NRCC	0	0	0	0	0	194.00
194.01	07951	AUXILIARY	646	0	0	0	2,763	194.01
194.02	07952	FOUNDATION	0	0	0	0	4,223	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,623,834	288,312	1,026,927	1,426,714	292,801	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	32.520257	6.358047	418.982864	5.941572	0.418809	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	88,134	38,666	23,655	76,179	15,634	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	1.765045	0.852688	9.651163	0.317249	0.022362	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0210 | Period: From 07/01/2016 To 06/30/2017 | Worksheet B-1 | Date/Time Prepared: 11/29/2017 1:19 pm

		Cost Center Description	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	
			13.00	14.00	15.00	16.00	19.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
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	494,170					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	768,010				14.00
15.00	01500	PHARMACY	0	4,938	2,614,048			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	6,492	0	144,276,476		16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	148,671	210,580	0	10,341,654	0	30.00
40.00	04000	SUBPROVIDER - IPF	126,970	39,256	0	12,287,184	0	40.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	55,617	197,341	0	6,264,970	0	50.00
53.00	05300	ANESTHESIOLOGY	0	10,963	0	4,202,812	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	3,066	0	4,795,293	0	54.00
54.01	05401	ULTRASOUND	0	3,277	0	4,536,929	0	54.01
54.02	03440	MAMMOGRAPHY	0	449	0	690,009	0	54.02
56.00	05600	RADIOISOTOPE	0	3,642	0	3,686,459	0	56.00
57.00	05700	CT SCAN	0	5,703	0	16,988,547	0	57.00
60.00	06000	LABORATORY	0	19,227	0	21,843,658	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	27,708	0	6,919,158	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	7,515	0	8,397,949	0	65.00
66.00	06600	PHYSICAL THERAPY	0	3,253	0	2,775,180	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	616	0	1,067,044	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	284,698	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,820	0	2,197,047	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	2,921,852	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	2,833,505	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	2,450,537	11,844,533	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	39,309	71,907	0	5,075,479	0	75.00
76.00	03950	FAITH CENTER CHEMOTHERAPY	4,707	13,191	0	83,375	0	76.00
76.97	07697	CARDIAC REHABILITATION	3,411	1,598	0	563,705	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RHC I	53,887	13,600	71,646	3,128,077	0	88.00
88.01	08801	RHC II	0	2,469	10,826	341,360	0	88.01
88.02	08802	RHC III	0	2,301	10,466	350,902	0	88.02
91.00	09100	EMERGENCY	40,394	99,961	0	8,991,576	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	21,204	6,385	0	863,521	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	494,170	757,258	2,543,475	144,276,476	0	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	9,448	70,573	0	0	192.00
194.00	07950	OTHER NRCC	0	0	0	0	0	194.00
194.01	07951	AUXILIARY	0	59	0	0	0	194.01
194.02	07952	FOUNDATION	0	1,245	0	0	0	194.02
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)	206,996	543,632	1,130,900	1,426,240	0	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.418876	0.707845	0.432624	0.009885	0.000000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	3,371	28,828	96,345	67,928	0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.006822	0.037536	0.036857	0.000471	0.000000	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0210 | Period: From 07/01/2016 To 06/30/2017 | Worksheet C Part I Date/Time Prepared: 11/29/2017 1:19 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	Costs Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,171,052		7,171,052	0	7,171,052	30.00
40.00	04000	SUBPROVIDER - IPF	6,335,056		6,335,056	250,875	6,585,931	40.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,838,665		2,838,665	0	2,838,665	50.00
53.00	05300	ANESTHESIOLOGY	138,856		138,856	0	138,856	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,549,938		1,549,938	0	1,549,938	54.00
54.01	05401	ULTRASOUND	499,390		499,390	0	499,390	54.01
54.02	03440	MAMMOGRAPHY	255,417		255,417	0	255,417	54.02
56.00	05600	RADIOISOTOPE	795,225		795,225	0	795,225	56.00
57.00	05700	CT SCAN	729,291		729,291	0	729,291	57.00
60.00	06000	LABORATORY	3,824,916		3,824,916	0	3,824,916	60.00
64.00	06400	INTRAVENOUS THERAPY	214,380		214,380	0	214,380	64.00
65.00	06500	RESPIRATORY THERAPY	1,336,163	0	1,336,163	0	1,336,163	65.00
66.00	06600	PHYSICAL THERAPY	1,136,731	0	1,136,731	0	1,136,731	66.00
67.00	06700	OCCUPATIONAL THERAPY	342,299	0	342,299	0	342,299	67.00
68.00	06800	SPEECH PATHOLOGY	176,930	0	176,930	0	176,930	68.00
69.00	06900	ELECTROCARDIOLOGY	279,656		279,656	0	279,656	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,333,525		1,333,525	0	1,333,525	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,184,306		2,184,306	0	2,184,306	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,158,064		4,158,064	0	4,158,064	73.00
75.00	07500	ASC (NON-DISTINCT PART)	1,716,948		1,716,948	0	1,716,948	75.00
76.00	03950	FAITH CENTER CHEMOTHERAPY	309,724		309,724	0	309,724	76.00
76.97	07697	CARDIAC REHABILITATION	185,042		185,042	0	185,042	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RHC I	3,576,658		3,576,658	0	3,576,658	88.00
88.01	08801	RHC II	457,792		457,792	0	457,792	88.01
88.02	08802	RHC III	506,513		506,513	0	506,513	88.02
91.00	09100	EMERGENCY	2,416,786		2,416,786	6,953	2,423,739	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2,214,699		2,214,699		2,214,699	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	856,621		856,621		856,621	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	47,540,643	0	47,540,643	257,828	47,798,471	200.00
201.00		Less Observation Beds	2,214,699		2,214,699		2,214,699	201.00
202.00		Total (see instructions)	45,325,944	0	45,325,944	257,828	45,583,772	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0210 | Period: From 07/01/2016 To 06/30/2017 | Worksheet C Part I Date/Time Prepared: 11/29/2017 1:19 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	4,969,527		4,969,527			30.00
40.00	04000	SUBPROVIDER - IPF	12,287,184		12,287,184			40.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,807,036	4,457,934	6,264,970	0.453101	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	955,192	3,247,620	4,202,812	0.033039	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	489,293	4,306,000	4,795,293	0.323221	0.000000	54.00
54.01	05401	ULTRASOUND	725,172	3,811,757	4,536,929	0.110072	0.000000	54.01
54.02	03440	MAMMOGRAPHY	0	690,009	690,009	0.370165	0.000000	54.02
56.00	05600	RADIOISOTOPE	158,512	3,527,947	3,686,459	0.215715	0.000000	56.00
57.00	05700	CT SCAN	1,893,551	15,094,996	16,988,547	0.042928	0.000000	57.00
60.00	06000	LABORATORY	3,741,552	18,102,106	21,843,658	0.175104	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	3,225,810	3,693,348	6,919,158	0.030984	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	4,831,134	3,566,815	8,397,949	0.159106	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	546,707	2,228,473	2,775,180	0.409606	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	345,270	721,774	1,067,044	0.320792	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	109,002	175,696	284,698	0.621466	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	357,626	1,839,421	2,197,047	0.127287	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,324,810	1,597,042	2,921,852	0.456397	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,877,115	956,390	2,833,505	0.770885	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,478,523	8,366,010	11,844,533	0.351053	0.000000	73.00
75.00	07500	ASC (NON-DISTINCT PART)	266,677	4,808,802	5,075,479	0.338283	0.000000	75.00
76.00	03950	FAITH CENTER CHEMOTHERAPY	0	83,375	83,375	3.714831	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	1,897	561,808	563,705	0.328260	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RHC I	0	3,128,077	3,128,077			88.00
88.01	08801	RHC II	0	341,360	341,360			88.01
88.02	08802	RHC III	0	350,902	350,902			88.02
91.00	09100	EMERGENCY	964,871	8,026,705	8,991,576	0.268783	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,287,493	4,084,634	5,372,127	0.412257	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	863,521	863,521			101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	45,643,954	98,632,522	144,276,476			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	45,643,954	98,632,522	144,276,476			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0210 | Period: From 07/01/2016 To 06/30/2017 | Worksheet C Part I Date/Time Prepared: 11/29/2017 1:19 pm

