

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: 15-0086	Period: From 01/01/2017 To 12/31/2017	Worksheet S Parts I-III Date/Time Prepared: 5/29/2018 2:12 pm
--	-----------------------	---------------------------------------	---

PART I - COST REPORT STATUS

Provider use only 1. Electronically filed cost report Date: 5/29/2018 Time: 2:12 pm
 2. Manually submitted cost report
 3. If this is an amended report enter the number of times the provider resubmitted this cost report
 4. Medicare Utilization. Enter "F" for full or "L" for low.

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

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 DEARBORN COUNTY HOSPITAL (15-0086) 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		HIT	Title XIX	
		Part A	Part B			
	1.00	2.00	3.00	4.00	5.00	
PART III - SETTLEMENT SUMMARY						
1.00 Hospital	0	251,143	83,739	0	8,186	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	0	0		0	5.00
6.00 Swing bed - NF	0	0	0		0	6.00
7.00 SKILLED NURSING FACILITY	0	0	0		0	7.00
9.00 HOME HEALTH AGENCY I	0	0	0		0	9.00
200.00 Total	0	251,143	83,739	0	8,186	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-MEDI-CARE.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-0086			Period: From 01/01/2017 To 12/31/2017		Worksheet S-2 Part I Date/Time Prepared: 5/29/2018 2:11 pm						
1.00 Hospital and Hospital Health Care Complex Address:		2.00 PO Box:		3.00 State: IN		4.00 Zip Code: 47025-		County: DEARBORN					
2.00 City: LAWRENCEBURG		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)					
1.00		2.00		3.00	4.00	5.00	6.00	7.00	8.00	9.00			
3.00 Hospital and Hospital-Based Component Identification:		DEARBORN COUNTY HOSPITAL		150086	17140	1	07/01/1966	N	P	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										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	HEALTH SERVICES CORP. OF SE IN		157055	17140		10/01/1978	N	P	N	12.00		
13.00	Separately Certified ASC										13.00		
14.00	Hospital-Based Hospice	HOSPICE OF SOUTHEASTERN INDIANA		151531	17140		12/22/1994				14.00		
15.00	Hospital-Based Health Clinic - RHC										15.00		
16.00	Hospital-Based Health Clinic - FQHC										16.00		
17.00	Hospital-Based (CMHC) I										17.00		
18.00	Renal Dialysis										18.00		
19.00	Other										19.00		
							From:	To:					
							1.00	2.00					
20.00	Cost Reporting Period (mm/dd/yyyy)						01/01/2017	12/31/2017		20.00			
21.00	Type of Control (see instructions)						9			21.00			
Inpatient PPS Information													
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2) (PickLe amendment hospital?) In column 2, enter "Y" for yes or "N" for no.						Y	N		22.00			
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)						Y	Y		22.01			
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.						N	N		22.02			
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.						N	N		22.03			
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.							3		N	23.00		
				In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days				
				1.00	2.00	3.00	4.00	5.00	6.00				
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.						233	1,329	0	476	1,168	0	24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.						0	0	0	0	0		25.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-0086	Period: From 01/01/2017 To 12/31/2017	Worksheet S-2 Part I Date/Time Prepared: 5/29/2018 2:11 pm		
		Urban/Rural	S	Date of Geogr		
		1.00	2.00			
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	1				26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	1				27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0				35.00
		Beginning:	Ending:			
		1.00	2.00			
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.					36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.	0				37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)					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
		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
61.01	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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-0086		Period: From 01/01/2017 To 12/31/2017		Worksheet S-2 Part I Date/Time Prepared: 5/29/2018 2:11 pm		
	Y/N	IME	Direct GME	IME	Direct GME			
	1.00	2.00	3.00	4.00	5.00			
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.						61.10	0.00 0.00
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.						61.20	0.00 0.00
							1.00	
62.00	ACA Provisions Affecting the Health Resources and Services Administration (HRSA) 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)						62.00	0.00
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) Teaching Hospitals that Claim Residents in Nonprovider Settings						62.01	0.00
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)						63.00	N
	Program Name		Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
	1.00		2.00	3.00	4.00	5.00		
64.00	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. 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)						64.00	0.00 0.00 0.000000

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 15-0086

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

Worksheet S-2
Part I
Date/Time Prepared:
5/29/2018 2:11 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	
70.00	Inpatient Psychiatric Facility PPS 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
75.00	Inpatient Rehabilitation Facility PPS Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.					N			75.00
76.00	If line 75 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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-0086		Period: From 01/01/2017 To 12/31/2017		Worksheet S-2 Part I Date/Time Prepared: 5/29/2018 2:11 pm			
						1.00			
Long Term Care Hospital PPS									
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.		N				80.00		
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.		N				81.00		
TEFRA Providers									
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.		N				85.00		
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.						86.00		
87.00	Is this hospital 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. 1? 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?		N				105.00		
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)		N				106.00		
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II.		N				107.00		
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.		N				108.00		
						Physical	Occupational	Speech	Respiratory
						1.00	2.00	3.00	4.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.		N		N		N		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	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-0086	Period: From 01/01/2017 To 12/31/2017	Worksheet S-2 Part I Date/Time Prepared: 5/29/2018 2:11 pm		
		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.	Y				117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1				118.00
		Premiums	Losses	Insurance		
		1.00	2.00	3.00		
118.01	List amounts of malpractice premiums and paid losses:	279,371	0	0		
		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						
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	N				140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-0086		Period: From 01/01/2017 To 12/31/2017		Worksheet S-2 Part I Date/Time Prepared: 5/29/2018 2:11 pm		
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		
165.00	Multi campus Is this hospital part of a Multi campus 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
						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)						9.99	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
						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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 15-0086		Period: From 01/01/2017 To 12/31/2017		Worksheet S-2 Part II Date/Time Prepared: 5/29/2018 2:11 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				
		1.00	2.00				
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				
		1.00	2.00				
Financial Data and Reports							
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A				4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N					5.00
		Y/N	Legal Oper.				
		1.00	2.00				
Approved Educational Activities							
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N					6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N					7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N					8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N					9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N					10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N					11.00
				Y/N			
				1.00			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.					Y	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	04/06/2018	Y	04/06/2018		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N			17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N			18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N			19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 15-0086	Period: From 01/01/2017 To 12/31/2017	Worksheet S-2 Part II Date/Time Prepared: 5/29/2018 2:11 pm	
		Description	Y/N	Y/N	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	0	1.00	3.00	20.00
			N	N	
		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 relieved for Medicare purposes? If yes, see instructions			N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.			N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions			Y	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.			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.			Y	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions			N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.			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.				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.				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.				38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.				39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.				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.	KYLE		SMT H	41.00
42.00	Enter the employer/company name of the cost report preparer.	BLUE & CO., LLC			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317-713-7957		KCSMT H@BLUEANDCO.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 15-0086	Period: From 01/01/2017 To 12/31/2017	Worksheet S-2 Part II Date/Time Prepared: 5/29/2018 2:11 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.	SENIOR 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: 15-0086

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

Worksheet S-3
Part I
Date/Time Prepared:
5/29/2018 2:11 pm

Component	Worksheet A	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P	
	Line Number				Visits	Trips
	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	78	28,470	0.00	0	1.00
2.00 HMO and other (see instructions)						2.00
3.00 HMO IPF Subprovider						3.00
4.00 HMO IRF Subprovider						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00 Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)		78	28,470	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	8	2,920	0.00	0	8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY	43.00				0	13.00
14.00 Total (see instructions)		86	31,390	0.00	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	44.00	0	0		0	19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	101.00				0	22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE	116.00	0	0			24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		86				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)		102	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: 15-0086

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

Worksheet S-3
Part I
Date/Time Prepared:
5/29/2018 2:11 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)	5,444	233	11,361			1.00
2.00 HMO and other (see instructions)	1,686	2,973				2.00
3.00 HMO IPF Subprovider	0	0				3.00
4.00 HMO IRF Subprovider	0	0				4.00
5.00 Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00 Hospital Adults & Peds. Swing Bed NF	0	0	0			6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	5,444	233	11,361			7.00
8.00 INTENSIVE CARE UNIT	875	0	1,874			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		0	681			13.00
14.00 Total (see instructions)	6,319	233	13,916	0.00	604.09	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	0	0	0	0.00	0.00	19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	3,481	697	6,918	0.00	15.55	22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE	0	0	0	0.00	3.31	24.00
24.10 HOSPICE (non-distinct part)	0	0	0			24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00 Total (sum of lines 14-26)				0.00	622.95	27.00
28.00 Observation Bed Days		0	1,482			28.00
29.00 Ambulance Trips	0					29.00
30.00 Employee discount days (see instruction)			0			30.00
31.00 Employee discount days - IRF			0			31.00
32.00 Labor & delivery days (see instructions)	0	0	26			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00 LTCH non-covered days	0					33.00
33.01 LTCH site neutral days and discharges	0					33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 15-0086

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

Worksheet S-3
Part I
Date/Time Prepared:
5/29/2018 2:11 pm

Component	Full Time Equivalents	Discharges			Total All Patients	
		Title V	Title XVIII	Title XIX		
		11.00	12.00	13.00		
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	1,676	56	3,878	1.00
2.00 HMO and other (see instructions)			424	901		2.00
3.00 HMO IPF Subprovider				0		3.00
4.00 HMO IRF Subprovider				0		4.00
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 Hospital Adults & Peds. Swing Bed NF						6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	0.00	0	1,676	56	3,878	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	0.00					19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	0.00					22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE	0.00					24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days			0			33.00
33.01 LTCH site neutral days and discharges			0			33.01

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 15-0086

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

Worksheet S-3
Part II
Date/Time Prepared:
5/29/2018 2:11 pm

	Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART II - WAGE DATA							
SALARIES							
1.00	Total salaries (see instructions)	200.00	34,538,682	0	34,538,682	1,286,586.00	26.85
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00
5.00	Physician and Non-Physician-Part B		0	0	0	0.00	0.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00
9.00	SNF	44.00	0	0	0	0.00	0.00
10.00	Excluded area salaries (see instructions)		1,737,339	57,314	1,794,653	63,515.00	28.26
OTHER WAGES & RELATED COSTS							
11.00	Contract Labor: Direct Patient Care		345,998	0	345,998	4,505.00	76.80
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00
13.00	Contract Labor: Physician-Part A - Administrative		362,793	0	362,793	1,722.00	210.68
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00
14.01	Home office salaries		0	0	0	0.00	0.00
14.02	Related organization salaries		0	0	0	0.00	0.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00
WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		10,816,271	0	10,816,271		
18.00	Wage-related costs (other) (see instructions)		0	0	0		
19.00	Excluded areas		561,698	0	561,698		
20.00	Non-physician anesthetist Part A		0	0	0		
21.00	Non-physician anesthetist Part B		0	0	0		
22.00	Physician Part A - Administrative		0	0	0		
22.01	Physician Part A - Teaching		0	0	0		
23.00	Physician Part B		0	0	0		
24.00	Wage-related costs (RHC/FQHC)		0	0	0		
25.00	Interns & residents (in an approved program)		0	0	0		
25.50	Home office wage-related (core)		0	0	0		
25.51	Related organization wage-related (core)		0	0	0		
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0		
25.53	Home office & Contract Physicians Part A - Teaching - wage-related (core)		0	0	0		
OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	312,379	0	312,379	10,420.00	29.98
27.00	Administrative & General	5.00	5,212,531	0	5,212,531	178,013.00	29.28

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 15-0086

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

Worksheet S-3
Part II
Date/Time Prepared:
5/29/2018 2:11 pm

	Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
28.00	Administrative & General under contract (see inst.)	253,115	0	253,115	3,050.00	82.99	28.00
29.00	Maintenance & Repairs	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	1,174,850	-57,314	1,117,536	39,522.00	28.28	30.00
31.00	Laundry & Linen Service	175,017	0	175,017	12,523.00	13.98	31.00
32.00	Housekeeping	723,683	0	723,683	59,290.00	12.21	32.00
33.00	Housekeeping under contract (see instructions)	0	0	0	0.00	0.00	33.00
34.00	Dietary	1,102,509	-836,915	265,594	15,768.00	16.84	34.00
35.00	Dietary under contract (see instructions)	0	0	0	0.00	0.00	35.00
36.00	Cafeteria	0	836,915	836,915	50,931.00	16.43	36.00
37.00	Maintenance of Personnel	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	841,071	0	841,071	19,563.00	42.99	38.00
39.00	Central Services and Supply	261,306	0	261,306	16,439.00	15.90	39.00
40.00	Pharmacy	1,538,395	0	1,538,395	40,964.00	37.55	40.00
41.00	Medical Records & Medical Records Library	820,274	0	820,274	37,622.00	21.80	41.00
42.00	Social Service	354,465	0	354,465	12,105.00	29.28	42.00
43.00	Other General Service	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 15-0086

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

Worksheet S-3
Part III
Date/Time Prepared:
5/29/2018 2:11 pm

	Worksheet A Line Number	Amount Reported	Recl assi fi cation of Sal aries (from Worksheet A-6)	Adjusted Sal aries (col . 2 ± col . 3)	Paid Hours Related to Sal aries in col . 4	Average Hourly Wage (col . 4 ÷ col . 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)	34,791,797	0	34,791,797	1,289,636.00	26.98	1.00
2.00	Excluded area salaries (see instructions)	1,737,339	57,314	1,794,653	63,515.00	28.26	2.00
3.00	Subtotal salaries (line 1 minus line 2)	33,054,458	-57,314	32,997,144	1,226,121.00	26.91	3.00
4.00	Subtotal other wages & related costs (see inst.)	708,791	0	708,791	6,227.00	113.83	4.00
5.00	Subtotal wage-related costs (see inst.)	10,816,271	0	10,816,271	0.00	32.78	5.00
6.00	Total (sum of lines 3 thru 5)	44,579,520	-57,314	44,522,206	1,232,348.00	36.13	6.00
7.00	Total overhead cost (see instructions)	12,769,595	-57,314	12,712,281	496,210.00	25.62	7.00

HOSPITAL WAGE RELATED COSTS

Provider CCN: 15-0086

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

Worksheet S-3
Part IV
Date/Time Prepared:
5/29/2018 2:11 pm

		Amount Reported	
		1.00	
PART IV - WAGE RELATED COSTS			
Part A - Core List			
RETIREMENT COST			
1.00	401K Employer Contributions	1,202,662	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)			
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
HEALTH AND INSURANCE COST			
8.00	Health Insurance (Purchased or Self Funded)	6,685,400	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)	0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	0	8.02
8.03	Health Insurance (Purchased)	0	8.03
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	234,335	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	53,865	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	107,166	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	263,692	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	0	16.00
TAXES			
17.00	FICA-Employers Portion Only	1,993,140	17.00
18.00	Medicare Taxes - Employers Portion Only	476,076	18.00
19.00	Unemployment Insurance	38,079	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
OTHER			
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	323,553	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	11,377,968	24.00
Part B - Other than Core Related Cost			
25.00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST

Provider CCN: 15-0086

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

Worksheet S-3
Part V
Date/Time Prepared:
5/29/2018 2:11 pm

Cost Center Description		Contract Labor	Benefit Cost	
PART V - Contract Labor and Benefit Cost		1.00	2.00	
Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost	0	0	1.00
2.00	Hospital	0	0	2.00
3.00	Subprovider - IPF			3.00
4.00	Subprovider - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital -Based SNF	0	0	8.00
9.00	Hospital -Based NF			9.00
10.00	Hospital -Based OLTC			10.00
11.00	Hospital -Based HHA	0	0	11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital -Based Hospice	0	0	13.00
14.00	Hospital -Based Health Clinic RHC			14.00
15.00	Hospital -Based Health Clinic FQHC			15.00
16.00	Hospital -Based-CMHC			16.00
17.00	Renal Dialysis			17.00
18.00	Other	0	0	18.00

HOME HEALTH AGENCY STATISTICAL DATA		Provider CCN: 15-0086 Component CCN: 15-7055	Period: From 01/01/2017 To 12/31/2017	Worksheet S-4 Date/Time Prepared: 5/29/2018 2:11 pm
			Home Health Agency I	PPS

					1.00	
--	--	--	--	--	------	--

0.00	County					0.00
------	--------	--	--	--	--	------

		Title V	Title XVIII	Title XIX	Other	Total
		1.00	2.00	3.00	4.00	5.00

HOME HEALTH AGENCY STATISTICAL DATA

1.00	Home Health Aide Hours	0	0	0	0	0	1.00
2.00	Unduplicated Census Count (see instructions)	0.00	222.00	0.00	0.00	0.00	2.00

		Number of Employees (Full Time Equivalent)			
		Enter the number of hours in your normal work week			
		Staff	Contract	Total	
		0	1.00	2.00	3.00

HOME HEALTH AGENCY - NUMBER OF EMPLOYEES

3.00	Administrator and Assistant Administrator(s)	40.00				0.00	0.00	0.00	3.00
4.00	Director(s) and Assistant Director(s)					0.00	0.00	0.00	4.00
5.00	Other Administrative Personnel					3.25	0.00	3.25	5.00
6.00	Direct Nursing Service					7.38	0.00	7.38	6.00
7.00	Nursing Supervisor					0.00	0.00	0.00	7.00
8.00	Physical Therapy Service					2.13	0.00	2.13	8.00
9.00	Physical Therapy Supervisor					0.00	0.00	0.00	9.00
10.00	Occupational Therapy Service					0.73	0.00	0.73	10.00
11.00	Occupational Therapy Supervisor					0.00	0.00	0.00	11.00
12.00	Speech Pathology Service					0.07	0.00	0.07	12.00
13.00	Speech Pathology Supervisor					0.00	0.00	0.00	13.00
14.00	Medical Social Service					0.44	0.00	0.44	14.00
15.00	Medical Social Service Supervisor					0.00	0.00	0.00	15.00
16.00	Home Health Aide					1.59	0.00	1.59	16.00
17.00	Home Health Aide Supervisor					0.00	0.00	0.00	17.00
18.00	Other (specify)					0.00	0.00	0.00	18.00

HOME HEALTH AGENCY CBSA CODES

19.00	Enter in column 1 the number of CBSAs where you provided services during the cost reporting period.					5			19.00
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).	17140							20.00
20.01		50031							20.01
20.02		50034							20.02
20.03		50035							20.03
20.04		99915							20.04

		Full Episodes				
		Without Outliers	With Outliers	LUPA Episodes	PEP Only Episodes	Total (cols. 1-4)
		1.00	2.00	3.00	4.00	5.00

PPS ACTIVITY DATA

21.00	Skilled Nursing Visits	1,426	332	77	1	1,836	21.00
22.00	Skilled Nursing Visit Charges	286,198	66,632	15,253	201	368,284	22.00
23.00	Physical Therapy Visits	930	36	24	5	995	23.00
24.00	Physical Therapy Visit Charges	202,410	7,929	3,965	1,101	215,405	24.00
25.00	Occupational Therapy Visits	229	20	6	0	255	25.00
26.00	Occupational Therapy Visit Charges	49,777	4,405	1,101	0	55,283	26.00
27.00	Speech Pathology Visits	34	3	1	0	38	27.00
28.00	Speech Pathology Visit Charges	7,489	661	220	0	8,370	28.00
29.00	Medical Social Service Visits	8	3	0	0	11	29.00
30.00	Medical Social Service Visit Charges	2,398	899	0	0	3,297	30.00
31.00	Home Health Aide Visits	238	105	3	0	346	31.00
32.00	Home Health Aide Visit Charges	47,070	23,827	584	0	71,481	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	2,865	499	111	6	3,481	33.00
34.00	Other Charges	0	0	0	0	0	34.00
35.00	Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)	595,342	104,353	21,123	1,302	722,120	35.00
36.00	Total Number of Episodes (standard/non outlier)	233		36	1	270	36.00
37.00	Total Number of Outlier Episodes		11		0	11	37.00
38.00	Total Non-Routine Medical Supply Charges	17,386	4,333	2,154	0	23,873	38.00

HOSPITAL-BASED HOSPI CE IDENTIFICATION DATA		Provider CCN: 15-0086 Hospice CCN: 15-1531	Period: From 01/01/2017 To 12/31/2017	Worksheet S-9 PARTS I THROUGH IV Date/Time Prepared: 5/29/2018 2:11 pm
---	--	---	---	---

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

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

		Title XVIII	Title XIX	Other	Total (sum of cols. 1 through 3)	
		1.00	2.00	3.00	4.00	
PART III - ENROLLMENT DAYS FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2015						
10.00	Hospice Continuous Home Care	0	0	0	0	10.00
11.00	Hospice Routine Home Care	3,628	139	547	4,314	11.00
12.00	Hospice Inpatient Respite Care	0	0	0	0	12.00
13.00	Hospice General Inpatient Care	211	24	19	254	13.00
14.00	Total Hospice Days	3,839	163	566	4,568	14.00
PART IV - CONTRACTED STATISTICAL DATA FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2015						
15.00	Hospice Inpatient Respite Care	0	0	0	0	15.00
16.00	Hospice General Inpatient Care	0	0	0	0	16.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 15-0086	Period: From 01/01/2017 To 12/31/2017	Worksheet S-10 Date/Time Prepared: 5/29/2018 2:11 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)			0.343152	1.00	
Medicaid (see instructions for each line)						
2.00	Net revenue from Medicaid			10,800,678	2.00	
3.00	Did you receive DSH or supplemental payments from Medicaid?				3.00	
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?				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			54,464,458	6.00	
7.00	Medicaid cost (line 1 times line 6)			18,689,588	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)			7,888,910	8.00	
Children's Health Insurance Program (CHIP) (see instructions for each line)						
9.00	Net revenue from stand-alone CHIP			14,712	9.00	
10.00	Stand-alone CHIP charges			25,521	10.00	
11.00	Stand-alone CHIP cost (line 1 times line 10)			8,758	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)			7,888,910	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)	1,035,789	1,172,244	2,208,033	20.00	
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	355,433	1,172,244	1,527,677	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)	355,433	1,172,244	1,527,677	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)			6,647,432	26.00	
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)			302,613	27.00	
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)			465,559	27.01	
28.00	Non-Medicare bad debt expense (see instructions)			6,181,873	28.00	
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)			2,284,268	29.00	
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)			3,811,945	30.00	
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)			11,700,855	31.00	

