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: 14-1327	Period: From 01/01/2017 To 12/31/2017	Worksheet S Parts I-III Date/Time Prepared: 5/29/2018 6:58 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 5/29/2018 Time: 6:58 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 CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by WABASH GENERAL HOSPITAL (14-1327) for the cost reporting period beginning 01/01/2017 and ending 12/31/2017 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

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

_____
Title

_____
Date

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	157,493	332,725	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	-125,480	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
10.00	RURAL HEALTH CLINIC I	0		-2,757		0	10.00
10.01	WABASH PRIMARY CARE-CHESTNUT II	0		19,466		0	10.01
10.02	WABASH PRIMARY CARE-COLLEGE DR. III	0		170,400		0	10.02
200.00	Total	0	32,013	519,834	0	0	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1327 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-2 Part I Date/Time Prepared: 5/24/2018 4:25 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 1418 COLLEGE DRIVE	PO Box:			1.00
2.00	City: MT. CARMEL	State: IL	Zip Code: 62863-	County: WABASH	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	WABASH GENERAL HOSPITAL	141327	99914	1	06/01/2003	N	O	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	WABASH GENERAL HOSPITAL SWING BEDS	14Z327	14999		06/01/2003	N	O	N	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC	WABASH GENERAL RHC	148501	14999		04/01/2009	N	O	N	15.00
15.01	Hospital-Based Health Clinic - RHC II	WABASH PRIMARY CARE	148568	14999		08/09/2016	N	O	N	15.01
15.02	Hospital-Based Health Clinic - RHC III	WABASH PRIMARY CARE - COLLEGE DR	148579	14999		10/01/2017	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)	01/01/2017	12/31/2017	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.	N	N	22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	N	N	22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N	22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.	N	N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	2	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.	0	0	0	0	0	0	24.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1327 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-2 Part I | Date/Time Prepared: 5/24/2018 4:25 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.	0		35.00

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

		Y/N	Y/N	
		1.00	2.00	
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i) or (ii)? Enter in column 1 “Y” for yes or “N” for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i) or (ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	N	N	39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	N	N	40.00

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

		NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code	
		1.00	2.00	3.00	
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under §413.85? (see instructions)	N			60.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1327 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-2 Part I Date/Time Prepared: 5/24/2018 4:25 pm

		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						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)						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).						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)						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)						61.06

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1327 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-2 Part I Date/Time Prepared: 5/24/2018 4:25 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.	N			70.00
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 14-1327	Period: From 01/01/2017 To 12/31/2017	Worksheet S-2 Part I Date/Time Prepared: 5/24/2018 4:25 pm

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

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

		V	XIX	
		1.00	2.00	
	Title V and XIX Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.06
	Rural Providers			
105.00	Does this hospital qualify as a CAH?	Y		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	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.	Y		108.00

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		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 Demonstration)for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.	N	110.00

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

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

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	187,101	0	0	118.01

		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	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 healthcare related taxes as defined in §1903(w)(3) of the Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N		122.00
	Transplant Center Information			
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 14-1327	Period: From 01/01/2017 To 12/31/2017	Worksheet S-2 Part I Date/Time Prepared: 5/24/2018 4:25 pm

		1.00	2.00	
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y		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.			145.00
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N		146.00

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

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

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

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

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

		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	01/01/2017	12/31/2017	170.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 14-1327	Period: From 01/01/2017 To 12/31/2017	Worksheet S-2 Part I Date/Time Prepared: 5/24/2018 4:25 pm

		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: 14-1327 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-2 Part II | Date/Time Prepared: 5/24/2018 4:25 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	C		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00

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

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

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	Y	03/15/2018	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)	N		Y	03/15/2018	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: 14-1327 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-2 Part II | Date/Time Prepared: 5/24/2018 4:25 pm

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

		1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)		
	Capital Related Cost		
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions	N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.	N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions	N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.	N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.	N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.	N	27.00
	Interest Expense		
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.	N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions	N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.	N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.	N	31.00
	Purchased Services		
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.	N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.	N	33.00
	Provider-Based Physicians		
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.	Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.	N	35.00

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

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	SHAWN	ADAMS	41.00
42.00	Enter the employer/company name of the cost report preparer.	ALLIANT MANAGEMENT SERVICES		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	5029923508	SADAMS@BLUEANDCO.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 14-1327	Period: From 01/01/2017 To 12/31/2017	Worksheet S-2 Part II Date/Time Prepared: 5/24/2018 4:25 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.	MANAGER		41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 14-1327 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-3 Part I | Date/Time Prepared: 5/24/2018 4:25 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	21	7,665	54,528.00	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)		21	7,665	54,528.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	4	1,460	1,584.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)		25	9,125	56,112.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						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						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	RURAL HEALTH CLINIC	88.00				0	26.00
26.01	WABASH PRIMARY CARE-CHESTNUT	88.01				0	26.01
26.02	WABASH PRIMARY CARE-COLLEGE DR.	88.02				0	26.02
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		25				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00
33.01	LTCH site neutral days and discharges						33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 14-1327 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-3 Part I | Date/Time Prepared: 5/24/2018 4:25 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)	1,372	144	2,272			1.00
2.00	HMO and other (see instructions)	96	0				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	191	0	191			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		37	37			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,563	181	2,500			7.00
8.00	INTENSIVE CARE UNIT	16	32	66			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)	1,579	213	2,566	0.00	254.68	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						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						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	RURAL HEALTH CLINIC	251	0	4,418	0.00	1.21	26.00
26.01	WABASH PRIMARY CARE-CHESTNUT	2,677	0	9,340	0.00	20.91	26.01
26.02	WABASH PRIMARY CARE-COLLEGE DR.	995	0	2,361	0.00	1.77	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	278.57	27.00
28.00	Observation Bed Days		0	193			28.00
29.00	Ambulance Trips	918					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
33.01	LTCH site neutral days and discharges	0					33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 14-1327 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-3 Part I | Date/Time Prepared: 5/24/2018 4:25 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	456	57	734	1.00
2.00	HMO and other (see instructions)			33	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	456	57	734	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						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						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	RURAL HEALTH CLINIC	0.00					26.00
26.01	WABASH PRIMARY CARE-CHESTNUT	0.00					26.01
26.02	WABASH PRIMARY CARE-COLLEGE DR.	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			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 14-1327 | Component CCN: 14-8501 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-8 | Date/Time Prepared: 5/24/2018 4:25 pm

RHC I | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			1418 COLLEGE DRIVE		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	MT.CARMEL		IL	62863	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
9.01						9.01
9.02						9.02
9.03						9.03
9.04						9.04
9.05						9.05
9.06						9.06
9.07						9.07
9.08						9.08
9.09						9.09
9.10						9.10
				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	10:00	22:00	15:00	21:00	15:00	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

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-1327
Component CCN: 14-8501

Period:
From 01/01/2017
To 12/31/2017

Worksheet S-8

Date/Time Prepared:
5/24/2018 4:25 pm

RHC I

Cost

			County				
			4.00				
2.00	City, State, ZIP Code, County		WABASH				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	21:00	18:00	21:00	18:00	21:00	11.00
		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	CLINIC	15:00	21:00	10:00	22:00		11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 14-1327 | Component CCN: 14-8568 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-8 | Date/Time Prepared: 5/24/2018 4:25 pm

RHC II | Cost

					1.00	
	Clinic Address and Identification					
1.00	Street			1123 CHESTNUT STREET		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	MOUNT CARMEL		IL	62863-1212	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		WABASH				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	18:00	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-1327
Component CCN: 14-8568

Period:
From 01/01/2017
To 12/31/2017

Worksheet S-8
Date/Time Prepared:
5/24/2018 4:25 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: 14-1327 | Component CCN: 14-8579 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-8 | Date/Time Prepared: 5/24/2018 4:25 pm

RHC III | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			1418 COLLEGE DR		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	MOUNT CARMEL		IL	62863	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?	Y	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		WABASH				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: 14-1327
Component CCN: 14-8579

Period:
From 01/01/2017
To 12/31/2017

Worksheet S-8
Date/Time Prepared:
5/24/2018 4:25 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: 14-1327 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-10 | Date/Time Prepared: 5/24/2018 4:25 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)	0.389906	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	4,182,652	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?	Y	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	15,154,010	6.00
7.00	Medicaid cost (line 1 times line 6)	5,908,639	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)	1,725,987	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)	1,725,987	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)	103,740	0	103,740	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	40,449	0	40,449	21.00
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	40,449	0	40,449	23.00

		1.00	
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	2,001,523	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	180,813	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	278,174	27.01
28.00	Non-Medicare bad debt expense (see instructions)	1,723,349	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	769,305	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	809,754	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	2,535,741	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-1327 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A | Date/Time Prepared: 5/24/2018 4:25 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	NEW CAP REL COSTS-BLDG & FIXT		929,975	929,975	0	929,975	1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		664,883	664,883	836,812	1,501,695	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	233,688	4,812,579	5,046,267	0	5,046,267	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,155,039	4,333,800	5,488,839	-166,287	5,322,552	5.00
7.00	00700	OPERATION OF PLANT	274,202	1,154,776	1,428,978	17,973	1,446,951	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	141,279	141,279	8.00
9.00	00900	HOUSEKEEPING	271,728	59,879	331,607	0	331,607	9.00
10.00	01000	DIETARY	360,664	250,800	611,464	-455,650	155,814	10.00
11.00	01100	CAFETERIA	0	0	0	454,501	454,501	11.00
13.00	01300	NURSING ADMINISTRATION	252,022	20,815	272,837	0	272,837	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	382,505	65,382	447,887	0	447,887	16.00
17.00	01700	SOCIAL SERVICE	147,420	11,180	158,600	0	158,600	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	790,658	75,019	865,677	-6,321	859,356	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,369,179	946,096	2,315,275	-48,767	2,266,508	30.00
31.00	03100	INTENSIVE CARE UNIT	269,869	3,150	273,019	-1,550	271,469	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	806,899	458,521	1,265,420	-128,440	1,136,980	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	726,866	982,268	1,709,134	-145,652	1,563,482	54.00
60.00	06000	LABORATORY	746,645	792,384	1,539,029	-116,577	1,422,452	60.00
65.00	06500	RESPIRATORY THERAPY	552,932	176,421	729,353	-18,024	711,329	65.00
66.00	06600	PHYSICAL THERAPY	910,987	183,119	1,094,106	-3,439	1,090,667	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	145,751	3,616,026	3,761,777	-2,357,715	1,404,062	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	2,517,958	2,517,958	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	393,170	1,691,759	2,084,929	5,353	2,090,282	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	75,024	169,827	244,851	0	244,851	88.00
88.01	08802	WABASH PRIMARY CARE-CHESTNUT	1,571,962	364,301	1,936,263	0	1,936,263	88.01
88.02	08801	WABASH PRIMARY CARE-COLLEGE DR.	253,590	43,319	296,909	0	296,909	88.02
90.00	09000	CLINIC	229,954	205,438	435,392	-13,609	421,783	90.00
90.01	09001	ORTHOPAEDIC CLINIC	3,526,579	550,557	4,077,136	-62,553	4,014,583	90.01
90.02	09002	SURGICAL CLINIC	507,929	97,273	605,202	-8,812	596,390	90.02
90.03	09003	OP CLINIC	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	897,081	1,266,510	2,163,591	-51,553	2,112,038	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	630,895	132,568	763,463	-32,645	730,818	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		336,563	336,563	-336,563	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	17,483,238	24,395,188	41,878,426	19,719	41,898,145	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	184,965	320,948	505,913	-19,719	486,194	192.00
200.00		TOTAL (SUM OF LINES 118 through 199)	17,668,203	24,716,136	42,384,339	0	42,384,339	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-1327 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A | Date/Time Prepared: 5/24/2018 4:25 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	0	929,975		1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	-223,879	1,277,816		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-440,559	4,605,708		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-248,384	5,074,168		5.00
7.00	00700	OPERATION OF PLANT	0	1,446,951		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	141,279		8.00
9.00	00900	HOUSEKEEPING	0	331,607		9.00
10.00	01000	DIETARY	-8,271	147,543		10.00
11.00	01100	CAFETERIA	-88,821	365,680		11.00
13.00	01300	NURSING ADMINISTRATION	0	272,837		13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-24,942	422,945		16.00
17.00	01700	SOCIAL SERVICE	0	158,600		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	-790,658	68,698		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-839,716	1,426,792		30.00
31.00	03100	INTENSIVE CARE UNIT	0	271,469		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	1,136,980		50.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-3,866	1,559,616		54.00
60.00	06000	LABORATORY	-59,226	1,363,226		60.00
65.00	06500	RESPIRATORY THERAPY	-52,158	659,171		65.00
66.00	06600	PHYSICAL THERAPY	0	1,090,667		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	-1,307	1,402,755		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	2,517,958		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-370	2,089,912		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	244,851		88.00
88.01	08802	WABASH PRIMARY CARE-CHESTNUT	-21,551	1,914,712		88.01
88.02	08801	WABASH PRIMARY CARE-COLLEGE DR.	0	296,909		88.02
90.00	09000	CLINIC	-132,800	288,983		90.00
90.01	09001	ORTHOPAEDIC CLINIC	-2,284,258	1,730,325		90.01
90.02	09002	SURGICAL CLINIC	-434,121	162,269		90.02
90.03	09003	OP CLINIC	0	0		90.03
91.00	09100	EMERGENCY	0	2,112,038		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0	730,818		95.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-5,654,887	36,243,258		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	486,194		192.00
200.00		TOTAL (SUM OF LINES 118 through 199)	-5,654,887	36,729,452		200.00