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		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
40.00	04000	SUBPROVIDER - IPF			40.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.453101		50.00
53.00	05300	ANESTHESIOLOGY	0.033039		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.323221		54.00
54.01	05401	ULTRASOUND	0.110072		54.01
54.02	03440	MAMMOGRAPHY	0.370165		54.02
56.00	05600	RADIOISOTOPE	0.215715		56.00
57.00	05700	CT SCAN	0.042928		57.00
60.00	06000	LABORATORY	0.175104		60.00
64.00	06400	INTRAVENOUS THERAPY	0.030984		64.00
65.00	06500	RESPIRATORY THERAPY	0.159106		65.00
66.00	06600	PHYSICAL THERAPY	0.409606		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.320792		67.00
68.00	06800	SPEECH PATHOLOGY	0.621466		68.00
69.00	06900	ELECTROCARDIOLOGY	0.127287		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.456397		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.770885		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.351053		73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.338283		75.00
76.00	03950	FAITH CENTER CHEMOTHERAPY	3.714831		76.00
76.97	07697	CARDIAC REHABILITATION	0.328260		76.97
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RHC I			88.00
88.01	08801	RHC II			88.01
88.02	08802	RHC III			88.02
91.00	09100	EMERGENCY	0.269557		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.412257		92.00
		OTHER REIMBURSABLE COST CENTERS			
101.00	10100	HOME HEALTH AGENCY			101.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
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: 14-0210 | Period: From 07/01/2016 To 06/30/2017 | Worksheet C Part I Date/Time Prepared: 11/29/2017 1:19 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	7,171,052		7,171,052	0	7,171,052	30.00
40.00	04000	SUBPROVIDER - IPF	6,335,056		6,335,056	250,875	6,585,931	40.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,838,665		2,838,665	0	2,838,665	50.00
53.00	05300	ANESTHESIOLOGY	138,856		138,856	0	138,856	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,549,938		1,549,938	0	1,549,938	54.00
54.01	05401	ULTRASOUND	499,390		499,390	0	499,390	54.01
54.02	03440	MAMMOGRAPHY	255,417		255,417	0	255,417	54.02
56.00	05600	RADIOISOTOPE	795,225		795,225	0	795,225	56.00
57.00	05700	CT SCAN	729,291		729,291	0	729,291	57.00
60.00	06000	LABORATORY	3,824,916		3,824,916	0	3,824,916	60.00
64.00	06400	INTRAVENOUS THERAPY	214,380		214,380	0	214,380	64.00
65.00	06500	RESPIRATORY THERAPY	1,336,163	0	1,336,163	0	1,336,163	65.00
66.00	06600	PHYSICAL THERAPY	1,136,731	0	1,136,731	0	1,136,731	66.00
67.00	06700	OCCUPATIONAL THERAPY	342,299	0	342,299	0	342,299	67.00
68.00	06800	SPEECH PATHOLOGY	176,930	0	176,930	0	176,930	68.00
69.00	06900	ELECTROCARDIOLOGY	279,656		279,656	0	279,656	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,333,525		1,333,525	0	1,333,525	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,184,306		2,184,306	0	2,184,306	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,158,064		4,158,064	0	4,158,064	73.00
75.00	07500	ASC (NON-DISTINCT PART)	1,716,948		1,716,948	0	1,716,948	75.00
76.00	03950	FAITH CENTER CHEMOTHERAPY	309,724		309,724	0	309,724	76.00
76.97	07697	CARDIAC REHABILITATION	185,042		185,042	0	185,042	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RHC I	3,576,658		3,576,658	0	3,576,658	88.00
88.01	08801	RHC II	457,792		457,792	0	457,792	88.01
88.02	08802	RHC III	506,513		506,513	0	506,513	88.02
91.00	09100	EMERGENCY	2,416,786		2,416,786	6,953	2,423,739	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2,214,699		2,214,699		2,214,699	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	856,621		856,621		856,621	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	47,540,643	0	47,540,643	257,828	47,798,471	200.00
201.00		Less Observation Beds	2,214,699		2,214,699		2,214,699	201.00
202.00		Total (see instructions)	45,325,944	0	45,325,944	257,828	45,583,772	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0210 | Period: From 07/01/2016 To 06/30/2017 | Worksheet C Part I Date/Time Prepared: 11/29/2017 1:19 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	4,969,527		4,969,527			30.00
40.00	04000	SUBPROVIDER - IPF	12,287,184		12,287,184			40.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,807,036	4,457,934	6,264,970	0.453101	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	955,192	3,247,620	4,202,812	0.033039	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	489,293	4,306,000	4,795,293	0.323221	0.000000	54.00
54.01	05401	ULTRASOUND	725,172	3,811,757	4,536,929	0.110072	0.000000	54.01
54.02	03440	MAMMOGRAPHY	0	690,009	690,009	0.370165	0.000000	54.02
56.00	05600	RADIOISOTOPE	158,512	3,527,947	3,686,459	0.215715	0.000000	56.00
57.00	05700	CT SCAN	1,893,551	15,094,996	16,988,547	0.042928	0.000000	57.00
60.00	06000	LABORATORY	3,741,552	18,102,106	21,843,658	0.175104	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	3,225,810	3,693,348	6,919,158	0.030984	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	4,831,134	3,566,815	8,397,949	0.159106	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	546,707	2,228,473	2,775,180	0.409606	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	345,270	721,774	1,067,044	0.320792	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	109,002	175,696	284,698	0.621466	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	357,626	1,839,421	2,197,047	0.127287	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,324,810	1,597,042	2,921,852	0.456397	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,877,115	956,390	2,833,505	0.770885	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,478,523	8,366,010	11,844,533	0.351053	0.000000	73.00
75.00	07500	ASC (NON-DISTINCT PART)	266,677	4,808,802	5,075,479	0.338283	0.000000	75.00
76.00	03950	FAITH CENTER CHEMOTHERAPY	0	83,375	83,375	3.714831	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	1,897	561,808	563,705	0.328260	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RHC I	0	3,128,077	3,128,077	1.143405	0.000000	88.00
88.01	08801	RHC II	0	341,360	341,360	1.341083	0.000000	88.01
88.02	08802	RHC III	0	350,902	350,902	1.443460	0.000000	88.02
91.00	09100	EMERGENCY	964,871	8,026,705	8,991,576	0.268783	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,287,493	4,084,634	5,372,127	0.412257	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	863,521	863,521			101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	45,643,954	98,632,522	144,276,476			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	45,643,954	98,632,522	144,276,476			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0210 | Period: From 07/01/2016 To 06/30/2017 | Worksheet C Part I Date/Time Prepared: 11/29/2017 1:19 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
40.00	04000	SUBPROVIDER - IPF			40.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
54.01	05401	ULTRASOUND	0.000000		54.01
54.02	03440	MAMMOGRAPHY	0.000000		54.02
56.00	05600	RADIOISOTOPE	0.000000		56.00
57.00	05700	CT SCAN	0.000000		57.00
60.00	06000	LABORATORY	0.000000		60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000		64.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000		75.00
76.00	03950	FAITH CENTER CHEMOTHERAPY	0.000000		76.00
76.97	07697	CARDIAC REHABILITATION	0.000000		76.97
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RHC I	0.000000		88.00
88.01	08801	RHC II	0.000000		88.01
88.02	08802	RHC III	0.000000		88.02
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
		OTHER REIMBURSABLE COST CENTERS			
101.00	10100	HOME HEALTH AGENCY			101.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
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: 14-0210 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D Part I Date/Time Prepared: 11/29/2017 1:19 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	444,000	1,021	442,979	6,826	64.90	30.00
40.00	SUBPROVIDER - IPF	319,784	0	319,784	9,716	32.91	40.00
200.00	Total (lines 30-199)	763,784		762,763	16,542		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	3,110	201,839				30.00
40.00	SUBPROVIDER - IPF	2,946	96,953				40.00
200.00	Total (lines 30-199)	6,056	298,792				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 14-0210 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D Part II Date/Time Prepared: 11/29/2017 1:19 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	496,190	6,264,970	0.079201	764,884	60,580	50.00
53.00	05300	ANESTHESIOLOGY	23,683	4,202,812	0.005635	438,755	2,472	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	249,084	4,795,293	0.051943	463,226	24,061	54.00
54.01	05401	ULTRASOUND	41,309	4,536,929	0.009105	699,056	6,365	54.01
54.02	03440	MAMMOGRAPHY	49,641	690,009	0.071943	0	0	54.02
56.00	05600	RADIOISOTOPE	80,919	3,686,459	0.021950	121,005	2,656	56.00
57.00	05700	CT SCAN	138,969	16,988,547	0.008180	1,782,308	14,579	57.00
60.00	06000	LABORATORY	156,680	21,843,658	0.007173	3,344,350	23,989	60.00
64.00	06400	INTRAVENOUS THERAPY	6,160	6,919,158	0.000890	1,962,789	1,747	64.00
65.00	06500	RESPIRATORY THERAPY	89,046	8,397,949	0.010603	3,493,816	37,045	65.00
66.00	06600	PHYSICAL THERAPY	35,854	2,775,180	0.012920	373,372	4,824	66.00
67.00	06700	OCCUPATIONAL THERAPY	7,484	1,067,044	0.007014	231,884	1,626	67.00
68.00	06800	SPEECH PATHOLOGY	2,758	284,698	0.009687	106,741	1,034	68.00
69.00	06900	ELECTROCARDIOLOGY	57,473	2,197,047	0.026159	333,617	8,727	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	20,040	2,921,852	0.006859	832,331	5,709	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	32,183	2,833,505	0.011358	780,365	8,863	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	138,541	11,844,533	0.011697	1,441,730	16,864	73.00
75.00	07500	ASC (NON-DISTINCT PART)	179,119	5,075,479	0.035291	159,195	5,618	75.00
76.00	03950	FAITH CENTER CHEMOTHERAPY	26,458	83,375	0.317337	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	14,008	563,705	0.024850	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RHC I	246,483	3,128,077	0.078797	0	0	88.00
88.01	08801	RHC II	10,320	341,360	0.030232	0	0	88.01
88.02	08802	RHC III	25,943	350,902	0.073932	0	0	88.02
91.00	09100	EMERGENCY	99,927	8,991,576	0.011113	846,646	9,409	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	137,125	5,372,127	0.025525	746,523	19,055	92.00
200.00		Total (lines 50-199)	2,365,397	126,156,244		18,922,593	255,223	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 14-0210 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D Part III Date/Time Prepared: 11/29/2017 1:19 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
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
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	6,826	0.00	3,110	0		30.00
40.00	04000	SUBPROVIDER - IPF	9,716	0.00	2,946	0		40.00
200.00		Total (lines 30-199)	16,542		6,056	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0210 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D Part IV | Date/Time Prepared: 11/29/2017 1:19 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
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
54.02	03440	MAMMOGRAPHY	0	0	0	0	0	54.02
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.00	03950	FAITH CENTER CHEMOTHERAPY	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RHC I	0	0	0	0	0	88.00
88.01	08801	RHC II	0	0	0	0	0	88.01
88.02	08802	RHC III	0	0	0	0	0	88.02
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: 14-0210 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D Part IV Date/Time Prepared: 11/29/2017 1:19 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	6,264,970	0.000000	0.000000	764,884	50.00
53.00	05300	ANESTHESIOLOGY	0	4,202,812	0.000000	0.000000	438,755	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	4,795,293	0.000000	0.000000	463,226	54.00
54.01	05401	ULTRASOUND	0	4,536,929	0.000000	0.000000	699,056	54.01
54.02	03440	MAMMOGRAPHY	0	690,009	0.000000	0.000000	0	54.02
56.00	05600	RADIOISOTOPE	0	3,686,459	0.000000	0.000000	121,005	56.00
57.00	05700	CT SCAN	0	16,988,547	0.000000	0.000000	1,782,308	57.00
60.00	06000	LABORATORY	0	21,843,658	0.000000	0.000000	3,344,350	60.00
64.00	06400	INTRAVENOUS THERAPY	0	6,919,158	0.000000	0.000000	1,962,789	64.00
65.00	06500	RESPIRATORY THERAPY	0	8,397,949	0.000000	0.000000	3,493,816	65.00
66.00	06600	PHYSICAL THERAPY	0	2,775,180	0.000000	0.000000	373,372	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,067,044	0.000000	0.000000	231,884	67.00
68.00	06800	SPEECH PATHOLOGY	0	284,698	0.000000	0.000000	106,741	68.00
69.00	06900	ELECTROCARDIOLOGY	0	2,197,047	0.000000	0.000000	333,617	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2,921,852	0.000000	0.000000	832,331	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	2,833,505	0.000000	0.000000	780,365	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	11,844,533	0.000000	0.000000	1,441,730	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	5,075,479	0.000000	0.000000	159,195	75.00
76.00	03950	FAITH CENTER CHEMOTHERAPY	0	83,375	0.000000	0.000000	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	563,705	0.000000	0.000000	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RHC I	0	3,128,077	0.000000	0.000000	0	88.00
88.01	08801	RHC II	0	341,360	0.000000	0.000000	0	88.01
88.02	08802	RHC III	0	350,902	0.000000	0.000000	0	88.02
91.00	09100	EMERGENCY	0	8,991,576	0.000000	0.000000	846,646	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	5,372,127	0.000000	0.000000	746,523	92.00
200.00		Total (lines 50-199)	0	126,156,244			18,922,593	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0210 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D Part IV Date/Time Prepared: 11/29/2017 1:19 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	1,353,790	0		50.00
53.00	05300	ANESTHESIOLOGY	0	1,078,826	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,217,022	0		54.00
54.01	05401	ULTRASOUND	0	1,338,632	0		54.01
54.02	03440	MAMMOGRAPHY	0	0	0		54.02
56.00	05600	RADIOISOTOPE	0	1,365,357	0		56.00
57.00	05700	CT SCAN	0	5,281,419	0		57.00
60.00	06000	LABORATORY	0	3,524,071	0		60.00
64.00	06400	INTRAVENOUS THERAPY	0	1,417,867	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	958,784	0		65.00
66.00	06600	PHYSICAL THERAPY	0	32,026	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	14,586	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	5,072	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	694,658	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	443,400	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	355,574	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,778,288	0		73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	1,849,135	0		75.00
76.00	03950	FAITH CENTER CHEMOTHERAPY	0	36,867	0		76.00
76.97	07697	CARDIAC REHABILITATION	0	210,438	0		76.97
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RHC I	0	0	0		88.00
88.01	08801	RHC II	0	0	0		88.01
88.02	08802	RHC III	0	0	0		88.02
91.00	09100	EMERGENCY	0	2,074,510	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	1,409,418	0		92.00
200.00		Total (lines 50-199)	0	28,439,740	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-0210 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D Part V Date/Time Prepared: 11/29/2017 1:19 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	0.453101	1,353,790	0	0	613,404	50.00
53.00	05300	ANESTHESIOLOGY	0.033039	1,078,826	0	0	35,643	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.323221	1,217,022	0	0	393,367	54.00
54.01	05401	ULTRASOUND	0.110072	1,338,632	0	0	147,346	54.01
54.02	03440	MAMMOGRAPHY	0.370165	0	0	0	0	54.02
56.00	05600	RADIOISOTOPE	0.215715	1,365,357	0	0	294,528	56.00
57.00	05700	CT SCAN	0.042928	5,281,419	0	0	226,721	57.00
60.00	06000	LABORATORY	0.175104	3,524,071	0	0	617,079	60.00
64.00	06400	INTRAVENOUS THERAPY	0.030984	1,417,867	0	0	43,931	64.00
65.00	06500	RESPIRATORY THERAPY	0.159106	958,784	0	0	152,548	65.00
66.00	06600	PHYSICAL THERAPY	0.409606	32,026	0	0	13,118	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.320792	14,586	0	0	4,679	67.00
68.00	06800	SPEECH PATHOLOGY	0.621466	5,072	0	0	3,152	68.00
69.00	06900	ELECTROCARDIOLOGY	0.127287	694,658	0	0	88,421	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.456397	443,400	0	0	202,366	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.770885	355,574	0	0	274,107	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.351053	3,778,288	0	914	1,326,379	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.338283	1,849,135	0	0	625,531	75.00
76.00	03950	FAITH CENTER CHEMOTHERAPY	3.714831	36,867	0	0	136,955	76.00
76.97	07697	CARDIAC REHABILITATION	0.328260	210,438	0	0	69,078	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RHC I	0.000000				0	88.00
88.01	08801	RHC II	0.000000				0	88.01
88.02	08802	RHC III	0.000000				0	88.02
91.00	09100	EMERGENCY	0.268783	2,074,510	0	549	557,593	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.412257	1,409,418	0	0	581,042	92.00
200.00		Subtotal (see instructions)		28,439,740	0	1,463	6,406,988	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		28,439,740	0	1,463	6,406,988	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-0210 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D Part V Date/Time Prepared: 11/29/2017 1:19 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
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
54.01	05401	ULTRASOUND	0	0	54.01
54.02	03440	MAMMOGRAPHY	0	0	54.02
56.00	05600	RADIOISOTOPE	0	0	56.00
57.00	05700	CT SCAN	0	0	57.00
60.00	06000	LABORATORY	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	321	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	75.00
76.00	03950	FAITH CENTER CHEMOTHERAPY	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RHC I	0	0	88.00
88.01	08801	RHC II	0	0	88.01
88.02	08802	RHC III	0	0	88.02
91.00	09100	EMERGENCY	0	148	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
200.00		Subtotal (see instructions)	0	469	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 +/- line 201)	0	469	202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0210 | Component CCN: 14-S210 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D Part II Date/Time Prepared: 11/29/2017 1:19 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	496,190	6,264,970	0.079201	0	0	50.00
53.00	05300	ANESTHESIOLOGY	23,683	4,202,812	0.005635	1,668	9	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	249,084	4,795,293	0.051943	24,987	1,298	54.00
54.01	05401	ULTRASOUND	41,309	4,536,929	0.009105	20,852	190	54.01
54.02	03440	MAMMOGRAPHY	49,641	690,009	0.071943	0	0	54.02
56.00	05600	RADIOISOTOPE	80,919	3,686,459	0.021950	0	0	56.00
57.00	05700	CT SCAN	138,969	16,988,547	0.008180	111,243	910	57.00
60.00	06000	LABORATORY	156,680	21,843,658	0.007173	388,156	2,784	60.00
64.00	06400	INTRAVENOUS THERAPY	6,160	6,919,158	0.000890	23,892	21	64.00
65.00	06500	RESPIRATORY THERAPY	89,046	8,397,949	0.010603	291,634	3,092	65.00
66.00	06600	PHYSICAL THERAPY	35,854	2,775,180	0.012920	40,554	524	66.00
67.00	06700	OCCUPATIONAL THERAPY	7,484	1,067,044	0.007014	11,778	83	67.00
68.00	06800	SPEECH PATHOLOGY	2,758	284,698	0.009687	1,104	11	68.00
69.00	06900	ELECTROCARDIOLOGY	57,473	2,197,047	0.026159	22,761	595	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	20,040	2,921,852	0.006859	34,889	239	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	32,183	2,833,505	0.011358	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	138,541	11,844,533	0.011697	510,020	5,966	73.00
75.00	07500	ASC (NON-DISTINCT PART)	179,119	5,075,479	0.035291	0	0	75.00
76.00	03950	FAITH CENTER CHEMOTHERAPY	26,458	83,375	0.317337	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	14,008	563,705	0.024850	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RHC I	246,483	3,128,077	0.078797	0	0	88.00
88.01	08801	RHC II	10,320	341,360	0.030232	0	0	88.01
88.02	08802	RHC III	25,943	350,902	0.073932	0	0	88.02
91.00	09100	EMERGENCY	99,927	8,991,576	0.011113	118,225	1,314	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	5,372,127	0.000000	0	0	92.00
200.00		Total (lines 50-199)	2,228,272	126,156,244		1,601,763	17,036	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0210 | Component CCN: 14-S210 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D Part IV | Date/Time Prepared: 11/29/2017 1:19 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
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
54.02	03440	MAMMOGRAPHY	0	0	0	0	0	54.02
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.00	03950	FAITH CENTER CHEMOTHERAPY	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RHC I	0	0	0	0	0	88.00
88.01	08801	RHC II	0	0	0	0	0	88.01
88.02	08802	RHC III	0	0	0	0	0	88.02
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: 14-0210 | Component CCN: 14-S210 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D Part IV Date/Time Prepared: 11/29/2017 1:19 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	6,264,970	0.000000	0.000000	0	50.00
53.00	05300	ANESTHESIOLOGY	0	4,202,812	0.000000	0.000000	1,668	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	4,795,293	0.000000	0.000000	24,987	54.00
54.01	05401	ULTRASOUND	0	4,536,929	0.000000	0.000000	20,852	54.01
54.02	03440	MAMMOGRAPHY	0	690,009	0.000000	0.000000	0	54.02
56.00	05600	RADIOISOTOPE	0	3,686,459	0.000000	0.000000	0	56.00
57.00	05700	CT SCAN	0	16,988,547	0.000000	0.000000	111,243	57.00
60.00	06000	LABORATORY	0	21,843,658	0.000000	0.000000	388,156	60.00
64.00	06400	INTRAVENOUS THERAPY	0	6,919,158	0.000000	0.000000	23,892	64.00
65.00	06500	RESPIRATORY THERAPY	0	8,397,949	0.000000	0.000000	291,634	65.00
66.00	06600	PHYSICAL THERAPY	0	2,775,180	0.000000	0.000000	40,554	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,067,044	0.000000	0.000000	11,778	67.00
68.00	06800	SPEECH PATHOLOGY	0	284,698	0.000000	0.000000	1,104	68.00
69.00	06900	ELECTROCARDIOLOGY	0	2,197,047	0.000000	0.000000	22,761	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2,921,852	0.000000	0.000000	34,889	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	2,833,505	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	11,844,533	0.000000	0.000000	510,020	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	5,075,479	0.000000	0.000000	0	75.00
76.00	03950	FAITH CENTER CHEMOTHERAPY	0	83,375	0.000000	0.000000	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	563,705	0.000000	0.000000	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RHC I	0	3,128,077	0.000000	0.000000	0	88.00
88.01	08801	RHC II	0	341,360	0.000000	0.000000	0	88.01
88.02	08802	RHC III	0	350,902	0.000000	0.000000	0	88.02
91.00	09100	EMERGENCY	0	8,991,576	0.000000	0.000000	118,225	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	5,372,127	0.000000	0.000000	0	92.00
200.00		Total (lines 50-199)	0	126,156,244			1,601,763	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0210 | Component CCN: 14-S210 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D Part IV | Date/Time Prepared: 11/29/2017 1:19 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
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	695	0		54.00
54.01	05401	ULTRASOUND	0	0	0		54.01
54.02	03440	MAMMOGRAPHY	0	0	0		54.02
56.00	05600	RADIOISOTOPE	0	0	0		56.00
57.00	05700	CT SCAN	0	0	0		57.00
60.00	06000	LABORATORY	0	0	0		60.00
64.00	06400	INTRAVENOUS THERAPY	0	172	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	1,656	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	312	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,557	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	03950	FAITH CENTER CHEMOTHERAPY	0	0	0		76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0		76.97
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RHC I	0	0	0		88.00
88.01	08801	RHC II	0	0	0		88.01
88.02	08802	RHC III	0	0	0		88.02
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	4,392	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0210 | Component CCN: 14-S210 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D Part V | Date/Time Prepared: 11/29/2017 1:19 pm