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES		Provider CCN: 15-0086		Period: From 01/01/2017 To 12/31/2017		Worksheet A Date/Time Prepared: 5/29/2018 2:11 pm	
Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassified (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		3,874,355		3,945,204	1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		2,234,370		2,287,374	2.00
3.00	00300	OTHER CAPITAL RELATED COSTS		0		0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	312,379	11,535,733		11,848,112	4.00
5.01	01160	COMMUNICATIONS	116,095	165,967		282,062	5.01
5.02	00550	DATA PROCESSING	1,052,163	1,470,289		2,522,452	5.02
5.03	00560	PURCHASING RECEIVING AND STORES	249,147	144,752		395,580	5.03
5.04	00570	ADMITTING	559,622	81,650		641,272	5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	759,677	578,312		1,337,989	5.05
5.06	00591	OTHER ADMINISTRATIVE AND GENERAL	2,475,827	6,596,338		8,938,029	5.06
7.00	00700	OPERATION OF PLANT	1,174,850	2,075,098		3,177,769	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	175,017	120,298		295,315	8.00
9.00	00900	HOUSEKEEPING	723,683	342,718		1,098,433	9.00
10.00	01000	DIETARY	1,102,509	654,004		423,144	10.00
11.00	01100	CAFETERIA	0	0		1,333,369	11.00
13.00	01300	NURSING ADMINISTRATION	841,071	30,094		871,165	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	261,306	789,443		417,295	14.00
15.00	01500	PHARMACY	1,538,395	233,823		1,753,996	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	820,274	157,536		977,206	16.00
17.00	01700	SOCIAL SERVICE	354,465	11,533		365,998	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	6,186,742	786,784		6,150,520	30.00
31.00	03100	INTENSIVE CARE UNIT	1,298,674	79,795		1,367,769	31.00
43.00	04300	NURSERY	0	0		523,105	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0		0	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,809,820	4,042,875		4,606,832	50.00
51.00	05100	RECOVERY ROOM	607,689	80,347		674,353	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		292,662	52.00
53.00	05300	ANESTHESIOLOGY	0	1,349,671		1,266,520	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,345,500	941,114		3,268,272	54.00
54.01	05401	ULTRASOUND	241,129	43,666		260,675	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	450,700	344,812		624,313	55.00
57.00	05700	CT SCAN	83,972	299,001		312,484	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	18,780	285,811		303,732	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		0	59.00
60.00	06000	LABORATORY	2,250,258	3,187,970		5,433,911	60.00
60.01	06001	BLOOD LABORATORY	0	0		0	60.01
65.00	06500	RESPIRATORY THERAPY	743,990	118,848		783,365	65.00
65.01	03950	SLEEP CLINIC	0	192,054		191,936	65.01
66.00	06600	PHYSICAL THERAPY	1,394,065	139,919		1,529,625	66.00
67.00	06700	OCCUPATIONAL THERAPY	257,586	9,860		263,988	67.00
68.00	06800	SPEECH PATHOLOGY	222,100	3,475		225,575	68.00
69.00	06900	ELECTROCARDIOLOGY	678,735	277,488		955,514	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		2,455,301	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	328,554		328,554	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,506,560		3,506,560	73.00
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	1,695,123	296,022		1,984,325	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	971,873	124,368		1,084,565	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE		0		0	113.00
116.00	11600	HOSPICE	225,201	296,545		473,520	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	33,998,417	47,831,852		81,779,740	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	66,537	0		66,537	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	253,312		304,070	192.00
192.01	19201	PHYSICIAN CLINIC	60,365	36,968		97,212	192.01
192.02	19202	LIFELINE	0	2,662		2,662	192.02
192.03	19203	CREDIT UNION	0	0		0	192.03
192.04	19204	BREAST MRI STUDY	0	0		0	192.04
192.05	19205	HOSPITALIST	0	1,031,396		1,031,396	192.05
194.00	07950	COMMUNITY MENTAL HEALTH	0	0		0	194.00
194.01	07951	MARKETING	131,841	362,629		494,470	194.01
194.02	07953	OCCUPATIONAL HEALTH	266,583	31,585		298,060	194.02
194.03	07952	PATHS EDUCATION	0	48,618		48,618	194.03
194.04	07954	FOUNDATION	14,939	0		14,939	194.04
200.00		TOTAL (SUM OF LINES 118 through 199)	34,538,682	49,599,022		84,137,704	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 15-0086

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

Worksheet A
Date/Time Prepared:
5/29/2018 2:11 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	-196,420	3,748,784	1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	-4,540	2,282,834	2.00
3.00	00300	OTHER CAPITAL RELATED COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-15,165	11,832,947	4.00
5.01	01160	COMMUNICATIONS	-7,359	274,703	5.01
5.02	00550	DATA PROCESSING	0	2,522,452	5.02
5.03	00560	PURCHASING RECEIVING AND STORES	0	395,580	5.03
5.04	00570	ADMINITTING	0	641,272	5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	-7,539	1,330,450	5.05
5.06	00591	OTHER ADMINISTRATIVE AND GENERAL	-4,917,435	4,020,594	5.06
7.00	00700	OPERATION OF PLANT	-128,371	3,049,398	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	295,315	8.00
9.00	00900	HOUSEKEEPING	0	1,098,433	9.00
10.00	01000	DIETARY	-4,397	418,747	10.00
11.00	01100	CAFETERIA	-408,923	924,446	11.00
13.00	01300	NURSING ADMINISTRATION	0	871,165	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	417,295	14.00
15.00	01500	PHARMACY	0	1,753,996	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-24,566	952,640	16.00
17.00	01700	SOCIAL SERVICE	0	365,998	17.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-384,835	5,765,685	30.00
31.00	03100	INTENSIVE CARE UNIT	0	1,367,769	31.00
43.00	04300	NURSERY	0	523,105	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	44.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-65,000	4,541,832	50.00
51.00	05100	RECOVERY ROOM	0	674,353	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	292,662	52.00
53.00	05300	ANESTHESIOLOGY	-1,226,362	40,158	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-135,554	3,132,718	54.00
54.01	05401	ULTRASOUND	0	260,675	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	624,313	55.00
57.00	05700	CT SCAN	-2,350	310,134	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	303,732	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000	LABORATORY	-112,052	5,321,859	60.00
60.01	06001	BLOOD LABORATORY	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	-11,148	772,217	65.00
65.01	03950	SLEEP CLINIC	0	191,936	65.01
66.00	06600	PHYSICAL THERAPY	0	1,529,625	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	263,988	67.00
68.00	06800	SPEECH PATHOLOGY	0	225,575	68.00
69.00	06900	ELECTROCARDIOLOGY	55,263	1,010,777	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2,455,301	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	328,554	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-893,091	2,613,469	73.00
OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	-82,889	1,901,436	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY	0	1,084,565	101.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	0	0	113.00
116.00	11600	HOSPICE	-6,016	467,504	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-8,578,749	73,200,991	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	66,537	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	304,070	192.00
192.01	19201	PHYSICIAN CLINIC	0	97,212	192.01
192.02	19202	LIFELINE	0	2,662	192.02
192.03	19203	CREDIT UNION	0	0	192.03
192.04	19204	BREAST MRI STUDY	0	0	192.04
192.05	19205	HOSPITALIST	0	1,031,396	192.05
194.00	07950	COMMUNITY MENTAL HEALTH	0	0	194.00
194.01	07951	MARKETING	0	494,470	194.01
194.02	07953	OCCUPATIONAL HEALTH	0	298,060	194.02
194.03	07952	PATHS EDUCATION	0	48,618	194.03
194.04	07954	FOUNDATION	0	14,939	194.04
200.00		TOTAL (SUM OF LINES 118 through 199)	-8,578,749	75,558,955	200.00

RECLASSIFICATIONS

Provider CCN: 15-0086

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

Worksheet A-6

Date/Time Prepared:
5/29/2018 2:11 pm

		Increases			
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
A - CAFETERIA					
1.00	CAFETERIA	11.00	836,915	496,454	1.00
	O		836,915	496,454	
B - NURSERY					
1.00	NURSERY	43.00	446,030	77,075	1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	249,541	43,121	2.00
	O		695,571	120,196	
C - UTILIZATION REVIEW COST					
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.06	0	604	1.00
	O		0	604	
D - SECURITY GUARD					
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	57,314	28	1.00
	O		57,314	28	
E - MED SUPPLY RECLASS					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	2,455,301	1.00
2.00	PURCHASING RECEIVING AND STORES	5.03	0	1,681	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
22.00		0.00	0	0	22.00
23.00		0.00	0	0	23.00
24.00		0.00	0	0	24.00
25.00		0.00	0	0	25.00
	O		0	2,456,982	
F - POB HOUSEKEEPING					
1.00	HOUSEKEEPING	9.00	0	32,143	1.00
2.00		0.00	0	0	2.00
	O		0	32,143	
G - INSURANCE					
1.00	OTHER CAPITAL RELATED COSTS	3.00	0	123,853	1.00
2.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	10,887	2.00
	O		0	134,740	
500.00	Grand Total: Increases		1,589,800	3,241,147	500.00

RECLASSIFICATIONS

Provider CCN: 15-0086

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

Worksheet A-6

Date/Time Prepared:
5/29/2018 2:11 pm

Decreases						
Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
6.00	7.00	8.00	9.00	10.00		
A - CAFETERIA						
1.00	DIETARY	10.00	836,915	496,454	0	1.00
	O		836,915	496,454		
B - NURSERY						
1.00	ADULTS & PEDIATRICS	30.00	695,571	120,196	0	1.00
2.00		0.00	0	0	0	2.00
	O		695,571	120,196		
C - UTILIZATION REVIEW COST						
1.00	MEDICAL RECORDS & LIBRARY	16.00	0	604	0	1.00
	O		0	604		
D - SECURITY GUARD						
1.00	OPERATION OF PLANT	7.00	57,314	28	0	1.00
	O		57,314	28		
E - MED SUPPLY RECLASS						
1.00	OPERATION OF PLANT	7.00	0	165	0	1.00
2.00	HOUSEKEEPING	9.00	0	111	0	2.00
3.00	CENTRAL SERVICE & SUPPLY	14.00	0	633,454	0	3.00
4.00	PHARMACY	15.00	0	18,222	0	4.00
5.00	ADULTS & PEDIATRICS	30.00	0	7,239	0	5.00
6.00	INTENSIVE CARE UNIT	31.00	0	10,700	0	6.00
7.00	OPERATING ROOM	50.00	0	1,245,863	0	7.00
8.00	RECOVERY ROOM	51.00	0	13,683	0	8.00
9.00	ANESTHESIOLOGY	53.00	0	83,151	0	9.00
10.00	RADIOLOGY-DIAGNOSTIC	54.00	0	18,342	0	10.00
11.00	ULTRASOUND	54.01	0	24,120	0	11.00
12.00	RADIOLOGY-THERAPEUTIC	55.00	0	171,199	0	12.00
13.00	CT SCAN	57.00	0	70,489	0	13.00
14.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	859	0	14.00
15.00	LABORATORY	60.00	0	4,317	0	15.00
16.00	RESPIRATORY THERAPY	65.00	0	79,473	0	16.00
17.00	SLEEP CLINIC	65.01	0	118	0	17.00
18.00	PHYSICAL THERAPY	66.00	0	4,359	0	18.00
19.00	OCCUPATIONAL THERAPY	67.00	0	3,458	0	19.00
20.00	ELECTROCARDIOLOGY	69.00	0	709	0	20.00
21.00	EMERGENCY	91.00	0	6,820	0	21.00
22.00	HOME HEALTH AGENCY	101.00	0	11,676	0	22.00
23.00	HOSPICE	116.00	0	48,226	0	23.00
24.00	PHYSICIAN CLINIC	192.01	0	121	0	24.00
25.00	OCCUPATIONAL HEALTH	194.02	0	108	0	25.00
	O		0	2,456,982		
F - POB HOUSEKEEPING						
1.00	OPERATION OF PLANT	7.00	0	14,672	0	1.00
2.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	17,471	0	2.00
	O		0	32,143		
G - INSURANCE						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.06	0	134,740	0	1.00
2.00		0.00	0	0	0	2.00
	O		0	134,740		
500.00	Grand Total: Decreases		1,589,800	3,241,147		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-0086

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

Worksheet A-7
Part I
Date/Time Prepared:
5/29/2018 2:11 pm

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
			1.00	2.00	3.00		
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	1,408,112	0	0	0	0	1.00
2.00	Land Improvements	2,590,591	24,349	0	24,349	0	2.00
3.00	Buildings and Fixtures	74,183,042	193,730	0	193,730	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	55,461,162	3,858,677	0	3,858,677	676,640	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	133,642,907	4,076,756	0	4,076,756	676,640	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	133,642,907	4,076,756	0	4,076,756	676,640	10.00
		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	1,408,112	0				1.00
2.00	Land Improvements	2,614,940	0				2.00
3.00	Buildings and Fixtures	74,376,772	0				3.00
4.00	Building Improvements	0	0				4.00
5.00	Fixed Equipment	0	0				5.00
6.00	Movable Equipment	58,643,199	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	137,043,023	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	137,043,023	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-0086

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

Worksheet A-7
Part II
Date/Time Prepared:
5/29/2018 2:11 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	3,140,178	0	689,517	0	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	1,877,397	356,973	0	0	0	2.00
3.00	Total (sum of lines 1-2)	5,017,575	356,973	689,517	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	44,660	3,874,355				1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	2,234,370				2.00
3.00	Total (sum of lines 1-2)	44,660	6,108,725				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-0086

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

Worksheet A-7
Part III
Date/Time Prepared:
5/29/2018 2:11 pm

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	78,400,824	0	78,400,824	0.572043	70,849	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	58,653,199	0	58,653,199	0.427957	53,004	2.00
3.00	Total (sum of lines 1-2)	137,054,023	0	137,054,023	1.000000	123,853	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of col.s. 5 through 7)	Depreciation	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	70,849	2,954,031	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	53,004	1,872,857	356,973	2.00
3.00	Total (sum of lines 1-2)	0	0	123,853	4,826,888	356,973	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of col.s. 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	679,244	70,849	0	44,660	3,748,784	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	53,004	0	0	2,282,834	2.00
3.00	Total (sum of lines 1-2)	679,244	123,853	0	44,660	6,031,618	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 15-0086

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

Worksheet A-8

Date/Time Prepared:
5/29/2018 2:11 pm

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
			Cost Center	Line #		
			1.00	2.00		
1.00 Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)			ONEW CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00 Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)			ONEW CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00 Investment income - other (chapter 2)		0		0.00	0	3.00
4.00 Trade, quantity, and time discounts (chapter 8)	B	-9,862	OTHER ADMINISTRATIVE AND GENERAL	5.06	0	4.00
5.00 Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00 Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00 Telephone services (pay stations excluded) (chapter 21)	A	-7,359	COMMUNICATIONS	5.01	0	7.00
8.00 Television and radio service (chapter 21)	A	-4,540	ONEW CAP REL COSTS-MVBLE EQUIP	2.00	9	8.00
9.00 Parking lot (chapter 21)		0		0.00	0	9.00
10.00 Provider-based physician adjustment	A-8-2	-1,947,589			0	10.00
11.00 Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00 Related organization transactions (chapter 10)	A-8-1	0			0	12.00
13.00 Laundry and linen service		0		0.00	0	13.00
14.00 Cafeteria-employees and guests	B	-408,923	CAFETERIA	11.00	0	14.00
15.00 Rental of quarters to employee and others		0		0.00	0	15.00
16.00 Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00 Sale of drugs to other than patients	B	-893,091	DRUGS CHARGED TO PATIENTS	73.00	0	17.00
18.00 Sale of medical records and abstracts	B	-24,566	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		ORESPIRATORY THERAPY	65.00		23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		OPHYSICAL 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			ONEW CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00 Depreciation - NEW CAP REL COSTS-MVBLE EQUIP			ONEW CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00 Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00 Physicians' assistant		0		0.00	0	29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		OCCUPATIONAL THERAPY	67.00		30.00
30.99 Hospice (non-distinct) (see instructions)			OADULTS & PEDIATRICS	30.00		30.99
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		OSPEECH PATHOLOGY	68.00		31.00

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.
			Cost Center	Line #	
			1.00	2.00	
32.00 CAH HIT Adjustment for Depreciation and Interest		0		0.00	0 32.00
33.00 REV - FITNESS CENTER	B	-15,165	EMPLOYEE BENEFITS DEPARTMENT	4.00	0 33.00
34.00 HEALTH SERV/WIC MANAGMNT FEE	B	-4,823	OTHER ADMINISTRATIVE AND GENERAL	5.06	0 34.00
35.00 RENT - LUDLOW HILL CLINIC	B	-11,061	OTHER ADMINISTRATIVE AND GENERAL	5.06	0 35.00
36.00 OTHER REVNUUE	B	-5,000	OTHER ADMINISTRATIVE AND GENERAL	5.06	0 36.00
37.00 SISI C BILLING SERVICES	B	-7,539	CASHIERING/ACCOUNTS RECEIVABLE	5.05	0 37.00
38.00 REV - COMMUNITY EDUCATION PROGRAM	B	-16,072	ADULTS & PEDIATRICS	30.00	0 38.00
39.00 MISCELLANEOUS INCOME	B	-1,266	RADIOLOGY-DIAGNOSTIC	54.00	0 39.00
40.00 DIET - NUTRITION COUNSELING	B	-4,397	DIETARY	10.00	0 40.00
40.01 ADVERTISING	A	-35,010	OTHER ADMINISTRATIVE AND GENERAL	5.06	0 40.01
41.00 AHA & IHA DUES	A	-6,841	OTHER ADMINISTRATIVE AND GENERAL	5.06	0 41.00
42.00 MISC. OFFSET	A	-29,668	OTHER ADMINISTRATIVE AND GENERAL	5.06	0 42.00
43.00 MISC. NONALLOWABLE	A	-6,016	HOSPICE	116.00	0 43.00
44.00 ADVERTISING STAFF	A	-11,761	OTHER ADMINISTRATIVE AND GENERAL	5.06	0 44.00
45.00 NON ALLOWABLE REPAIRS	A	-59,279	OPERATION OF PLANT	7.00	0 45.00
45.01 PHYSICIAN RECRUITMENT & HSC LOSS	A	-232,997	OTHER ADMINISTRATIVE AND GENERAL	5.06	0 45.01
45.02 MENTAL HEALTH UTILITIES	A	-69,092	OPERATION OF PLANT	7.00	0 45.02
45.03 NON-ALLOWABLE DEPRECIATION	A	-186,147	NEW CAP REL COSTS-BLDG & FIXT	1.00	9 45.03
45.04 NON ALLOWABLE INTEREST	A	-10,273	NEW CAP REL COSTS-BLDG & FIXT	1.00	11 45.04
45.05 HAF OFFSET	A	-4,570,412	OTHER ADMINISTRATIVE AND GENERAL	5.06	0 45.05
45.06 OTHER ADJUSTMENTS (SPECIFY (3))		0		0.00	0 45.06
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-8,578,749			50.00

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1.

(2) Basis for adjustment (see instructions).

A. Costs - if cost, including applicable overhead, can be determined.

B. Amount Received - if cost cannot be determined.

(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.

Note: See instructions for column 5 referencing to Worksheet A-7.

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 15-0086

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

Worksheet A-8-2

Date/Time Prepared:
5/29/2018 2:11 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	368,763	368,763	0	0	0	1.00
2.00	50.00	OPERATING ROOM	65,000	65,000	0	0	0	2.00
3.00	53.00	ANESTHESIOLOGY	1,226,362	1,226,362	0	0	0	3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	134,288	134,288	0	0	0	4.00
5.00	57.00	CT SCAN	2,350	2,350	0	0	0	5.00
6.00	60.00	LABORATORY	175,000	0	175,000	260,300	503	6.00
7.00	65.00	RESPIRATORY THERAPY	11,148	11,148	0	0	0	7.00
8.00	69.00	ELECTROCARDIOLOGY	-55,263	-55,263	0	0	0	8.00
9.00	91.00	EMERGENCY	187,793	0	187,793	179,000	1,219	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			2,115,441	1,752,648	362,793		1,722	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	50.00	OPERATING ROOM	0	0	0	0	0	2.00
3.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	4.00
5.00	57.00	CT SCAN	0	0	0	0	0	5.00
6.00	60.00	LABORATORY	62,948	3,147	0	0	0	6.00
7.00	65.00	RESPIRATORY THERAPY	0	0	0	0	0	7.00
8.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	8.00
9.00	91.00	EMERGENCY	104,904	5,245	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			167,852	8,392	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	368,763		1.00
2.00	50.00	OPERATING ROOM	0	0	0	65,000		2.00
3.00	53.00	ANESTHESIOLOGY	0	0	0	1,226,362		3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	134,288		4.00
5.00	57.00	CT SCAN	0	0	0	2,350		5.00
6.00	60.00	LABORATORY	0	62,948	112,052	112,052		6.00
7.00	65.00	RESPIRATORY THERAPY	0	0	0	11,148		7.00
8.00	69.00	ELECTROCARDIOLOGY	0	0	0	-55,263		8.00
9.00	91.00	EMERGENCY	0	104,904	82,889	82,889		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	167,852	194,941	1,947,589		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0086

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

Worksheet B
Part I
Date/Time Prepared:
5/29/2018 2:11 pm

Cost Center Description	Net Expenses for Cost Allocation (from Wkst Allocation 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	COMMUNICATIONS	
		NEW BLDG & FIXT	NEW MVBLE EQUIP			
	0	1.00	2.00	4.00	5.01	
GENERAL SERVICE COST CENTERS						
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT	3,748,784	3,748,784				1.00
2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP	2,282,834		2,282,834			2.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	11,832,947	24,027	14,889	11,871,863		4.00
5.01 01160 COMMUNICATIONS	274,703	3,800	2,355	40,269	321,127	5.01
5.02 00550 DATA PROCESSING	2,522,452	36,416	22,566	364,957	13,484	5.02
5.03 00560 PURCHASING RECEIVING AND STORES	395,580	79,896	49,509	86,420	3,496	5.03
5.04 00570 ADMITTING	641,272	43,192	26,765	194,113	4,744	5.04
5.05 00580 CASHIERING/ACCOUNTS RECEIVABLE	1,330,450	8,476	5,252	263,505	12,985	5.05
5.06 00591 OTHER ADMINISTRATIVE AND GENERAL	4,020,594	149,328	92,534	858,775	8,740	5.06
7.00 00700 OPERATION OF PLANT	3,049,398	1,220,012	756,004	387,633	15,232	7.00
8.00 00800 LAUNDRY & LINEN SERVICE	295,315	19,902	12,333	60,707	499	8.00
9.00 00900 HOUSEKEEPING	1,098,433	14,727	9,126	251,020	4,744	9.00
10.00 01000 DIETARY	418,747	50,005	30,987	92,125	1,748	10.00
11.00 01100 CAFETERIA	924,446	35,466	21,977	290,296	5,494	11.00
13.00 01300 NURSING ADMINISTRATION	871,165	7,501	4,648	291,737	5,244	13.00
14.00 01400 CENTRAL SERVICE & SUPPLY	417,295	88,609	54,908	90,638	4,744	14.00
15.00 01500 PHARMACY	1,753,996	22,202	13,758	533,614	10,488	15.00
16.00 01600 MEDICAL RECORDS & LIBRARY	952,640	60,094	37,238	284,524	20,476	16.00
17.00 01700 SOCIAL SERVICE	365,998	7,288	4,516	122,951	2,997	17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000 ADULTS & PEDIATRICS	5,765,685	765,841	474,569	1,904,681	39,704	30.00
31.00 03100 INTENSIVE CARE UNIT	1,367,769	92,509	57,325	450,463	4,744	31.00
43.00 04300 NURSERY	523,105	5,001	3,099	154,712	0	43.00
44.00 04400 SKILLED NURSING FACILITY	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	4,541,832	322,358	199,756	627,761	16,980	50.00
51.00 05100 RECOVERY ROOM	674,353	14,539	9,009	210,785	5,244	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	292,662	6,301	3,904	86,557	0	52.00
53.00 05300 ANESTHESIOLOGY	40,158	200	124	0	1,748	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	3,132,718	146,603	90,845	813,570	18,479	54.00
54.01 05401 ULTRASOUND	260,675	7,751	4,803	83,639	499	54.01
55.00 05500 RADIOLOGY-THERAPEUTIC	624,313	14,439	8,947	156,332	2,747	55.00
57.00 05700 CT SCAN	310,134	0	0	29,127	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	303,732	10,039	6,221	6,514	0	58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00 06000 LABORATORY	5,321,859	84,009	52,058	780,533	10,738	60.00
60.01 06001 BLOOD LABORATORY	0	0	0	0	0	60.01
65.00 06500 RESPIRATORY THERAPY	772,217	14,551	9,017	258,063	8,740	65.00
65.01 03950 SLEEP CLINIC	191,936	0	0	0	0	65.01
66.00 06600 PHYSICAL THERAPY	1,529,625	94,560	58,596	483,551	5,244	66.00
67.00 06700 OCCUPATIONAL THERAPY	263,988	9,926	6,151	89,347	3,496	67.00
68.00 06800 SPEECH PATHOLOGY	225,575	5,301	3,285	77,038	999	68.00
69.00 06900 ELECTROCARDIOLOGY	1,010,777	41,804	25,905	235,429	3,246	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	2,455,301	0	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	328,554	0	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	2,613,469	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS						
91.00 09100 EMERGENCY	1,901,436	121,062	75,019	587,977	8,490	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS						
101.00 10100 HOME HEALTH AGENCY	1,084,565	38,566	23,898	337,108	1,498	101.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300 INTEREST EXPENSE						113.00
116.00 11600 HOSPICE	467,504	3,938	2,440	78,114	0	116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	73,200,991	3,670,239	2,274,336	11,664,585	247,711	118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	66,537	30,503	0	23,079	749	190.00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	304,070	0	0	19,880	65,675	192.00
192.01 19201 PHYSICIAN CLINIC	97,212	21,252	0	20,938	0	192.01
192.02 19202 LIFELINE	2,662	13,076	0	0	2,997	192.02
192.03 19203 CREDIT UNION	0	0	0	0	3,246	192.03
192.04 19204 BREAST MRI STUDY	0	0	0	0	749	192.04
192.05 19205 HOSPITALIST	1,031,396	4,088	2,533	0	0	192.05
194.00 07950 COMMUNITY MENTAL HEALTH	0	0	0	0	0	194.00
194.01 07951 MARKETING	494,470	9,001	5,578	45,731	0	194.01
194.02 07953 OCCUPATIONAL HEALTH	298,060	0	0	92,468	0	194.02
194.03 07952 PATHS EDUCATION	48,618	0	0	0	0	194.03
194.04 07954 FOUNDATION	14,939	625	387	5,182	0	194.04