RECLASSIFICATIONS | Provider CCN: 14-1327 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-6 | Date/Time Prepared: 5/24/2018 4:25 pm

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - RENT					
1.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	343,186		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
	TOTALS		0	343,186		
	B - CAFETERIA					
1.00	CAFETERIA	11.00	268,586	185,915		1.00
	0		268,586	185,915		
	C - IV SOLUTIONS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	6,680		1.00
	0		0	6,680		
	E - INTEREST					
1.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	336,563		1.00
	0		0	336,563		
	F - OXYGEN					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	5,699		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
	0		0	5,699		
	G - MED SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	302,503		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
	0		0	302,503		
	H - UTILITIES					
1.00	OPERATION OF PLANT	7.00	0	17,973		1.00
2.00		0.00	0	0		2.00
	0		0	17,973		
	I - IMPLANTS					
1.00	IMPL. DEV. CHARGED TO PATIENT	72.00	0	2,517,958		1.00
	0		0	2,517,958		
	J - LINEN					
1.00	LAUNDRY & LINEN SERVICE	8.00	0	141,279		1.00
	0		0	141,279		
	L - INSURANCE					
1.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	157,063		1.00
	0		0	157,063		
500.00	Grand Total: Increases		268,586	4,014,819		500.00

RECLASSIFICATIONS | Provider CCN: 14-1327 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-6 | Date/Time Prepared: 5/24/2018 4:25 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - RENT						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	9,224	10		1.00
2.00	DIETARY	10.00	0	1,149	0		2.00
3.00	OPERATING ROOM	50.00	0	34,299	0		3.00
4.00	RADIOLOGY-DIAGNOSTIC	54.00	0	125,407	0		4.00
5.00	LABORATORY	60.00	0	82,049	0		5.00
6.00	RESPIRATORY THERAPY	65.00	0	10,438	0		6.00
7.00	ORTHOPAEDIC CLINIC	90.01	0	45,062	0		7.00
8.00	AMBULANCE SERVICES	95.00	0	25,000	0		8.00
9.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	10,558	0		9.00
	TOTALS		0	343,186			
	B - CAFETERIA						
1.00	DIETARY	10.00	268,586	185,915	0		1.00
	0		268,586	185,915			
	C - IV SOLUTIONS						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	6,680	0		1.00
	0		0	6,680			
	E - INTEREST						
1.00	INTEREST EXPENSE	113.00	0	336,563	9		1.00
	0		0	336,563			
	F - OXYGEN						
1.00	OPERATING ROOM	50.00	0	25	0		1.00
2.00	RESPIRATORY THERAPY	65.00	0	4,950	0		2.00
3.00	AMBULANCE SERVICES	95.00	0	724	0		3.00
	0		0	5,699			
	G - MED SUPPLIES						
1.00	NONPHYSICIAN ANESTHETISTS	19.00	0	6,321	0		1.00
2.00	ADULTS & PEDIATRICS	30.00	0	48,767	0		2.00
3.00	INTENSIVE CARE UNIT	31.00	0	1,550	0		3.00
4.00	OPERATING ROOM	50.00	0	94,116	0		4.00
5.00	RADIOLOGY-DIAGNOSTIC	54.00	0	20,245	0		5.00
6.00	LABORATORY	60.00	0	34,528	0		6.00
7.00	RESPIRATORY THERAPY	65.00	0	2,636	0		7.00
8.00	PHYSICAL THERAPY	66.00	0	3,439	0		8.00
9.00	DRUGS CHARGED TO PATIENTS	73.00	0	1,327	0		9.00
10.00	CLINIC	90.00	0	13,609	0		10.00
11.00	ORTHOPAEDIC CLINIC	90.01	0	17,491	0		11.00
12.00	EMERGENCY	91.00	0	51,553	0		12.00
13.00	AMBULANCE SERVICES	95.00	0	6,921	0		13.00
	0		0	302,503			
	H - UTILITIES						
1.00	SURGICAL CLINIC	90.02	0	8,812	0		1.00
2.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	9,161	0		2.00
	0		0	17,973			
	I - IMPLANTS						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	2,517,958	0		1.00
	0		0	2,517,958			
	J - LINEN						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	141,279	0		1.00
	0		0	141,279			
	L - INSURANCE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	157,063	9		1.00
	0		0	157,063			
500.00	Grand Total: Decreases		268,586	4,014,819			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1327 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-7 Part I | Date/Time Prepared: 5/24/2018 4:25 pm

		Beginning Balances	Acquisitions: Purchases	Acquisitions: Donation	Acquisitions: Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	416,867	50,500	0	50,500	0	1.00
2.00	Land Improvements	1,985,324	9,047	0	9,047	0	2.00
3.00	Buildings and Fixtures	21,023,604	1,986,605	0	1,986,605	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	4,267,351	391,566	0	391,566	0	5.00
6.00	Movable Equipment	13,265,245	588,718	0	588,718	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	40,958,391	3,026,436	0	3,026,436	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	40,958,391	3,026,436	0	3,026,436	0	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	467,367	0	1.00
2.00	Land Improvements	1,994,371	0	2.00
3.00	Buildings and Fixtures	23,010,209	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	4,658,917	0	5.00
6.00	Movable Equipment	13,853,963	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	43,984,827	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	43,984,827	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1327 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-7 Part II | Date/Time Prepared: 5/24/2018 4:25 pm

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	NEW CAP REL COSTS-BLDG & FIXT	929,975	0	0	0	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	664,883	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	1,594,858	0	0	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL			
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)		
		14.00	15.00		
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2				
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	929,975		1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	664,883		2.00
3.00	Total (sum of lines 1-2)	0	1,594,858		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1327 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-7 Part III Date/Time Prepared: 5/24/2018 4:25 pm

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	COMPUTATION OF RATIOS: Capitalized Leases	COMPUTATION OF RATIOS: Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	ALLOCATION OF OTHER CAPITAL: Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	30,130,864	0	30,130,864	0.685029	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	13,853,963	0	13,853,963	0.314971	0	2.00
3.00	Total (sum of lines 1-2)	43,984,827	0	43,984,827	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	ALLOCATION OF OTHER CAPITAL: Other Capital-Related Costs	ALLOCATION OF OTHER CAPITAL: Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	SUMMARY OF CAPITAL: Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	929,975	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	934,630	343,186	2.00
3.00	Total (sum of lines 1-2)	0	0	0	1,864,605	343,186	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	SUMMARY OF CAPITAL: Insurance (see instructions)	SUMMARY OF CAPITAL: Taxes (see instructions)	SUMMARY OF CAPITAL: Other Capital-Related Costs (see instructions)	SUMMARY OF CAPITAL: Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	0	929,975	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	1,277,816	2.00
3.00	Total (sum of lines 1-2)	0	0	0	0	2,207,791	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-1327 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-8 | Date/Time Prepared: 5/24/2018 4:25 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 - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)	B	-239,868	NEW CAP REL COSTS-MVBLE EQUIP	2.00	9	2.00
3.00	Investment income - other (chapter 2)	B	-9,685	ADMINISTRATIVE & GENERAL	5.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-3,804,837			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	-1,308			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-88,821	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients	B	-1,307	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	16.00
17.00	Sale of drugs to other than patients	B	-370	DRUGS CHARGED TO PATIENTS	73.00	0	17.00
18.00	Sale of medical records and abstracts	B	-24,942	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	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 - NEW CAP REL COSTS-BLDG & FIXT		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - NEW CAP REL COSTS-MVBLE EQUIP		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	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	*** Cost Center Deleted ***	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-1327 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-8 | Date/Time Prepared: 5/24/2018 4:25 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	
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	DIETARY	B	-8,271	DIETARY	10.00	0	33.00
34.00	A&G OTHER REVENUE	B	-59,339	ADMINISTRATIVE & GENERAL	5.00	0	34.00
35.00	PHYSICIAN RECRUITMENT	A	-165,551	ADMINISTRATIVE & GENERAL	5.00	0	35.00
36.00	PHYSICIAN RECRUITMENT	A	-141,563	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	36.00
36.01	PUBLIC RELATIONS	A	-159,919	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	36.01
37.00	LOBBYING DUES	A	-13,809	ADMINISTRATIVE & GENERAL	5.00	0	37.00
38.00	CRNA SALARY	A	-790,658	NONPHYSICIAN ANESTHETISTS	19.00	0	38.00
39.00	CRNA EMP BEN	A	-139,077	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	39.00
40.00	BOND INSURANCE	A	15,989	NEW CAP REL COSTS-MVBLE EQUIP	2.00	9	40.00
42.00	DR ANADKAT SALARY OVERPAYMENT	A	-21,551	WABASH PRIMARY CARE-CHESTNUT	88.01	0	42.00
43.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	43.00
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-5,654,887				50.00

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 14-1327 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-8-1 | Date/Time Prepared: 5/24/2018 4:25 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	54.00	RADIOLOGY-DIAGNOSTIC	DSS MRI	249,736	251,044	1.00
2.00	0.00			0	0	2.00
3.00	0.00			0	0	3.00
4.00	0.00			0	0	4.00
5.00	0		0	249,736	251,044	5.00

* The amounts on lines 1-4 (and subscripts as appropriate) are transferred in detail to Worksheet A, column 6, lines as appropriate.Positive amounts increase cost and negative amounts decrease cost.For related organization or home office cost which has not been posted to Worksheet A, columns 1 and/or 2, the amount allowable should be indicated in column 4 of this part.

				Related Organization(s) and/or Home Office		
	Symbol (1)	Name	Percentage of Ownership	Name	Percentage of Ownership	
	1.00	2.00	3.00	4.00	5.00	
	B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:					

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

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

6.00	A	DSS MRI	100.00		0.00	6.00
7.00			0.00		0.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	Provider CCN: 14-1327	Period: From 01/01/2017 To 12/31/2017	Worksheet A-8-1 Date/Time Prepared: 5/24/2018 4:25 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	-1,308	0		1.00
2.00	0	0		2.00
3.00	0	0		3.00
4.00	0	0		4.00
5.00	-1,308			5.00

* The amounts on lines 1-4 (and subscripts as appropriate) are transferred in detail to Worksheet A, column 6, lines as appropriate.Positive amounts increase cost and negative amounts decrease cost.For related organization or home office cost which has not been posted to Worksheet A, columns 1 and/or 2, the amount allowable should be indicated in column 4 of this part.