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.453101	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.033039	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.323221	695	0	0	225	54.00
54.01	05401	ULTRASOUND	0.110072	0	0	0	0	54.01
54.02	03440	MAMMOGRAPHY	0.370165	0	0	0	0	54.02
56.00	05600	RADIOISOTOPE	0.215715	0	0	0	0	56.00
57.00	05700	CT SCAN	0.042928	0	0	0	0	57.00
60.00	06000	LABORATORY	0.175104	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.030984	172	0	0	5	64.00
65.00	06500	RESPIRATORY THERAPY	0.159106	1,656	0	0	263	65.00
66.00	06600	PHYSICAL THERAPY	0.409606	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.320792	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.621466	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.127287	312	0	0	40	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.456397	1,557	0	0	711	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.770885	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.351053	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.338283	0	0	0	0	75.00
76.00	03950	FAITH CENTER CHEMOTHERAPY	3.714831	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.328260	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RHC I	0.000000				0	88.00
88.01	08801	RHC II	0.000000				0	88.01
88.02	08802	RHC III	0.000000				0	88.02
91.00	09100	EMERGENCY	0.268783	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.412257	0	0	0	0	92.00
200.00		Subtotal (see instructions)		4,392	0	0	1,244	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		4,392	0	0	1,244	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0210 | Component CCN: 14-S210 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D Part V | Date/Time Prepared: 11/29/2017 1:19 pm