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0086

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

Worksheet B
Part I
Date/Time Prepared:
5/29/2018 2:11 pm

Cost Center Description		Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	COMMUNICATIONS	
			NEW BLDG & FIXT	NEW MVBLE EQUIP			
		0	1.00	2.00	4.00	5.01	
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers		0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	75,558,955	3,748,784	2,282,834	11,871,863	321,127	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0086

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

Worksheet B
Part I
Date/Time Prepared:
5/29/2018 2:11 pm

Cost Center Description			DATA PROCESSING	PURCHASING RECEIVING AND STORES	ADMINITTING	CASHIERING/ACCOUNTS RECEIVABLE	Subtotal	
			5.02	5.03	5.04	5.05	5A.05	
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
5.01	01160	COMMUNICATIONS						5.01
5.02	00550	DATA PROCESSING	2,959,875					5.02
5.03	00560	PURCHASING RECEIVING AND STORES	35,412	650,313				5.03
5.04	00570	ADMINITTING	97,384	2,741	1,010,211			5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	153,453	856	0	1,774,977		5.05
5.06	00591	OTHER ADMINISTRATIVE AND GENERAL	159,355	11,514	0	0	5,300,840	5.06
7.00	00700	OPERATION OF PLANT	41,314	11,097	0	0	5,480,690	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	5,991	0	0	394,747	8.00
9.00	00900	HOUSEKEEPING	14,755	11,794	0	0	1,404,599	9.00
10.00	01000	DIETARY	94,433	7,350	0	0	695,395	10.00
11.00	01100	CAFETERIA	0	0	0	0	1,277,679	11.00
13.00	01300	NURSING ADMINISTRATION	50,167	838	0	0	1,231,300	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	61,971	52,934	0	0	771,099	14.00
15.00	01500	PHARMACY	91,482	5,216	0	0	2,430,756	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	159,355	1,547	0	0	1,515,874	16.00
17.00	01700	SOCIAL SERVICE	26,559	441	0	0	530,750	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	525,284	14,930	68,377	144,906	9,703,977	30.00
31.00	03100	INTENSIVE CARE UNIT	79,678	3,152	9,154	32,120	2,096,914	31.00
43.00	04300	NURSERY	0	0	7,615	4,766	698,298	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	185,914	117,075	0	264,793	6,276,469	50.00
51.00	05100	RECOVERY ROOM	0	1,915	0	29,518	945,363	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	12,882	402,306	52.00
53.00	05300	ANESTHESIOLOGY	0	7,564	0	19,225	69,019	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	141,649	23,429	0	160,268	4,527,561	54.00
54.01	05401	ULTRASOUND	0	1,983	0	31,437	390,787	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	29,510	17,321	0	49,344	902,953	55.00
57.00	05700	CT SCAN	0	9,916	0	166,387	515,564	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	2,844	0	27,526	356,876	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	200,669	122,740	0	319,953	6,892,559	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	106,237	4,295	0	52,673	1,225,793	65.00
65.01	03950	SLEEP CLINIC	0	77	0	7,306	199,319	65.01
66.00	06600	PHYSICAL THERAPY	64,922	2,779	0	56,170	2,295,447	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	453	0	7,635	380,996	67.00
68.00	06800	SPEECH PATHOLOGY	0	141	0	5,411	317,750	68.00
69.00	06900	ELECTROCARDIOLOGY	0	2,345	0	65,473	1,384,979	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	40,144	2,495,445	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	190,259	0	2,545	521,358	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	105,107	2,718,576	73.00
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	100,335	5,715	0	149,550	2,949,584	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	120,992	2,890	0	10,923	1,620,440	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE	0	0	0	0	0	113.00
116.00	11600	HOSPICE	0	4,336	0	8,915	565,247	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,540,830	648,478	85,146	1,774,977	71,487,309	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	120,868	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	377,731	653	0	0	768,009	192.00
192.01	19201	PHYSICIAN CLINIC	26,559	221	0	0	166,182	192.01
192.02	19202	LIFELINE	0	0	0	0	18,735	192.02
192.03	19203	CREDIT UNION	0	0	0	0	3,246	192.03
192.04	19204	BREAST MRI STUDY	0	0	0	0	749	192.04
192.05	19205	HOSPITALIST	11,804	80	0	0	1,049,901	192.05
194.00	07950	COMMUNITY MENTAL HEALTH	0	0	0	0	0	194.00
194.01	07951	MARKETING	2,951	254	0	0	557,985	194.01
194.02	07953	OCCUPATIONAL HEALTH	0	613	925,065	0	1,316,206	194.02
194.03	07952	PATHS EDUCATION	0	14	0	0	48,632	194.03
194.04	07954	FOUNDATION	0	0	0	0	21,133	194.04
200.00		Cross Foot Adjustments	0	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	2,959,875	650,313	1,010,211	1,774,977	75,558,955	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0086

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

Worksheet B
Part I
Date/Time Prepared:
5/29/2018 2:11 pm

Cost Center Description		OTHER ADMINISTRATIVE AND GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.06	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
5.01	01160	COMMUNICATIONS					5.01
5.02	00550	DATA PROCESSING					5.02
5.03	00560	PURCHASING RECEIVING AND STORES					5.03
5.04	00570	ADMINITTING					5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE					5.05
5.06	00591	OTHER ADMINISTRATIVE AND GENERAL	5,300,840				5.06
7.00	00700	OPERATION OF PLANT	413,507	5,894,197			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	29,783	53,721	478,251		8.00
9.00	00900	HOUSEKEEPING	105,974	39,751	61,968	1,612,292	9.00
10.00	01000	DIETARY	52,466	134,977	3,669	37,516	924,023
11.00	01100	CAFETERIA	96,398	95,732	12,285	26,608	0
13.00	01300	NURSING ADMINISTRATION	92,899	20,247	0	5,627	0
14.00	01400	CENTRAL SERVICE & SUPPLY	58,178	239,179	2,786	66,479	0
15.00	01500	PHARMACY	183,396	59,930	0	16,657	0
16.00	01600	MEDICAL RECORDS & LIBRARY	114,370	162,208	0	45,085	0
17.00	01700	SOCIAL SERVICE	40,044	19,673	0	5,468	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	732,152	2,067,200	163,158	574,575	683,245
31.00	03100	INTENSIVE CARE UNIT	158,208	249,707	30,838	69,405	53,962
43.00	04300	NURSERY	52,685	13,498	0	3,752	0
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	473,547	870,127	22,401	241,849	0
51.00	05100	RECOVERY ROOM	71,326	39,244	19,183	10,908	2,948
52.00	05200	DELIVERY ROOM & LABOR ROOM	30,353	17,007	0	4,727	0
53.00	05300	ANESTHESIOLOGY	5,207	540	0	150	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	341,595	395,718	35,147	109,988	0
54.01	05401	ULTRASOUND	29,484	20,921	0	5,815	0
55.00	05500	RADIOLOGY-THERAPEUTIC	68,126	38,975	3,248	10,833	0
57.00	05700	CT SCAN	38,898	0	0	0	0
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	26,926	27,097	0	7,531	0
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0
60.00	06000	LABORATORY	520,030	226,761	221	63,027	0
60.01	06001	BLOOD LABORATORY	0	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	92,484	39,278	0	10,917	0
65.01	03950	SLEEP CLINIC	15,038	0	0	0	0
66.00	06600	PHYSICAL THERAPY	173,187	255,241	15,645	70,943	0
67.00	06700	OCCUPATIONAL THERAPY	28,745	26,793	776	7,447	0
68.00	06800	SPEECH PATHOLOGY	23,974	14,308	0	3,977	0
69.00	06900	ELECTROCARDIOLOGY	104,494	112,841	2,077	31,364	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	188,276	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	39,335	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	205,111	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	222,540	326,779	92,813	90,827	13,588
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	122,259	104,101	0	28,934	0
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					
116.00	11600	HOSPICE	42,647	10,629	0	2,954	0
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	4,993,642	5,682,183	466,215	1,553,363	753,743
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	9,119	82,336	0	22,885	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	57,945	0	967	0	0
192.01	19201	PHYSICIAN CLINIC	12,538	57,365	0	15,944	0
192.02	19202	LIFELINE	1,414	35,296	0	9,811	0
192.03	19203	CREDIT UNION	245	0	0	0	0
192.04	19204	BREAST MRI STUDY	57	0	0	0	0
192.05	19205	HOSPITALIST	79,213	11,034	0	3,067	0
194.00	07950	COMMUNITY MENTAL HEALTH	0	0	11,069	0	170,280
194.01	07951	MARKETING	42,099	24,296	0	6,753	0
194.02	07953	OCCUPATIONAL HEALTH	99,305	0	0	0	0
194.03	07952	PATHS EDUCATION	3,669	0	0	0	0
194.04	07954	FOUNDATION	1,594	1,687	0	469	0
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118 through 201)	5,300,840	5,894,197	478,251	1,612,292	924,023

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0086

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

Worksheet B
Part I
Date/Time Prepared:
5/29/2018 2:11 pm

Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICE & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.01	01160						5.01
5.02	00550						5.02
5.03	00560						5.03
5.04	00570						5.04
5.05	00580						5.05
5.06	00591						5.06
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	1,508,702					11.00
13.00	01300	34,228	1,384,301				13.00
14.00	01400	28,195	52,744	1,218,660			14.00
15.00	01500	71,057	0	0	2,761,796		15.00
16.00	01600	64,133	0	0	0	1,901,670	16.00
17.00	01700	20,770	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	351,583	657,698	0	0	137,856	30.00
31.00	03100	72,215	135,089	0	0	34,934	31.00
43.00	04300	26,300	49,198	0	0	5,184	43.00
44.00	04400	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	101,116	189,153	0	0	287,335	50.00
51.00	05100	33,613	62,878	0	0	32,103	51.00
52.00	05200	14,715	27,526	0	0	13,691	52.00
53.00	05300	0	0	0	0	20,910	53.00
54.00	05400	149,485	0	0	0	174,150	54.00
54.01	05401	11,251	0	0	0	34,191	54.01
55.00	05500	20,947	0	0	0	53,451	55.00
57.00	05700	0	0	0	0	180,963	57.00
58.00	05800	0	0	0	0	29,371	58.00
59.00	05900	0	0	0	0	0	59.00
60.00	06000	169,652	0	0	0	347,964	60.00
60.01	06001	0	0	0	0	0	60.01
65.00	06500	42,751	0	0	0	56,490	65.00
65.01	03950	0	0	0	0	7,946	65.01
66.00	06600	79,896	0	0	0	61,090	66.00
67.00	06700	12,108	0	0	0	8,304	67.00
68.00	06800	8,580	0	0	0	5,885	68.00
69.00	06900	41,284	0	0	0	63,851	69.00
71.00	07100	0	0	1,218,660	0	43,661	71.00
72.00	07200	0	0	0	0	3,798	72.00
73.00	07300	0	0	0	2,761,796	114,315	73.00
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	112,268	210,015	0	0	162,651	91.00
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	0	0	0	0	11,880	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
116.00	11600	0	0	0	0	9,696	116.00
118.00		1,466,147	1,384,301	1,218,660	2,761,796	1,901,670	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	10,030	0	0	0	0	190.00
192.00	19200	3,416	0	0	0	0	192.00
192.01	19201	8,356	0	0	0	0	192.01
192.02	19202	0	0	0	0	0	192.02
192.03	19203	0	0	0	0	0	192.03
192.04	19204	0	0	0	0	0	192.04
192.05	19205	0	0	0	0	0	192.05
194.00	07950	0	0	0	0	0	194.00
194.01	07951	0	0	0	0	0	194.01
194.02	07953	7,097	0	0	0	0	194.02
194.03	07952	13,656	0	0	0	0	194.03
194.04	07954	0	0	0	0	0	194.04
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		1,508,702	1,384,301	1,218,660	2,761,796	1,901,670	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0086

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

Worksheet B
Part I
Date/Time Prepared:
5/29/2018 2:11 pm

Cost Center Description			SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			17.00	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
5.01	01160	COMMUNICATIONS					5.01
5.02	00550	DATA PROCESSING					5.02
5.03	00560	PURCHASING RECEIVING AND STORES					5.03
5.04	00570	ADMITTING					5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE					5.05
5.06	00591	OTHER ADMINISTRATIVE AND GENERAL					5.06
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICE & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
17.00	01700	SOCIAL SERVICE	616,705				17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	584,731	15,656,175	0	15,656,175	30.00
31.00	03100	INTENSIVE CARE UNIT	19,853	2,921,125	0	2,921,125	31.00
43.00	04300	NURSERY	0	848,915	0	848,915	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	2,299	8,464,296	0	8,464,296	50.00
51.00	05100	RECOVERY ROOM	627	1,218,193	0	1,218,193	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	510,325	0	510,325	52.00
53.00	05300	ANESTHESIOLOGY	0	95,826	0	95,826	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	5,733,644	0	5,733,644	54.00
54.01	05401	ULTRASOUND	0	492,449	0	492,449	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	1,098,533	0	1,098,533	55.00
57.00	05700	CT SCAN	0	735,425	0	735,425	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	447,801	0	447,801	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	0	8,220,214	0	8,220,214	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	1,467,713	0	1,467,713	65.00
65.01	03950	SLEEP CLINIC	0	222,303	0	222,303	65.01
66.00	06600	PHYSICAL THERAPY	0	2,951,449	0	2,951,449	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	465,169	0	465,169	67.00
68.00	06800	SPEECH PATHOLOGY	0	374,474	0	374,474	68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,740,890	0	1,740,890	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	3,946,042	0	3,946,042	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	564,491	0	564,491	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	5,799,798	0	5,799,798	73.00
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	9,195	4,190,260	0	4,190,260	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0		92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	0	1,887,614	0	1,887,614	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
116.00	11600	HOSPICE	0	631,173	0	631,173	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	616,705	70,684,297	0	70,684,297	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	245,238	0	245,238	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	830,337	0	830,337	192.00
192.01	19201	PHYSICIAN CLINIC	0	260,385	0	260,385	192.01
192.02	19202	LIFELINE	0	65,256	0	65,256	192.02
192.03	19203	CREDIT UNION	0	3,491	0	3,491	192.03
192.04	19204	BREAST MRI STUDY	0	806	0	806	192.04
192.05	19205	HOSPITALIST	0	1,143,215	0	1,143,215	192.05
194.00	07950	COMMUNITY MENTAL HEALTH	0	181,349	0	181,349	194.00
194.01	07951	MARKETING	0	631,133	0	631,133	194.01
194.02	07953	OCCUPATIONAL HEALTH	0	1,422,608	0	1,422,608	194.02
194.03	07952	PATHS EDUCATION	0	65,957	0	65,957	194.03
194.04	07954	FOUNDATION	0	24,883	0	24,883	194.04
200.00		Cross Foot Adjustments		0		0	200.00
201.00		Negative Cost Centers	0	0	0	0	201.00

COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 15-0086		Period: From 01/01/2017 To 12/31/2017		Worksheet B Part I Date/Time Prepared: 5/29/2018 2:11 pm	
Cost Center Description		SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
202.00	TOTAL (sum lines 118 through 201)	616,705	75,558,955	25.00	75,558,955		202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0086

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

Worksheet B
Part II
Date/Time Prepared:
5/29/2018 2:11 pm

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		NEW BLDG & FIXT	NEW MVBLE EQUIP			
		0	1.00			
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	24,027	14,889	38,916	4.00
5.01 01160	COMMUNICATIONS	0	3,800	2,355	6,155	5.01
5.02 00550	DATA PROCESSING	0	36,416	22,566	58,982	5.02
5.03 00560	PURCHASING RECEIVING AND STORES	0	79,896	49,509	129,405	5.03
5.04 00570	ADMITTING	0	43,192	26,765	69,957	5.04
5.05 00580	CASHIERING/ACCOUNTS RECEIVABLE	0	8,476	5,252	13,728	5.05
5.06 00591	OTHER ADMINISTRATIVE AND GENERAL	0	149,328	92,534	241,862	5.06
7.00 00700	OPERATION OF PLANT	0	1,220,012	756,004	1,976,016	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	19,902	12,333	32,235	8.00
9.00 00900	HOUSEKEEPING	0	14,727	9,126	23,853	9.00
10.00 01000	DIETARY	0	50,005	30,987	80,992	10.00
11.00 01100	CAFETERIA	0	35,466	21,977	57,443	11.00
13.00 01300	NURSING ADMINISTRATION	0	7,501	4,648	12,149	13.00
14.00 01400	CENTRAL SERVICE & SUPPLY	0	88,609	54,908	143,517	14.00
15.00 01500	PHARMACY	0	22,202	13,758	35,960	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	60,094	37,238	97,332	16.00
17.00 01700	SOCIAL SERVICE	0	7,288	4,516	11,804	17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	0	765,841	474,569	1,240,410	30.00
31.00 03100	INTENSIVE CARE UNIT	0	92,509	57,325	149,834	31.00
43.00 04300	NURSERY	0	5,001	3,099	8,100	43.00
44.00 04400	SKILLED NURSING FACILITY	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	0	322,358	199,756	522,114	50.00
51.00 05100	RECOVERY ROOM	0	14,539	9,009	23,548	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	6,301	3,904	10,205	52.00
53.00 05300	ANESTHESIOLOGY	0	200	124	324	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	146,603	90,845	237,448	54.00
54.01 05401	ULTRASOUND	0	7,751	4,803	12,554	54.01
55.00 05500	RADIOLOGY-THERAPEUTIC	0	14,439	8,947	23,386	55.00
57.00 05700	CT SCAN	0	0	0	0	57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	10,039	6,221	16,260	58.00
59.00 05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00 06000	LABORATORY	0	84,009	52,058	136,067	60.00
60.01 06001	BLOOD LABORATORY	0	0	0	0	60.01
65.00 06500	RESPIRATORY THERAPY	0	14,551	9,017	23,568	65.00
65.01 03950	SLEEP CLINIC	0	0	0	0	65.01
66.00 06600	PHYSICAL THERAPY	0	94,560	58,596	153,156	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	9,926	6,151	16,077	67.00
68.00 06800	SPEECH PATHOLOGY	0	5,301	3,285	8,586	68.00
69.00 06900	ELECTROCARDIOLOGY	0	41,804	25,905	67,709	69.00
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						
91.00 09100	EMERGENCY	0	121,062	75,019	196,081	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
101.00 10100	HOME HEALTH AGENCY	0	38,566	23,898	62,464	101.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					113.00
116.00 11600	HOSPICE	0	3,938	2,440	6,378	116.00
118.00 11800	SUBTOTALS (SUM OF LINES 1 through 117)	0	3,670,239	2,274,336	5,944,575	118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	30,503	0	30,503	190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
192.01 19201	PHYSICIAN CLINIC	0	21,252	0	21,252	192.01
192.02 19202	LIFELINE	0	13,076	0	13,076	192.02
192.03 19203	CREDIT UNION	0	0	0	0	192.03
192.04 19204	BREAST MRI STUDY	0	0	0	0	192.04
192.05 19205	HOSPITALIST	0	4,088	2,533	6,621	192.05
194.00 07950	COMMUNITY MENTAL HEALTH	0	0	0	0	194.00
194.01 07951	MARKETING	0	9,001	5,578	14,579	194.01
194.02 07953	OCCUPATIONAL HEALTH	0	0	0	0	194.02
194.03 07952	PATHS EDUCATION	0	0	0	0	194.03
194.04 07954	FOUNDATION	0	625	387	1,012	194.04
200.00	Cross Foot Adjustments				0	200.00

Cost Center Description		Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			NEW BLDG & FIXT	NEW MVBLE EQUIP			
		0	1.00	2.00	2A	4.00	
201.00	Negative Cost Centers		0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	0	3,748,784	2,282,834	6,031,618	38,916	202.00