	Related Organization(s) and/or Home Office		
	Type of Business		
	6.00		
	B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:		

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

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

6.00			6.00
7.00			7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 14-1327 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-8-2 | Date/Time Prepared: 5/24/2018 4:25 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	839,716	839,716	0	0	0	1.00
2.00	54.00	RADIOLOGY-DIAGNOSTIC	2,558	2,558	0	0	0	2.00
3.00	60.00	LABORATORY	59,226	59,226	0	0	0	3.00
4.00	65.00	RESPIRATORY THERAPY	52,158	52,158	0	0	0	4.00
5.00	90.00	CLINIC	132,800	132,800	0	0	0	5.00
6.00	90.01	ORTHOPAEDIC CLINIC	2,284,258	2,284,258	0	0	0	6.00
7.00	90.02	SURGICAL CLINIC	434,121	434,121	0	0	0	7.00
8.00	91.00	EMERGENCY	1,149,000	0	1,149,000	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			4,953,837	3,804,837	1,149,000		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	2.00
3.00	60.00	LABORATORY	0	0	0	0	0	3.00
4.00	65.00	RESPIRATORY THERAPY	0	0	0	0	0	4.00
5.00	90.00	CLINIC	0	0	0	0	0	5.00
6.00	90.01	ORTHOPAEDIC CLINIC	0	0	0	0	0	6.00
7.00	90.02	SURGICAL CLINIC	0	0	0	0	0	7.00
8.00	91.00	EMERGENCY	0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	839,716		1.00
2.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	2,558		2.00
3.00	60.00	LABORATORY	0	0	0	59,226		3.00
4.00	65.00	RESPIRATORY THERAPY	0	0	0	52,158		4.00
5.00	90.00	CLINIC	0	0	0	132,800		5.00
6.00	90.01	ORTHOPAEDIC CLINIC	0	0	0	2,284,258		6.00
7.00	90.02	SURGICAL CLINIC	0	0	0	434,121		7.00
8.00	91.00	EMERGENCY	0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	3,804,837		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1327 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part I Date/Time Prepared: 5/24/2018 4:25 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS NEW BLDG & FIXT	CAPITAL RELATED COSTS NEW MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	929,975	929,975				1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	1,277,816		1,277,816			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4,605,708	4,407	6,055	4,616,170		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5,074,168	60,180	82,689	305,822	5,522,859	5.00
7.00	00700	OPERATION OF PLANT	1,446,951	35,722	49,084	72,601	1,604,358	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	141,279	0	0	0	141,279	8.00
9.00	00900	HOUSEKEEPING	331,607	3,500	4,809	71,946	411,862	9.00
10.00	01000	DIETARY	147,543	27,334	37,558	24,380	236,815	10.00
11.00	01100	CAFETERIA	365,680	10,996	15,109	71,114	462,899	11.00
13.00	01300	NURSING ADMINISTRATION	272,837	2,069	2,843	66,728	344,477	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	422,945	12,087	16,608	101,277	552,917	16.00
17.00	01700	SOCIAL SERVICE	158,600	2,522	3,466	39,033	203,621	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	68,698	0	0	209,344	278,042	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,426,792	111,829	153,657	362,520	2,054,798	30.00
31.00	03100	INTENSIVE CARE UNIT	271,469	11,293	15,518	71,454	369,734	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,136,980	175,144	240,647	213,644	1,766,415	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,559,616	37,380	51,362	192,454	1,840,812	54.00
60.00	06000	LABORATORY	1,363,226	26,654	36,623	197,691	1,624,194	60.00
65.00	06500	RESPIRATORY THERAPY	659,171	11,704	16,082	146,401	833,358	65.00
66.00	06600	PHYSICAL THERAPY	1,090,667	57,813	79,438	241,204	1,469,122	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,402,755	33,314	45,774	38,591	1,520,434	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	2,517,958	0	0	0	2,517,958	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,089,912	7,864	10,806	104,100	2,212,682	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	244,851	13,235	18,185	19,864	296,135	88.00
88.01	08802	WABASH PRIMARY CARE-CHESTNUT	1,914,712	0	0	416,212	2,330,924	88.01
88.02	08801	WABASH PRIMARY CARE-COLLEGE DR.	296,909	56,680	77,880	67,144	498,613	88.02
90.00	09000	CLINIC	288,983	28,779	39,544	60,885	418,191	90.00
90.01	09001	ORTHOPAEDIC CLINIC	1,730,325	109,831	150,912	933,737	2,924,805	90.01
90.02	09002	SURGICAL CLINIC	162,269	0	0	134,485	296,754	90.02
90.03	09003	OP CLINIC	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	2,112,038	31,684	43,535	237,522	2,424,779	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	730,818	50,558	69,469	167,043	1,017,888	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	36,243,258	922,579	1,267,653	4,567,196	36,176,725	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	3,117	4,283	0	7,400	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	486,194	4,279	5,880	48,974	545,327	192.00
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 through 201)	36,729,452	929,975	1,277,816	4,616,170	36,729,452	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1327 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part I | Date/Time Prepared: 5/24/2018 4:25 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5,522,859					5.00
7.00	00700	OPERATION OF PLANT	283,934	1,888,292				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	25,003	0	166,282			8.00
9.00	00900	HOUSEKEEPING	72,890	8,699	1,711	495,162		9.00
10.00	01000	DIETARY	41,911	67,936	2,960	17,897	367,519	10.00
11.00	01100	CAFETERIA	81,922	27,329	0	7,200	0	11.00
13.00	01300	NURSING ADMINISTRATION	60,965	5,142	0	1,355	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	97,854	30,041	0	7,914	0	16.00
17.00	01700	SOCIAL SERVICE	36,036	6,269	0	1,651	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	49,207	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	363,652	277,942	62,861	73,221	357,155	30.00
31.00	03100	INTENSIVE CARE UNIT	65,434	28,069	0	7,394	10,364	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	312,615	435,296	32,920	114,676	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	325,781	92,906	16,017	24,475	0	54.00
60.00	06000	LABORATORY	287,445	66,245	815	17,452	0	60.00
65.00	06500	RESPIRATORY THERAPY	147,485	29,090	3,953	7,664	0	65.00
66.00	06600	PHYSICAL THERAPY	260,001	143,690	13,579	37,854	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	269,082	82,798	0	21,812	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	445,621	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	391,594	19,546	0	5,149	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	52,409	0	0	0	0	88.00
88.01	08802	WABASH PRIMARY CARE-CHESTNUT	412,520	0	98	0	0	88.01
88.02	08801	WABASH PRIMARY CARE-COLLEGE DR.	88,243	0	0	0	0	88.02
90.00	09000	CLINIC	74,010	71,528	514	18,843	0	90.00
90.01	09001	ORTHOPAEDIC CLINIC	517,633	272,976	0	71,913	0	90.01
90.02	09002	SURGICAL CLINIC	52,519	0	0	0	0	90.02
90.03	09003	OP CLINIC	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	429,130	78,748	30,260	20,745	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	180,143	125,658	346	33,104	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	5,425,039	1,869,908	166,034	490,319	367,519	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,310	7,748	0	2,041	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	96,510	10,636	248	2,802	0	192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	5,522,859	1,888,292	166,282	495,162	367,519	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1327 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part I Date/Time Prepared: 5/24/2018 4:25 pm

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	
			11.00	13.00	16.00	17.00	19.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	579,350					11.00
13.00	01300	NURSING ADMINISTRATION	8,015	419,954				13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	30,590	0	719,316			16.00
17.00	01700	SOCIAL SERVICE	7,504	0	0	255,081		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	10,058	0	0	0	337,307	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	88,863	186,818	82,325	247,880	0	30.00
31.00	03100	INTENSIVE CARE UNIT	14,241	29,939	0	7,201	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	46,172	97,067	134,806	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	337,307	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	37,966	0	120,401	0	0	54.00
60.00	06000	LABORATORY	43,330	0	40,134	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	29,791	0	41,163	0	0	65.00
66.00	06600	PHYSICAL THERAPY	44,990	0	9,262	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	9,515	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	13,092	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	17,494	0	0	88.00
88.01	08802	WABASH PRIMARY CARE-CHESTNUT	0	0	99,819	0	0	88.01
88.02	08801	WABASH PRIMARY CARE-COLLEGE DR.	0	0	0	0	0	88.02
90.00	09000	CLINIC	13,890	0	33,959	0	0	90.00
90.01	09001	ORTHOPAEDIC CLINIC	114,502	0	0	0	0	90.01
90.02	09002	SURGICAL CLINIC	16,349	0	0	0	0	90.02
90.03	09003	OP CLINIC	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	50,482	106,130	126,575	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	13,378	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	579,350	419,954	719,316	255,081	337,307	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	579,350	419,954	719,316	255,081	337,307	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1327 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part I | Date/Time Prepared: 5/24/2018 4:25 pm

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
17.00	01700	SOCIAL SERVICE					17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS					19.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	3,795,515	0	3,795,515		30.00
31.00	03100	INTENSIVE CARE UNIT	532,376	0	532,376		31.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	2,939,967	0	2,939,967		50.00
53.00	05300	ANESTHESIOLOGY	337,307	0	337,307		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,458,358	0	2,458,358		54.00
60.00	06000	LABORATORY	2,079,615	0	2,079,615		60.00
65.00	06500	RESPIRATORY THERAPY	1,092,504	0	1,092,504		65.00
66.00	06600	PHYSICAL THERAPY	1,978,498	0	1,978,498		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,903,641	0	1,903,641		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	2,963,579	0	2,963,579		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,642,063	0	2,642,063		73.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	366,038	0	366,038		88.00
88.01	08802	WABASH PRIMARY CARE-CHESTNUT	2,843,361	0	2,843,361		88.01
88.02	08801	WABASH PRIMARY CARE-COLLEGE DR.	586,856	0	586,856		88.02
90.00	09000	CLINIC	630,935	0	630,935		90.00
90.01	09001	ORTHOPAEDIC CLINIC	3,901,829	0	3,901,829		90.01
90.02	09002	SURGICAL CLINIC	365,622	0	365,622		90.02
90.03	09003	OP CLINIC	0	0	0		90.03
91.00	09100	EMERGENCY	3,266,849	0	3,266,849		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0			92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	1,370,517	0	1,370,517		95.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	36,055,430	0	36,055,430		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	18,499	0	18,499		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	655,523	0	655,523		192.00
200.00		Cross Foot Adjustments	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	36,729,452	0	36,729,452		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1327 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part II Date/Time Prepared: 5/24/2018 4:25 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS NEW BLDG & FIXT	CAPITAL RELATED COSTS NEW MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	4,407	6,055	10,462	10,462	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	60,180	82,689	142,869	693	5.00
7.00	00700	OPERATION OF PLANT	0	35,722	49,084	84,806	165	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	0	3,500	4,809	8,309	163	9.00
10.00	01000	DIETARY	0	27,334	37,558	64,892	55	10.00
11.00	01100	CAFETERIA	0	10,996	15,109	26,105	161	11.00
13.00	01300	NURSING ADMINISTRATION	0	2,069	2,843	4,912	151	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	12,087	16,608	28,695	230	16.00
17.00	01700	SOCIAL SERVICE	0	2,522	3,466	5,988	88	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	474	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	111,829	153,657	265,486	822	30.00
31.00	03100	INTENSIVE CARE UNIT	0	11,293	15,518	26,811	162	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	175,144	240,647	415,791	484	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	37,380	51,362	88,742	436	54.00
60.00	06000	LABORATORY	0	26,654	36,623	63,277	448	60.00
65.00	06500	RESPIRATORY THERAPY	0	11,704	16,082	27,786	332	65.00
66.00	06600	PHYSICAL THERAPY	0	57,813	79,438	137,251	547	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	33,314	45,774	79,088	87	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	7,864	10,806	18,670	236	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	13,235	18,185	31,420	45	88.00
88.01	08802	WABASH PRIMARY CARE-CHESTNUT	0	0	0	0	943	88.01
88.02	08801	WABASH PRIMARY CARE-COLLEGE DR.	0	56,680	77,880	134,560	152	88.02
90.00	09000	CLINIC	0	28,779	39,544	68,323	138	90.00
90.01	09001	ORTHOPAEDIC CLINIC	0	109,831	150,912	260,743	2,117	90.01
90.02	09002	SURGICAL CLINIC	0	0	0	0	305	90.02
90.03	09003	OP CLINIC	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	0	31,684	43,535	75,219	538	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	50,558	69,469	120,027	379	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	922,579	1,267,653	2,190,232	10,351	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	3,117	4,283	7,400	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	4,279	5,880	10,159	111	192.00
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 through 201)	0	929,975	1,277,816	2,207,791	10,462	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1327 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part II | Date/Time Prepared: 5/24/2018 4:25 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	143,562					5.00
7.00	00700	OPERATION OF PLANT	7,380	92,351				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	650	0	650			8.00
9.00	00900	HOUSEKEEPING	1,895	425	7	10,799		9.00
10.00	01000	DIETARY	1,089	3,323	12	390	69,761	10.00
11.00	01100	CAFETERIA	2,129	1,337	0	157	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,585	251	0	30	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,543	1,469	0	173	0	16.00
17.00	01700	SOCIAL SERVICE	937	307	0	36	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	1,279	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	9,452	13,593	246	1,597	67,794	30.00
31.00	03100	INTENSIVE CARE UNIT	1,701	1,373	0	161	1,967	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	8,126	21,290	129	2,500	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,468	4,544	63	534	0	54.00
60.00	06000	LABORATORY	7,471	3,240	3	381	0	60.00
65.00	06500	RESPIRATORY THERAPY	3,833	1,423	15	167	0	65.00
66.00	06600	PHYSICAL THERAPY	6,758	7,027	53	826	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	6,994	4,049	0	476	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	11,583	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	10,178	956	0	112	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,362	0	0	0	0	88.00
88.01	08802	WABASH PRIMARY CARE-CHESTNUT	10,722	0	0	0	0	88.01
88.02	08801	WABASH PRIMARY CARE-COLLEGE DR.	2,294	0	0	0	0	88.02
90.00	09000	CLINIC	1,924	3,498	2	411	0	90.00
90.01	09001	ORTHOPAEDIC CLINIC	13,465	13,350	0	1,568	0	90.01
90.02	09002	SURGICAL CLINIC	1,365	0	0	0	0	90.02
90.03	09003	OP CLINIC	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	11,154	3,851	118	452	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	4,682	6,146	1	722	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	141,019	91,452	649	10,693	69,761	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	34	379	0	45	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2,509	520	1	61	0	192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	143,562	92,351	650	10,799	69,761	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1327 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part II | Date/Time Prepared: 5/24/2018 4:25 pm