Title XVIII | Subprovider - IPF | 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
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
54.01	05401	ULTRASOUND	0	0		54.01
54.02	03440	MAMMOGRAPHY	0	0		54.02
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
60.00	06000	LABORATORY	0	0		60.00
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0		75.00
76.00	03950	FAITH CENTER CHEMOTHERAPY	0	0		76.00
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RHC I	0	0		88.00
88.01	08801	RHC II	0	0		88.01
88.02	08802	RHC III	0	0		88.02
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
200.00		Subtotal (see instructions)	0	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	0	0		202.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 14-0210	Period: From 07/01/2016 To 06/30/2017	Worksheet D-1 Date/Time Prepared: 11/29/2017 1:19 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)	6,902	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	6,826	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.	995	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	3,718	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	22	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)	54	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)	3,110	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)	9	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)	53	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	212.56	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	218.85	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)	7,171,052	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)	4,676	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)	11,818	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)	16,494	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	7,154,558	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	4,929,247	28.00
29.00	Private room charges (excluding swing-bed charges)	917,649	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	4,011,598	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	1.451450	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	922.26	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	1,078.97	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)	7,154,558	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,048.13	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	3,259,684	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)	3,259,684	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-0210 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D-1 | Date/Time Prepared: 11/29/2017 1:19 pm

Title XVIII | Hospital | PPS

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	4,306,184	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	7,565,868	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)	201,839	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	255,223	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	457,062	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	7,108,806	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)	1,913	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	11,599	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	13,512	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)	2,113	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,048.13	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	2,214,699	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-0210 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D-1 | Date/Time Prepared: 11/29/2017 1:19 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	444,000	7,171,052	0.061916	2,214,699	137,125	90.00
91.00	Nursing School cost	0	7,171,052	0.000000	2,214,699	0	91.00
92.00	Allied health cost	0	7,171,052	0.000000	2,214,699	0	92.00
93.00	All other Medical Education	0	7,171,052	0.000000	2,214,699	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 14-0210 Component CCN: 14-S210	Period: From 07/01/2016 To 06/30/2017	Worksheet D-1 Date/Time Prepared: 11/29/2017 1:19 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)	9,716	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	9,716	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)	9,716	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	2,946	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)	6,585,931	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)	6,585,931	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)	6,585,931	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)	677.84	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,996,917	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)	1,996,917	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0210 | Component CCN: 14-S210 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D-1 | Date/Time Prepared: 11/29/2017 1:19 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)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	381,117	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	2,378,034	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)	96,953	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	17,036	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	113,989	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	2,264,045	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: 14-0210 Component CCN: 14-S210	Period: From 07/01/2016 To 06/30/2017	Worksheet D-1 Date/Time Prepared: 11/29/2017 1:19 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	319,784	6,585,931	0.048556	0	0	90.00
91.00	Nursing School cost	0	6,585,931	0.000000	0	0	91.00
92.00	Allied health cost	0	6,585,931	0.000000	0	0	92.00
93.00	All other Medical Education	0	6,585,931	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 14-0210 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D-3 | Date/Time Prepared: 11/29/2017 1:19 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		3,321,876		30.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.453101	764,884	346,570	50.00
53.00	05300	ANESTHESIOLOGY	0.033039	438,755	14,496	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.323221	463,226	149,724	54.00
54.01	05401	ULTRASOUND	0.110072	699,056	76,946	54.01
54.02	03440	MAMMOGRAPHY	0.370165	0	0	54.02
56.00	05600	RADIOISOTOPE	0.215715	121,005	26,103	56.00
57.00	05700	CT SCAN	0.042928	1,782,308	76,511	57.00
60.00	06000	LABORATORY	0.175104	3,344,350	585,609	60.00
64.00	06400	INTRAVENOUS THERAPY	0.030984	1,962,789	60,815	64.00
65.00	06500	RESPIRATORY THERAPY	0.159106	3,493,816	555,887	65.00
66.00	06600	PHYSICAL THERAPY	0.409606	373,372	152,935	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.320792	231,884	74,387	67.00
68.00	06800	SPEECH PATHOLOGY	0.621466	106,741	66,336	68.00
69.00	06900	ELECTROCARDIOLOGY	0.127287	333,617	42,465	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.456397	832,331	379,873	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.770885	780,365	601,572	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.351053	1,441,730	506,124	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.338283	159,195	53,853	75.00
76.00	03950	FAITH CENTER CHEMOTHERAPY	3.714831	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.328260	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RHC I	0.000000		0	88.00
88.01	08801	RHC II	0.000000		0	88.01
88.02	08802	RHC III	0.000000		0	88.02
91.00	09100	EMERGENCY	0.269557	846,646	228,219	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.412257	746,523	307,759	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		18,922,593	4,306,184	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)		18,922,593		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 14-0210 | Component CCN: 14-S210 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D-3 | Date/Time Prepared: 11/29/2017 1:19 pm

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
40.00	04000	SUBPROVIDER - IPF		3,721,546		40.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.453101	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.033039	1,668	55	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.323221	24,987	8,076	54.00
54.01	05401	ULTRASOUND	0.110072	20,852	2,295	54.01
54.02	03440	MAMMOGRAPHY	0.370165	0	0	54.02
56.00	05600	RADIOISOTOPE	0.215715	0	0	56.00
57.00	05700	CT SCAN	0.042928	111,243	4,775	57.00
60.00	06000	LABORATORY	0.175104	388,156	67,968	60.00
64.00	06400	INTRAVENOUS THERAPY	0.030984	23,892	740	64.00
65.00	06500	RESPIRATORY THERAPY	0.159106	291,634	46,401	65.00
66.00	06600	PHYSICAL THERAPY	0.409606	40,554	16,611	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.320792	11,778	3,778	67.00
68.00	06800	SPEECH PATHOLOGY	0.621466	1,104	686	68.00
69.00	06900	ELECTROCARDIOLOGY	0.127287	22,761	2,897	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.456397	34,889	15,923	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.770885	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.351053	510,020	179,044	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.338283	0	0	75.00
76.00	03950	FAITH CENTER CHEMOTHERAPY	3.714831	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.328260	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RHC I	0.000000		0	88.00
88.01	08801	RHC II	0.000000		0	88.01
88.02	08802	RHC III	0.000000		0	88.02
91.00	09100	EMERGENCY	0.269557	118,225	31,868	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.412257	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		1,601,763	381,117	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		1,601,763		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 14-0210 | Component CCN: 14-U210 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D-3 | Date/Time Prepared: 11/29/2017 1:19 pm