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 15-0086		Period: From 01/01/2017 To 12/31/2017		Worksheet B Part II Date/Time Prepared: 5/29/2018 2:11 pm	
Cost Center Description			COMMUNICATIONS	DATA PROCESSING	PURCHASING RECEIVING AND STORES	ADMINITTING	CASHIERING/ACCOUNTS RECEIVABLE	
			5.01	5.02	5.03	5.04	5.05	
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
5.01	01160	COMMUNICATIONS	6,287					5.01
5.02	00550	DATA PROCESSING	264	60,442				5.02
5.03	00560	PURCHASING RECEIVING AND STORES	68	723	130,479			5.03
5.04	00570	ADMINITTING	93	1,989	550	73,225		5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	254	3,134	172	0	18,152	5.05
5.06	00591	OTHER ADMINISTRATIVE AND GENERAL	171	3,254	2,310	0	0	5.06
7.00	00700	OPERATION OF PLANT	298	844	2,227	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	10	0	1,202	0	0	8.00
9.00	00900	HOUSEKEEPING	93	301	2,366	0	0	9.00
10.00	01000	DIETARY	34	1,928	1,475	0	0	10.00
11.00	01100	CAFETERIA	108	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	103	1,024	168	0	0	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	93	1,265	10,621	0	0	14.00
15.00	01500	PHARMACY	205	1,868	1,047	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	401	3,254	310	0	0	16.00
17.00	01700	SOCIAL SERVICE	59	542	89	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	777	10,728	2,996	4,956	1,486	30.00
31.00	03100	INTENSIVE CARE UNIT	93	1,627	632	664	329	31.00
43.00	04300	NURSERY	0	0	0	552	49	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	332	3,796	23,490	0	2,715	50.00
51.00	05100	RECOVERY ROOM	103	0	384	0	303	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	132	52.00
53.00	05300	ANESTHESIOLOGY	34	0	1,518	0	197	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	362	2,893	4,701	0	1,643	54.00
54.01	05401	ULTRASOUND	10	0	398	0	322	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	54	603	3,475	0	506	55.00
57.00	05700	CT SCAN	0	0	1,990	0	1,706	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	571	0	282	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	210	4,098	24,627	0	3,235	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	171	2,169	862	0	540	65.00
65.01	03950	SLEEP CLINIC	0	0	15	0	75	65.01
66.00	06600	PHYSICAL THERAPY	103	1,326	558	0	576	66.00
67.00	06700	OCCUPATIONAL THERAPY	68	0	91	0	78	67.00
68.00	06800	SPEECH PATHOLOGY	20	0	28	0	55	68.00
69.00	06900	ELECTROCARDIOLOGY	64	0	470	0	671	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	412	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	38,171	0	26	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	1,078	73.00
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	166	2,049	1,147	0	1,533	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	29	2,471	580	0	112	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	870	0	91	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	4,850	51,886	130,111	6,172	18,152	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	15	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,284	7,713	131	0	0	192.00
192.01	19201	PHYSICIAN CLINIC	0	542	44	0	0	192.01
192.02	19202	LIFELINE	59	0	0	0	0	192.02
192.03	19203	CREDIT UNION	64	0	0	0	0	192.03
192.04	19204	BREAST MRI STUDY	15	0	0	0	0	192.04
192.05	19205	HOSPITALIST	0	241	16	0	0	192.05
194.00	07950	COMMUNITY MENTAL HEALTH	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	60	51	0	0	194.01
194.02	07953	OCCUPATIONAL HEALTH	0	0	123	67,053	0	194.02
194.03	07952	PATHS EDUCATION	0	0	3	0	0	194.03
194.04	07954	FOUNDATION	0	0	0	0	0	194.04
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)	6,287	60,442	130,479	73,225	18,152	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0086

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

Worksheet B
Part II
Date/Time Prepared:
5/29/2018 2:11 pm

Cost Center Description		OTHER ADMINISTRATIVE AND GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.06	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.01	01160						5.01
5.02	00550						5.02
5.03	00560						5.03
5.04	00570						5.04
5.05	00580						5.05
5.06	00591	250,412					5.06
7.00	00700	19,533	2,000,189				7.00
8.00	00800	1,407	18,230	53,283			8.00
9.00	00900	5,006	13,489	6,904	52,835		9.00
10.00	01000	2,478	45,804	409	1,229	134,651	10.00
11.00	01100	4,554	32,487	1,369	872	0	11.00
13.00	01300	4,388	6,871	0	184	0	13.00
14.00	01400	2,748	81,165	310	2,179	0	14.00
15.00	01500	8,663	20,337	0	546	0	15.00
16.00	01600	5,403	55,045	0	1,477	0	16.00
17.00	01700	1,892	6,676	0	179	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	34,598	701,503	18,177	18,831	99,564	30.00
31.00	03100	7,473	84,738	3,436	2,274	7,863	31.00
43.00	04300	2,489	4,580	0	123	0	43.00
44.00	04400	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	22,369	295,277	2,496	7,925	0	50.00
51.00	05100	3,369	13,318	2,137	357	430	51.00
52.00	05200	1,434	5,771	0	155	0	52.00
53.00	05300	246	183	0	5	0	53.00
54.00	05400	16,136	134,286	3,916	3,604	0	54.00
54.01	05401	1,393	7,100	0	191	0	54.01
55.00	05500	3,218	13,226	362	355	0	55.00
57.00	05700	1,837	0	0	0	0	57.00
58.00	05800	1,272	9,195	0	247	0	58.00
59.00	05900	0	0	0	0	0	59.00
60.00	06000	24,565	76,951	25	2,065	0	60.00
60.01	06001	0	0	0	0	0	60.01
65.00	06500	4,369	13,329	0	358	0	65.00
65.01	03950	710	0	0	0	0	65.01
66.00	06600	8,181	86,616	1,743	2,325	0	66.00
67.00	06700	1,358	9,092	87	244	0	67.00
68.00	06800	1,132	4,855	0	130	0	68.00
69.00	06900	4,936	38,292	231	1,028	0	69.00
71.00	07100	8,894	0	0	0	0	71.00
72.00	07200	1,858	0	0	0	0	72.00
73.00	07300	9,689	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	10,512	110,892	10,340	2,976	1,980	91.00
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	5,775	35,326	0	948	0	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
116.00	11600	2,015	3,607	0	97	0	116.00
118.00		235,900	1,928,241	51,942	50,904	109,837	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	431	27,941	0	750	0	190.00
192.00	19200	2,737	0	108	0	0	192.00
192.01	19201	592	19,467	0	523	0	192.01
192.02	19202	67	11,978	0	321	0	192.02
192.03	19203	12	0	0	0	0	192.03
192.04	19204	3	0	0	0	0	192.04
192.05	19205	3,742	3,744	0	101	0	192.05
194.00	07950	0	0	1,233	0	24,814	194.00
194.01	07951	1,989	8,245	0	221	0	194.01
194.02	07953	4,691	0	0	0	0	194.02
194.03	07952	173	0	0	0	0	194.03
194.04	07954	75	573	0	15	0	194.04
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		250,412	2,000,189	53,283	52,835	134,651	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0086

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

Worksheet B
Part II
Date/Time Prepared:
5/29/2018 2:11 pm

Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICE & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.01	01160						5.01
5.02	00550						5.02
5.03	00560						5.03
5.04	00570						5.04
5.05	00580						5.05
5.06	00591						5.06
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	97,785					11.00
13.00	01300	2,218	28,061				13.00
14.00	01400	1,827	1,069	245,091			14.00
15.00	01500	4,605	0	0	74,980		15.00
16.00	01600	4,157	0	0	0	168,312	16.00
17.00	01700	1,346	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	22,787	13,333	0	0	12,197	30.00
31.00	03100	4,681	2,738	0	0	3,091	31.00
43.00	04300	1,705	997	0	0	459	43.00
44.00	04400	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	6,554	3,834	0	0	25,422	50.00
51.00	05100	2,179	1,275	0	0	2,840	51.00
52.00	05200	954	558	0	0	1,211	52.00
53.00	05300	0	0	0	0	1,850	53.00
54.00	05400	9,689	0	0	0	15,408	54.00
54.01	05401	729	0	0	0	3,025	54.01
55.00	05500	1,358	0	0	0	4,729	55.00
57.00	05700	0	0	0	0	16,011	57.00
58.00	05800	0	0	0	0	2,599	58.00
59.00	05900	0	0	0	0	0	59.00
60.00	06000	10,996	0	0	0	30,847	60.00
60.01	06001	0	0	0	0	0	60.01
65.00	06500	2,771	0	0	0	4,998	65.00
65.01	03950	0	0	0	0	703	65.01
66.00	06600	5,178	0	0	0	5,405	66.00
67.00	06700	785	0	0	0	735	67.00
68.00	06800	556	0	0	0	521	68.00
69.00	06900	2,676	0	0	0	5,649	69.00
71.00	07100	0	0	245,091	0	3,863	71.00
72.00	07200	0	0	0	0	336	72.00
73.00	07300	0	0	0	74,980	10,114	73.00
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	7,276	4,257	0	0	14,390	91.00
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	0	0	0	0	1,051	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
116.00	11600	0	0	0	0	858	116.00
118.00		95,027	28,061	245,091	74,980	168,312	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	650	0	0	0	0	190.00
192.00	19200	221	0	0	0	0	192.00
192.01	19201	542	0	0	0	0	192.01
192.02	19202	0	0	0	0	0	192.02
192.03	19203	0	0	0	0	0	192.03
192.04	19204	0	0	0	0	0	192.04
192.05	19205	0	0	0	0	0	192.05
194.00	07950	0	0	0	0	0	194.00
194.01	07951	0	0	0	0	0	194.01
194.02	07953	460	0	0	0	0	194.02
194.03	07952	885	0	0	0	0	194.03
194.04	07954	0	0	0	0	0	194.04
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		97,785	28,061	245,091	74,980	168,312	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 15-0086	Period: From 01/01/2017 To 12/31/2017	Worksheet B Part II Date/Time Prepared: 5/29/2018 2:11 pm		
Cost Center	Description	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		17.00	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
5.01	01160	COMMUNICATIONS				5.01
5.02	00550	DATA PROCESSING				5.02
5.03	00560	PURCHASING RECEIVING AND STORES				5.03
5.04	00570	ADMITTING				5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE				5.05
5.06	00591	OTHER ADMINISTRATIVE AND GENERAL				5.06
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICE & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
17.00	01700	SOCIAL SERVICE	22,990			17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	21,798	2,210,384	0	2,210,384
31.00	03100	INTENSIVE CARE UNIT	740	271,690	0	271,690
43.00	04300	NURSERY	0	19,561	0	19,561
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	86	918,468	0	918,468
51.00	05100	RECOVERY ROOM	23	50,957	0	50,957
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	20,704	0	20,704
53.00	05300	ANESTHESIOLOGY	0	4,357	0	4,357
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	432,753	0	432,753
54.01	05401	ULTRASOUND	0	25,996	0	25,996
55.00	05500	RADIOLOGY-THERAPEUTIC	0	51,784	0	51,784
57.00	05700	CT SCAN	0	21,639	0	21,639
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	30,447	0	30,447
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0
60.00	06000	LABORATORY	0	316,245	0	316,245
60.01	06001	BLOOD LABORATORY	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	0	53,981	0	53,981
65.01	03950	SLEEP CLINIC	0	1,503	0	1,503
66.00	06600	PHYSICAL THERAPY	0	266,752	0	266,752
67.00	06700	OCCUPATIONAL THERAPY	0	28,908	0	28,908
68.00	06800	SPEECH PATHOLOGY	0	16,136	0	16,136
69.00	06900	ELECTROCARDIOLOGY	0	122,498	0	122,498
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	258,260	0	258,260
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	40,391	0	40,391
73.00	07300	DRUGS CHARGED TO PATIENTS	0	95,861	0	95,861
OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	343	365,869	0	365,869
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0	
OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	109,861	0	109,861
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
116.00	11600	HOSPICE	0	14,172	0	14,172
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	22,990	5,749,177	0	5,749,177
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	60,366	0	60,366
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	12,259	0	12,259
192.01	19201	PHYSICIAN CLINIC	0	43,031	0	43,031
192.02	19202	LIFELINE	0	25,501	0	25,501
192.03	19203	CREDIT UNION	0	76	0	76
192.04	19204	BREAST MRI STUDY	0	18	0	18
192.05	19205	HOSPITALIST	0	14,465	0	14,465
194.00	07950	COMMUNITY MENTAL HEALTH	0	26,047	0	26,047
194.01	07951	MARKETING	0	25,295	0	25,295
194.02	07953	OCCUPATIONAL HEALTH	0	72,630	0	72,630
194.03	07952	PATHS EDUCATION	0	1,061	0	1,061
194.04	07954	FOUNDATION	0	1,692	0	1,692
200.00		Cross Foot Adjustments		0		0
201.00		Negative Cost Centers	0	0	0	0

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 15-0086		Period: From 01/01/2017 To 12/31/2017		Worksheet B Part II Date/Time Prepared: 5/29/2018 2:11 pm	
Cost Center Description		SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
202.00	TOTAL (sum lines 118 through 201)	22,990	6,031,618	25.00	6,031,618		202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0086

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

Worksheet B-1

Date/Time Prepared:
5/29/2018 2:11 pm

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	COMMUNICATIONS (PHONES)	DATA PROCESSING (DP EQUIPMENT)	
	NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)				
	1.00	2.00				
GENERAL SERVICE COST CENTERS						
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT	299,872				1.00
2.00 00200	NEW CAP REL COSTS-MVBLE EQUIP		294,686			2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	1,922	1,922	34,226,303		4.00
5.01 01160	COMMUNICATIONS	304	304	116,095	1,286	5.01
5.02 00550	DATA PROCESSING	2,913	2,913	1,052,163	54	1,003 5.02
5.03 00560	PURCHASING RECEIVING AND STORES	6,391	6,391	249,147	14	12 5.03
5.04 00570	ADMINISTRATIVE	3,455	3,455	559,622	19	33 5.04
5.05 00580	CASHIERING/ACCOUNTS RECEIVABLE	678	678	759,677	52	52 5.05
5.06 00591	OTHER ADMINISTRATIVE AND GENERAL	11,945	11,945	2,475,827	35	54 5.06
7.00 00700	OPERATION OF PLANT	97,591	97,591	1,117,536	61	14 7.00
8.00 00800	LAUNDRY & LINEN SERVICE	1,592	1,592	175,017	2	0 8.00
9.00 00900	HOUSEKEEPING	1,178	1,178	723,683	19	5 9.00
10.00 01000	DIETARY	4,000	4,000	265,594	7	32 10.00
11.00 01100	CAFETERIA	2,837	2,837	836,915	22	0 11.00
13.00 01300	NURSING ADMINISTRATION	600	600	841,071	21	17 13.00
14.00 01400	CENTRAL SERVICE & SUPPLY	7,088	7,088	261,306	19	21 14.00
15.00 01500	PHARMACY	1,776	1,776	1,538,395	42	31 15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	4,807	4,807	820,274	82	54 16.00
17.00 01700	SOCIAL SERVICE	583	583	354,465	12	9 17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	61,261	61,261	5,491,171	159	178 30.00
31.00 03100	INTENSIVE CARE UNIT	7,400	7,400	1,298,674	19	27 31.00
43.00 04300	NURSERY	400	400	446,030	0	0 43.00
44.00 04400	SKILLED NURSING FACILITY	0	0	0	0	0 44.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	25,786	25,786	1,809,820	68	63 50.00
51.00 05100	RECOVERY ROOM	1,163	1,163	607,689	21	0 51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	504	504	249,541	0	0 52.00
53.00 05300	ANESTHESIOLOGY	16	16	0	7	0 53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	11,727	11,727	2,345,500	74	48 54.00
54.01 05401	ULTRASOUND	620	620	241,129	2	0 54.01
55.00 05500	RADIOLOGY-THERAPEUTIC	1,155	1,155	450,700	11	10 55.00
57.00 05700	CT SCAN	0	0	83,972	0	0 57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	803	803	18,780	0	0 58.00
59.00 05900	CARDIAC CATHETERIZATION	0	0	0	0	0 59.00
60.00 06000	LABORATORY	6,720	6,720	2,250,258	43	68 60.00
60.01 06001	BLOOD LABORATORY	0	0	0	0	0 60.01
65.00 06500	RESPIRATORY THERAPY	1,164	1,164	743,990	35	36 65.00
65.01 03950	SLEEP CLINIC	0	0	0	0	0 65.01
66.00 06600	PHYSICAL THERAPY	7,564	7,564	1,394,065	21	22 66.00
67.00 06700	OCCUPATIONAL THERAPY	794	794	257,586	14	0 67.00
68.00 06800	SPEECH PATHOLOGY	424	424	222,100	4	0 68.00
69.00 06900	ELECTROCARDIOLOGY	3,344	3,344	678,735	13	0 69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0 71.00
72.00 07200	IMPL. DEV. CHARGED TO 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						
91.00 09100	EMERGENCY	9,684	9,684	1,695,123	34	34 91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					
OTHER REIMBURSABLE COST CENTERS						
101.00 10100	HOME HEALTH AGENCY	3,085	3,085	971,873	6	41 101.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					
116.00 11600	HOSPICE	315	315	225,201	0	0 116.00
118.00 11800	SUBTOTALS (SUM OF LINES 1 through 117)	293,589	293,589	33,628,724	992	861 118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,440	0	66,537	3	0 190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	57,314	263	128 192.00
192.01 19201	PHYSICIAN CLINIC	1,700	0	60,365	0	9 192.01
192.02 19202	LIFELINE	1,046	0	0	12	0 192.02
192.03 19203	CREDIT UNION	0	0	0	13	0 192.03
192.04 19204	BREAST MRI STUDY	0	0	0	3	0 192.04
192.05 19205	HOSPITALIST	327	327	0	0	4 192.05
194.00 07950	COMMUNITY MENTAL HEALTH	0	0	0	0	0 194.00
194.01 07951	MARKETING	720	720	131,841	0	1 194.01
194.02 07953	OCCUPATIONAL HEALTH	0	0	266,583	0	0 194.02
194.03 07952	PATHS EDUCATION	0	0	0	0	0 194.03
194.04 07954	FOUNDATION	50	50	14,939	0	0 194.04

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0086

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

Worksheet B-1

Date/Time Prepared:
5/29/2018 2:11 pm

Cost Center Description		CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	COMMUNICATIONS (PHONES)	DATA PROCESSING (DP EQUIPMENT)	
		NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)				
		1.00	2.00				
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)	3,748,784	2,282,834	11,871,863	321,127	2,959,875	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	12.501281	7.746666	0.346864	249.709953	2,951.021934	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)			38,916	6,287	60,442	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)			0.001137	4.888802	60.261216	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: 15-0086

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

Worksheet B-1
Date/Time Prepared:
5/29/2018 2:11 pm

Cost Center Description		PURCHASING RECEIVING AND STORES (SUPPLY EXPENSE)	ADMINITTING (ADMINISTRATIONS)	CASHIERING/ACCOUNTS RECEIVABLE (GROSS CHARGES)	Reconciliation	OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST)	
		5.03	5.04	5.05	5A.06	5.06	
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
5.01	01160	COMMUNICATIONS					5.01
5.02	00550	DATA PROCESSING					5.02
5.03	00560	PURCHASING RECEIVING AND STORES	8,609,801				5.03
5.04	00570	ADMINITTING	36,293	50,542			5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	11,334	0	206,769,054		5.05
5.06	00591	OTHER ADMINISTRATIVE AND GENERAL	152,434	0	0	-5,300,840	70,258,115
7.00	00700	OPERATION OF PLANT	146,921	0	0	0	5,480,690
8.00	00800	LAUNDRY & LINEN SERVICE	79,316	0	0	0	394,747
9.00	00900	HOUSEKEEPING	156,152	0	0	0	1,404,599
10.00	01000	DIETARY	97,310	0	0	0	695,395
11.00	01100	CAFETERIA	0	0	0	0	1,277,679
13.00	01300	NURSING ADMINISTRATION	11,097	0	0	0	1,231,300
14.00	01400	CENTRAL SERVICE & SUPPLY	700,816	0	0	0	771,099
15.00	01500	PHARMACY	69,057	0	0	0	2,430,756
16.00	01600	MEDICAL RECORDS & LIBRARY	20,475	0	0	0	1,515,874
17.00	01700	SOCIAL SERVICE	5,844	0	0	0	530,750
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	197,670	3,421	16,880,940	0	9,703,977
31.00	03100	INTENSIVE CARE UNIT	41,730	458	3,741,903	0	2,096,914
43.00	04300	NURSERY	0	381	555,272	0	698,298
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,550,010	0	30,847,263	0	6,276,469
51.00	05100	RECOVERY ROOM	25,354	0	3,438,671	0	945,363
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	1,500,679	0	402,306
53.00	05300	ANESTHESIOLOGY	100,148	0	2,239,675	0	69,019
54.00	05400	RADIOLOGY-DIAGNOSTIC	310,180	0	18,670,600	0	4,527,561
54.01	05401	ULTRASOUND	26,257	0	3,662,260	0	390,787
55.00	05500	RADIOLOGY-THERAPEUTIC	229,316	0	5,748,389	0	902,953
57.00	05700	CT SCAN	131,281	0	19,383,352	0	515,564
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	37,657	0	3,206,648	0	356,876
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0
60.00	06000	LABORATORY	1,625,001	0	37,264,822	0	6,892,559
60.01	06001	BLOOD LABORATORY	0	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	56,865	0	6,136,164	0	1,225,793
65.01	03950	SLEEP CLINIC	1,021	0	851,106	0	199,319
66.00	06600	PHYSICAL THERAPY	36,798	0	6,543,541	0	2,295,447
67.00	06700	OCCUPATIONAL THERAPY	5,991	0	889,488	0	380,996
68.00	06800	SPEECH PATHOLOGY	1,861	0	630,320	0	317,750
69.00	06900	ELECTROCARDIOLOGY	31,040	0	7,627,334	0	1,384,979
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	4,676,636	0	2,495,445
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	2,518,933	0	296,456	0	521,358
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	12,244,562	0	2,718,576
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	75,664	0	17,421,896	0	2,949,584
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	38,266	0	1,272,524	0	1,620,440
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					
116.00	11600	HOSPICE	57,409	0	1,038,553	0	565,247
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	8,585,501	4,260	206,769,054	-5,300,840	66,186,469
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	120,868
192.00	19200	PHYSICIANS' PRIVATE OFFICES	8,651	0	0	0	768,009
192.01	19201	PHYSICIAN CLINIC	2,922	0	0	0	166,182
192.02	19202	LIFELINE	0	0	0	0	18,735
192.03	19203	CREDIT UNION	0	0	0	0	3,246
192.04	19204	BREAST MRI STUDY	0	0	0	0	749
192.05	19205	HOSPITALIST	1,062	0	0	0	1,049,901
194.00	07950	COMMUNITY MENTAL HEALTH	0	0	0	0	0
194.01	07951	MARKETING	3,369	0	0	0	557,985
194.02	07953	OCCUPATIONAL HEALTH	8,113	46,282	0	0	1,316,206
194.03	07952	PATHS EDUCATION	183	0	0	0	48,632
194.04	07954	FOUNDATION	0	0	0	0	21,133
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers					

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0086

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

Worksheet B-1

Date/Time Prepared:
5/29/2018 2:11 pm

Cost Center Description		PURCHASING RECEIVING AND STORES (SUPPLY EXPENSE)	ADMINISTRATIVE (ADMINISTRATIONS)	CASHIERING/ACCOUNTS RECEIVABLE (GROSS CHARGES)	Reconciliation	OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST)	
		5.03	5.04	5.05	5A.06	5.06	
202.00	Cost to be allocated (per Wkst. B, Part I)	650,313	1,010,211	1,774,977		5,300,840	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	0.075532	19.987555	0.008584		0.075448	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	130,479	73,225	18,152		250,412	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.015155	1.448795	0.000088		0.003564	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: 15-0086