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	
			11.00	13.00	16.00	17.00	19.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	29,889					11.00
13.00	01300	NURSING ADMINISTRATION	413	7,342				13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,578	0	34,688			16.00
17.00	01700	SOCIAL SERVICE	387	0	0	7,743		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	519	0	0	0	2,272	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,584	3,267	3,970	7,524		30.00
31.00	03100	INTENSIVE CARE UNIT	735	523	0	219		31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,382	1,697	6,500	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,959	0	5,806	0		54.00
60.00	06000	LABORATORY	2,235	0	1,935	0		60.00
65.00	06500	RESPIRATORY THERAPY	1,537	0	1,985	0		65.00
66.00	06600	PHYSICAL THERAPY	2,321	0	447	0		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	491	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	675	0	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	844	0		88.00
88.01	08802	WABASH PRIMARY CARE-CHESTNUT	0	0	4,814	0		88.01
88.02	08801	WABASH PRIMARY CARE-COLLEGE DR.	0	0	0	0		88.02
90.00	09000	CLINIC	717	0	1,638	0		90.00
90.01	09001	ORTHOPAEDIC CLINIC	5,909	0	0	0		90.01
90.02	09002	SURGICAL CLINIC	843	0	0	0		90.02
90.03	09003	OP CLINIC	0	0	0	0		90.03
91.00	09100	EMERGENCY	2,604	1,855	6,104	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	645	0		95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	29,889	7,342	34,688	7,743	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192.00
200.00		Cross Foot Adjustments					2,272	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	29,889	7,342	34,688	7,743	2,272	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1327 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part II | Date/Time Prepared: 5/24/2018 4:25 pm

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
17.00	01700	SOCIAL SERVICE					17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS					19.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	378,335	0	378,335		30.00
31.00	03100	INTENSIVE CARE UNIT	33,652	0	33,652		31.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	458,899	0	458,899		50.00
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	110,552	0	110,552		54.00
60.00	06000	LABORATORY	78,990	0	78,990		60.00
65.00	06500	RESPIRATORY THERAPY	37,078	0	37,078		65.00
66.00	06600	PHYSICAL THERAPY	155,230	0	155,230		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	91,185	0	91,185		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	11,583	0	11,583		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	30,827	0	30,827		73.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	33,671	0	33,671		88.00
88.01	08802	WABASH PRIMARY CARE-CHESTNUT	16,479	0	16,479		88.01
88.02	08801	WABASH PRIMARY CARE-COLLEGE DR.	137,006	0	137,006		88.02
90.00	09000	CLINIC	76,651	0	76,651		90.00
90.01	09001	ORTHOPAEDIC CLINIC	297,152	0	297,152		90.01
90.02	09002	SURGICAL CLINIC	2,513	0	2,513		90.02
90.03	09003	OP CLINIC	0	0	0		90.03
91.00	09100	EMERGENCY	101,895	0	101,895		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0			92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	132,602	0	132,602		95.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,184,300	0	2,184,300		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	7,858	0	7,858		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	13,361	0	13,361		192.00
200.00		Cross Foot Adjustments	2,272	0	2,272		200.00
201.00		Negative Cost Centers	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	2,207,791	0	2,207,791		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1327 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B-1 | Date/Time Prepared: 5/24/2018 4:25 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)	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	NEW CAP REL COSTS-BLDG & FIXT	65,630					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		65,630				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	311	311	17,434,515			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	4,247	4,247	1,155,039	-5,522,859	31,206,593	5.00
7.00	00700	OPERATION OF PLANT	2,521	2,521	274,202	0	1,604,358	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	141,279	8.00
9.00	00900	HOUSEKEEPING	247	247	271,728	0	411,862	9.00
10.00	01000	DIETARY	1,929	1,929	92,078	0	236,815	10.00
11.00	01100	CAFETERIA	776	776	268,586	0	462,899	11.00
13.00	01300	NURSING ADMINISTRATION	146	146	252,022	0	344,477	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	853	853	382,505	0	552,917	16.00
17.00	01700	SOCIAL SERVICE	178	178	147,420	0	203,621	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	790,658	0	278,042	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,892	7,892	1,369,179	0	2,054,798	30.00
31.00	03100	INTENSIVE CARE UNIT	797	797	269,869	0	369,734	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	12,360	12,360	806,899	0	1,766,415	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,638	2,638	726,866	0	1,840,812	54.00
60.00	06000	LABORATORY	1,881	1,881	746,645	0	1,624,194	60.00
65.00	06500	RESPIRATORY THERAPY	826	826	552,932	0	833,358	65.00
66.00	06600	PHYSICAL THERAPY	4,080	4,080	910,987	0	1,469,122	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,351	2,351	145,751	0	1,520,434	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	2,517,958	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	555	555	393,170	0	2,212,682	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	934	934	75,024	0	296,135	88.00
88.01	08802	WABASH PRIMARY CARE-CHESTNUT	0	0	1,571,962	0	2,330,924	88.01
88.02	08801	WABASH PRIMARY CARE-COLLEGE DR.	4,000	4,000	253,590	0	498,613	88.02
90.00	09000	CLINIC	2,031	2,031	229,954	0	418,191	90.00
90.01	09001	ORTHOPAEDIC CLINIC	7,751	7,751	3,526,579	0	2,924,805	90.01
90.02	09002	SURGICAL CLINIC	0	0	507,929	0	296,754	90.02
90.03	09003	OP CLINIC	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	2,236	2,236	897,081	0	2,424,779	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	3,568	3,568	630,895	0	1,017,888	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	65,108	65,108	17,249,550	-5,522,859	30,653,866	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	220	220	0	0	7,400	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	302	302	184,965	0	545,327	192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	929,975	1,277,816	4,616,170		5,522,859	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	14.169968	19.469998	0.264772		0.176977	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			10,462		143,562	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000600		0.004600	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1327 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B-1 | Date/Time Prepared: 5/24/2018 4:25 pm

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	53,617					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	18,760				8.00
9.00	00900	HOUSEKEEPING	247	193	53,370			9.00
10.00	01000	DIETARY	1,929	334	1,929	7,163		10.00
11.00	01100	CAFETERIA	776	0	776	0	18,144	11.00
13.00	01300	NURSING ADMINISTRATION	146	0	146	0	251	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	853	0	853	0	958	16.00
17.00	01700	SOCIAL SERVICE	178	0	178	0	235	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	315	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,892	7,092	7,892	6,961	2,783	30.00
31.00	03100	INTENSIVE CARE UNIT	797	0	797	202	446	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	12,360	3,714	12,360	0	1,446	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,638	1,807	2,638	0	1,189	54.00
60.00	06000	LABORATORY	1,881	92	1,881	0	1,357	60.00
65.00	06500	RESPIRATORY THERAPY	826	446	826	0	933	65.00
66.00	06600	PHYSICAL THERAPY	4,080	1,532	4,080	0	1,409	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,351	0	2,351	0	298	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	555	0	555	0	410	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08802	WABASH PRIMARY CARE-CHESTNUT	0	11	0	0	0	88.01
88.02	08801	WABASH PRIMARY CARE-COLLEGE DR.	0	0	0	0	0	88.02
90.00	09000	CLINIC	2,031	58	2,031	0	435	90.00
90.01	09001	ORTHOPAEDIC CLINIC	7,751	0	7,751	0	3,586	90.01
90.02	09002	SURGICAL CLINIC	0	0	0	0	512	90.02
90.03	09003	OP CLINIC	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	2,236	3,414	2,236	0	1,581	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	3,568	39	3,568	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	53,095	18,732	52,848	7,163	18,144	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	220	0	220	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	302	28	302	0	0	192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,888,292	166,282	495,162	367,519	579,350	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	35.218158	8.863646	9.277909	51.307972	31.930666	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	92,351	650	10,799	69,761	29,889	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	1.722420	0.034648	0.202342	9.739076	1.647321	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1327 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B-1 | Date/Time Prepared: 5/24/2018 4:25 pm

		Cost Center Description	NURSING ADMINISTRATION (NURSE FTE'S)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (TOTAL PATIENT DAYS)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)		
			13.00	16.00	17.00	19.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	6,256					13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	699				16.00
17.00	01700	SOCIAL SERVICE	0	0	2,338			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	100		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,783	80	2,272	0		30.00
31.00	03100	INTENSIVE CARE UNIT	446	0	66	0		31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,446	131	0	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	100		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	117	0	0		54.00
60.00	06000	LABORATORY	0	39	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	40	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	9	0	0		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	17	0	0		88.00
88.01	08802	WABASH PRIMARY CARE-CHESTNUT	0	97	0	0		88.01
88.02	08801	WABASH PRIMARY CARE-COLLEGE DR.	0	0	0	0		88.02
90.00	09000	CLINIC	0	33	0	0		90.00
90.01	09001	ORTHOPAEDIC CLINIC	0	0	0	0		90.01
90.02	09002	SURGICAL CLINIC	0	0	0	0		90.02
90.03	09003	OP CLINIC	0	0	0	0		90.03
91.00	09100	EMERGENCY	1,581	123	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	13	0	0		95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	6,256	699	2,338	100		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	419,954	719,316	255,081	337,307		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	67.128197	1,029.064378	109.102224	3,373.070000		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	7,342	34,688	7,743	2,272		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	1.173593	49.625179	3.311805	22.720000		205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1327 | Period: From 01/01/2017 To 12/31/2017 | Worksheet C Part I Date/Time Prepared: 5/24/2018 4:25 pm