Title XVIII | Swing Beds - SNF | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.453101	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.033039	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.323221	1,080	349	54.00
54.01	05401	ULTRASOUND	0.110072	716	79	54.01
54.02	03440	MAMMOGRAPHY	0.370165	0	0	54.02
56.00	05600	RADIOISOTOPE	0.215715	0	0	56.00
57.00	05700	CT SCAN	0.042928	0	0	57.00
60.00	06000	LABORATORY	0.175104	9,046	1,584	60.00
64.00	06400	INTRAVENOUS THERAPY	0.030984	2,654	82	64.00
65.00	06500	RESPIRATORY THERAPY	0.159106	48,722	7,752	65.00
66.00	06600	PHYSICAL THERAPY	0.409606	21,053	8,623	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.320792	16,322	5,236	67.00
68.00	06800	SPEECH PATHOLOGY	0.621466	1,157	719	68.00
69.00	06900	ELECTROCARDIOLOGY	0.127287	1,248	159	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.456397	5,702	2,602	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.770885	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.351053	10,323	3,624	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.338283	0	0	75.00
76.00	03950	FAITH CENTER CHEMOTHERAPY	3.714831	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.328260	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RHC I	0.000000		0	88.00
88.01	08801	RHC II	0.000000		0	88.01
88.02	08802	RHC III	0.000000		0	88.02
91.00	09100	EMERGENCY	0.268783	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.412257	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		118,023	30,809	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)		118,023		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0210	Period: From 07/01/2016 To 06/30/2017	Worksheet E Part A Date/Time Prepared: 11/29/2017 1:19 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)	1,352,338	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	4,590,624	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)	4,659	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)	40.00	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)	6.97	30.00
31.00	Percentage of Medicaid patient days (see instructions)	15.91	31.00
32.00	Sum of lines 30 and 31	22.88	32.00
33.00	Allowable disproportionate share percentage (see instructions)	8.09	33.00
34.00	Disproportionate share adjustment (see instructions)	120,196	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 14-0210 | Period: From 07/01/2016 To 06/30/2017 | Worksheet E Part A Date/Time Prepared: 11/29/2017 1:19 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)	0.000013277	0.000015466	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	85,054	92,448	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	21,380	69,146	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	90,526		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)	6,158,343		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)	7,171,734		48.00
			Amount	
			1.00	
49.00	Total payment for inpatient operating costs (see instructions)		7,171,734	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		473,519	50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)		0	51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).		0	52.00
53.00	Nursing and Allied Health Managed Care payment		0	53.00
54.00	Special add-on payments for new technologies		0	54.00
54.01	Islet isolation add-on payment		0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)		0	55.00
56.00	Cost of physicians' services in a teaching hospital (see intructions)		0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).		0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)		0	58.00
59.00	Total (sum of amounts on lines 49 through 58)		7,645,253	59.00
60.00	Primary payer payments		4,652	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		7,640,601	61.00
62.00	Deductibles billed to program beneficiaries		899,612	62.00
63.00	Coinsurance billed to program beneficiaries		17,444	63.00
64.00	Allowable bad debts (see instructions)		244,271	64.00
65.00	Adjusted reimbursable bad debts (see instructions)		158,776	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		244,271	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		6,882,321	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)		56,586	70.93
70.94	HRR adjustment amount (see instructions)		-124,542	70.94
70.95	Recovery of accelerated depreciation		0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0210	Period: From 07/01/2016 To 06/30/2017	Worksheet E Part A Date/Time Prepared: 11/29/2017 1:19 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)	2016	193,736	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)	2017	458,335	70.97
70.98	Low Volume Payment-3		0	70.98
70.99	HAC adjustment amount (see instructions)		0	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		7,466,436	71.00
71.01	Sequestration adjustment (see instructions)		149,329	71.01
72.00	Interim payments		7,324,801	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)		-7,694	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)	1.0093327500	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)	0.9767	0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)	0	0	104.00

LOW VOLUME CALCULATION EXHIBIT 4 | Provider CCN: 14-0210 | Period: From 07/01/2016 To 06/30/2017 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 11/29/2017 1:19 pm

Title XVIII | Hospital | PPS

		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	1,352,338	0	1,352,338		1,352,338	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	4,590,624	0		4,590,624	4,590,624	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00	4,659	0	2,487	2,172	4,659	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0	2.01
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	0	4.00
	Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	0	6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	0	9.01
	Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0809	0.0809	0.0809	0.0809		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	120,196	0	27,351	92,845	120,196	11.00
11.01	Uncompensated care payments	36.00	90,526	0	21,380	69,146	90,526	11.01
	Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	6,158,343	0	1,403,556	4,754,787	6,158,343	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	7,171,734	0	1,639,018	5,532,716	7,171,734	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	7,171,734	0	1,639,018	5,532,716	7,171,734	15.00
16.00	Payment for inpatient program capital	50.00	473,519	0	119,353	354,166	473,519	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	0	17.00
17.01	Net organ aquisition cost							17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0	18.00

LOW VOLUME CALCULATION EXHIBIT 4 | Provider CCN: 14-0210 | Period: From 07/01/2016 To 06/30/2017 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 11/29/2017 1:19 pm

Title XVIII | Hospital | PPS

		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
19.00	SUBTOTAL			0	1,758,371	5,886,882	7,645,253	19.00
		W/S L, line	(Amounts from L)					
		0	1.00	2.00	3.00	4.00	5.00	
20.00	Capital DRG other than outlier	1.00	473,519	0	119,353	354,166	473,519	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	0	0	0	0	0	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	473,519	0	119,353	354,166	473,519	26.00
		W/S E, Part A line	(Amounts to E, Part A)					
		0	1.00	2.00	3.00	4.00	5.00	
27.00	Low volume adjustment factor				0.110179	0.077857		27.00
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			193,736		193,736	28.00
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				458,335	458,335	29.00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0210	Period: From 07/01/2016 To 06/30/2017	Worksheet E Part B Date/Time Prepared: 11/29/2017 1:19 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	469	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	6,406,988	2.00
3.00	PPS payments	6,042,794	3.00
4.00	Outlier payment (see instructions)	2,168	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.850	5.00
6.00	Line 2 times line 5	5,445,940	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)	469	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	1,463	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	1,463	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	1,463	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	994	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)	469	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)	6,044,962	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)	1,230,527	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)	4,814,904	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)	4,814,904	30.00
31.00	Primary payer payments	1,170	31.00
32.00	Subtotal (line 30 minus line 31)	4,813,734	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)	372,233	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	241,951	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	372,233	36.00
37.00	Subtotal (see instructions)	5,055,685	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)	5,055,685	40.00
40.01	Sequestration adjustment (see instructions)	101,114	40.01
41.00	Interim payments	4,940,579	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	13,992	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0210 Component CCN: 14-S210	Period: From 07/01/2016 To 06/30/2017	Worksheet E Part B Date/Time Prepared: 11/29/2017 1:19 pm
	Title XVIII	Subprovider - IPF	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	0	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	1,244	2.00
3.00	PPS payments	181	3.00
4.00	Outlier payment (see instructions)	0	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	0	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	0	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a 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)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)	0	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)	181	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)	36	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)	145	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)	145	30.00
31.00	Primary payer payments	0	31.00
32.00	Subtotal (line 30 minus line 31)	145	32.00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
33.00	Composite rate ESRD (from Wkst. I-5, line 11)	0	33.00
34.00	Allowable bad debts (see instructions)	0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	36.00
37.00	Subtotal (see instructions)	145	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	39.50
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	145	40.00
40.01	Sequestration adjustment (see instructions)	3	40.01
41.00	Interim payments	142	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	0	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: 14-0210 | Period: From 07/01/2016 To 06/30/2017 | Worksheet E-1 Part I | Date/Time Prepared: 11/29/2017 1:19 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		7,324,801		4,940,579	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)		7,324,801		4,940,579	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		13,992	6.01
6.02	SETTLEMENT TO PROGRAM		7,694		0	6.02
7.00	Total Medicare program liability (see instructions)		7,317,107		4,954,571	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: 14-0210 | Component CCN: 14-S210 | Period: From 07/01/2016 To 06/30/2017 | Worksheet E-1 Part I | Date/Time Prepared: 11/29/2017 1:19 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		2,305,702		142	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)		2,305,702		142	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		15,026		0	6.02
7.00	Total Medicare program liability (see instructions)		2,290,676		142	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: 14-0210 | Component CCN: 14-U210 | Period: From 07/01/2016 To 06/30/2017 | Worksheet E-1 Part I | Date/Time Prepared: 11/29/2017 1:19 pm

Title XVIII | Swing Beds - SNF | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		20,580		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)		20,580		0	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		20,580		0	7.00

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

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS	Provider CCN: 14-0210 Component CCN: 14-U210	Period: From 07/01/2016 To 06/30/2017	Worksheet E-2 Date/Time Prepared: 11/29/2017 1:19 pm
	Title XVIII	Swing Beds - SNF	PPS