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

Worksheet B-1
Date/Time Prepared:
5/29/2018 2:11 pm

Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (MAN HOURS)	
		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
5.01	01160	COMMUNICATIONS					5.01
5.02	00550	DATA PROCESSING					5.02
5.03	00560	PURCHASING RECEIVING AND STORES					5.03
5.04	00570	ADMINISTRATIVE					5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE					5.05
5.06	00591	OTHER ADMINISTRATIVE AND GENERAL					5.06
7.00	00700	OPERATION OF PLANT	174,673				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,592	847,593			8.00
9.00	00900	HOUSEKEEPING	1,178	109,824	171,903		9.00
10.00	01000	DIETARY	4,000	6,503	4,000	47,330	10.00
11.00	01100	CAFETERIA	2,837	21,772	2,837	0	885,043
13.00	01300	NURSING ADMINISTRATION	600	0	600	0	20,079
14.00	01400	CENTRAL SERVICE & SUPPLY	7,088	4,938	7,088	0	16,540
15.00	01500	PHARMACY	1,776	0	1,776	0	41,684
16.00	01600	MEDICAL RECORDS & LIBRARY	4,807	0	4,807	0	37,622
17.00	01700	SOCIAL SERVICE	583	0	583	0	12,184
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	61,261	289,162	61,261	34,997	206,249
31.00	03100	INTENSIVE CARE UNIT	7,400	54,653	7,400	2,764	42,363
43.00	04300	NURSERY	400	0	400	0	15,428
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	25,786	39,701	25,786	0	59,317
51.00	05100	RECOVERY ROOM	1,163	33,997	1,163	151	19,718
52.00	05200	DELIVERY ROOM & LABOR ROOM	504	0	504	0	8,632
53.00	05300	ANESTHESIOLOGY	16	0	16	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	11,727	62,291	11,727	0	87,692
54.01	05401	ULTRASOUND	620	0	620	0	6,600
55.00	05500	RADIOLOGY-THERAPEUTIC	1,155	5,756	1,155	0	12,288
57.00	05700	CT SCAN	0	0	0	0	0
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	803	0	803	0	0
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0
60.00	06000	LABORATORY	6,720	391	6,720	0	99,522
60.01	06001	BLOOD LABORATORY	0	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	1,164	0	1,164	0	25,079
65.01	03950	SLEEP CLINIC	0	0	0	0	0
66.00	06600	PHYSICAL THERAPY	7,564	27,727	7,564	0	46,869
67.00	06700	OCCUPATIONAL THERAPY	794	1,376	794	0	7,103
68.00	06800	SPEECH PATHOLOGY	424	0	424	0	5,033
69.00	06900	ELECTROCARDIOLOGY	3,344	3,681	3,344	0	24,218
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	9,684	164,490	9,684	696	65,859
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	3,085	0	3,085	0	0
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					
116.00	11600	HOSPICE	315	0	315	0	0
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	168,390	826,262	165,620	38,608	860,079
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,440	0	2,440	0	5,884
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	1,714	0	0	2,004
192.01	19201	PHYSICIAN CLINIC	1,700	0	1,700	0	4,902
192.02	19202	LIFELINE	1,046	0	1,046	0	0
192.03	19203	CREDIT UNION	0	0	0	0	0
192.04	19204	BREAST MRI STUDY	0	0	0	0	0
192.05	19205	HOSPITALIST	327	0	327	0	0
194.00	07950	COMMUNITY MENTAL HEALTH	0	19,617	0	8,722	0
194.01	07951	MARKETING	720	0	720	0	0
194.02	07953	OCCUPATIONAL HEALTH	0	0	0	0	4,163
194.03	07952	PATHS EDUCATION	0	0	0	0	8,011
194.04	07954	FOUNDATION	50	0	50	0	0
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers					

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0086

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

Worksheet B-1

Date/Time Prepared:
5/29/2018 2:11 pm

Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (MAN HOURS)	
		7.00	8.00	9.00	10.00	11.00	
202.00	Cost to be allocated (per Wkst. B, Part I)	5,894,197	478,251	1,612,292	924,023	1,508,702	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	33.744179	0.564246	9.379080	19.522988	1.704665	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	2,000,189	53,283	52,835	134,651	97,785	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	11.451049	0.062864	0.307354	2.844940	0.110486	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: 15-0086

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

Worksheet B-1
Date/Time Prepared:
5/29/2018 2:11 pm

Cost Center Description		NURSING ADMINISTRATION (GROSS HOURS)	CENTRAL SERVICE & SUPPLY (100%)	PHARMACY (100%)	MEDICAL RECORDS & LIBRARY (ADJUSTED CHARGES)	SOCIAL SERVICE (TIME SPENT)	
		13.00	14.00	15.00	16.00	17.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.01	01160						5.01
5.02	00550						5.02
5.03	00560						5.03
5.04	00570						5.04
5.05	00580						5.05
5.06	00591						5.06
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100						11.00
13.00	01300	434,106					13.00
14.00	01400	16,540	100				14.00
15.00	01500	0	0	100			15.00
16.00	01600	0	0	0	203,685,838		16.00
17.00	01700	0	0	0	0	2,951	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	206,249	0	0	14,766,032	2,798	30.00
31.00	03100	42,363	0	0	3,741,903	95	31.00
43.00	04300	15,428	0	0	555,272	0	43.00
44.00	04400	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	59,317	0	0	30,777,073	11	50.00
51.00	05100	19,718	0	0	3,438,671	3	51.00
52.00	05200	8,632	0	0	1,466,483	0	52.00
53.00	05300	0	0	0	2,239,675	0	53.00
54.00	05400	0	0	0	18,653,550	0	54.00
54.01	05401	0	0	0	3,662,260	0	54.01
55.00	05500	0	0	0	5,725,280	0	55.00
57.00	05700	0	0	0	19,383,352	0	57.00
58.00	05800	0	0	0	3,145,970	0	58.00
59.00	05900	0	0	0	0	0	59.00
60.00	06000	0	0	0	37,264,822	0	60.00
60.01	06001	0	0	0	0	0	60.01
65.00	06500	0	0	0	6,050,821	0	65.00
65.01	03950	0	0	0	851,106	0	65.01
66.00	06600	0	0	0	6,543,541	0	66.00
67.00	06700	0	0	0	889,488	0	67.00
68.00	06800	0	0	0	630,320	0	68.00
69.00	06900	0	0	0	6,839,243	0	69.00
71.00	07100	0	100	0	4,676,636	0	71.00
72.00	07200	0	0	0	406,805	0	72.00
73.00	07300	0	0	100	12,244,562	0	73.00
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	65,859	0	0	17,421,896	44	91.00
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	0	0	0	1,272,524	0	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
116.00	11600	0	0	0	1,038,553	0	116.00
118.00		434,106	100	100	203,685,838	2,951	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	0	0	0	0	0	192.00
192.01	19201	0	0	0	0	0	192.01
192.02	19202	0	0	0	0	0	192.02
192.03	19203	0	0	0	0	0	192.03
192.04	19204	0	0	0	0	0	192.04
192.05	19205	0	0	0	0	0	192.05
194.00	07950	0	0	0	0	0	194.00
194.01	07951	0	0	0	0	0	194.01
194.02	07953	0	0	0	0	0	194.02
194.03	07952	0	0	0	0	0	194.03
194.04	07954	0	0	0	0	0	194.04
200.00							200.00
201.00							201.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0086

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

Worksheet B-1

Date/Time Prepared:
5/29/2018 2:11 pm

Cost Center Description		NURSING ADMINISTRATION (GROSS HOURS)	CENTRAL SERVICE & SUPPLY (100%)	PHARMACY (100%)	MEDICAL RECORDS & LIBRARY (ADJUSTED CHARGES)	SOCIAL SERVICE (TIME SPENT)	
		13.00	14.00	15.00	16.00	17.00	
202.00	Cost to be allocated (per Wkst. B, Part I)	1,384,301	1,218,660	2,761,796	1,901,670	616,705	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	3.188855	12,186.600000	27,617.960000	0.009336	208.981701	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	28,061	245,091	74,980	168,312	22,990	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.064641	2,450.910000	749.800000	0.000826	7.790579	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: 15-0086

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

Worksheet C
Part I
Date/Time Prepared:
5/29/2018 2:11 pm

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	15,656,175		15,656,175	0	15,656,175	30.00
31.00	03100 INTENSIVE CARE UNIT	2,921,125		2,921,125	0	2,921,125	31.00
43.00	04300 NURSERY	848,915		848,915	0	848,915	43.00
44.00	04400 SKILLED NURSING FACILITY	0		0	0	0	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	8,464,296		8,464,296	0	8,464,296	50.00
51.00	05100 RECOVERY ROOM	1,218,193		1,218,193	0	1,218,193	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	510,325		510,325	0	510,325	52.00
53.00	05300 ANESTHESIOLOGY	95,826		95,826	0	95,826	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	5,733,644		5,733,644	0	5,733,644	54.00
54.01	05401 ULTRASOUND	492,449		492,449	0	492,449	54.01
55.00	05500 RADIOLOGY-THERAPEUTIC	1,098,533		1,098,533	0	1,098,533	55.00
57.00	05700 CT SCAN	735,425		735,425	0	735,425	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	447,801		447,801	0	447,801	58.00
59.00	05900 CARDIAC CATHETERIZATION	0		0	0	0	59.00
60.00	06000 LABORATORY	8,220,214		8,220,214	112,052	8,332,266	60.00
60.01	06001 BLOOD LABORATORY	0		0	0	0	60.01
65.00	06500 RESPIRATORY THERAPY	1,467,713	0	1,467,713	0	1,467,713	65.00
65.01	03950 SLEEP CLINIC	222,303	0	222,303	0	222,303	65.01
66.00	06600 PHYSICAL THERAPY	2,951,449	0	2,951,449	0	2,951,449	66.00
67.00	06700 OCCUPATIONAL THERAPY	465,169	0	465,169	0	465,169	67.00
68.00	06800 SPEECH PATHOLOGY	374,474	0	374,474	0	374,474	68.00
69.00	06900 ELECTROCARDIOLOGY	1,740,890		1,740,890	0	1,740,890	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	3,946,042		3,946,042	0	3,946,042	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	564,491		564,491	0	564,491	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	5,799,798		5,799,798	0	5,799,798	73.00
OUTPATIENT SERVICE COST CENTERS							
91.00	09100 EMERGENCY	4,190,260		4,190,260	82,889	4,273,149	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1,806,617		1,806,617		1,806,617	92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100 HOME HEALTH AGENCY	1,887,614		1,887,614		1,887,614	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300 INTEREST EXPENSE						113.00
116.00	11600 HOSPICE	631,173		631,173		631,173	116.00
200.00	Subtotal (see instructions)	72,490,914	0	72,490,914	194,941	72,685,855	200.00
201.00	Less Observation Beds	1,806,617		1,806,617		1,806,617	201.00
202.00	Total (see instructions)	70,684,297	0	70,684,297	194,941	70,879,238	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0086	Period: From 01/01/2017 To 12/31/2017	Worksheet C Part I Date/Time Prepared: 5/29/2018 2:11 pm
Title XVIII			Hospital	PPS

Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
	Inpatient	Outpatient	Total (col. 6 + col. 7)			
	6.00	7.00	8.00			
9.00	10.00					
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	14,766,032		14,766,032	30.00
31.00	03100	INTENSIVE CARE UNIT	3,741,903		3,741,903	31.00
43.00	04300	NURSERY	555,272		555,272	43.00
44.00	04400	SKILLED NURSING FACILITY	0		0	44.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	10,267,863	20,579,400	30,847,263	50.00
51.00	05100	RECOVERY ROOM	649,908	2,788,763	3,438,671	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,381,629	84,854	1,466,483	52.00
53.00	05300	ANESTHESIOLOGY	782,532	1,457,144	2,239,676	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,687,671	15,982,929	18,670,600	54.00
54.01	05401	ULTRASOUND	482,523	3,179,737	3,662,260	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	2,586,711	3,161,678	5,748,389	55.00
57.00	05700	CT SCAN	4,543,329	14,840,023	19,383,352	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	388,611	2,757,360	3,145,971	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	59.00
60.00	06000	LABORATORY	9,144,521	28,120,301	37,264,822	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	5,126,933	923,888	6,050,821	65.00
65.01	03950	SLEEP CLINIC	0	851,106	851,106	65.01
66.00	06600	PHYSICAL THERAPY	1,234,125	5,309,416	6,543,541	66.00
67.00	06700	OCCUPATIONAL THERAPY	546,320	343,168	889,488	67.00
68.00	06800	SPEECH PATHOLOGY	183,091	447,230	630,321	68.00
69.00	06900	ELECTROCARDIOLOGY	2,466,368	5,160,966	7,627,334	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,166,948	1,509,688	4,676,636	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	83,962	212,494	296,456	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	8,025,713	4,218,849	12,244,562	73.00
OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	3,753,869	13,668,027	17,421,896	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	197,738	1,313,971	1,511,709	92.00
OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	1,272,524	1,272,524	101.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
116.00	11600	HOSPICE	0	1,038,553	1,038,553	116.00
200.00		Subtotal (see instructions)	76,763,572	129,222,069	205,985,641	200.00
201.00		Less Observation Beds				201.00
202.00		Total (see instructions)	76,763,572	129,222,069	205,985,641	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0086	Period: From 01/01/2017 To 12/31/2017	Worksheet C Part I Date/Time Prepared: 5/29/2018 2:11 pm
		Title XVIII	Hospital	PPS

Cost Center Description		PPS Inpatient Ratio		
		11.00		
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
43.00	04300	NURSERY		43.00
44.00	04400	SKILLED NURSING FACILITY		44.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.274394	50.00
51.00	05100	RECOVERY ROOM	0.354263	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.347992	52.00
53.00	05300	ANESTHESIOLOGY	0.042786	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.307095	54.00
54.01	05401	ULTRASOUND	0.134466	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0.191103	55.00
57.00	05700	CT SCAN	0.037941	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.142341	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	59.00
60.00	06000	LABORATORY	0.223596	60.00
60.01	06001	BLOOD LABORATORY	0.000000	60.01
65.00	06500	RESPIRATORY THERAPY	0.242564	65.00
65.01	03950	SLEEP CLINIC	0.261193	65.01
66.00	06600	PHYSICAL THERAPY	0.451048	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.522963	67.00
68.00	06800	SPEECH PATHOLOGY	0.594100	68.00
69.00	06900	ELECTROCARDIOLOGY	0.228244	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.843778	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1.904131	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.473663	73.00
OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.245275	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.195083	92.00
OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY		101.00
SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE		113.00
116.00	11600	HOSPICE		116.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0086

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

Worksheet C
Part I
Date/Time Prepared:
5/29/2018 2:11 pm

		Title XIX		Hospital		Cost	
Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		Total Costs	
				Total Costs	RCE Disallowance		
		1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	15,656,175		15,656,175	0	15,656,175	30.00
31.00	03100 INTENSIVE CARE UNIT	2,921,125		2,921,125	0	2,921,125	31.00
43.00	04300 NURSERY	848,915		848,915	0	848,915	43.00
44.00	04400 SKILLED NURSING FACILITY	0		0	0	0	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	8,464,296		8,464,296	0	8,464,296	50.00
51.00	05100 RECOVERY ROOM	1,218,193		1,218,193	0	1,218,193	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	510,325		510,325	0	510,325	52.00
53.00	05300 ANESTHESIOLOGY	95,826		95,826	0	95,826	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	5,733,644		5,733,644	0	5,733,644	54.00
54.01	05401 ULTRASOUND	492,449		492,449	0	492,449	54.01
55.00	05500 RADIOLOGY-THERAPEUTIC	1,098,533		1,098,533	0	1,098,533	55.00
57.00	05700 CT SCAN	735,425		735,425	0	735,425	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	447,801		447,801	0	447,801	58.00
59.00	05900 CARDIAC CATHETERIZATION	0		0	0	0	59.00
60.00	06000 LABORATORY	8,220,214		8,220,214	112,052	8,332,266	60.00
60.01	06001 BLOOD LABORATORY	0		0	0	0	60.01
65.00	06500 RESPIRATORY THERAPY	1,467,713	0	1,467,713	0	1,467,713	65.00
65.01	03950 SLEEP CLINIC	222,303	0	222,303	0	222,303	65.01
66.00	06600 PHYSICAL THERAPY	2,951,449	0	2,951,449	0	2,951,449	66.00
67.00	06700 OCCUPATIONAL THERAPY	465,169	0	465,169	0	465,169	67.00
68.00	06800 SPEECH PATHOLOGY	374,474	0	374,474	0	374,474	68.00
69.00	06900 ELECTROCARDIOLOGY	1,740,890		1,740,890	0	1,740,890	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	3,946,042		3,946,042	0	3,946,042	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	564,491		564,491	0	564,491	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	5,799,798		5,799,798	0	5,799,798	73.00
OUTPATIENT SERVICE COST CENTERS							
91.00	09100 EMERGENCY	4,190,260		4,190,260	82,889	4,273,149	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1,806,617		1,806,617		1,806,617	92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100 HOME HEALTH AGENCY	1,887,614		1,887,614		1,887,614	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300 INTEREST EXPENSE						113.00
116.00	11600 HOSPICE	631,173		631,173		631,173	116.00
200.00	Subtotal (see instructions)	72,490,914	0	72,490,914	194,941	72,685,855	200.00
201.00	Less Observation Beds	1,806,617		1,806,617		1,806,617	201.00
202.00	Total (see instructions)	70,684,297	0	70,684,297	194,941	70,879,238	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0086	Period: From 01/01/2017 To 12/31/2017	Worksheet C Part I Date/Time Prepared: 5/29/2018 2:11 pm
--	--	-----------------------	---	---

Cost Center Description		Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	Cost
		Inpatient	Outpatient	Total (col. 6 + col. 7)			
		6.00	7.00	8.00			
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	14,766,032		14,766,032		30.00
31.00	03100	INTENSIVE CARE UNIT	3,741,903		3,741,903		31.00
43.00	04300	NURSERY	555,272		555,272		43.00
44.00	04400	SKILLED NURSING FACILITY	0		0		44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	10,267,863	20,579,400	30,847,263	0.274394	50.00
51.00	05100	RECOVERY ROOM	649,908	2,788,763	3,438,671	0.354263	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,381,629	84,854	1,466,483	0.347992	52.00
53.00	05300	ANESTHESIOLOGY	782,532	1,457,144	2,239,676	0.042786	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,687,671	15,982,929	18,670,600	0.307095	54.00
54.01	05401	ULTRASOUND	482,523	3,179,737	3,662,260	0.134466	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	2,586,711	3,161,678	5,748,389	0.191103	55.00
57.00	05700	CT SCAN	4,543,329	14,840,023	19,383,352	0.037941	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	388,611	2,757,360	3,145,971	0.142341	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	59.00
60.00	06000	LABORATORY	9,144,521	28,120,301	37,264,822	0.220589	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	60.01
65.00	06500	RESPIRATORY THERAPY	5,126,933	923,888	6,050,821	0.242564	65.00
65.01	03950	SLEEP CLINIC	0	851,106	851,106	0.261193	65.01
66.00	06600	PHYSICAL THERAPY	1,234,125	5,309,416	6,543,541	0.451048	66.00
67.00	06700	OCCUPATIONAL THERAPY	546,320	343,168	889,488	0.522963	67.00
68.00	06800	SPEECH PATHOLOGY	183,091	447,230	630,321	0.594100	68.00
69.00	06900	ELECTROCARDIOLOGY	2,466,368	5,160,966	7,627,334	0.228244	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,166,948	1,509,688	4,676,636	0.843778	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	83,962	212,494	296,456	1.904131	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	8,025,713	4,218,849	12,244,562	0.473663	73.00
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	3,753,869	13,668,027	17,421,896	0.240517	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	197,738	1,313,971	1,511,709	1.195083	92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	0	1,272,524	1,272,524		101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
116.00	11600	HOSPICE	0	1,038,553	1,038,553		116.00
200.00		Subtotal (see instructions)	76,763,572	129,222,069	205,985,641		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	76,763,572	129,222,069	205,985,641		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0086	Period: From 01/01/2017 To 12/31/2017	Worksheet C Part I Date/Time Prepared: 5/29/2018 2:11 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
43.00	04300	NURSERY		43.00
44.00	04400	SKILLED NURSING FACILITY		44.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.000000	50.00
51.00	05100	RECOVERY ROOM	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	54.00
54.01	05401	ULTRASOUND	0.000000	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	55.00
57.00	05700	CT SCAN	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	59.00
60.00	06000	LABORATORY	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0.000000	60.01
65.00	06500	RESPIRATORY THERAPY	0.000000	65.00
65.01	03950	SLEEP CLINIC	0.000000	65.01
66.00	06600	PHYSICAL THERAPY	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	73.00
OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY		101.00
SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE		113.00
116.00	11600	HOSPICE		116.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS	Provider CCN: 15-0086	Period: From 01/01/2017 To 12/31/2017	Worksheet D Part I Date/Time Prepared: 5/29/2018 2:11 pm
--	-----------------------	---	---

Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
Title XVIII Hospital PPS							
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	2,210,384	0	2,210,384	12,843	172.11	30.00
31.00	INTENSIVE CARE UNIT	271,690		271,690	1,874	144.98	31.00
43.00	NURSERY	19,561		19,561	681	28.72	43.00
44.00	SKILLED NURSING FACILITY	0		0	0	0.00	44.00
200.00	Total (lines 30 through 199)	2,501,635		2,501,635	15,398		200.00
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
		6.00	7.00				
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	5,444	936,967				
31.00	INTENSIVE CARE UNIT	875	126,858				
43.00	NURSERY	0	0				
44.00	SKILLED NURSING FACILITY	0	0				
200.00	Total (lines 30 through 199)	6,319	1,063,825				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 15-0086	Period: From 01/01/2017 To 12/31/2017	Worksheet D Part II Date/Time Prepared: 5/29/2018 2:11 pm
--	--	-----------------------	---	--

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	918,468	30,847,263	0.029775	4,651,295	138,492	50.00
51.00	05100	RECOVERY ROOM	50,957	3,438,671	0.014819	290,997	4,312	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	20,704	1,466,483	0.014118	3,109	44	52.00
53.00	05300	ANESTHESIOLOGY	4,357	2,239,676	0.001945	329,924	642	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	432,753	18,670,600	0.023178	1,738,706	40,300	54.00
54.01	05401	ULTRASOUND	25,996	3,662,260	0.007098	168,745	1,198	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	51,784	5,748,389	0.009008	1,016,907	9,160	55.00
57.00	05700	CT SCAN	21,639	19,383,352	0.001116	2,539,977	2,835	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	30,447	3,145,971	0.009678	225,890	2,186	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	06000	LABORATORY	316,245	37,264,822	0.008486	4,770,039	40,479	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	53,981	6,050,821	0.008921	3,496,108	31,189	65.00
65.01	03950	SLEEP CLINIC	1,503	851,106	0.001766	0	0	65.01
66.00	06600	PHYSICAL THERAPY	266,752	6,543,541	0.040766	724,873	29,550	66.00
67.00	06700	OCCUPATIONAL THERAPY	28,908	889,488	0.032500	319,449	10,382	67.00
68.00	06800	SPEECH PATHOLOGY	16,136	630,321	0.025600	132,415	3,390	68.00
69.00	06900	ELECTROCARDIOLOGY	122,498	7,627,334	0.016060	2,326,583	37,365	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	258,260	4,676,636	0.055223	993,959	54,889	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	40,391	296,456	0.136246	5,688	775	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	95,861	12,244,562	0.007829	4,387,275	34,348	73.00
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	365,869	17,421,896	0.021001	1,971,338	41,400	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	255,064	1,511,709	0.168726	118,571	20,006	92.00
200.00		Total (lines 50 through 199)	3,378,573	184,611,357		30,211,848	502,942	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0086	Period: From 01/01/2017 To 12/31/2017	Worksheet D Part III Date/Time Prepared: 5/29/2018 2:11 pm
---	-----------------------	---	---