Title XVIII | 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	3,795,515		3,795,515	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	532,376		532,376	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,939,967		2,939,967	0	0	50.00
53.00	05300	ANESTHESIOLOGY	337,307		337,307	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,458,358		2,458,358	0	0	54.00
60.00	06000	LABORATORY	2,079,615		2,079,615	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	1,092,504	0	1,092,504	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,978,498	0	1,978,498	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,903,641		1,903,641	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	2,963,579		2,963,579	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,642,063		2,642,063	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	366,038		366,038	0	0	88.00
88.01	08802	WABASH PRIMARY CARE-CHESTNUT	2,843,361		2,843,361	0	0	88.01
88.02	08801	WABASH PRIMARY CARE-COLLEGE DR.	586,856		586,856	0	0	88.02
90.00	09000	CLINIC	630,935		630,935	0	0	90.00
90.01	09001	ORTHOPAEDIC CLINIC	3,901,829		3,901,829	0	0	90.01
90.02	09002	SURGICAL CLINIC	365,622		365,622	0	0	90.02
90.03	09003	OP CLINIC	0		0	0	0	90.03
91.00	09100	EMERGENCY	3,266,849		3,266,849	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	275,372		275,372		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1,370,517		1,370,517	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	36,330,802	0	36,330,802	0	0	200.00
201.00		Less Observation Beds	275,372		275,372		0	201.00
202.00		Total (see instructions)	36,055,430	0	36,055,430	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1327 | Period: From 01/01/2017 To 12/31/2017 | Worksheet C Part I Date/Time Prepared: 5/24/2018 4:25 pm

Title XVIII | 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	2,599,763		2,599,763			30.00
31.00	03100	INTENSIVE CARE UNIT	60,118		60,118			31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	10,775,878	7,119,420	17,895,298	0.164287	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	1,309,817	1,627,311	2,937,128	0.114842	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	628,178	15,259,194	15,887,372	0.154737	0.000000	54.00
60.00	06000	LABORATORY	1,044,628	11,448,837	12,493,465	0.166456	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	286,901	2,191,396	2,478,297	0.440829	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	896,506	4,796,091	5,692,597	0.347556	0.000000	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	5,320,892	1,304,636	6,625,528	0.287319	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	6,291,916	314,076	6,605,992	0.448620	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,327,740	6,529,632	7,857,372	0.336253	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	520,734	520,734			88.00
88.01	08802	WABASH PRIMARY CARE-CHESTNUT	0	1,645,284	1,645,284			88.01
88.02	08801	WABASH PRIMARY CARE-COLLEGE DR.	0	348,761	348,761			88.02
90.00	09000	CLINIC	0	481,838	481,838	1.309434	0.000000	90.00
90.01	09001	ORTHOPAEDIC CLINIC	0	1,766,821	1,766,821	2.208390	0.000000	90.01
90.02	09002	SURGICAL CLINIC	0	196,726	196,726	1.858534	0.000000	90.02
90.03	09003	OP CLINIC	0	0	0	0.000000	0.000000	90.03
91.00	09100	EMERGENCY	20,580	3,802,809	3,823,389	0.854438	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	12,497	318,857	331,354	0.831051	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	2,224,241	2,224,241	0.616173	0.000000	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	30,575,414	61,896,664	92,472,078			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	30,575,414	61,896,664	92,472,078			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1327 | Period: From 01/01/2017 To 12/31/2017 | Worksheet C Part I Date/Time Prepared: 5/24/2018 4:25 pm

Title XVIII | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
		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
60.00	06000	LABORATORY	0.000000		60.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC			88.00
88.01	08802	WABASH PRIMARY CARE-CHESTNUT			88.01
88.02	08801	WABASH PRIMARY CARE-COLLEGE DR.			88.02
90.00	09000	CLINIC	0.000000		90.00
90.01	09001	ORTHOPAEDIC CLINIC	0.000000		90.01
90.02	09002	SURGICAL CLINIC	0.000000		90.02
90.03	09003	OP CLINIC	0.000000		90.03
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0.000000		95.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1327 | Period: From 01/01/2017 To 12/31/2017 | Worksheet C Part I Date/Time Prepared: 5/24/2018 4:25 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	3,795,515		3,795,515	0	3,795,515	30.00
31.00	03100	INTENSIVE CARE UNIT	532,376		532,376	0	532,376	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,939,967		2,939,967	0	2,939,967	50.00
53.00	05300	ANESTHESIOLOGY	337,307		337,307	0	337,307	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,458,358		2,458,358	0	2,458,358	54.00
60.00	06000	LABORATORY	2,079,615		2,079,615	0	2,079,615	60.00
65.00	06500	RESPIRATORY THERAPY	1,092,504	0	1,092,504	0	1,092,504	65.00
66.00	06600	PHYSICAL THERAPY	1,978,498	0	1,978,498	0	1,978,498	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,903,641		1,903,641	0	1,903,641	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	2,963,579		2,963,579	0	2,963,579	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,642,063		2,642,063	0	2,642,063	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	366,038		366,038	0	366,038	88.00
88.01	08802	WABASH PRIMARY CARE-CHESTNUT	2,843,361		2,843,361	0	2,843,361	88.01
88.02	08801	WABASH PRIMARY CARE-COLLEGE DR.	586,856		586,856	0	586,856	88.02
90.00	09000	CLINIC	630,935		630,935	0	630,935	90.00
90.01	09001	ORTHOPAEDIC CLINIC	3,901,829		3,901,829	0	3,901,829	90.01
90.02	09002	SURGICAL CLINIC	365,622		365,622	0	365,622	90.02
90.03	09003	OP CLINIC	0		0	0	0	90.03
91.00	09100	EMERGENCY	3,266,849		3,266,849	0	3,266,849	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	275,372		275,372		275,372	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1,370,517		1,370,517	0	1,370,517	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	36,330,802	0	36,330,802	0	36,330,802	200.00
201.00		Less Observation Beds	275,372		275,372		275,372	201.00
202.00		Total (see instructions)	36,055,430	0	36,055,430	0	36,055,430	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1327 | Period: From 01/01/2017 To 12/31/2017 | Worksheet C Part I Date/Time Prepared: 5/24/2018 4:25 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	2,599,763		2,599,763			30.00
31.00	03100	INTENSIVE CARE UNIT	60,118		60,118			31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	10,775,878	7,119,420	17,895,298	0.164287	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	1,309,817	1,627,311	2,937,128	0.114842	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	628,178	15,259,194	15,887,372	0.154737	0.000000	54.00
60.00	06000	LABORATORY	1,044,628	11,448,837	12,493,465	0.166456	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	286,901	2,191,396	2,478,297	0.440829	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	896,506	4,796,091	5,692,597	0.347556	0.000000	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	5,320,892	1,304,636	6,625,528	0.287319	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	6,291,916	314,076	6,605,992	0.448620	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,327,740	6,529,632	7,857,372	0.336253	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	520,734	520,734	0.702927	0.000000	88.00
88.01	08802	WABASH PRIMARY CARE-CHESTNUT	0	1,645,284	1,645,284	1.728189	0.000000	88.01
88.02	08801	WABASH PRIMARY CARE-COLLEGE DR.	0	348,761	348,761	1.682688	0.000000	88.02
90.00	09000	CLINIC	0	481,838	481,838	1.309434	0.000000	90.00
90.01	09001	ORTHOPAEDIC CLINIC	0	1,766,821	1,766,821	2.208390	0.000000	90.01
90.02	09002	SURGICAL CLINIC	0	196,726	196,726	1.858534	0.000000	90.02
90.03	09003	OP CLINIC	0	0	0	0.000000	0.000000	90.03
91.00	09100	EMERGENCY	20,580	3,802,809	3,823,389	0.854438	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	12,497	318,857	331,354	0.831051	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	2,224,241	2,224,241	0.616173	0.000000	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	30,575,414	61,896,664	92,472,078			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	30,575,414	61,896,664	92,472,078			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1327 | Period: From 01/01/2017 To 12/31/2017 | Worksheet C Part I Date/Time Prepared: 5/24/2018 4:25 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
31.00	03100	INTENSIVE CARE UNIT			31.00
		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
60.00	06000	LABORATORY	0.000000		60.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	0.000000		88.00
88.01	08802	WABASH PRIMARY CARE-CHESTNUT	0.000000		88.01
88.02	08801	WABASH PRIMARY CARE-COLLEGE DR.	0.000000		88.02
90.00	09000	CLINIC	0.000000		90.00
90.01	09001	ORTHOPAEDIC CLINIC	0.000000		90.01
90.02	09002	SURGICAL CLINIC	0.000000		90.02
90.03	09003	OP CLINIC	0.000000		90.03
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0.000000		95.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 14-1327 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part II Date/Time Prepared: 5/24/2018 4:25 pm

Title XVIII | Hospital | Cost

		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	458,899	17,895,298	0.025644	5,565,855	142,731	50.00
53.00	05300	ANESTHESIOLOGY	0	2,937,128	0.000000	665,735	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	110,552	15,887,372	0.006958	469,328	3,266	54.00
60.00	06000	LABORATORY	78,990	12,493,465	0.006323	707,939	4,476	60.00
65.00	06500	RESPIRATORY THERAPY	37,078	2,478,297	0.014961	202,007	3,022	65.00
66.00	06600	PHYSICAL THERAPY	155,230	5,692,597	0.027269	479,267	13,069	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	91,185	6,625,528	0.013763	1,093,742	15,053	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	11,583	6,605,992	0.001753	5,176,874	9,075	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	30,827	7,857,372	0.003923	629,007	2,468	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	33,671	520,734	0.064661	0	0	88.00
88.01	08802	WABASH PRIMARY CARE-CHESTNUT	16,479	1,645,284	0.010016	0	0	88.01
88.02	08801	WABASH PRIMARY CARE-COLLEGE DR.	137,006	348,761	0.392836	0	0	88.02
90.00	09000	CLINIC	76,651	481,838	0.159080	0	0	90.00
90.01	09001	ORTHOPAEDIC CLINIC	297,152	1,766,821	0.168185	0	0	90.01
90.02	09002	SURGICAL CLINIC	2,513	196,726	0.012774	0	0	90.02
90.03	09003	OP CLINIC	0	0	0.000000	0	0	90.03
91.00	09100	EMERGENCY	101,895	3,823,389	0.026650	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	27,449	331,354	0.082839	4,861	403	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	1,667,160	87,587,956		14,994,615	193,563	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1327 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part IV | Date/Time Prepared: 5/24/2018 4:25 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	337,307	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08802	WABASH PRIMARY CARE-CHESTNUT	0	0	0	0	0	88.01
88.02	08801	WABASH PRIMARY CARE-COLLEGE DR.	0	0	0	0	0	88.02
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	ORTHOPAEDIC CLINIC	0	0	0	0	0	90.01
90.02	09002	SURGICAL CLINIC	0	0	0	0	0	90.02
90.03	09003	OP CLINIC	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	337,307	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 14-1327 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part IV Date/Time Prepared: 5/24/2018 4:25 pm