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	21,000	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)			2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202, for Part B) (For CAH, see instructions)			3.00
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)		0.00	4.00
5.00	Program days	62	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)		0	6.00
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	21,000	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	21,000	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0	0	11.00
12.00	Subtotal (line 10 minus line 11)	21,000	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	0	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)	21,000	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	0	16.50
16.55	410A RURAL DEMONSTRATION PROJECT	0		16.55
17.00	Allowable bad debts (see instructions)	0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (see instructions)	21,000	0	19.00
19.01	Sequestration adjustment (see instructions)	420	0	19.01
20.00	Interim payments	20,580	0	20.00
21.00	Tentative settlement (for contractor use only)	0	0	21.00
22.00	Balance due provider/program (line 19 minus lines 19.01, 20, and 21)	0	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	23.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0210 Component CCN: 14-S210	Period: From 07/01/2016 To 06/30/2017	Worksheet E-3 Part II Date/Time Prepared: 11/29/2017 1:19 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)	2,576,676	1.00
2.00	Net IPF PPS Outlier Payments	0	2.00
3.00	Net IPF PPS ECT Payments	872	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)	26.619178	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)	2,577,548	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)	2,577,548	16.00
17.00	Primary payer payments	0	17.00
18.00	Subtotal (line 16 less line 17).	2,577,548	18.00
19.00	Deductibles	246,016	19.00
20.00	Subtotal (line 18 minus line 19)	2,331,532	20.00
21.00	Coinsurance	105,623	21.00
22.00	Subtotal (line 20 minus line 21)	2,225,909	22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	171,562	23.00
24.00	Adjusted reimbursable bad debts (see instructions)	111,515	24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	171,562	25.00
26.00	Subtotal (sum of lines 22 and 24)	2,337,424	26.00
27.00	Direct graduate medical education payments (from Wkst. E-4, line 49)	0	27.00
28.00	Other pass through costs (see instructions)	0	28.00
29.00	Outlier payments reconciliation	0	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	30.50
30.99	Recovery of Accelerated Depreciation	0	30.99
31.00	Total amount payable to the provider (see instructions)	2,337,424	31.00
31.01	Sequestration adjustment (see instructions)	46,748	31.01
32.00	Interim payments	2,305,702	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)	-15,026	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	35.00
	TO BE COMPLETED BY CONTRACTOR		
50.00	Original outlier amount from Worksheet E-3, Part II, line 2	0	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)	0	51.00
52.00	The rate used to calculate the Time Value of Money	0.00	52.00
53.00	Time Value of Money (see instructions)	0	53.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 14-0210 | Period: From 07/01/2016 To 06/30/2017 | Worksheet G | Date/Time Prepared: 11/29/2017 1:19 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	1,315,373	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	12,374,219	0	0	0	4.00
5.00	Other receivable	3,552,525	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	1,369,511	0	0	0	7.00
8.00	Prepaid expenses	928,290	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)	19,539,918	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	810,438	0	0	0	12.00
13.00	Land improvements	851,102	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	24,950,101	0	0	0	15.00
16.00	Accumulated depreciation	0	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	14,168,767	0	0	0	23.00
24.00	Accumulated depreciation	0	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	1,032,011	0	0	0	27.00
28.00	Accumulated depreciation	-23,419,739	0	0	0	28.00
29.00	Minor equipment-nondepreciable	5,106,287	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	23,498,967	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	2,619,843	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	-180,274	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	2,439,569	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	45,478,454	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	2,330,168	0	0	0	37.00
38.00	Salaries, wages, and fees payable	2,060,425	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	412,987	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	753,230	0	0	0	43.00
44.00	Other current liabilities	760,704	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	6,317,514	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	13,316,856	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	13,316,856	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	19,634,370	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	25,844,084				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)	25,844,084	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	45,478,454	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 14-0210 | Period: From 07/01/2016 To 06/30/2017 | Worksheet G-1 | Date/Time Prepared: 11/29/2017 1:19 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		25,302,604		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		541,480				2.00
3.00	Total (sum of line 1 and line 2)		25,844,084		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)		25,844,084		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)		25,844,084		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: 14-0210 | Period: From 07/01/2016 To 06/30/2017 | Worksheet G-2 Parts I & II Date/Time Prepared: 11/29/2017 1:19 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	4,929,247		4,929,247	1.00
2.00	SUBPROVIDER - IPF	12,287,184		12,287,184	2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	40,280		40,280	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	17,256,711		17,256,711	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	17,256,711		17,256,711	17.00
18.00	Ancillary services	24,619,858	83,352,344	107,972,202	18.00
19.00	Outpatient services	1,739,609	12,624,094	14,363,703	19.00
20.00	RHC I	0	3,128,077	3,128,077	20.00
20.01	RHC II	0	341,360	341,360	20.01
20.02	RHC III	0	350,902	350,902	20.02
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		863,521	863,521	22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PROFESSIONAL FEES	1,997,562	8,587,459	10,585,021	27.00
27.01	PHYSICIANS' PRIVATE OFFICES	0	5,219,143	5,219,143	27.01
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	45,613,740	114,466,900	160,080,640	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		57,786,553		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	ELIMINATION ENTRY	50,000			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)		50,000		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		57,736,553		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 14-0210 | Period: From 07/01/2016 To 06/30/2017 | Worksheet G-3 | Date/Time Prepared: 11/29/2017 1:19 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	160,080,640	1.00
2.00	Less contractual allowances and discounts on patients' accounts	102,202,558	2.00
3.00	Net patient revenues (line 1 minus line 2)	57,878,082	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	57,736,553	4.00
5.00	Net income from service to patients (line 3 minus line 4)	141,529	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	51,927	6.00
7.00	Income from investments	-26,163	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	5,196	9.00
10.00	Purchase discounts	4,435	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	112,171	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	359	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	114,408	22.00
23.00	Governmental appropriations	0	23.00
24.00	MISCELLANEOUS INCOME	55,726	24.00
24.01	UNREALIZED GAIN ON INVESTMENTS	232,739	24.01
25.00	Total other income (sum of lines 6-24)	550,798	25.00
26.00	Total (line 5 plus line 25)	692,327	26.00
27.00	UNDISTRIBUTED LOSS OF SUBSIDIARY	118,344	27.00
27.01	LOSS ON DISPOSAL OF ASSETS	32,503	27.01
28.00	Total other expenses (sum of line 27 and subscripts)	150,847	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	541,480	29.00

ANALYSIS OF HOSPITAL-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 14-0210 | HHA CCN: 14-7419 | Period: From 07/01/2016 To 06/30/2017 | Worksheet H | Date/Time Prepared: 11/29/2017 1:19 pm

Home Health Agency I | PPS

		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	108,472	0	0	4,961	16,302	129,735	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	250,671	0	26,801	0	0	277,472	6.00
7.00	Physical Therapy	110,210	0	18,657	0	0	128,867	7.00
8.00	Occupational Therapy	5,342	0	1,146	0	0	6,488	8.00
9.00	Speech Pathology	2,441	0	264	0	0	2,705	9.00
10.00	Medical Social Services	0	0	0	0	0	0	10.00
11.00	Home Health Aide	0	0	0	0	0	0	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)	477,136	0	46,868	4,961	16,302	545,267	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	-54,802	74,933	0	74,933			5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	277,472	0	277,472			6.00
7.00	Physical Therapy	0	128,867	0	128,867			7.00
8.00	Occupational Therapy	0	6,488	0	6,488			8.00
9.00	Speech Pathology	0	2,705	0	2,705			9.00
10.00	Medical Social Services	0	0	0	0			10.00
11.00	Home Health Aide	0	0	0	0			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)	-54,802	490,465	0	490,465			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: 14-0210 | HHA CCN: 14-7419 | Period: From 07/01/2016 To 06/30/2017 | Worksheet H-1 Part I | Date/Time Prepared: 11/29/2017 1:19 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	74,933	0	0	0	0	74,933	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	277,472	0	0	0	0	277,472	6.00
7.00	Physical Therapy	128,867	0	0	0	0	128,867	7.00
8.00	Occupational Therapy	6,488	0	0	0	0	6,488	8.00
9.00	Speech Pathology	2,705	0	0	0	0	2,705	9.00
10.00	Medical Social Services	0	0	0	0	0	0	10.00
11.00	Home Health Aide	0	0	0	0	0	0	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)	490,465	0	0	0	0	490,465	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	74,933			5.00
	HHA REIMBURSABLE SERVICES				
6.00	Skilled Nursing Care	50,036	327,508		6.00
7.00	Physical Therapy	23,239	152,106		7.00
8.00	Occupational Therapy	1,170	7,658		8.00
9.00	Speech Pathology	488	3,193		9.00
10.00	Medical Social Services	0	0		10.00
11.00	Home Health Aide	0	0		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)		490,465		24.00

COST ALLOCATION - HHA STATISTICAL BASIS | Provider CCN: 14-0210 | HHA CCN: 14-7419 | Period: From 07/01/2016 To 06/30/2017 | Worksheet H-1 Part II | Date/Time Prepared: 11/29/2017 1:19 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	-74,933	415,532	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	0	277,472	6.00
7.00	Physical Therapy	0	0	0	0	0	128,867	7.00
8.00	Occupational Therapy	0	0	0	0	0	6,488	8.00
9.00	Speech Pathology	0	0	0	0	0	2,705	9.00
10.00	Medical Social Services	0	0	0	0	0	0	10.00
11.00	Home Health Aide	0	0	0	0	0	0	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	-74,933	415,532	24.00
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0	0		74,933	25.00
26.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000		0.180330	26.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 14-0210 | HHA CCN: 14-7419 | Period: From 07/01/2016 To 06/30/2017 | Worksheet H-2 Part I | Date/Time Prepared: 11/29/2017 1:19 pm

Home Health Agency I | PPS

	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	0	6,592	19,606	26,198	5,669	1.00
2.00	Skilled Nursing Care	327,508	0	0	91,572	419,080	90,687	2.00
3.00	Physical Therapy	152,106	0	0	40,260	192,366	41,627	3.00
4.00	Occupational Therapy	7,658	0	0	1,951	9,609	2,079	4.00
5.00	Speech Pathology	3,193	0	0	892	4,085	884	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)	490,465	0	6,592	154,281	651,338	140,946	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	0	0	33,519	0	332	8,882	1.00
2.00	Skilled Nursing Care	0	0	0	0	5,728	0	2.00
3.00	Physical Therapy	0	0	0	0	2,633	0	3.00
4.00	Occupational Therapy	0	0	0	0	131	0	4.00
5.00	Speech Pathology	0	0	0	0	56	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)	0	0	33,519	0	8,880	8,882	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: 14-0210 | HHA CCN: 14-7419 | Period: From 07/01/2016 To 06/30/2017 | Worksheet H-2 Part I | Date/Time Prepared: 11/29/2017 1:19 pm

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	Cost Center Description	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
		14.00	15.00	16.00	19.00	24.00	25.00	
1.00	Administrative and General	4,520	0	8,536	0	87,656	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	515,495	0	2.00
3.00	Physical Therapy	0	0	0	0	236,626	0	3.00
4.00	Occupational Therapy	0	0	0	0	11,819	0	4.00
5.00	Speech Pathology	0	0	0	0	5,025	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)	4,520	0	8,536	0	856,621	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

	Cost Center Description	Subtotal	Allocated HHA A&G (see Part II)	Total HHA Costs				
		26.00	27.00	28.00				
1.00	Administrative and General	87,656						1.00
2.00	Skilled Nursing Care	515,495	58,763	574,258				2.00
3.00	Physical Therapy	236,626	26,973	263,599				3.00
4.00	Occupational Therapy	11,819	1,347	13,166				4.00
5.00	Speech Pathology	5,025	573	5,598				5.00
6.00	Medical Social Services	0	0	0				6.00
7.00	Home Health Aide	0	0	0				7.00
8.00	Supplies (see instructions)	0	0	0				8.00
9.00	Drugs	0	0	0				9.00
10.00	DME	0	0	0				10.00
11.00	Home Dialysis Aide Services	0	0	0				11.00
12.00	Respiratory Therapy	0	0	0				12.00
13.00	Private Duty Nursing	0	0	0				13.00
14.00	Clinic	0	0	0				14.00
15.00	Health Promotion Activities	0	0	0				15.00
16.00	Day Care Program	0	0	0				16.00
17.00	Home Delivered Meals Program	0	0	0				17.00
18.00	Homemaker Service	0	0	0				18.00
19.00	All Others (specify)	0	0	0				19.00
19.50	Telemedicine	0	0	0				19.50
20.00	Total (sum of lines 1-19) (2)	856,621	87,656	856,621				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.		0.113992					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: 14-0210 HHA CCN: 14-7419