Cost Center Description			Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
			1A	1.00	2A	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
200.00		Total (lines 30 through 199)	0	0	0	0	0	200.00
Cost Center Description			Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
			4.00	5.00	6.00	7.00	8.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	12,843	0.00	5,444	30.00
31.00	03100	INTENSIVE CARE UNIT		0	1,874	0.00	875	31.00
43.00	04300	NURSERY		0	681	0.00	0	43.00
44.00	04400	SKILLED NURSING FACILITY		0	0	0.00	0	44.00
200.00		Total (lines 30 through 199)		0	15,398		6,319	200.00
Cost Center Description			Inpatient Program Pass-Through Cost (col. 7 x col. 8)					
			9.00					
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0					30.00
31.00	03100	INTENSIVE CARE UNIT	0					31.00
43.00	04300	NURSERY	0					43.00
44.00	04400	SKILLED NURSING FACILITY	0					44.00
200.00		Total (lines 30 through 199)	0					200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0086	Period: From 01/01/2017 To 12/31/2017	Worksheet D Part IV Date/Time Prepared: 5/29/2018 2:11 pm
--	-----------------------	---	--

Cost Center Description	Title XVIII					Hospital		
	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	PPS		
	1.00	2A	2.00	3A	3.00			
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
65.01	03950	SLEEP CLINIC	0	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO 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								
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0086	Period: From 01/01/2017 To 12/31/2017	Worksheet D Part IV Date/Time Prepared: 5/29/2018 2:11 pm
--	-----------------------	---	--

Cost Center Description			Title XVIII		Hospital	PPS		
			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	30,847,263	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	3,438,671	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	1,466,483	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	2,239,676	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	18,670,600	0.000000	54.00
54.01	05401	ULTRASOUND	0	0	0	3,662,260	0.000000	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	5,748,389	0.000000	55.00
57.00	05700	CT SCAN	0	0	0	19,383,352	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	3,145,971	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	37,264,822	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0.000000	60.01
65.00	06500	RESPIRATORY THERAPY	0	0	0	6,050,821	0.000000	65.00
65.01	03950	SLEEP CLINIC	0	0	0	851,106	0.000000	65.01
66.00	06600	PHYSICAL THERAPY	0	0	0	6,543,541	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	889,488	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	630,321	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	7,627,334	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	4,676,636	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	296,456	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	12,244,562	0.000000	73.00
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	0	0	0	17,421,896	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	1,511,709	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	184,611,357		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0086	Period: From 01/01/2017 To 12/31/2017	Worksheet D Part IV Date/Time Prepared: 5/29/2018 2:11 pm
--	-----------------------	---	--

Cost Center Description		Title XVIII					Hospital	
		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)	PPS	
		9.00	10.00	11.00	12.00	13.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.000000	4,651,295	0	5,873,746	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	290,997	0	1,077,875	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	3,109	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	329,924	0	270,434	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	1,738,706	0	4,739,403	0	54.00
54.01	05401	ULTRASOUND	0.000000	168,745	0	597,594	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	1,016,907	0	1,725,728	0	55.00
57.00	05700	CT SCAN	0.000000	2,539,977	0	5,297,504	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	225,890	0	851,323	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY	0.000000	4,770,039	0	2,819,668	0	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0.000000	3,496,108	0	492,391	0	65.00
65.01	03950	SLEEP CLINIC	0.000000	0	0	192,657	0	65.01
66.00	06600	PHYSICAL THERAPY	0.000000	724,873	0	289,748	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	319,449	0	14,499	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	132,415	0	1,958	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	2,326,583	0	1,741,501	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	993,959	0	91,302	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000	5,688	0	126,673	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	4,387,275	0	1,664,213	0	73.00
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	0.000000	1,971,338	0	3,042,689	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	118,571	0	1,057,169	0	92.00
200.00		Total (lines 50 through 199)		30,211,848	0	31,968,075	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-0086	Period: From 01/01/2017 To 12/31/2017	Worksheet D Part V Date/Time Prepared: 5/29/2018 2:11 pm
--	-----------------------	---	---

Title XVIII		Hospital		PPS			
Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs			
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)		
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0.274394	5,873,746	0	0	1,611,721	50.00
51.00	05100 RECOVERY ROOM	0.354263	1,077,875	0	0	381,851	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.347992	0	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.042786	270,434	0	0	11,571	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.307095	4,739,403	0	0	1,455,447	54.00
54.01	05401 ULTRASOUND	0.134466	597,594	0	0	80,356	54.01
55.00	05500 RADIOLOGY-THERAPEUTIC	0.191103	1,725,728	0	0	329,792	55.00
57.00	05700 CT SCAN	0.037941	5,297,504	0	0	200,993	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.142341	851,323	0	0	121,178	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000 LABORATORY	0.220589	2,819,668	0	0	621,988	60.00
60.01	06001 BLOOD LABORATORY	0.000000	0	0	0	0	60.01
65.00	06500 RESPIRATORY THERAPY	0.242564	492,391	0	0	119,436	65.00
65.01	03950 SLEEP CLINIC	0.261193	192,657	0	0	50,321	65.01
66.00	06600 PHYSICAL THERAPY	0.451048	289,748	0	0	130,690	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.522963	14,499	0	0	7,582	67.00
68.00	06800 SPEECH PATHOLOGY	0.594100	1,958	0	0	1,163	68.00
69.00	06900 ELECTROCARDIOLOGY	0.228244	1,741,501	0	0	397,487	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.843778	91,302	0	0	77,039	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	1.904131	126,673	0	0	241,202	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.473663	1,664,213	0	2,484	788,276	73.00
OUTPATIENT SERVICE COST CENTERS							
91.00	09100 EMERGENCY	0.240517	3,042,689	0	0	731,818	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1.195083	1,057,169	0	0	1,263,405	92.00
200.00	Subtotal (see instructions)		31,968,075	0	2,484	8,623,316	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00	Net Charges (line 200 - line 201)		31,968,075	0	2,484	8,623,316	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-0086	Period: From 01/01/2017 To 12/31/2017	Worksheet D Part V Date/Time Prepared: 5/29/2018 2:11 pm
Title XVIII		Hospital	PPS

Cost Center Description	Costs			
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0	0	50.00
51.00	05100 RECOVERY ROOM	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	54.00
54.01	05401 ULTRASOUND	0	0	54.01
55.00	05500 RADIOLOGY-THERAPEUTIC	0	0	55.00
57.00	05700 CT SCAN	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000 LABORATORY	0	0	60.00
60.01	06001 BLOOD LABORATORY	0	0	60.01
65.00	06500 RESPIRATORY THERAPY	0	0	65.00
65.01	03950 SLEEP CLINIC	0	0	65.01
66.00	06600 PHYSICAL THERAPY	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	1,177	73.00
OUTPATIENT SERVICE COST CENTERS				
91.00	09100 EMERGENCY	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
200.00	Subtotal (see instructions)	0	1,177	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00	Net Charges (line 200 - line 201)	0	1,177	202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0086	Period: From 01/01/2017 To 12/31/2017	Worksheet D-1
		Title XVIII	Hospital	Date/Time Prepared: 5/29/2018 2:11 pm
Cost Center Description				PPS
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		12,843	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		12,843	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		11,361	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		5,444	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		15,656,175	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		15,656,175	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)		15,656,175	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)		1,219.04	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		6,636,454	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)		6,636,454	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0086		Period: From 01/01/2017 To 12/31/2017		Worksheet D-1 Date/Time Prepared: 5/29/2018 2:11 pm	
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)	PPS
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	2,921,125	1,874	1,558.76	875	1,363,915	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)					8,845,194	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					16,845,563	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)					1,063,825	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					502,942	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					1,566,767	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					15,278,796	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)					1,482	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,219.04	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					1,806,617	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0086		Period: From 01/01/2017 To 12/31/2017		Worksheet D-1 Date/Time Prepared: 5/29/2018 2:11 pm	
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	2,210,384	15,656,175	0.141183	1,806,617	255,064	90.00
91.00	Nursing School cost	0	15,656,175	0.000000	1,806,617	0	91.00
92.00	Allied health cost	0	15,656,175	0.000000	1,806,617	0	92.00
93.00	All other Medical Education	0	15,656,175	0.000000	1,806,617	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0086	Period: From 01/01/2017 To 12/31/2017	Worksheet D-1
		Title XIX	Hospital	Date/Time Prepared: 5/29/2018 2:11 pm
Cost Center Description			Cost	
			1.00	
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		12,843	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		12,843	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		11,361	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		233	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)		681	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		15,656,175	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		15,656,175	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)		15,656,175	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)		1,219.04	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		284,036	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)		284,036	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0086		Period: From 01/01/2017 To 12/31/2017		Worksheet D-1	
Title XIX		Hospital		Cost		Date/Time Prepared: 5/29/2018 2:11 pm	
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)		
42.00 NURSERY (title V & XIX only)	848,915	681	1,246.57	0	0	42.00	
Intensive Care Type Inpatient Hospital Units							
43.00 INTENSIVE CARE UNIT	2,921,125	1,874	1,558.76	0	0	43.00	
44.00 CORONARY CARE UNIT						44.00	
45.00 BURN INTENSIVE CARE UNIT						45.00	
46.00 SURGICAL INTENSIVE CARE UNIT						46.00	
47.00 OTHER SPECIAL CARE (SPECIFY)						47.00	
Cost Center Description							
					1.00		
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					237,759	48.00	
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					521,795	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)					1,482	87.00	
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,219.04	88.00	
89.00 Observation bed cost (line 87 x line 88) (see instructions)					1,806,617	89.00	

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0086		Period: From 01/01/2017 To 12/31/2017		Worksheet D-1 Date/Time Prepared: 5/29/2018 2:11 pm	
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	2,210,384	15,656,175	0.141183	1,806,617	255,064	90.00
91.00	Nursing School cost	0	15,656,175	0.000000	1,806,617	0	91.00
92.00	Allied health cost	0	15,656,175	0.000000	1,806,617	0	92.00
93.00	All other Medical Education	0	15,656,175	0.000000	1,806,617	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-0086	Period: From 01/01/2017 To 12/31/2017	Worksheet D-3 Date/Time Prepared: 5/29/2018 2:11 pm
--	--	-----------------------	---	---

Cost Center Description		Ratio of Cost To Charges	Hospital Inpatient Program Charges	PPS Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		4,899,494		30.00
31.00	03100 INTENSIVE CARE UNIT		1,679,508		31.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.274394	4,651,295	1,276,287	50.00
51.00	05100 RECOVERY ROOM	0.354263	290,997	103,089	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.347992	3,109	1,082	52.00
53.00	05300 ANESTHESIOLOGY	0.042786	329,924	14,116	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.307095	1,738,706	533,948	54.00
54.01	05401 ULTRASOUND	0.134466	168,745	22,690	54.01
55.00	05500 RADIOLOGY-THERAPEUTIC	0.191103	1,016,907	194,334	55.00
57.00	05700 CT SCAN	0.037941	2,539,977	96,369	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.142341	225,890	32,153	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	06000 LABORATORY	0.223596	4,770,039	1,066,562	60.00
60.01	06001 BLOOD LABORATORY	0.000000	0	0	60.01
65.00	06500 RESPIRATORY THERAPY	0.242564	3,496,108	848,030	65.00
65.01	03950 SLEEP CLINIC	0.261193	0	0	65.01
66.00	06600 PHYSICAL THERAPY	0.451048	724,873	326,953	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.522963	319,449	167,060	67.00
68.00	06800 SPEECH PATHOLOGY	0.594100	132,415	78,668	68.00
69.00	06900 ELECTROCARDIOLOGY	0.228244	2,326,583	531,029	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.843778	993,959	838,681	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	1.904131	5,688	10,831	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.473663	4,387,275	2,078,090	73.00
OUTPATIENT SERVICE COST CENTERS					
91.00	09100 EMERGENCY	0.245275	1,971,338	483,520	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1.195083	118,571	141,702	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		30,211,848	8,845,194	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net charges (line 200 minus line 201)		30,211,848		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CCN: 15-0086	Period: From 01/01/2017 To 12/31/2017	Worksheet D-3 Date/Time Prepared: 5/29/2018 2:11 pm
--	-----------------------	---	---

Cost Center Description		Ratio of Cost To Charges	Hospital Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	Cost
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		188,528		30.00
31.00	03100 INTENSIVE CARE UNIT		14,998		31.00
43.00	04300 NURSERY		33,722		43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.274394	70,387	19,314	50.00
51.00	05100 RECOVERY ROOM	0.354263	1,746	619	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.347992	24,984	8,694	52.00
53.00	05300 ANESTHESIOLOGY	0.042786	71,608	3,064	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.307095	20,914	6,423	54.00
54.01	05401 ULTRASOUND	0.134466	73,939	9,942	54.01
55.00	05500 RADIOLOGY-THERAPEUTIC	0.191103	10,337	1,975	55.00
57.00	05700 CT SCAN	0.037941	231,238	8,773	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.142341	63,041	8,973	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	06000 LABORATORY	0.220589	110,949	24,474	60.00
60.01	06001 BLOOD LABORATORY	0.000000	0	0	60.01
65.00	06500 RESPIRATORY THERAPY	0.242564	23,932	5,805	65.00
65.01	03950 SLEEP CLINIC	0.261193	0	0	65.01
66.00	06600 PHYSICAL THERAPY	0.451048	15,347	6,922	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.522963	142	74	67.00
68.00	06800 SPEECH PATHOLOGY	0.594100	141	84	68.00
69.00	06900 ELECTROCARDIOLOGY	0.228244	135,241	30,868	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.843778	6,503	5,487	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	1.904131	47,856	91,124	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.473663	0	0	73.00
OUTPATIENT SERVICE COST CENTERS					
91.00	09100 EMERGENCY	0.240517	21,387	5,144	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1.195083	0	0	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		929,692	237,759	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net charges (line 200 minus line 201)		929,692		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0086	Period: From 01/01/2017 To 12/31/2017	Worksheet E Part A Date/Time Prepared: 5/29/2018 2:11 pm
		Title XVIII	Hospital	PPS
				1.00
PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS				
1.00	DRG Amounts Other than Outlier Payments			0 1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)			0 1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		11,988,409	1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)			0 1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)			0 1.04
2.00	Outlier payments for discharges. (see instructions)		226,100	2.00
2.01	Outlier reconciliation amount			0 2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)			0 2.02
3.00	Managed Care Simulated Payments			0 3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		81.94	4.00
Indirect Medical Education Adjustment				
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996. (see instructions)			0.00 5.00
6.00	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)			0.00 6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)			0.00 7.00
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.			0.00 7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).			0.00 8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.			0.00 8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)			0.00 8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8.01 and 8.02) (see instructions)			0.00 9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records			0.00 10.00
11.00	FTE count for residents in dental and podiatric programs.			0.00 11.00
12.00	Current year allowable FTE (see instructions)			0.00 12.00
13.00	Total allowable FTE count for the prior year.			0.00 13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.			0.00 14.00
15.00	Sum of lines 12 through 14 divided by 3.			0.00 15.00
16.00	Adjustment for residents in initial years of the program			0.00 16.00
17.00	Adjustment for residents displaced by program or hospital closure			0.00 17.00
18.00	Adjusted rolling average FTE count			0.00 18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)		0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.000000	21.00
22.00	IME payment adjustment (see instructions)			0 22.00
22.01	IME payment adjustment - Managed Care (see instructions)			0 22.01
Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA				
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C).			0.00 23.00
24.00	IME FTE Resident Count Over Cap (see instructions)			0.00 24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)			0.00 25.00
26.00	Resident to bed ratio (divide line 25 by line 4)		0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)		0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)			0 28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)			0 28.01
29.00	Total IME payment (sum of lines 22 and 28)			0 29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)			0 29.01
Disproportionate Share Adjustment				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		4.44	30.00
31.00	Percentage of Medicaid patient days (see instructions)		23.00	31.00
32.00	Sum of lines 30 and 31		27.44	32.00
33.00	Allowable disproportionate share percentage (see instructions)		11.85	33.00
34.00	Disproportionate share adjustment (see instructions)		355,157	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0086	Period: From 01/01/2017 To 12/31/2017	Worksheet E Part A Date/Time Prepared: 5/29/2018 2:11 pm
		Title XVIII	Hospital	PPS
		Prior to 10/1	On/After 10/1	
		1.00	2.00	
Uncompensated Care Adjustment				
35.00	Total uncompensated care amount (see instructions)	5,977,483,147	6,766,695,163	35.00
35.01	Factor 3 (see instructions)	0.000089427	0.000109418	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	534,550	740,400	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	399,814	186,622	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	586,436		36.00
Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)				
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)	0		40.00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)	0		41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)	0		41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)	0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)	0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)	0.00		45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)	0		46.00
47.00	Subtotal (see instructions)	13,156,102		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)	0		48.00
				Amount
				1.00
49.00	Total payment for inpatient operating costs (see instructions)		13,156,102	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		993,228	50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)		0	51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).		0	52.00
53.00	Nursing and Allied Health Managed Care payment		0	53.00
54.00	Special add-on payments for new technologies		0	54.00
54.01	Islet isolation add-on payment		0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)		0	55.00
56.00	Cost of physicians' services in a teaching hospital (see instructions)		0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).		0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)		0	58.00
59.00	Total (sum of amounts on lines 49 through 58)		14,149,330	59.00
60.00	Primary payer payments		11,063	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		14,138,267	61.00
62.00	Deductibles billed to program beneficiaries		1,566,936	62.00
63.00	Coinurance billed to program beneficiaries		44,415	63.00
64.00	Allowable bad debts (see instructions)		234,731	64.00
65.00	Adjusted reimbursable bad debts (see instructions)		152,575	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		128,349	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		12,679,491	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)		0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions)		0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	70.00
70.50	Rural Community Hospital Demonstration Project (\$410A Demonstration) adjustment (see instructions)		0	70.50
70.87	Demonstration payment adjustment amount before sequestration		0	70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)		0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)		0	70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)		0	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)		0	70.91
70.92	Bundled Model 1 discount amount (see instructions)		0	70.92
70.93	HVBP payment adjustment amount (see instructions)		-24,883	70.93
70.94	HRR adjustment amount (see instructions)		-129,055	70.94
70.95	Recovery of accelerated depreciation		0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0086	Period: From 01/01/2017 To 12/31/2017	Worksheet E Part A Date/Time Prepared: 5/29/2018 2:11 pm
		Title XVIII	Hospital	PPS
		FFY (yyyy)	Amount	
		0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0	70.97
70.98	Low Volume Payment-3		0	70.98
70.99	HAC adjustment amount (see instructions)		0	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		12,525,553	71.00
71.01	Sequestration adjustment (see instructions)		250,511	71.01
71.02	Demonstration payment adjustment amount after sequestration		0	71.02
72.00	Interim payments		12,023,899	72.00
73.00	Tentative settlement (for contractor use only)		0	73.00
74.00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 73)		251,143	74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		231,839	75.00
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)				
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2 (see instructions)		0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00
95.00	Time value of money for operating expenses (see instructions)		0	95.00
96.00	Time value of money for capital related expenses (see instructions)		0	96.00
			Prior to 10/1	On/After 10/1
			1.00	2.00
HSP Bonus Payment Amount				
100.00	HSP bonus amount (see instructions)		0	100.00
HVBP Adjustment for HSP Bonus Payment				
101.00	HVBP adjustment factor (see instructions)		0.0000000000	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)		0	102.00
HRR Adjustment for HSP Bonus Payment				
103.00	HRR adjustment factor (see instructions)		0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)		0	104.00
Rural Community Hospital Demonstration Project (\$410A Demonstration) Adjustment				
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
Cost Reimbursement				
201.00	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)			201.00
202.00	Medicare discharges (see instructions)			202.00
203.00	Case-mix adjustment factor (see instructions)			203.00
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)				
204.00	Medicare target amount			204.00
205.00	Case-mix adjusted target amount (line 203 times line 204)			205.00
206.00	Medicare inpatient routine cost cap (line 202 times line 205)			206.00
Adjustment to Medicare Part A Inpatient Reimbursement				
207.00	Program reimbursement under the \$410A Demonstration (see instructions)			207.00
208.00	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)			208.00
209.00	Adjustment to Medicare IPPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
211.00	Total adjustment to Medicare IPPS payments (see instructions)			211.00
Comparison of PPS versus Cost Reimbursement				
212.00	Total adjustment to Medicare Part A IPPS payments (from line 211)			212.00
213.00	Low-volume adjustment (see instructions)			213.00
218.00	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)			218.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 15-0086

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

Worksheet E
Part A Exhibit 4
Date/Time Prepared:
5/29/2018 2:11 pm

		Title XVIII			Hospital		PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	0	0	0	0	0	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	11,988,409	0	0	11,988,409	11,988,409	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0	0	0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0	0	0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00	226,100	0	0	226,100	226,100	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0	2.01
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	0	4.00
Indirect Medical Education Adjustment								
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	0.000000	0.000000	5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	0	6.01
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA								
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000	0.000000	7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	0	9.01
Disproportionate Share Adjustment								
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.1185	0.1185	0.1185	0.1185	0.1185	10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	355,157	0	0	355,157	355,157	11.00
11.01	Uncompensated care payments	36.00	586,436	0	399,814	186,622	586,436	11.01
Additional payment for high percentage of ESRD beneficiary discharges								
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	13,156,102	0	399,814	12,756,288	13,156,102	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	13,156,102	0	399,814	12,756,288	13,156,102	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	993,228	0	0	993,228	993,228	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	0	17.00
17.01	Net organ aquisition cost							17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0	17.02

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 15-0086

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

Worksheet E
Part A Exhibit 4
Date/Time Prepared:
5/29/2018 2:11 pm

		Title XVIII			Hospital		PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0	18.00
19.00	SUBTOTAL			0	399,814	13,749,516	14,149,330	19.00
		W/S L, line	(Amounts from L)					
		0	1.00	2.00	3.00	4.00	5.00	
20.00	Capital DRG other than outlier	1.00	966,883	0	0	966,883	966,883	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	26,345	0	0	26,345	26,345	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	993,228	0	0	993,228	993,228	26.00
		W/S E, Part A line	(Amounts to E, Part A)					
		0	1.00	2.00	3.00	4.00	5.00	
27.00	Low volume adjustment factor				0.000000	0.000000		27.00
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			0		0	28.00
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				0	0	29.00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 15-0086

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

Worksheet E
Part A Exhibit 5
Date/Time Prepared:
5/29/2018 2:11 pm

		Title XVIII			Hospital	PPS	
	Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (col s. 2 and 3)		
	0	1.00	2.00	3.00	4.00		
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	0	0	0	0	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	11,988,409		11,988,409	11,988,409	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00	226,100	0	226,100	226,100	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	2.01
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	4.00
Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	6.01
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	9.01
Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.1185	0.1185	0.1185		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	355,157	0	355,157	355,157	11.00
11.01	Uncompensated care payments	36.00	586,436	399,814	186,622	586,436	11.01
Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	13,156,102	399,814	12,756,288	13,156,102	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	13,156,102	399,814	12,756,288	13,156,102	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	993,228	0	993,228	993,228	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	17.00
17.01	Net organ acquisition cost						17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	18.00
19.00	SUBTOTAL			399,814	13,749,516	14,149,330	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 15-0086