Title XVIII | Hospital | Cost

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	17,895,298	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	337,307	0	2,937,128	0.114842	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	15,887,372	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	12,493,465	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	2,478,297	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	5,692,597	0.000000	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	6,625,528	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	6,605,992	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	7,857,372	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	520,734	0.000000	88.00
88.01	08802	WABASH PRIMARY CARE-CHESTNUT	0	0	0	1,645,284	0.000000	88.01
88.02	08801	WABASH PRIMARY CARE-COLLEGE DR.	0	0	0	348,761	0.000000	88.02
90.00	09000	CLINIC	0	0	0	481,838	0.000000	90.00
90.01	09001	ORTHOPAEDIC CLINIC	0	0	0	1,766,821	0.000000	90.01
90.02	09002	SURGICAL CLINIC	0	0	0	196,726	0.000000	90.02
90.03	09003	OP CLINIC	0	0	0	0	0.000000	90.03
91.00	09100	EMERGENCY	0	0	0	3,823,389	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	331,354	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	337,307	0	87,587,956		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 14-1327 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part IV Date/Time Prepared: 5/24/2018 4:25 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	5,565,855	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	665,735	76,454	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	469,328	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	707,939	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	202,007	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	479,267	0	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	1,093,742	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000	5,176,874	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	629,007	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
88.01	08802	WABASH PRIMARY CARE-CHESTNUT	0.000000	0	0	0	0	88.01
88.02	08801	WABASH PRIMARY CARE-COLLEGE DR.	0.000000	0	0	0	0	88.02
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	ORTHOPAEDIC CLINIC	0.000000	0	0	0	0	90.01
90.02	09002	SURGICAL CLINIC	0.000000	0	0	0	0	90.02
90.03	09003	OP CLINIC	0.000000	0	0	0	0	90.03
91.00	09100	EMERGENCY	0.000000	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	4,861	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)		14,994,615	76,454	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-1327 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part V Date/Time Prepared: 5/24/2018 4:25 pm

Title XVIII | Hospital | Cost

		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	0.164287	0	1,529,307	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.114842	0	360,483	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.154737	0	5,850,244	0	0	54.00
60.00	06000	LABORATORY	0.166456	0	5,058,562	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.440829	0	832,829	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.347556	0	1,765,540	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.287319	0	300,678	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.448620	0	115,172	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.336253	0	3,743,566	2,388	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
88.01	08802	WABASH PRIMARY CARE-CHESTNUT	0.000000				0	88.01
88.02	08801	WABASH PRIMARY CARE-COLLEGE DR.	0.000000				0	88.02
90.00	09000	CLINIC	1.309434	0	239,351	261	0	90.00
90.01	09001	ORTHOPAEDIC CLINIC	2.208390	0	612,845	0	0	90.01
90.02	09002	SURGICAL CLINIC	1.858534	0	68,326	0	0	90.02
90.03	09003	OP CLINIC	0.000000	0	0	0	0	90.03
91.00	09100	EMERGENCY	0.854438	0	1,285,975	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.831051	0	178,698	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.616173		0			95.00
200.00		Subtotal (see instructions)		0	21,941,576	2,649	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	21,941,576	2,649	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-1327 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part V Date/Time Prepared: 5/24/2018 4:25 pm

Title XVIII | Hospital | Cost

		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	251,245	0		50.00
53.00	05300	ANESTHESIOLOGY	41,399	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	905,249	0		54.00
60.00	06000	LABORATORY	842,028	0		60.00
65.00	06500	RESPIRATORY THERAPY	367,135	0		65.00
66.00	06600	PHYSICAL THERAPY	613,624	0		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	86,391	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	51,668	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,258,785	803		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
88.01	08802	WABASH PRIMARY CARE-CHESTNUT	0	0		88.01
88.02	08801	WABASH PRIMARY CARE-COLLEGE DR.	0	0		88.02
90.00	09000	CLINIC	313,414	342		90.00
90.01	09001	ORTHOPAEDIC CLINIC	1,353,401	0		90.01
90.02	09002	SURGICAL CLINIC	126,986	0		90.02
90.03	09003	OP CLINIC	0	0		90.03
91.00	09100	EMERGENCY	1,098,786	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	148,507	0		92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	7,458,618	1,145		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	7,458,618	1,145		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-1327 | Component CCN: 14-Z327 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part V Date/Time Prepared: 5/24/2018 4:25 pm

Title XVIII | Swing Beds - SNF | Cost

		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	0.164287	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.114842	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.154737	0	0	0	0	54.00
60.00	06000	LABORATORY	0.166456	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.440829	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.347556	0	0	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.287319	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.448620	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.336253	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
88.01	08802	WABASH PRIMARY CARE-CHESTNUT	0.000000				0	88.01
88.02	08801	WABASH PRIMARY CARE-COLLEGE DR.	0.000000				0	88.02
90.00	09000	CLINIC	1.309434	0	0	0	0	90.00
90.01	09001	ORTHOPAEDIC CLINIC	2.208390	0	0	0	0	90.01
90.02	09002	SURGICAL CLINIC	1.858534	0	0	0	0	90.02
90.03	09003	OP CLINIC	0.000000	0	0	0	0	90.03
91.00	09100	EMERGENCY	0.854438	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.831051	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.616173		0			95.00
200.00		Subtotal (see instructions)		0	0	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-1327 | Component CCN: 14-Z327 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part V Date/Time Prepared: 5/24/2018 4:25 pm

Title XVIII | Swing Beds - SNF | Cost

		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
60.00	06000	LABORATORY	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
88.01	08802	WABASH PRIMARY CARE-CHESTNUT	0	0		88.01
88.02	08801	WABASH PRIMARY CARE-COLLEGE DR.	0	0		88.02
90.00	09000	CLINIC	0	0		90.00
90.01	09001	ORTHOPAEDIC CLINIC	0	0		90.01
90.02	09002	SURGICAL CLINIC	0	0		90.02
90.03	09003	OP CLINIC	0	0		90.03
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
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

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-1327 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part V Date/Time Prepared: 5/24/2018 4:25 pm

Title XIX | Hospital | Cost

		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	0.164287	0	0	1,511,504	0	50.00
53.00	05300	ANESTHESIOLOGY	0.114842	0	0	352,458	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.154737	0	0	3,646,138	0	54.00
60.00	06000	LABORATORY	0.166456	0	0	2,087,528	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.440829	0	0	505,593	0	65.00
66.00	06600	PHYSICAL THERAPY	0.347556	0	0	722,487	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.287319	0	0	256,054	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.448620	0	0	74,471	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.336253	0	0	500,849	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.702927				0	88.00
88.01	08802	WABASH PRIMARY CARE-CHESTNUT	1.728189				0	88.01
88.02	08801	WABASH PRIMARY CARE-COLLEGE DR.	1.682688				0	88.02
90.00	09000	CLINIC	1.309434	0	0	40,714	0	90.00
90.01	09001	ORTHOPAEDIC CLINIC	2.208390	0	0	360,911	0	90.01
90.02	09002	SURGICAL CLINIC	1.858534	0	0	0	0	90.02
90.03	09003	OP CLINIC	0.000000	0	0	0	0	90.03
91.00	09100	EMERGENCY	0.854438	0	0	1,210,115	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.831051	0	0	25,777	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.616173	0	0			95.00
200.00		Subtotal (see instructions)		0	0	11,294,599	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	0	11,294,599	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-1327 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part V Date/Time Prepared: 5/24/2018 4:25 pm

Title XIX | Hospital | Cost

		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	248,320		50.00
53.00	05300	ANESTHESIOLOGY	0	40,477		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	564,192		54.00
60.00	06000	LABORATORY	0	347,482		60.00
65.00	06500	RESPIRATORY THERAPY	0	222,880		65.00
66.00	06600	PHYSICAL THERAPY	0	251,105		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	73,569		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	33,409		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	168,412		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
88.01	08802	WABASH PRIMARY CARE-CHESTNUT	0	0		88.01
88.02	08801	WABASH PRIMARY CARE-COLLEGE DR.	0	0		88.02
90.00	09000	CLINIC	0	53,312		90.00
90.01	09001	ORTHOPAEDIC CLINIC	0	797,032		90.01
90.02	09002	SURGICAL CLINIC	0	0		90.02
90.03	09003	OP CLINIC	0	0		90.03
91.00	09100	EMERGENCY	0	1,033,968		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	21,422		92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	0	3,855,580		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	3,855,580		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1327 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-1 | Date/Time Prepared: 5/24/2018 4:25 pm

Title XVIII | Hospital | Cost

	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)	2,693	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,465	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)	2,272	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	191	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	37	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	1,372	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)	191	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		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	160.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	160.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	3,795,515	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)	5,920	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)	278,441	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	3,517,074	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	3,517,074	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)	1,426.81	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,957,583	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)	1,957,583	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1327 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-1 | Date/Time Prepared: 5/24/2018 4:25 pm

Title XVIII | Hospital | Cost

	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	532,376	66	8,066.30	16	129,061	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)	4,289,185	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	6,375,829	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	272,521	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)	272,521	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)	193	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,426.80	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	275,372	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1327 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-1 | Date/Time Prepared: 5/24/2018 4:25 pm

Title XVIII | Hospital | Cost

	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	378,335	3,795,515	0.099679	275,372	27,449	90.00
91.00	Nursing School cost	0	3,795,515	0.000000	275,372	0	91.00
92.00	Allied health cost	0	3,795,515	0.000000	275,372	0	92.00
93.00	All other Medical Education	0	3,795,515	0.000000	275,372	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1327 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-1 | Date/Time Prepared: 5/24/2018 4:25 pm

Title XIX | Hospital | Cost

	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)	2,693	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,465	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)	2,272	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	191	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	37	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)	144	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		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	160.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	160.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	3,795,515	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)	5,920	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)	278,441	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	3,517,074	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	3,517,074	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)	1,426.81	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	205,461	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)	205,461	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1327 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-1 | Date/Time Prepared: 5/24/2018 4:25 pm

Title XIX | Hospital | Cost

	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	532,376	66	8,066.30	32	258,122	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)	431,218	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	894,801	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	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)	193	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,426.80	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	275,372	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1327 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-1 | Date/Time Prepared: 5/24/2018 4:25 pm

Title XIX | Hospital | Cost

	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	378,335	3,795,515	0.099679	275,372	27,449	90.00
91.00	Nursing School cost	0	3,795,515	0.000000	275,372	0	91.00
92.00	Allied health cost	0	3,795,515	0.000000	275,372	0	92.00
93.00	All other Medical Education	0	3,795,515	0.000000	275,372	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 14-1327 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-3 | Date/Time Prepared: 5/24/2018 4:25 pm

Title XVIII | Hospital | Cost

		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		1,786,421		30.00
31.00	03100	INTENSIVE CARE UNIT		34,317		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.164287	5,565,855	914,398	50.00
53.00	05300	ANESTHESIOLOGY	0.114842	665,735	76,454	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.154737	469,328	72,622	54.00
60.00	06000	LABORATORY	0.166456	707,939	117,841	60.00
65.00	06500	RESPIRATORY THERAPY	0.440829	202,007	89,051	65.00
66.00	06600	PHYSICAL THERAPY	0.347556	479,267	166,572	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.287319	1,093,742	314,253	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.448620	5,176,874	2,322,449	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.336253	629,007	211,505	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08802	WABASH PRIMARY CARE-CHESTNUT	0.000000		0	88.01
88.02	08801	WABASH PRIMARY CARE-COLLEGE DR.	0.000000		0	88.02
90.00	09000	CLINIC	1.309434	0	0	90.00
90.01	09001	ORTHOPAEDIC CLINIC	2.208390	0	0	90.01
90.02	09002	SURGICAL CLINIC	1.858534	0	0	90.02
90.03	09003	OP CLINIC	0.000000	0	0	90.03
91.00	09100	EMERGENCY	0.854438	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.831051	4,861	4,040	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		14,994,615	4,289,185	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)		14,994,615		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 14-1327 | Component CCN: 14-Z327 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-3 | Date/Time Prepared: 5/24/2018 4:25 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.164287	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.114842	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.154737	22,803	3,528	54.00
60.00	06000	LABORATORY	0.166456	43,501	7,241	60.00
65.00	06500	RESPIRATORY THERAPY	0.440829	27,948	12,320	65.00
66.00	06600	PHYSICAL THERAPY	0.347556	75,217	26,142	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.287319	25,451	7,313	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.448620	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.336253	52,074	17,510	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08802	WABASH PRIMARY CARE-CHESTNUT	0.000000		0	88.01
88.02	08801	WABASH PRIMARY CARE-COLLEGE DR.	0.000000		0	88.02
90.00	09000	CLINIC	1.309434	0	0	90.00
90.01	09001	ORTHOPAEDIC CLINIC	2.208390	0	0	90.01
90.02	09002	SURGICAL CLINIC	1.858534	0	0	90.02
90.03	09003	OP CLINIC	0.000000	0	0	90.03
91.00	09100	EMERGENCY	0.854438	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.831051	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		246,994	74,054	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)		246,994		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 14-1327 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-3 | Date/Time Prepared: 5/24/2018 4:25 pm