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

Worksheet H-2 Part II Date/Time Prepared: 11/29/2017 1:19 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	0	6,335	53,670	0	26,198	0	1.00
2.00	Skilled Nursing Care	0	0	250,671	0	419,080	0	2.00
3.00	Physical Therapy	0	0	110,210	0	192,366	0	3.00
4.00	Occupational Therapy	0	0	5,342	0	9,609	0	4.00
5.00	Speech Pathology	0	0	2,441	0	4,085	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	6,335	422,334		651,338	0	20.00
21.00	Total cost to be allocated	0	6,592	154,281		140,946	0	21.00
22.00	Unit cost multiplier	0.000000	1.040568	0.365306		0.216395	0.000000	22.00

	Cost Center Description	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (TIME SPENT)	DIETARY (MEALS SERVED)	CAFETERIA (ASSIGNED TIME)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	
		8.00	9.00	10.00	11.00	13.00	14.00	
1.00	Administrative and General	0	80	0	793	21,204	6,385	1.00
2.00	Skilled Nursing Care	0	0	0	13,678	0	0	2.00
3.00	Physical Therapy	0	0	0	6,286	0	0	3.00
4.00	Occupational Therapy	0	0	0	314	0	0	4.00
5.00	Speech Pathology	0	0	0	133	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	80	0	21,204	21,204	6,385	20.00
21.00	Total cost to be allocated	0	33,519	0	8,880	8,882	4,520	21.00
22.00	Unit cost multiplier	0.000000	418.987500	0.000000	0.418789	0.418883	0.707909	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 14-0210
HHA CCN: 14-7419

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

Worksheet H-2 Part II
Date/Time Prepared: 11/29/2017 1:19 pm

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	Cost Center Description	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)			
		15.00	16.00	19.00			
1.00	Administrative and General	0	863,521	0			1.00
2.00	Skilled Nursing Care	0	0	0			2.00
3.00	Physical Therapy	0	0	0			3.00
4.00	Occupational Therapy	0	0	0			4.00
5.00	Speech Pathology	0	0	0			5.00
6.00	Medical Social Services	0	0	0			6.00
7.00	Home Health Aide	0	0	0			7.00
8.00	Supplies (see instructions)	0	0	0			8.00
9.00	Drugs	0	0	0			9.00
10.00	DME	0	0	0			10.00
11.00	Home Dialysis Aide Services	0	0	0			11.00
12.00	Respiratory Therapy	0	0	0			12.00
13.00	Private Duty Nursing	0	0	0			13.00
14.00	Clinic	0	0	0			14.00
15.00	Health Promotion Activities	0	0	0			15.00
16.00	Day Care Program	0	0	0			16.00
17.00	Home Delivered Meals Program	0	0	0			17.00
18.00	Homemaker Service	0	0	0			18.00
19.00	All Others (specify)	0	0	0			19.00
19.50	Telemedicine	0	0	0			19.50
20.00	Total (sum of lines 1-19)	0	863,521	0			20.00
21.00	Total cost to be allocated	0	8,536	0			21.00
22.00	Unit cost multiplier	0.000000	0.009885	0.000000			22.00

APPORTIONMENT OF PATIENT SERVICE COSTS | Provider CCN: 14-0210 | HHA CCN: 14-7419 | Period: From 07/01/2016 To 06/30/2017 | Worksheet H-3 Part I | Date/Time Prepared: 11/29/2017 1:19 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	574,258		574,258	2,129	269.73	1.00
2.00	Physical Therapy	3.00	263,599	0	263,599	1,482	177.87	2.00
3.00	Occupational Therapy	4.00	13,166	0	13,166	91	144.68	3.00
4.00	Speech Pathology	5.00	5,598	0	5,598	21	266.57	4.00
5.00	Medical Social Services	6.00	0		0	0	0.00	5.00
6.00	Home Health Aide	7.00	0		0	0	0.00	6.00
7.00	Total (sum of lines 1-6)		856,621	0	856,621	3,723		7.00

	Cost Center Description	Cost Limits	CBSA No. (1)	Part A	Program Visits Part B Not Subject to Deductibles & Coinsurance	Part B Subject to Deductibles		
		0	1.00	2.00	3.00	4.00	5.00	
	Limitation Cost Computation							
8.00	Skilled Nursing Care		99914	0	949			8.00
9.00	Physical Therapy		99914	0	891			9.00
10.00	Occupational Therapy		99914	0	65			10.00
11.00	Speech Pathology		99914	0	19			11.00
12.00	Medical Social Services		99914	0	0			12.00
13.00	Home Health Aide		99914	0	0			13.00
14.00	Total (sum of lines 8-13)			0	1,924			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	14,530	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	Part B Not Subject to Deductibles & Coinsurance	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	949		0	255,974		1.00
2.00	Physical Therapy	0	891		0	158,482		2.00
3.00	Occupational Therapy	0	65		0	9,404		3.00
4.00	Speech Pathology	0	19		0	5,065		4.00
5.00	Medical Social Services	0	0		0	0		5.00
6.00	Home Health Aide	0	0		0	0		6.00
7.00	Total (sum of lines 1-6)	0	1,924		0	428,925		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: 14-0210 HHA CCN: 14-7419 | Period: From 07/01/2016 To 06/30/2017 | Worksheet H-3 Part I Date/Time Prepared: 11/29/2017 1:19 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	15,164	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	255,974	1.00
2.00	Physical Therapy	158,482	2.00
3.00	Occupational Therapy	9,404	3.00
4.00	Speech Pathology	5,065	4.00
5.00	Medical Social Services	0	5.00
6.00	Home Health Aide	0	6.00
7.00	Total (sum of lines 1-6)	428,925	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: 14-0210 | HHA CCN: 14-7419 | Period: From 07/01/2016 To 06/30/2017 | Worksheet H-3 Part II | Date/Time Prepared: 11/29/2017 1:19 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	0.409606	0	0	col. 2, line 2.00		1.00
2.00	Occupational Therapy	67.00	0.320792	0	0	col. 2, line 3.00		2.00
3.00	Speech Pathology	68.00	0.621466	0	0	col. 2, line 4.00		3.00
4.00	Cost of Medical Supplies	71.00	0.456397	0	0	col. 2, line 15.00		4.00
5.00	Cost of Drugs	73.00	0.351053	0	0	col. 2, line 16.00		5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT

Provider CCN: 14-0210 | HHA CCN: 14-7419 | Period: From 07/01/2016 To 06/30/2017 | Worksheet H-4 Part I-II | Date/Time Prepared: 11/29/2017 1:19 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	375,812	11.00
12.00	Total PPS Reimbursement - Full Episodes with Outliers	0	0	12.00
13.00	Total PPS Reimbursement - LUPA Episodes	0	13,228	13.00
14.00	Total PPS Reimbursement - PEP Episodes	0	2,881	14.00
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers	0	0	15.00
16.00	Total PPS Outlier Reimbursement - PEP Episodes	0	0	16.00
17.00	Total Other Payments	0	0	17.00
18.00	DME Payments	0	0	18.00
19.00	Oxygen Payments	0	0	19.00
20.00	Prosthetic and Orthotic Payments	0	0	20.00
21.00	Part B deductibles billed to Medicare patients (exclude coinsurance)		0	21.00
22.00	Subtotal (sum of lines 10 thru 20 minus line 21)	0	391,921	22.00
23.00	Excess reasonable cost (from line 8)	0	0	23.00
24.00	Subtotal (line 22 minus line 23)	0	391,921	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	391,921	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	391,921	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	391,921	31.00
31.01	Sequestration adjustment (see instructions)	0	0	31.01
32.00	Interim payments (see instructions)	0	391,921	32.00
33.00	Tentative settlement (for contractor use only)	0	0	33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 32, and 33)	0	0	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	35.00