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

Worksheet E
Part A Exhibit 5
Date/Time Prepared:
5/29/2018 2:11 pm

		Title XVIII		Hospital		PPS	
		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	966,883	0	966,883	966,883	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	26,345	0	26,345	26,345	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	993,228	0	993,228	993,228	26.00
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
		0	1.00	2.00	3.00	4.00	
27.00							27.00
28.00	Low volume adjustment prior to October 1	70.96	0	0		0	28.00
29.00	Low volume adjustment on or after October 1	70.97	0		0	0	29.00
30.00	HVBP payment adjustment (see instructions)	70.93	-24,883	0	-24,883	-24,883	30.00
30.01	HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	0	0	0	0	30.01
31.00	HRR adjustment (see instructions)	70.94	-129,055	0	-129,055	-129,055	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	0	0	0	0	31.01
						(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3.00	4.00	
32.00	HAC Reduction Program adjustment (see instructions)	70.99		0	0	0	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		N				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0086	Period: From 01/01/2017 To 12/31/2017	Worksheet E Part B Date/Time Prepared: 5/29/2018 2:11 pm
		Title XVIII	Hospital	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		1,177	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		8,623,316	2.00
3.00	OPPS payments		6,536,951	3.00
4.00	Outlier payment (see instructions)		13,578	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)		1,177	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		2,484	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)		2,484	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 charge basis 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)		2,484	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		1,307	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)		1,177	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)		6,550,529	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		1,330,602	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)		5,221,104	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)		5,221,104	30.00
31.00	Primary payer payments		4,206	31.00
32.00	Subtotal (line 30 minus line 31)		5,216,898	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)		230,828	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		150,038	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		156,817	36.00
37.00	Subtotal (see instructions)		5,366,936	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	39.50
39.97	Demonstration payment adjustment amount before sequestration		0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		5,366,936	40.00
40.01	Sequestration adjustment (see instructions)		107,339	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
41.00	Interim payments		5,175,858	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		83,739	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: 15-0086

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

Worksheet E-1
Part I
Date/Time Prepared:
5/29/2018 2:11 pm

		Title XVIII		Hospital		PPS	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		11,988,194		5,111,754	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	12/31/2017	35,705	12/31/2017	64,104	3.01	
3.02			0		0	3.02	
3.03			0		0	3.03	
3.04			0		0	3.04	
3.05			0		0	3.05	
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50	
3.51			0		0	3.51	
3.52			0		0	3.52	
3.53			0		0	3.53	
3.54			0		0	3.54	
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		35,705		64,104	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)		12,023,899		5,175,858	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		251,143		83,739	6.01	
6.02	SETTLEMENT TO PROGRAM		0		0	6.02	
7.00	Total Medicare program liability (see instructions)		12,275,042		5,259,597	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: 15-0086	Period: From 01/01/2017 To 12/31/2017	Worksheet E-1 Part II Date/Time Prepared: 5/29/2018 2:11 pm
		Title XVIII	Hospital	PPS
				1.00
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14			1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12			2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2			3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12			4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20			6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168			7.00
8.00	Calculation of the HIT incentive payment (see instructions)			8.00
9.00	Sequestration adjustment amount (see instructions)			9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)			10.00
INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)			30.00
31.00	Other Adjustment (specify)			31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)			32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0086	Period: From 01/01/2017 To 12/31/2017	Worksheet E-3 Part VII Date/Time Prepared: 5/29/2018 2:11 pm	
		Title XIX	Hospital	Cost	
			Inpatient	Outpatient	
			1.00	2.00	
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES					
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient hospital/SNF/NF services		521,795		1.00
2.00	Medical and other services			0	2.00
3.00	Organ acquisition (certified transplant centers only)		0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		521,795	0	4.00
5.00	Inpatient primary payer payments		0		5.00
6.00	Outpatient primary payer payments			0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		521,795	0	7.00
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable Charges					
8.00	Routine service charges		237,247		8.00
9.00	Ancillary service charges		929,692	0	9.00
10.00	Organ acquisition charges, net of revenue		0		10.00
11.00	Incentive from target amount computation		0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)		1,166,939	0	12.00
CUSTOMARY CHARGES					
13.00	Amount actually collected from patients liable for payment for services on a charge basis		0	0	13.00
14.00	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	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)		1,166,939	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		645,144	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)		0	0	18.00
19.00	Interns and Residents (see instructions)		0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)		0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)		521,795	0	21.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.					
22.00	Other than outlier payments		0	0	22.00
23.00	Outlier payments		0	0	23.00
24.00	Program capital payments		0		24.00
25.00	Capital exception payments (see instructions)		0		25.00
26.00	Routine and Ancillary service other pass through costs		0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)		0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)		0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)		521,795	0	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT					
30.00	Excess of reasonable cost (from line 18)		0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		521,795	0	31.00
32.00	Deductibles		0		32.00
33.00	Coinurance		0		33.00
34.00	Allowable bad debts (see instructions)		0		34.00
35.00	Utilization review		0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		521,795	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		37.00
38.00	Subtotal (line 36 ± line 37)		521,795	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)		0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		521,795	0	40.00
41.00	Interim payments		513,609	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)		8,186	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2		0	0	43.00

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

Provider CCN: 15-0086

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

Worksheet G

Date/Time Prepared:
5/29/2018 2:11 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	1,627,134	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	37,594,076	0	0	0	4.00
5.00	Other receivable	416	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-21,321,527	0	0	0	6.00
7.00	Inventory	1,785,977	0	0	0	7.00
8.00	Prepaid expenses	1,019,666	0	0	0	8.00
9.00	Other current assets	5,982,423	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)	26,688,165	0	0	0	11.00
FIXED ASSETS						
12.00	Land	75,208	0	0	0	12.00
13.00	Land improvements	1,548,970	0	0	0	13.00
14.00	Accumulated depreciation	-1,274,118	0	0	0	14.00
15.00	Buildings	55,735,760	0	0	0	15.00
16.00	Accumulated depreciation	-34,771,841	0	0	0	16.00
17.00	Leasehold improvements	11,404,914	0	0	0	17.00
18.00	Accumulated depreciation	-8,573,338	0	0	0	18.00
19.00	Fixed equipment	17,264,991	0	0	0	19.00
20.00	Accumulated depreciation	-13,017,791	0	0	0	20.00
21.00	Automobiles and trucks	252,980	0	0	0	21.00
22.00	Accumulated depreciation	-206,908	0	0	0	22.00
23.00	Major movable equipment	36,266,460	0	0	0	23.00
24.00	Accumulated depreciation	-29,376,630	0	0	0	24.00
25.00	Minor equipment depreciable	4,775	0	0	0	25.00
26.00	Accumulated depreciation	-4,775	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)	35,328,657	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	79,155,973	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	79,155,973	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	141,172,795	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	31,132,447	0	0	0	37.00
38.00	Salaries, wages, and fees payable	3,903,323	0	0	0	38.00
39.00	Payroll taxes payable	384,052	0	0	0	39.00
40.00	Notes and loans payable (short term)	700,000	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	1,663,930	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	37,783,752	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	28,384,836	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	2,034,672	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	30,419,508	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	68,203,260	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	72,969,535				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)	72,969,535	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	141,172,795	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 15-0086

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

Worksheet G-1

Date/Time Prepared:
5/29/2018 2:11 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		71,935,206		0		1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		1,034,331				2.00
3.00	Total (sum of line 1 and line 2)		72,969,537		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)		72,969,537		0		11.00
12.00	OTHER	2		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)		2		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		72,969,535		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	OTHER		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: 15-0086

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

Worksheet G-2
Parts I & II
Date/Time Prepared:
5/29/2018 2:11 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	15,321,304		15,321,304	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	0		0	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)	15,321,304		15,321,304	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	3,741,903		3,741,903	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)	3,741,903		3,741,903	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	19,063,207		19,063,207	17.00
18.00	Ancillary services	53,768,030	111,121,629	164,889,659	18.00
19.00	Outpatient services	3,951,607	14,981,998	18,933,605	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		1,272,524	1,272,524	22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE	0	1,038,553	1,038,553	26.00
27.00	OCCUPATIONAL HEALTH	0	46,282	46,282	27.00
27.01	PROFESSIONAL FEES	0	1,571,507	1,571,507	27.01
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	76,782,844	130,032,493	206,815,337	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		84,137,704		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)		84,137,704		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 15-0086

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

Worksheet G-3

Date/Time Prepared:
5/29/2018 2:11 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	206,815,337	1.00
2.00	Less contractual allowances and discounts on patients' accounts	130,925,214	2.00
3.00	Net patient revenues (line 1 minus line 2)	75,890,123	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	84,137,704	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-8,247,581	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	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	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	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OPERATING REVENUE	2,288,988	24.00
24.01	INVESTMENT INCOME	6,880,702	24.01
24.02	OTHER NON-OPERATING EXPENSES	112,222	24.02
25.00	Total other income (sum of lines 6-24)	9,281,912	25.00
26.00	Total (line 5 plus line 25)	1,034,331	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	1,034,331	29.00

ANALYSIS OF HOSPITAL-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 15-0086

Period: From 01/01/2017

Worksheet H

HHA CCN: 15-7055

To 12/31/2017

Date/Time Prepared: 5/29/2018 2:11 pm

Home Health Agency I

PPS

		Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased Services	Other Costs	Total (sum of col.s. 1 thru 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
GENERAL SERVICE COST CENTERS								
1.00	Capital Related - Bldg. & Fixtures			0		0	0	1.00
2.00	Capital Related - Movable Equipment			0		0	0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0	0	0	3.00
4.00	Transportation	0	0	0	0	0	0	4.00
5.00	Administrative and General	203,453	0	69,369	0	54,999	327,821	5.00
HHA REIMBURSABLE SERVICES								
6.00	Skilled Nursing Care	487,251	0	0	0	0	487,251	6.00
7.00	Physical Therapy	148,609	0	0	0	0	148,609	7.00
8.00	Occupational Therapy	51,278	0	0	0	0	51,278	8.00
9.00	Speech Pathology	6,501	0	0	0	0	6,501	9.00
10.00	Medical Social Services	21,244	0	0	0	0	21,244	10.00
11.00	Home Health Aide	53,537	0	0	0	0	53,537	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	0	14.00
HHA NONREIMBURSABLE SERVICES								
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
23.50	Tel emedicine	0	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	971,873	0	69,369	0	54,999	1,096,241	24.00
		Reclassified	Reclassified	Adjustments	Net Expenses			
		7.00	8.00	9.00	10.00			
GENERAL SERVICE COST CENTERS								
1.00	Capital Related - Bldg. & Fixtures	0	0	0	0			1.00
2.00	Capital Related - Movable Equipment	0	0	0	0			2.00
3.00	Plant Operation & Maintenance	0	0	0	0			3.00
4.00	Transportation	0	0	0	0			4.00
5.00	Administrative and General	-11,676	316,145	0	316,145			5.00
HHA REIMBURSABLE SERVICES								
6.00	Skilled Nursing Care	0	487,251	0	487,251			6.00
7.00	Physical Therapy	0	148,609	0	148,609			7.00
8.00	Occupational Therapy	0	51,278	0	51,278			8.00
9.00	Speech Pathology	0	6,501	0	6,501			9.00
10.00	Medical Social Services	0	21,244	0	21,244			10.00
11.00	Home Health Aide	0	53,537	0	53,537			11.00
12.00	Supplies (see instructions)	0	0	0	0			12.00
13.00	Drugs	0	0	0	0			13.00
14.00	DME	0	0	0	0			14.00
HHA NONREIMBURSABLE SERVICES								
15.00	Home Dialysis Aide Services	0	0	0	0			15.00
16.00	Respiratory Therapy	0	0	0	0			16.00
17.00	Private Duty Nursing	0	0	0	0			17.00
18.00	Clinic	0	0	0	0			18.00
19.00	Health Promotion Activities	0	0	0	0			19.00
20.00	Day Care Program	0	0	0	0			20.00
21.00	Home Delivered Meals Program	0	0	0	0			21.00
22.00	Homemaker Service	0	0	0	0			22.00
23.00	All Others (specify)	0	0	0	0			23.00
23.50	Tel emedicine	0	0	0	0			23.50
24.00	Total (sum of lines 1-23)	-11,676	1,084,565	0	1,084,565			24.00

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

COST ALLOCATION - HHA GENERAL SERVICE COST		Provider CCN: 15-0086	Period: From 01/01/2017 To 12/31/2017	Worksheet H-1 Part I Date/Time Prepared: 5/29/2018 2:11 pm
		HHA CCN: 15-7055	Home Health Agency I	PPS

	Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Capital Related Costs		Plant Operation & Maintenance	Transportation	Subtotal (cols. 0-4)		
		Bldgs & Fixtures	Movable Equipment					
		1.00	2.00					3.00
GENERAL SERVICE COST CENTERS								
1.00	Capital Related - Bldg. & Fixtures	0	0			0	1.00	
2.00	Capital Related - Movable Equipment	0	0			0	2.00	
3.00	Plant Operation & Maintenance	0	0	0		0	3.00	
4.00	Transportation	0	0	0	0	0	4.00	
5.00	Administrative and General	316,145	0	0	0	316,145	5.00	
HHA REIMBURSABLE SERVICES								
6.00	Skilled Nursing Care	487,251	0	0	0	487,251	6.00	
7.00	Physical Therapy	148,609	0	0	0	148,609	7.00	
8.00	Occupational Therapy	51,278	0	0	0	51,278	8.00	
9.00	Speech Pathology	6,501	0	0	0	6,501	9.00	
10.00	Medical Social Services	21,244	0	0	0	21,244	10.00	
11.00	Home Health Aide	53,537	0	0	0	53,537	11.00	
12.00	Supplies (see instructions)	0	0	0	0	0	12.00	
13.00	Drugs	0	0	0	0	0	13.00	
14.00	DME	0	0	0	0	0	14.00	
HHA NONREIMBURSABLE SERVICES								
15.00	Home Dialysis Aide Services	0	0	0	0	0	15.00	
16.00	Respiratory Therapy	0	0	0	0	0	16.00	
17.00	Private Duty Nursing	0	0	0	0	0	17.00	
18.00	Clinic	0	0	0	0	0	18.00	
19.00	Health Promotion Activities	0	0	0	0	0	19.00	
20.00	Day Care Program	0	0	0	0	0	20.00	
21.00	Home Delivered Meals Program	0	0	0	0	0	21.00	
22.00	Homemaker Service	0	0	0	0	0	22.00	
23.00	All Others (specify)	0	0	0	0	0	23.00	
23.50	Telemedicine	0	0	0	0	0	23.50	
24.00	Total (sum of lines 1-23)	1,084,565	0	0	0	1,084,565	24.00	
		Administrative & General	Total (cols. 4A + 5)					
		5.00	6.00					
GENERAL SERVICE COST CENTERS								
1.00	Capital Related - Bldg. & Fixtures						1.00	
2.00	Capital Related - Movable Equipment						2.00	
3.00	Plant Operation & Maintenance						3.00	
4.00	Transportation						4.00	
5.00	Administrative and General	316,145					5.00	
HHA REIMBURSABLE SERVICES								
6.00	Skilled Nursing Care	200,466	687,717				6.00	
7.00	Physical Therapy	61,141	209,750				7.00	
8.00	Occupational Therapy	21,097	72,375				8.00	
9.00	Speech Pathology	2,675	9,176				9.00	
10.00	Medical Social Services	8,740	29,984				10.00	
11.00	Home Health Aide	22,026	75,563				11.00	
12.00	Supplies (see instructions)	0	0				12.00	
13.00	Drugs	0	0				13.00	
14.00	DME	0	0				14.00	
HHA NONREIMBURSABLE SERVICES								
15.00	Home Dialysis Aide Services	0	0				15.00	
16.00	Respiratory Therapy	0	0				16.00	
17.00	Private Duty Nursing	0	0				17.00	
18.00	Clinic	0	0				18.00	
19.00	Health Promotion Activities	0	0				19.00	
20.00	Day Care Program	0	0				20.00	
21.00	Home Delivered Meals Program	0	0				21.00	
22.00	Homemaker Service	0	0				22.00	
23.00	All Others (specify)	0	0				23.00	
23.50	Telemedicine	0	0				23.50	
24.00	Total (sum of lines 1-23)		1,084,565				24.00	

COST ALLOCATION - HHA STATISTICAL BASIS

Provider CCN: 15-0086

Period: From 01/01/2017

Worksheet H-1

HHA CCN: 15-7055

To 12/31/2017

Part II
Date/Time Prepared:
5/29/2018 2:11 pm

Home Health
Agency I

PPS

	Capital Related Costs		Plant Operation & Maintenance (SQUARE FEET)	Transportation (MILEAGE)	Reconciliation	Administrative & General (ACCUM. COST)	
	Bl dgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)					
	1.00	2.00					
GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0			0		1.00
2.00	Capital Related - Movable Equipment		0		0		2.00
3.00	Plant Operation & Maintenance	0	0	0	0		3.00
4.00	Transportation (see instructions)	0	0	0	0		4.00
5.00	Administrative and General	0	0	0	0	-316,145	768,420
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	0	487,251
7.00	Physical Therapy	0	0	0	0	0	148,609
8.00	Occupational Therapy	0	0	0	0	0	51,278
9.00	Speech Pathology	0	0	0	0	0	6,501
10.00	Medical Social Services	0	0	0	0	0	21,244
11.00	Home Health Aide	0	0	0	0	0	53,537
12.00	Supplies (see instructions)	0	0	0	0	0	0
13.00	Drugs	0	0	0	0	0	0
14.00	DME	0	0	0	0	0	0
HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0
16.00	Respiratory Therapy	0	0	0	0	0	0
17.00	Private Duty Nursing	0	0	0	0	0	0
18.00	Clinic	0	0	0	0	0	0
19.00	Health Promotion Activities	0	0	0	0	0	0
20.00	Day Care Program	0	0	0	0	0	0
21.00	Home Delivered Meals Program	0	0	0	0	0	0
22.00	Homemaker Service	0	0	0	0	0	0
23.00	All Others (specify)	0	0	0	0	0	0
23.50	Telemedicine	0	0	0	0	0	0
24.00	Total (sum of lines 1-23)	0	0	0	0	-316,145	768,420
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0	0		316,145
26.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000		0.411422

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 15-0086

Period: From 01/01/2017

Worksheet H-2

HHA CCN: 15-7055

To 12/31/2017

Part I
Date/Time Prepared: 5/29/2018 2:11 pm

Home Health Agency I

PPS

Cost Center Description	HHA Trial Balance (1)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	COMMUNICATIONS	DATA PROCESSING	
		NEW BLDG & FIXT	NEW MVBLE EQUIP				
		1.00	2.00				
1.00 Administrative and General	0	38,566	23,898	337,108	1,498	120,992	1.00
2.00 Skilled Nursing Care	687,717	0	0	0	0	0	2.00
3.00 Physical Therapy	209,750	0	0	0	0	0	3.00
4.00 Occupational Therapy	72,375	0	0	0	0	0	4.00
5.00 Speech Pathology	9,176	0	0	0	0	0	5.00
6.00 Medical Social Services	29,984	0	0	0	0	0	6.00
7.00 Home Health Aide	75,563	0	0	0	0	0	7.00
8.00 Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00 Drugs	0	0	0	0	0	0	9.00
10.00 DME	0	0	0	0	0	0	10.00
11.00 Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00 Respiratory Therapy	0	0	0	0	0	0	12.00
13.00 Private Duty Nursing	0	0	0	0	0	0	13.00
14.00 Clinic	0	0	0	0	0	0	14.00
15.00 Health Promotion Activities	0	0	0	0	0	0	15.00
16.00 Day Care Program	0	0	0	0	0	0	16.00
17.00 Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00 Homemaker Service	0	0	0	0	0	0	18.00
19.00 All Others (specify)	0	0	0	0	0	0	19.00
19.50 Telemedicine	0	0	0	0	0	0	19.50
20.00 Total (sum of lines 1-19) (2)	1,084,565	38,566	23,898	337,108	1,498	120,992	20.00
21.00 Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00
Cost Center Description	PURCHASING RECEIVING AND STORES	ADMINITTING	CASHIERING/ACCOUNTS RECEIVABLE	Subtotal	OTHER ADMINISTRATIVE AND GENERAL	OPERATION OF PLANT	
	5.03	5.04	5.05	5A.05	5.06	7.00	
1.00 Administrative and General	2,890	0	10,923	535,875	40,431	104,101	1.00
2.00 Skilled Nursing Care	0	0	0	687,717	51,887	0	2.00
3.00 Physical Therapy	0	0	0	209,750	15,825	0	3.00
4.00 Occupational Therapy	0	0	0	72,375	5,461	0	4.00
5.00 Speech Pathology	0	0	0	9,176	692	0	5.00
6.00 Medical Social Services	0	0	0	29,984	2,262	0	6.00
7.00 Home Health Aide	0	0	0	75,563	5,701	0	7.00
8.00 Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00 Drugs	0	0	0	0	0	0	9.00
10.00 DME	0	0	0	0	0	0	10.00
11.00 Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00 Respiratory Therapy	0	0	0	0	0	0	12.00
13.00 Private Duty Nursing	0	0	0	0	0	0	13.00
14.00 Clinic	0	0	0	0	0	0	14.00
15.00 Health Promotion Activities	0	0	0	0	0	0	15.00
16.00 Day Care Program	0	0	0	0	0	0	16.00
17.00 Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00 Homemaker Service	0	0	0	0	0	0	18.00
19.00 All Others (specify)	0	0	0	0	0	0	19.00
19.50 Telemedicine	0	0	0	0	0	0	19.50
20.00 Total (sum of lines 1-19) (2)	2,890	0	10,923	1,620,440	122,259	104,101	20.00
21.00 Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.				0.000000			21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 15-0086

Period: From 01/01/2017

Worksheet H-2

HHA CCN: 15-7055

To 12/31/2017

Part I
Date/Time Prepared:
5/29/2018 2:11 pm

Home Health Agency I

PPS

Cost Center Description		LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICE & SUPPLY	
		8.00	9.00	10.00	11.00	13.00	14.00	
1.00	Administrative and General	0	28,934	0	0	0	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	0	28,934	0	0	0	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00
Cost Center Description		PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	
		15.00	16.00	17.00	24.00	25.00	26.00	
1.00	Administrative and General	0	11,880	0	721,221	0	721,221	1.00
2.00	Skilled Nursing Care	0	0	0	739,604	0	739,604	2.00
3.00	Physical Therapy	0	0	0	225,575	0	225,575	3.00
4.00	Occupational Therapy	0	0	0	77,836	0	77,836	4.00
5.00	Speech Pathology	0	0	0	9,868	0	9,868	5.00
6.00	Medical Social Services	0	0	0	32,246	0	32,246	6.00
7.00	Home Health Aide	0	0	0	81,264	0	81,264	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	0	11,880	0	1,887,614	0	1,887,614	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS		Provider CCN: 15-0086	Period: From 01/01/2017	Worksheet H-2
		HHA CCN: 15-7055	To 12/31/2017	Part I
			Home Health Agency I	Date/Time Prepared: 5/29/2018 2:11 pm
				PPS