Title XIX | Hospital | Cost

		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		175,440		30.00
31.00	03100	INTENSIVE CARE UNIT		10,750		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.164287	592,886	97,403	50.00
53.00	05300	ANESTHESIOLOGY	0.114842	92,975	10,677	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.154737	32,086	4,965	54.00
60.00	06000	LABORATORY	0.166456	79,695	13,266	60.00
65.00	06500	RESPIRATORY THERAPY	0.440829	14,441	6,366	65.00
66.00	06600	PHYSICAL THERAPY	0.347556	51,344	17,845	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.287319	340,458	97,820	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.448620	326,284	146,378	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.336253	105,352	35,425	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.702927	0	0	88.00
88.01	08802	WABASH PRIMARY CARE-CHESTNUT	1.728189	0	0	88.01
88.02	08801	WABASH PRIMARY CARE-COLLEGE DR.	1.682688	0	0	88.02
90.00	09000	CLINIC	1.309434	0	0	90.00
90.01	09001	ORTHOPAEDIC CLINIC	2.208390	0	0	90.01
90.02	09002	SURGICAL CLINIC	1.858534	0	0	90.02
90.03	09003	OP CLINIC	0.000000	0	0	90.03
91.00	09100	EMERGENCY	0.854438	1,256	1,073	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.831051	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		1,636,777	431,218	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)		1,636,777		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-1327	Period: From 01/01/2017 To 12/31/2017	Worksheet E Part B Date/Time Prepared: 5/24/2018 4:25 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	7,459,763	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	OPPS payments	0	3.00
4.00	Outlier payment (see instructions)	0	4.00
4.01	Outlier reconciliation amount (see instructions)	0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	7,459,763	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 (see instructions)	7,534,361	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	0	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	86,385	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	3,378,421	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)	4,069,555	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)	4,069,555	30.00
31.00	Primary payer payments	594	31.00
32.00	Subtotal (line 30 minus line 31)	4,068,961	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)	238,597	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	155,088	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	238,597	36.00
37.00	Subtotal (see instructions)	4,224,049	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)		39.50
39.97	Demonstration payment adjustment amount before sequestration	0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	4,224,049	40.00
40.01	Sequestration adjustment (see instructions)	84,481	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
41.00	Interim payments	3,806,843	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	332,725	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: 14-1327 | Period: From 01/01/2017 To 12/31/2017 | Worksheet E-1 Part I Date/Time Prepared: 5/24/2018 4:25 pm

Title XVIII | Hospital | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		4,811,427		3,548,749	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	12/07/2017	1,002,796	12/07/2017	54,605	3.01
3.02			0	08/03/2017	203,489	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	08/03/2017	83,147		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)		919,649		258,094	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)		5,731,076		3,806,843	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		157,493		332,725	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		5,888,569		4,139,568	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: 14-1327 | Component CCN: 14-Z327 | Period: From 01/01/2017 To 12/31/2017 | Worksheet E-1 Part I | Date/Time Prepared: 5/24/2018 4:25 pm

Title XVIII | Swing Beds - SNF | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		338,345		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	12/07/2017	132,568		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	08/03/2017	5,779		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)		126,789		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)		465,134		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		125,480		0	6.02
7.00	Total Medicare program liability (see instructions)		339,654		0	7.00

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

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 14-1327	Period: From 01/01/2017 To 12/31/2017	Worksheet E-1 Part II Date/Time Prepared: 5/24/2018 4:25 pm
	Title XVIII	Hospital	Cost

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

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

Provider CCN: 14-1327 | Component CCN: 14-Z327 | Period: From 01/01/2017 To 12/31/2017 | Worksheet E-2 | Date/Time Prepared: 5/24/2018 4:25 pm

Title XVIII | Swing Beds - SNF | Cost

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	275,246	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)	74,795	0	3.00
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)		0.00	4.00
5.00	Program days	191	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)	350,041	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	350,041	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)	350,041	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	3,455	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)	346,586	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)			16.50
16.55	Rural community hospital demonstration project (§410A Demonstration) payment adjustment (see instructions)	0		16.55
16.99	Demonstration payment adjustment amount before sequestration	0	0	16.99
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)	346,586	0	19.00
19.01	Sequestration adjustment (see instructions)	6,932	0	19.01
19.02	Demonstration payment adjustment amount after sequestration)	0	0	19.02
20.00	Interim payments	465,134	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)	-125,480	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
	Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment			
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
	Cost Reimbursement			
201.00	Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital))			201.00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))			202.00
203.00	Total (sum of lines 201 and 202)			203.00
204.00	Medicare swing-bed SNF discharges (see instructions)			204.00
	Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)			
205.00	Medicare swing-bed SNF target amount			205.00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)			206.00
	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement			
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)			208.00
209.00	Adjustment to Medicare swing-bed SNF PPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
	Comparision of PPS versus Cost Reimbursement			
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see instructions)			215.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-1327	Period: From 01/01/2017 To 12/31/2017	Worksheet E-3 Part V Date/Time Prepared: 5/24/2018 4:25 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	6,375,829	1.00
2.00	Nursing and Allied Health Managed Care payment (see instructions)	0	2.00
3.00	Organ acquisition	0	3.00
4.00	Subtotal (sum of lines 1 through 3)	6,375,829	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	6,439,587	6.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
7.00	Routine service charges	0	7.00
8.00	Ancillary service charges	0	8.00
9.00	Organ acquisition charges, net of revenue	0	9.00
10.00	Total reasonable charges	0	10.00
	Customary charges		
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)	0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)	0.000000	13.00
14.00	Total customary charges (see instructions)	0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)	0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)	0	16.00
17.00	Cost of physicians' services in a teaching hospital (see instructions)	0	17.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)	0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)	6,439,587	19.00
20.00	Deductibles (exclude professional component)	456,568	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	5,983,019	22.00
23.00	Coinsurance	0	23.00
24.00	Subtotal (line 22 minus line 23)	5,983,019	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	39,577	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	25,725	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	39,577	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	6,008,744	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	29.50
29.99	Demonstration payment adjustment amount before sequestration	0	29.99
30.00	Subtotal (see instructions)	6,008,744	30.00
30.01	Sequestration adjustment (see instructions)	120,175	30.01
30.02	Demonstration payment adjustment amount after sequestration	0	30.02
31.00	Interim payments	5,731,076	31.00
32.00	Tentative settlement (for contractor use only)	0	32.00
33.00	Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32)	157,493	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	34.00

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

Provider CCN: 14-1327 | Period: From 01/01/2017 To 12/31/2017 | Worksheet G | Date/Time Prepared: 5/24/2018 4:25 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	5,335,551	0	0	0	1.00
2.00	Temporary investments	5,421,439	0	0	0	2.00
3.00	Notes receivable	18,129	0	0	0	3.00
4.00	Accounts receivable	20,175,139	0	0	0	4.00
5.00	Other receivable	28,143	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-9,451,810	0	0	0	6.00
7.00	Inventory	802,631	0	0	0	7.00
8.00	Prepaid expenses	0	0	0	0	8.00
9.00	Other current assets	489,651	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)	22,818,873	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	467,367	0	0	0	12.00
13.00	Land improvements	1,994,371	0	0	0	13.00
14.00	Accumulated depreciation	-1,012,071	0	0	0	14.00
15.00	Buildings	23,010,209	0	0	0	15.00
16.00	Accumulated depreciation	-10,375,554	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	4,658,917	0	0	0	19.00
20.00	Accumulated depreciation	-2,418,788	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	13,853,963	0	0	0	23.00
24.00	Accumulated depreciation	-10,192,743	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	19,985,671	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	124,169	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	124,169	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	42,928,713	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	1,177,552	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,597,902	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	4,995,600	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	0	0	0	0	43.00
44.00	Other current liabilities	1,064,486	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	8,835,540	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	3,715,000	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)	3,715,000	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	12,550,540	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	30,378,173				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)	30,378,173	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	42,928,713	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 14-1327 | Period: From 01/01/2017 To 12/31/2017 | Worksheet G-1 | Date/Time Prepared: 5/24/2018 4:25 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		25,141,174		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		5,236,999				2.00
3.00	Total (sum of line 1 and line 2)		30,378,173		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)		30,378,173		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)		30,378,173		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: 14-1327 | Period: From 01/01/2017 To 12/31/2017 | Worksheet G-2 Parts I & II Date/Time Prepared: 5/24/2018 4:25 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	3,333,933		3,333,933	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	3,333,933		3,333,933	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	64,561		64,561	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)	64,561		64,561	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	3,398,494		3,398,494	17.00
18.00	Ancillary services	29,262,207	61,207,531	90,469,738	18.00
19.00	Outpatient services	20,520	4,467,442	4,487,962	19.00
20.00	RURAL HEALTH CLINIC	0	520,734	520,734	20.00
20.01	WABASH PRIMARY CARE-CHESTNUT	0	1,645,284	1,645,284	20.01
20.02	WABASH PRIMARY CARE-COLLEGE DR.	0	348,761	348,761	20.02
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES	0	2,224,241	2,224,241	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PRO FEES	0	434,970	434,970	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	32,681,221	70,848,963	103,530,184	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		42,384,339		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		42,384,339		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 14-1327	Period: From 01/01/2017 To 12/31/2017	Worksheet G-3 Date/Time Prepared: 5/24/2018 4:25 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	103,530,184	1.00
2.00	Less contractual allowances and discounts on patients' accounts	56,902,807	2.00
3.00	Net patient revenues (line 1 minus line 2)	46,627,377	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	42,384,339	4.00
5.00	Net income from service to patients (line 3 minus line 4)	4,243,038	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	9,685	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	97,092	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	1,307	16.00
17.00	Revenue from sale of drugs to other than patients	1,505	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	8,239	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER OPERATING INCOME	519,888	24.00
25.00	Total other income (sum of lines 6-24)	637,716	25.00
26.00	Total (line 5 plus line 25)	4,880,754	26.00
27.00	NON-OPERATING G/L	-356,246	27.00
27.01	ROUNDING	1	27.01
28.00	Total other expenses (sum of line 27 and subscripts)	-356,245	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	5,236,999	29.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1327 | Component CCN: 14-8501 | Period: From 01/01/2017 To 12/31/2017 | Worksheet M-1 | Date/Time Prepared: 5/24/2018 4:25 pm

RHC I | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	0	0	0	0	0	1.00
2.00	Physician Assistant	0	159,287	159,287	10,509	169,796	2.00
3.00	Nurse Practitioner	0	0	0	0	0	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	75,024	0	75,024	-10,509	64,515	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)	75,024	159,287	234,311	0	234,311	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	9,707	9,707	0	9,707	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	9,707	9,707	0	9,707	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	75,024	168,994	244,018	0	244,018	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	0	0	0	0	29.00
30.00	Administrative Costs	0	833	833	0	833	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	833	833	0	833	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	75,024	169,827	244,851	0	244,851	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1327 | Component CCN: 14-8501 | Period: From 01/01/2017 To 12/31/2017 | Worksheet M-1 | Date/Time Prepared: 5/24/2018 4:25 pm

RHC I | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	0		1.00
2.00	Physician Assistant	0	169,796		2.00
3.00	Nurse Practitioner	0	0		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	64,515		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	234,311		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	9,707		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	9,707		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	244,018		22.00
	COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
25.01	Telehealth	0	0		25.01
25.02	Chronic Care Management	0	0		25.02
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs				27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	0		29.00
30.00	Administrative Costs	0	833		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	833		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	244,851		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1327 | Component CCN: 14-8568 | Period: From 01/01/2017 To 12/31/2017 | Worksheet M-1 | Date/Time Prepared: 5/24/2018 4:25 pm