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

Provider CCN: 14-0210 | HHA CCN: 14-7419 | Period: From 07/01/2016 To 06/30/2017 | Worksheet H-5 | Date/Time Prepared: 11/29/2017 1:19 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		391,921	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		391,921	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01			0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50			0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		0		391,921	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 14-0210	Period: From 07/01/2016 To 06/30/2017	Worksheet L Parts I-III Date/Time Prepared: 11/29/2017 1:19 pm
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		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	473,519	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	0	2.00
2.01	Model 4 BPCI Capital DRG outlier payments	0	2.01
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)	12.91	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)	473,519	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: 14-0210 | Component CCN: 14-3473 | Period: From 07/01/2016 To 06/30/2017 | Worksheet M-1 | Date/Time Prepared: 11/29/2017 1:19 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	422,527	0	422,527	0	422,527	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	437,794	0	437,794	0	437,794	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	226,673	0	226,673	0	226,673	5.00
6.00	Clinical Psychologist	179,882	0	179,882	0	179,882	6.00
7.00	Clinical Social Worker	59,536	0	59,536	0	59,536	7.00
8.00	Laboratory Technician	33,741	0	33,741	-33,741	0	8.00
9.00	Other Facility Health Care Staff Costs	57,129	0	57,129	0	57,129	9.00
10.00	Subtotal (sum of lines 1 through 9)	1,417,282	0	1,417,282	-33,741	1,383,541	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	94,244	94,244	0	94,244	15.00
16.00	Transportation (Health Care Staff)	0	6,185	6,185	0	6,185	16.00
17.00	Depreciation-Medical Equipment	0	0	0	152,680	152,680	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	100,429	100,429	152,680	253,109	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	1,417,282	100,429	1,517,711	118,939	1,636,650	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	93,690	93,690	0	93,690	29.00
30.00	Administrative Costs	301,907	102,906	404,813	0	404,813	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	301,907	196,596	498,503	0	498,503	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	1,719,189	297,025	2,016,214	118,939	2,135,153	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-0210 | Component CCN: 14-3473 | Period: From 07/01/2016 To 06/30/2017 | Worksheet M-1 | Date/Time Prepared: 11/29/2017 1:19 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	422,527		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	437,794		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	226,673		5.00
6.00	Clinical Psychologist	0	179,882		6.00
7.00	Clinical Social Worker	0	59,536		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	57,129		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	1,383,541		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	94,244		15.00
16.00	Transportation (Health Care Staff)	0	6,185		16.00
17.00	Depreciation-Medical Equipment	0	152,680		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	253,109		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	1,636,650		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	93,690		29.00
30.00	Administrative Costs	-18,337	386,476		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-18,337	480,166		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-18,337	2,116,816		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-0210 | Component CCN: 14-8518 | Period: From 07/01/2016 To 06/30/2017 | Worksheet M-1 | Date/Time Prepared: 11/29/2017 1:19 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	36,646	0	36,646	0	36,646	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	100,220	0	100,220	0	100,220	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	43,352	0	43,352	0	43,352	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	180,218	0	180,218	0	180,218	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	14,118	14,118	0	14,118	15.00
16.00	Transportation (Health Care Staff)	0	3,526	3,526	0	3,526	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	17,644	17,644	0	17,644	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	180,218	17,644	197,862	0	197,862	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	35,698	35,698	0	35,698	29.00
30.00	Administrative Costs	24,110	12,835	36,945	0	36,945	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	24,110	48,533	72,643	0	72,643	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	204,328	66,177	270,505	0	270,505	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-0210 | Component CCN: 14-8518 | Period: From 07/01/2016 To 06/30/2017 | Worksheet M-1 | Date/Time Prepared: 11/29/2017 1:19 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	36,646		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	100,220		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	43,352		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	0		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	180,218		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	14,118		15.00
16.00	Transportation (Health Care Staff)	0	3,526		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	17,644		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	197,862		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	35,698		29.00
30.00	Administrative Costs	0	36,945		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	72,643		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	270,505		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-0210 | Component CCN: 14-8560 | Period: From 07/01/2016 To 06/30/2017 | Worksheet M-1 | Date/Time Prepared: 11/29/2017 1:19 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	24,188	0	24,188	0	24,188	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	143,355	0	143,355	0	143,355	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	33,521	0	33,521	0	33,521	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	201,064	0	201,064	0	201,064	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	14,034	14,034	0	14,034	15.00
16.00	Transportation (Health Care Staff)	0	2,348	2,348	0	2,348	16.00
17.00	Depreciation-Medical Equipment	0	0	0	4,536	4,536	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	16,382	16,382	4,536	20,918	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	201,064	16,382	217,446	4,536	221,982	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	29,134	29,134	0	29,134	29.00
30.00	Administrative Costs	32,160	20,987	53,147	0	53,147	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	32,160	50,121	82,281	0	82,281	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	233,224	66,503	299,727	4,536	304,263	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-0210 | Component CCN: 14-8560 | Period: From 07/01/2016 To 06/30/2017 | Worksheet M-1 | Date/Time Prepared: 11/29/2017 1:19 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	24,188		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	143,355		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	33,521		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	0		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	201,064		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	14,034		15.00
16.00	Transportation (Health Care Staff)	0	2,348		16.00
17.00	Depreciation-Medical Equipment	0	4,536		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	20,918		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	221,982		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	29,134		29.00
30.00	Administrative Costs	0	53,147		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	82,281		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	304,263		32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-0210 | Component CCN: 14-3473 | Period: From 07/01/2016 To 06/30/2017 | Worksheet M-2 | Date/Time Prepared: 11/29/2017 1:19 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	1.60	5,829	4,200	6,720		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	2.45	10,102	2,100	5,145		3.00
4.00	Subtotal (sum of lines 1 through 3)	4.05	15,931		11,865	15,931	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	1.82	1,825			1,825	6.00
7.00	Clinical Social Worker	0.96	1,152			1,152	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)	6.83	18,908			18,908	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)					1,636,650	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)					1,636,650	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)					480,166	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					1,459,842	15.00
16.00	Total overhead (sum of lines 14 and 15)					1,940,008	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					1,940,008	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					1,940,008	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					3,576,658	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-0210 | Component CCN: 14-8518 | Period: From 07/01/2016 To 06/30/2017 | Worksheet M-2 | Date/Time Prepared: 11/29/2017 1:19 pm

RHC II | 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	0.10	289	4,200	420		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	0.80	2,063	2,100	1,680		3.00
4.00	Subtotal (sum of lines 1 through 3)	0.90	2,352		2,100	2,352	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)	0.90	2,352			2,352	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)					197,862	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)					197,862	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)					72,643	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					187,287	15.00
16.00	Total overhead (sum of lines 14 and 15)					259,930	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					259,930	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					259,930	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					457,792	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-0210 | Component CCN: 14-8560 | Period: From 07/01/2016 To 06/30/2017 | Worksheet M-2 | Date/Time Prepared: 11/29/2017 1:19 pm

RHC III | 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	0.01	0	4,200	42		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	0.80	2,251	2,100	1,680		3.00
4.00	Subtotal (sum of lines 1 through 3)	0.81	2,251		1,722	2,251	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)	0.81	2,251			2,251	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)					221,982	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)					221,982	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)					82,281	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					202,250	15.00
16.00	Total overhead (sum of lines 14 and 15)					284,531	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					284,531	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					284,531	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					506,513	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 14-0210 Component CCN: 14-3473	Period: From 07/01/2016 To 06/30/2017	Worksheet M-3 Date/Time Prepared: 11/29/2017 1:19 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)		3,576,658	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)		28,455	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		3,548,203	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		18,908	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)		18,908	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		187.66	7.00
		Calculation of Limit (1)		
		Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	0.00	0.00	8.00
9.00	Rate for Program covered visits (see instructions)	187.66	187.66	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	1,037	3,182	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	194,603	597,134	11.00
12.00	Program covered visits for mental health services (from contractor records)	126	274	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	23,645	51,419	13.00
14.00	Limit adjustment for mental health services (see instructions)	23,645	51,419	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	866,801	16.00
16.01	Total program charges (see instructions)(from contractor's records)		764,060	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		2,549	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		2,892	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.)		645,051	16.04
16.05	Total program cost (see instructions)	0	647,943	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		57,595	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		140,783	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		647,943	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		27,524	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		675,467	22.00
23.00	Allowable bad debts (see instructions)		52,796	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		34,317	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		52,796	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)		709,784	26.00
26.01	Sequestration adjustment (see instructions)		14,196	26.01
27.00	Interim payments		612,772	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)		82,816	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: 14-0210 Component CCN: 14-8518	Period: From 07/01/2016 To 06/30/2017	Worksheet M-3 Date/Time Prepared: 11/29/2017 1:19 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)		457,792	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)		3,248	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		454,544	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		2,352	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)		2,352	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		193.26	7.00

		Calculation of Limit (1)		
		Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	0.00	0.00	8.00
9.00	Rate for Program covered visits (see instructions)	193.26	193.26	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	116	311	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	22,418	60,104	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	82,522	16.00
16.01	Total program charges (see instructions)(from contractor's records)		64,467	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.)		60,954	16.04
16.05	Total program cost (see instructions)	0	60,954	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		6,330	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		11,627	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		60,954	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		3,248	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		64,202	22.00
23.00	Allowable bad debts (see instructions)		6,751	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		4,388	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		6,751	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)		68,590	26.00
26.01	Sequestration adjustment (see instructions)		1,372	26.01
27.00	Interim payments		52,813	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)		14,405	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: 14-0210 Component CCN: 14-8560	Period: From 07/01/2016 To 06/30/2017	Worksheet M-3 Date/Time Prepared: 11/29/2017 1:19 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)	506,513	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)	5,166	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)	501,347	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)	2,251	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)	2,251	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)	222.72	7.00

		Calculation of Limit (1)		
		Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	0.00	0.00	8.00
9.00	Rate for Program covered visits (see instructions)	222.72	222.72	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	81	281	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	18,040	62,584	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	80,624	16.00
16.01	Total program charges (see instructions)(from contractor's records)		48,170	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		563	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		942	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.)		60,310	16.04
16.05	Total program cost (see instructions)	0	61,252	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		4,295	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		8,662	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		61,252	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		5,166	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		66,418	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)		66,418	26.00
26.01	Sequestration adjustment (see instructions)		1,328	26.01
27.00	Interim payments		17,476	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)		47,614	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: 14-0210 | Component CCN: 14-3473 | Period: From 07/01/2016 To 06/30/2017 | Worksheet M-4 | Date/Time Prepared: 11/29/2017 1:19 pm

Title XVIII | RHC I | Cost

		Pneumococcal	Influenza	
		1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	1,383,541	1,383,541	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000196	0.000618	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	271	855	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	8,505	3,390	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	8,776	4,245	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	1,636,650	1,636,650	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	1,940,008	1,940,008	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.005362	0.002594	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	10,402	5,032	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	19,178	9,277	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	65	205	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	295.05	45.25	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	62	204	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	18,293	9,231	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)		28,455	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)		27,524	16.00

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

Provider CCN: 14-0210 | Component CCN: 14-8518 | Period: From 07/01/2016 To 06/30/2017 | Worksheet M-4 | Date/Time Prepared: 11/29/2017 1:19 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)	180,218	180,218	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000110	0.000510	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	20	92	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	810	482	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	830	574	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	197,862	197,862	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	259,930	259,930	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.004195	0.002901	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	1,090	754	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	1,920	1,328	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	6	29	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	320.00	45.79	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	6	29	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	1,920	1,328	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)		3,248	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)		3,248	16.00

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

Provider CCN: 14-0210 | Component CCN: 14-8560 | Period: From 07/01/2016 To 06/30/2017 | Worksheet M-4 | Date/Time Prepared: 11/29/2017 1:19 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)	201,064	201,064	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000180	0.000490	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	36	99	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	1,047	1,082	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	1,083	1,181	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	221,982	221,982	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	284,531	284,531	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.004879	0.005320	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	1,388	1,514	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	2,471	2,695	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	11	30	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	224.64	89.83	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	11	30	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	2,471	2,695	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)		5,166	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)		5,166	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 14-0210 Component CCN: 14-3473	Period: From 07/01/2016 To 06/30/2017	Worksheet M-5 Date/Time Prepared: 11/29/2017 1:19 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		612,772	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)		612,772	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		82,816	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		695,588	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: 14-0210 Component CCN: 14-8518	Period: From 07/01/2016 To 06/30/2017	Worksheet M-5 Date/Time Prepared: 11/29/2017 1:19 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		52,813	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)		52,813	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		14,405	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		67,218	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: 14-0210 Component CCN: 14-8560	Period: From 07/01/2016 To 06/30/2017	Worksheet M-5 Date/Time Prepared: 11/29/2017 1:19 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		17,476	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)		17,476	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		47,614	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		65,090	7.00

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