RHC II | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	0	0	0	790,279	790,279	1.00
2.00	Physician Assistant	0	73,869	73,869	85,819	159,688	2.00
3.00	Nurse Practitioner	0	0	0	111,862	111,862	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	1,571,962	0	1,571,962	-1,343,221	228,741	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	3,487	3,487	9.00
10.00	Subtotal (sum of lines 1 through 9)	1,571,962	73,869	1,645,831	-351,774	1,294,057	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	196,824	196,824	0	196,824	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	196,824	196,824	0	196,824	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	1,571,962	270,693	1,842,655	-351,774	1,490,881	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	0	0	0	0	29.00
30.00	Administrative Costs	0	93,608	93,608	351,774	445,382	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	93,608	93,608	351,774	445,382	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	1,571,962	364,301	1,936,263	0	1,936,263	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1327 | Component CCN: 14-8568 | Period: From 01/01/2017 To 12/31/2017 | Worksheet M-1 | Date/Time Prepared: 5/24/2018 4:25 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	-21,551	768,728		1.00
2.00	Physician Assistant	0	159,688		2.00
3.00	Nurse Practitioner	0	111,862		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	228,741		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	3,487		9.00
10.00	Subtotal (sum of lines 1 through 9)	-21,551	1,272,506		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	196,824		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	196,824		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-21,551	1,469,330		22.00
	COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
25.01	Telehealth	0	0		25.01
25.02	Chronic Care Management	0	0		25.02
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs				27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	0		29.00
30.00	Administrative Costs	0	445,382		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	445,382		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-21,551	1,914,712		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1327 | Component CCN: 14-8579 | Period: From 01/01/2017 To 12/31/2017 | Worksheet M-1 | Date/Time Prepared: 5/24/2018 4:25 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	0	0	0	167,071	167,071	1.00
2.00	Physician Assistant	0	0	0	27,226	27,226	2.00
3.00	Nurse Practitioner	0	0	0	0	0	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	253,590	0	253,590	-239,232	14,358	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	10,034	10,034	9.00
10.00	Subtotal (sum of lines 1 through 9)	253,590	0	253,590	-34,901	218,689	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	40,439	40,439	0	40,439	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	40,439	40,439	0	40,439	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	253,590	40,439	294,029	-34,901	259,128	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	0	0	0	0	29.00
30.00	Administrative Costs	0	2,880	2,880	34,901	37,781	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	2,880	2,880	34,901	37,781	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	253,590	43,319	296,909	0	296,909	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1327 | Component CCN: 14-8579 | Period: From 01/01/2017 To 12/31/2017 | Worksheet M-1 | Date/Time Prepared: 5/24/2018 4:25 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	167,071		1.00
2.00	Physician Assistant	0	27,226		2.00
3.00	Nurse Practitioner	0	0		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	14,358		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	10,034		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	218,689		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	40,439		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	40,439		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	259,128		22.00
	COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
25.01	Telehealth	0	0		25.01
25.02	Chronic Care Management	0	0		25.02
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs				27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	0		29.00
30.00	Administrative Costs	0	37,781		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	37,781		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	296,909		32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1327 | Component CCN: 14-8501 | Period: From 01/01/2017 To 12/31/2017 | Worksheet M-2 | Date/Time Prepared: 5/24/2018 4:25 pm

RHC I | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	0.00	15	4,200	0		1.00
2.00	Physician Assistant	0.57	3,124	2,100	1,197		2.00
3.00	Nurse Practitioner	0.27	1,279	2,100	567		3.00
4.00	Subtotal (sum of lines 1 through 3)	0.84	4,418		1,764	4,418	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)	0.84	4,418			4,418	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)					244,018	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)					244,018	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)					833	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					121,187	15.00
16.00	Total overhead (sum of lines 14 and 15)					122,020	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					122,020	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					122,020	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					366,038	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1327 | Component CCN: 14-8568 | Period: From 01/01/2017 To 12/31/2017 | Worksheet M-2 | Date/Time Prepared: 5/24/2018 4:25 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	2.74	5,244	4,200	11,508		1.00
2.00	Physician Assistant	0.96	1,486	2,100	2,016		2.00
3.00	Nurse Practitioner	0.96	2,610	2,100	2,016		3.00
4.00	Subtotal (sum of lines 1 through 3)	4.66	9,340		15,540	15,540	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)	4.66	9,340			15,540	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)					1,469,330	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)					1,469,330	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)					445,382	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					928,649	15.00
16.00	Total overhead (sum of lines 14 and 15)					1,374,031	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					1,374,031	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					1,374,031	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					2,843,361	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1327 | Component CCN: 14-8579 | Period: From 01/01/2017 To 12/31/2017 | Worksheet M-2 | Date/Time Prepared: 5/24/2018 4:25 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	0.25	1,437	1,050	263		1.00
2.00	Physician Assistant	0.27	924	525	142		2.00
3.00	Nurse Practitioner	0.00	0	525	0		3.00
4.00	Subtotal (sum of lines 1 through 3)	0.52	2,361		405	2,361	4.00
5.00	Visiting Nurse	0.27	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)	0.79	2,361			2,361	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)					259,128	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)					259,128	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)					37,781	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					289,947	15.00
16.00	Total overhead (sum of lines 14 and 15)					327,728	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					327,728	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					327,728	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					586,856	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 14-1327 Component CCN: 14-8501	Period: From 01/01/2017 To 12/31/2017	Worksheet M-3 Date/Time Prepared: 5/24/2018 4:25 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)			366,038	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			0	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			366,038	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			4,418	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)			4,418	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			82.85	7.00
		Calculation of Limit (1)			
		Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)		
		1.00	2.00		
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	81.32	82.30		8.00
9.00	Rate for Program covered visits (see instructions)	82.85	82.85		9.00
	CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	0	251		10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	20,795		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	20,795		16.00
16.01	Total program charges (see instructions)(from contractor's records)		29,832		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.)		12,555		16.04
16.05	Total program cost (see instructions)	0	12,555		16.05
17.00	Primary payer amounts		0		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		5,101		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		4,947		19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		12,555		20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		0		21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		12,555		22.00
23.00	Allowable bad debts (see instructions)		0		23.00
23.01	Adjusted reimbursable bad debts (see instructions)		0		23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0		24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0		25.50
25.99	Demonstration payment adjustment amount before sequestration		0		25.99
26.00	Net reimbursable amount (see instructions)		12,555		26.00
26.01	Sequestration adjustment (see instructions)		251		26.01
26.02	Demonstration payment adjustment amount after sequestration		0		26.02
27.00	Interim payments		15,061		27.00
28.00	Tentative settlement (for contractor use only)		0		28.00
29.00	Balance due component/program (line 26 minus lines 26.01, 26.02, 27, and 28)		-2,757		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: 14-1327 Component CCN: 14-8568	Period: From 01/01/2017 To 12/31/2017	Worksheet M-3 Date/Time Prepared: 5/24/2018 4:25 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)		2,843,361	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)		153,473	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		2,689,888	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		15,540	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)		15,540	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		173.09	7.00

		Calculation of Limit (1)		
		Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	81.32	82.30	8.00
9.00	Rate for Program covered visits (see instructions)	173.09	173.09	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	2,677	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	463,362	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	463,362	16.00
16.01	Total program charges (see instructions)(from contractor's records)		467,144	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		43,148	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		42,799	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.)		327,866	16.04
16.05	Total program cost (see instructions)	0	370,665	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		10,731	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		82,653	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		370,665	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		85,647	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		456,312	22.00
23.00	Allowable bad debts (see instructions)		0	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		0	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	25.50
25.99	Demonstration payment adjustment amount before sequestration		0	25.99
26.00	Net reimbursable amount (see instructions)		456,312	26.00
26.01	Sequestration adjustment (see instructions)		9,126	26.01
26.02	Demonstration payment adjustment amount after sequestration		0	26.02
27.00	Interim payments		427,720	27.00
28.00	Tentative settlement (for contractor use only)		0	28.00
29.00	Balance due component/program (line 26 minus lines 26.01, 26.02, 27, and 28)		19,466	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: 14-1327 Component CCN: 14-8579	Period: From 01/01/2017 To 12/31/2017	Worksheet M-3 Date/Time Prepared: 5/24/2018 4:25 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)			586,856	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			43,917	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			542,939	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			2,361	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)			2,361	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			229.96	7.00
		Calculation of Limit (1)			
		Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)		
		1.00	2.00		
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	81.32	82.30		8.00
9.00	Rate for Program covered visits (see instructions)	229.96	229.96		9.00
	CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	0	995		10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	228,810		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	228,810		16.00
16.01	Total program charges (see instructions)(from contractor's records)		130,305		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		1,316		16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		2,311		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.)		180,054		16.04
16.05	Total program cost (see instructions)	0	182,365		16.05
17.00	Primary payer amounts		0		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		1,432		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		25,510		19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		182,365		20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		30,058		21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		212,423		22.00
23.00	Allowable bad debts (see instructions)		0		23.00
23.01	Adjusted reimbursable bad debts (see instructions)		0		23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0		24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0		25.50
25.99	Demonstration payment adjustment amount before sequestration		0		25.99
26.00	Net reimbursable amount (see instructions)		212,423		26.00
26.01	Sequestration adjustment (see instructions)		4,248		26.01
26.02	Demonstration payment adjustment amount after sequestration		0		26.02
27.00	Interim payments		37,775		27.00
28.00	Tentative settlement (for contractor use only)		0		28.00
29.00	Balance due component/program (line 26 minus lines 26.01, 26.02, 27, and 28)		170,400		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: 14-1327 Component CCN: 14-8501	Period: From 01/01/2017 To 12/31/2017	Worksheet M-4 Date/Time Prepared: 5/24/2018 4:25 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)	234,311	234,311	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000000	0.000000	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	0	0	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	0	0	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	244,018	244,018	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	122,020	122,020	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.000000	0.000000	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	0	0	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	0	0	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	0	0	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	0.00	0.00	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	0	0	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	0	0	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)		0	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)		0	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA VACCINE COST	Provider CCN: 14-1327 Component CCN: 14-8568	Period: From 01/01/2017 To 12/31/2017	Worksheet M-4 Date/Time Prepared: 5/24/2018 4:25 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)	1,272,506	1,272,506	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.005777	0.006353	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	7,351	8,084	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	54,960	8,913	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	62,311	16,997	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	1,469,330	1,469,330	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	1,374,031	1,374,031	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.042408	0.011568	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	58,270	15,895	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	120,581	32,892	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	336	704	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	358.87	46.72	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	197	320	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	70,697	14,950	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)		153,473	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)		85,647	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA VACCINE COST	Provider CCN: 14-1327 Component CCN: 14-8579	Period: From 01/01/2017 To 12/31/2017	Worksheet M-4 Date/Time Prepared: 5/24/2018 4:25 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)	218,689	218,689	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.005376	0.027795	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	1,176	6,078	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	8,669	3,469	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	9,845	9,547	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	259,128	259,128	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	327,728	327,728	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.037993	0.036843	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	12,451	12,074	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	22,296	21,621	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	53	274	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	420.68	78.91	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	39	173	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	16,407	13,651	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)		43,917	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)		30,058	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 14-1327 Component CCN: 14-8501	Period: From 01/01/2017 To 12/31/2017	Worksheet M-5 Date/Time Prepared: 5/24/2018 4:25 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		15,061	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)		15,061	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		0	6.01
6.02	SETTLEMENT TO PROGRAM		2,757	6.02
7.00	Total Medicare program liability (see instructions)		12,304	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: 14-1327 Component CCN: 14-8568	Period: From 01/01/2017 To 12/31/2017	Worksheet M-5 Date/Time Prepared: 5/24/2018 4:25 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		512,849	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		12/07/2017	85,129	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)		-85,129	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		427,720	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		19,466	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		447,186	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: 14-1327 Component CCN: 14-8579	Period: From 01/01/2017 To 12/31/2017	Worksheet M-5 Date/Time Prepared: 5/24/2018 4:25 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		37,775	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)		37,775	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		170,400	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		208,175	7.00

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