Cost Center Description		Allocated HHA A&G (see Part II)	Total HHA Costs		
		27.00	28.00		
1.00	Administrative and General				1.00
2.00	Skilled Nursing Care	457,322	1,196,926		2.00
3.00	Physical Therapy	139,481	365,056		3.00
4.00	Occupational Therapy	48,129	125,965		4.00
5.00	Speech Pathology	6,102	15,970		5.00
6.00	Medical Social Services	19,939	52,185		6.00
7.00	Home Health Aide	50,248	131,512		7.00
8.00	Supplies (see instructions)	0	0		8.00
9.00	Drugs	0	0		9.00
10.00	DME	0	0		10.00
11.00	Home Dialysis Aide Services	0	0		11.00
12.00	Respiratory Therapy	0	0		12.00
13.00	Private Duty Nursing	0	0		13.00
14.00	Clinic	0	0		14.00
15.00	Health Promotion Activities	0	0		15.00
16.00	Day Care Program	0	0		16.00
17.00	Home Delivered Meals Program	0	0		17.00
18.00	Homemaker Service	0	0		18.00
19.00	All Others (specify)	0	0		19.00
19.50	Telemedicine	0	0		19.50
20.00	Total (sum of lines 1-19) (2)	721,221	1,887,614		20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.	0.618334			21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 15-0086
HHA CCN: 15-7055

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

Worksheet H-2 Part II
Date/Time Prepared: 5/29/2018 2:11 pm

Home Health Agency I

PPS

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	COMMUNICATIONS (PHONES)	DATA PROCESSING (DP EQUIPMENT)	PURCHASING RECEIVING AND STORES (SUPPLY EXPENSE)	
	NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)					
	1.00	2.00					
1.00 Administrative and General	3,085	3,085	971,873	6	41	38,266	1.00
2.00 Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00 Physical Therapy	0	0	0	0	0	0	3.00
4.00 Occupational Therapy	0	0	0	0	0	0	4.00
5.00 Speech Pathology	0	0	0	0	0	0	5.00
6.00 Medical Social Services	0	0	0	0	0	0	6.00
7.00 Home Health Aide	0	0	0	0	0	0	7.00
8.00 Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00 Drugs	0	0	0	0	0	0	9.00
10.00 DME	0	0	0	0	0	0	10.00
11.00 Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00 Respiratory Therapy	0	0	0	0	0	0	12.00
13.00 Private Duty Nursing	0	0	0	0	0	0	13.00
14.00 Clinic	0	0	0	0	0	0	14.00
15.00 Health Promotion Activities	0	0	0	0	0	0	15.00
16.00 Day Care Program	0	0	0	0	0	0	16.00
17.00 Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00 Homemaker Service	0	0	0	0	0	0	18.00
19.00 All Others (specify)	0	0	0	0	0	0	19.00
19.50 Telemedicine	0	0	0	0	0	0	19.50
20.00 Total (sum of lines 1-19)	3,085	3,085	971,873	6	41	38,266	20.00
21.00 Total cost to be allocated	38,566	23,898	337,108	1,498	120,992	2,890	21.00
22.00 Unit cost multiplier	12.501135	7.746515	0.346864	249.666667	2,951.024390	0.075524	22.00
Cost Center Description	ADMITTING (ADMISSIONS)	CASHIERING/ACCOUNTS RECEIVABLE (GROSS CHARGES)	Reconciliation	OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	
	5.04	5.05	5A.06	5.06	7.00	8.00	
1.00 Administrative and General	0	1,272,524	0	535,875	3,085	0	1.00
2.00 Skilled Nursing Care	0	0	0	687,717	0	0	2.00
3.00 Physical Therapy	0	0	0	209,750	0	0	3.00
4.00 Occupational Therapy	0	0	0	72,375	0	0	4.00
5.00 Speech Pathology	0	0	0	9,176	0	0	5.00
6.00 Medical Social Services	0	0	0	29,984	0	0	6.00
7.00 Home Health Aide	0	0	0	75,563	0	0	7.00
8.00 Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00 Drugs	0	0	0	0	0	0	9.00
10.00 DME	0	0	0	0	0	0	10.00
11.00 Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00 Respiratory Therapy	0	0	0	0	0	0	12.00
13.00 Private Duty Nursing	0	0	0	0	0	0	13.00
14.00 Clinic	0	0	0	0	0	0	14.00
15.00 Health Promotion Activities	0	0	0	0	0	0	15.00
16.00 Day Care Program	0	0	0	0	0	0	16.00
17.00 Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00 Homemaker Service	0	0	0	0	0	0	18.00
19.00 All Others (specify)	0	0	0	0	0	0	19.00
19.50 Telemedicine	0	0	0	0	0	0	19.50
20.00 Total (sum of lines 1-19)	0	1,272,524	0	1,620,440	3,085	0	20.00
21.00 Total cost to be allocated	0	10,923	0	122,259	104,101	0	21.00
22.00 Unit cost multiplier	0.000000	0.008584	0	0.075448	33.744246	0.000000	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS	Provider CCN: 15-0086 HHA CCN: 15-7055	Period: From 01/01/2017 To 12/31/2017	Worksheet H-2 Part II Date/Time Prepared: 5/29/2018 2:11 pm
---	---	---	--

Cost Center Description		HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (MAN HOURS)	NURSING ADMINISTRATION (GROSS HOURS)	CENTRAL SERVICE & SUPPLY (100%)	PHARMACY (100%)	
		9.00	10.00	11.00	13.00	14.00	15.00	
1.00	Administrative and General	3,085	0	0	0	0	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	3,085	0	0	0	0	0	20.00
21.00	Total cost to be allocated	28,934	0	0	0	0	0	21.00
22.00	Unit cost multiplier	9.378930	0.000000	0.000000	0.000000	0.000000	0.000000	22.00
Cost Center Description		MEDICAL RECORDS & LIBRARY (ADJUSTED CHARGES)	SOCIAL SERVICE (TIME SPENT)					
		16.00	17.00					
1.00	Administrative and General	1,272,524	0					1.00
2.00	Skilled Nursing Care	0	0					2.00
3.00	Physical Therapy	0	0					3.00
4.00	Occupational Therapy	0	0					4.00
5.00	Speech Pathology	0	0					5.00
6.00	Medical Social Services	0	0					6.00
7.00	Home Health Aide	0	0					7.00
8.00	Supplies (see instructions)	0	0					8.00
9.00	Drugs	0	0					9.00
10.00	DME	0	0					10.00
11.00	Home Dialysis Aide Services	0	0					11.00
12.00	Respiratory Therapy	0	0					12.00
13.00	Private Duty Nursing	0	0					13.00
14.00	Clinic	0	0					14.00
15.00	Health Promotion Activities	0	0					15.00
16.00	Day Care Program	0	0					16.00
17.00	Home Delivered Meals Program	0	0					17.00
18.00	Homemaker Service	0	0					18.00
19.00	All Others (specify)	0	0					19.00
19.50	Telemedicine	0	0					19.50
20.00	Total (sum of lines 1-19)	1,272,524	0					20.00
21.00	Total cost to be allocated	11,880	0					21.00
22.00	Unit cost multiplier	0.009336	0.000000					22.00

APPORTIONMENT OF PATIENT SERVICE COSTS		Provider CCN: 15-0086	Period: From 01/01/2017 To 12/31/2017	Worksheet H-3 Part I Date/Time Prepared: 5/29/2018 2:11 pm
		HHA CCN: 15-7055	Title XVIII	Home Health Agency I PPS

Cost Center Description	From, Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Visits	Average Cost Per Visit (col. 3 ÷ col. 4)
	0	1.00	2.00	3.00	4.00	5.00

PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION

Cost Per Visit Computation								
1.00	Skilled Nursing Care	2.00	1,196,926		1,196,926	3,425	349.47	1.00
2.00	Physical Therapy	3.00	365,056	0	365,056	1,945	187.69	2.00
3.00	Occupational Therapy	4.00	125,965	0	125,965	572	220.22	3.00
4.00	Speech Pathology	5.00	15,970	0	15,970	100	159.70	4.00
5.00	Medical Social Services	6.00	52,185		52,185	22	2,372.05	5.00
6.00	Home Health Aide	7.00	131,512		131,512	854	154.00	6.00
7.00	Total (sum of lines 1-6)		1,887,614	0	1,887,614	6,918		7.00

Cost Center Description	Cost Limits	CBSA No. (1)	Part A	Program Visits		5.00
				Part B		
				Not Subject to Deductibles & Coinsurance	Subject to Deductibles	
	0	1.00	2.00	3.00	4.00	5.00

Limitation Cost Computation

8.00	Skilled Nursing Care		17140	0	1,349			8.00
8.01	Skilled Nursing Care		50031	0	0			8.01
8.02	Skilled Nursing Care		50034	0	0			8.02
8.03	Skilled Nursing Care		50035	0	0			8.03
8.04	Skilled Nursing Care		99915	0	487			8.04
9.00	Physical Therapy		17140	0	756			9.00
9.01	Physical Therapy		50031	0	0			9.01
9.02	Physical Therapy		50034	0	0			9.02
9.03	Physical Therapy		50035	0	0			9.03
9.04	Physical Therapy		99915	0	239			9.04
10.00	Occupational Therapy		17140	0	172			10.00
10.01	Occupational Therapy		50031	0	0			10.01
10.02	Occupational Therapy		50034	0	0			10.02
10.03	Occupational Therapy		50035	0	0			10.03
10.04	Occupational Therapy		99915	0	83			10.04
11.00	Speech Pathology		17140	0	20			11.00
11.01	Speech Pathology		50031	0	0			11.01
11.02	Speech Pathology		50034	0	0			11.02
11.03	Speech Pathology		50035	0	0			11.03
11.04	Speech Pathology		99915	0	18			11.04
12.00	Medical Social Services		17140	0	8			12.00
12.01	Medical Social Services		50031	0	0			12.01
12.02	Medical Social Services		50034	0	0			12.02
12.03	Medical Social Services		50035	0	0			12.03
12.04	Medical Social Services		99915	0	3			12.04
13.00	Home Health Aide		17140	0	287			13.00
13.01	Home Health Aide		50031	0	0			13.01
13.02	Home Health Aide		50034	0	0			13.02
13.03	Home Health Aide		50035	0	0			13.03
13.04	Home Health Aide		99915	0	59			13.04
14.00	Total (sum of lines 8-13)			0	3,481			14.00

Cost Center Description	From Wkst. H-2 Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Charges (from HHA Records)	Ratio (col. 3 ÷ col. 4)
	0	1.00	2.00	3.00	4.00	5.00

Supplies and Drugs Cost Computations

15.00	Cost of Medical Supplies	8.00	0	0	0	0	0.000000	15.00
16.00	Cost of Drugs	9.00	0	0	0	0	0.000000	16.00

APPORTIONMENT OF PATIENT SERVICE COSTS		Provider CCN: 15-0086	Period: From 01/01/2017 To 12/31/2017	Worksheet H-3 Part I Date/Time Prepared: 5/29/2018 2:11 pm
		HHA CCN: 15-7055	Title XVIII	Home Health Agency I PPS

Cost Center Description	Program Visits			Cost of Services			
	Part A	Part B		Part A	Part B		
		Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance		Not Subject to Deductibles & Coinsurance		Subject to Deductibles & Coinsurance
6.00	7.00	8.00	9.00	10.00	11.00		

PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION
 Cost Per Visit Computation

1.00	Skilled Nursing Care	0	1,836		0	641,627		1.00
2.00	Physical Therapy	0	995		0	186,752		2.00
3.00	Occupational Therapy	0	255		0	56,156		3.00
4.00	Speech Pathology	0	38		0	6,069		4.00
5.00	Medical Social Services	0	11		0	26,093		5.00
6.00	Home Health Aide	0	346		0	53,284		6.00
7.00	Total (sum of lines 1-6)	0	3,481		0	969,981		7.00
Cost Center Description		6.00	7.00	8.00	9.00	10.00	11.00	

Limitation Cost Computation

8.00	Skilled Nursing Care							8.00
8.01	Skilled Nursing Care							8.01
8.02	Skilled Nursing Care							8.02
8.03	Skilled Nursing Care							8.03
8.04	Skilled Nursing Care							8.04
9.00	Physical Therapy							9.00
9.01	Physical Therapy							9.01
9.02	Physical Therapy							9.02
9.03	Physical Therapy							9.03
9.04	Physical Therapy							9.04
10.00	Occupational Therapy							10.00
10.01	Occupational Therapy							10.01
10.02	Occupational Therapy							10.02
10.03	Occupational Therapy							10.03
10.04	Occupational Therapy							10.04
11.00	Speech Pathology							11.00
11.01	Speech Pathology							11.01
11.02	Speech Pathology							11.02
11.03	Speech Pathology							11.03
11.04	Speech Pathology							11.04
12.00	Medical Social Services							12.00
12.01	Medical Social Services							12.01
12.02	Medical Social Services							12.02
12.03	Medical Social Services							12.03
12.04	Medical Social Services							12.04
13.00	Home Health Aide							13.00
13.01	Home Health Aide							13.01
13.02	Home Health Aide							13.02
13.03	Home Health Aide							13.03
13.04	Home Health Aide							13.04
14.00	Total (sum of lines 8-13)							14.00

Cost Center Description	Program Covered Charges			Cost of Services			
	Part A	Part B		Part A	Part B		
		Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance		Not Subject to Deductibles & Coinsurance		Subject to Deductibles & Coinsurance
6.00	7.00	8.00	9.00	10.00	11.00		

Supplies and Drugs Cost Computations

15.00	Cost of Medical Supplies	0	0	0	0	0	0	15.00
16.00	Cost of Drugs		0	0		0	0	16.00

APPORTIONMENT OF PATIENT SERVICE COSTS		Provider CCN: 15-0086 HHA CCN: 15-7055	Period: From 01/01/2017 To 12/31/2017	Worksheet H-3 Part I Date/Time Prepared: 5/29/2018 2:11 pm
		Title XVIII	Home Health Agency I	PPS

Cost Center Description		Total Program Cost (sum of cols. 9-10)		
		12.00		
PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION				
Cost Per Visit Computation				
1.00	Skilled Nursing Care	641,627		1.00
2.00	Physical Therapy	186,752		2.00
3.00	Occupational Therapy	56,156		3.00
4.00	Speech Pathology	6,069		4.00
5.00	Medical Social Services	26,093		5.00
6.00	Home Health Aide	53,284		6.00
7.00	Total (sum of lines 1-6)	969,981		7.00
Cost Center Description		12.00		
Limitation Cost Computation				
8.00	Skilled Nursing Care			8.00
8.01	Skilled Nursing Care			8.01
8.02	Skilled Nursing Care			8.02
8.03	Skilled Nursing Care			8.03
8.04	Skilled Nursing Care			8.04
9.00	Physical Therapy			9.00
9.01	Physical Therapy			9.01
9.02	Physical Therapy			9.02
9.03	Physical Therapy			9.03
9.04	Physical Therapy			9.04
10.00	Occupational Therapy			10.00
10.01	Occupational Therapy			10.01
10.02	Occupational Therapy			10.02
10.03	Occupational Therapy			10.03
10.04	Occupational Therapy			10.04
11.00	Speech Pathology			11.00
11.01	Speech Pathology			11.01
11.02	Speech Pathology			11.02
11.03	Speech Pathology			11.03
11.04	Speech Pathology			11.04
12.00	Medical Social Services			12.00
12.01	Medical Social Services			12.01
12.02	Medical Social Services			12.02
12.03	Medical Social Services			12.03
12.04	Medical Social Services			12.04
13.00	Home Health Aide			13.00
13.01	Home Health Aide			13.01
13.02	Home Health Aide			13.02
13.03	Home Health Aide			13.03
13.04	Home Health Aide			13.04
14.00	Total (sum of lines 8-13)			14.00

APPORTIONMENT OF PATIENT SERVICE COSTS		Provider CCN: 15-0086 HHA CCN: 15-7055	Period: From 01/01/2017 To 12/31/2017	Worksheet H-3 Part II Date/Time Prepared: 5/29/2018 2:11 pm
Title XVIII			Home Health Agency I	PPS

Cost Center Description	From Wkst. C, Part I, col. 9, line	Cost to Charge Ratio	Total HHA Charge (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)	Transfer to Part I as Indicated		
	0	1.00	2.00	3.00	4.00		
PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS							
1.00	Physical Therapy	66.00	0.451048	0	0	col. 2, line 2.00	1.00
2.00	Occupational Therapy	67.00	0.522963	0	0	col. 2, line 3.00	2.00
3.00	Speech Pathology	68.00	0.594100	0	0	col. 2, line 4.00	3.00
4.00	Cost of Medical Supplies	71.00	0.843778	0	0	col. 2, line 15.00	4.00
5.00	Cost of Drugs	73.00	0.473663	0	0	col. 2, line 16.00	5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0086 HHA CCN: 15-7055	Period: From 01/01/2017 To 12/31/2017	Worksheet H-4 Part I-II Date/Time Prepared: 5/29/2018 2:11 pm
		Title XVIII	Home Health Agency I	PPS
		Part A	Part B	
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance
		1.00	2.00	3.00
PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES				
Reasonable Cost of Part A & Part B Services				
1.00	Reasonable cost of services (see instructions)	0	0	0
2.00	Total charges	0	0	0
Customary Charges				
3.00	Amount actually collected from patients liable for payment for services on a charge basis (from your records)	0	0	0
4.00	Amount that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(b)	0	0	0
5.00	Ratio of line 3 to line 4 (not to exceed 1.000000)	0.000000	0.000000	0.000000
6.00	Total customary charges (see instructions)	0	0	0
7.00	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)	0	0	0
8.00	Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6)	0	0	0
9.00	Primary payer amounts	0	0	0
			Part A Services	Part B Services
			1.00	2.00
PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT				
10.00	Total reasonable cost (see instructions)		0	0
11.00	Total PPS Reimbursement - Full Episodes without Outliers		0	542,736
12.00	Total PPS Reimbursement - Full Episodes with Outliers		0	30,832
13.00	Total PPS Reimbursement - LUPA Episodes		0	15,730
14.00	Total PPS Reimbursement - PEP Episodes		0	415
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers		0	25,933
16.00	Total PPS Outlier Reimbursement - PEP Episodes		0	0
17.00	Total Other Payments		0	0
18.00	DME Payments		0	0
19.00	Oxygen Payments		0	0
20.00	Prosthetic and Orthotic Payments		0	0
21.00	Part B deductibles billed to Medicare patients (exclude coinsurance)		0	0
22.00	Subtotal (sum of lines 10 thru 20 minus line 21)		0	615,646
23.00	Excess reasonable cost (from line 8)		0	0
24.00	Subtotal (line 22 minus line 23)		0	615,646
25.00	Coinsurance billed to program patients (from your records)		0	0
26.00	Net cost (line 24 minus line 25)		0	615,646
27.00	Reimbursable bad debts (from your records)		0	0
28.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)		0	0
29.00	Total costs - current cost reporting period (line 26 plus line 27)		0	615,646
30.00	OTHER		0	-128
30.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	0
30.99	Demonstration payment adjustment amount before sequestration		0	0
31.00	Subtotal (see instructions)		0	615,518
31.01	Sequestration adjustment (see instructions)		0	12,310
31.02	Demonstration payment adjustment amount after sequestration		0	0
32.00	Interim payments (see instructions)		0	603,208
33.00	Tentative settlement (for contractor use only)		0	0
34.00	Balance due provider/program (line 31 minus lines 31.01, 32, and 33)		0	0
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	0

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

Provider CCN: 15-0086

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

Worksheet H-5

HHA CCN: 15-7055

Date/Time Prepared:
5/29/2018 2:11 pm

Home Health
Agency I

PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		0		603,208	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01			0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50			0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate, line 32)		0		603,208	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01			0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50			0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		0		603,208	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
				0	1.00	2.00
8.00	Name of Contractor					8.00

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS

Provider CCN: 15-0086

Period: From 01/01/2017

Worksheet 0

Hospice CCN: 15-1531

To 12/31/2017

Date/Time Prepared: 5/29/2018 2:11 pm

		Hospice I				
		SALARIES	OTHER	SUBTOTAL (col. 1 plus col. 2)	RECLASSIFI - CATIONS	SUBTOTAL
		1.00	2.00	3.00	4.00	5.00
GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT*		0	0	0	0
2.00	CAP REL COSTS-MVBLE EQUIP*		506	506	0	506
3.00	EMPLOYEE BENEFITS DEPARTMENT*	0	0	0	0	0
4.00	ADMINISTRATIVE & GENERAL*	55,549	31,069	86,618	0	86,618
5.00	PLANT OPERATION & MAINTENANCE*	0	0	0	0	0
6.00	LAUNDRY & LINEN SERVICE*	0	0	0	0	0
7.00	HOUSEKEEPING*	0	0	0	0	0
8.00	DIETARY*	0	0	0	0	0
9.00	NURSING ADMINISTRATION*	0	0	0	0	0
10.00	ROUTINE MEDICAL SUPPLIES*	0	0	0	0	0
11.00	MEDICAL RECORDS*	20,092	0	20,092	0	20,092
12.00	STAFF TRANSPORTATION*	0	0	0	0	0
13.00	VOLUNTEER SERVICE COORDINATION*	0	0	0	0	0
14.00	PHARMACY*	0	0	0	0	0
15.00	PHYSICIAN ADMINISTRATIVE SERVICES*	0	12,000	12,000	0	12,000
16.00	OTHER GENERAL SERVICE*	0	198,169	198,169	0	198,169
17.00	PATIENT/RESIDENTIAL CARE SERVICES					
DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED**		0	0	0	0
26.00	PHYSICIAN SERVICES**	0	0	0	0	0
27.00	NURSE PRACTITIONER**	0	0	0	0	0
28.00	REGISTERED NURSE**	106,184	0	106,184	0	106,184
29.00	LPN/LVN**	0	0	0	0	0
30.00	PHYSICAL THERAPY**	0	0	0	0	0
31.00	OCCUPATIONAL THERAPY**	0	0	0	0	0
32.00	SPEECH/LANGUAGE PATHOLOGY**	0	0	0	0	0
33.00	MEDICAL SOCIAL SERVICES**	24,977	0	24,977	0	24,977
34.00	SPIRITUAL COUNSELING**	10,472	0	10,472	0	10,472
35.00	DIETARY COUNSELING**	0	0	0	0	0
36.00	COUNSELING - OTHER**	0	0	0	0	0
37.00	HOSPICE AIDE & HOME MAKER SERVICES**	7,926	0	7,926	0	7,926
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN**	0	0	0	0	0
39.00	PATIENT TRANSPORTATION**	0	0	0	0	0
40.00	IMAGING SERVICES**	0	0	0	0	0
41.00	LABS & DIAGNOSTICS**	0	0	0	0	0
42.00	MEDICAL SUPPLIES-NON-ROUTINE**	0	48,784	48,784	-48,226	558
42.50	DRUGS CHARGED TO PATIENTS**	0	0	0	0	0
43.00	OUTPATIENT SERVICES**	0	0	0	0	0
44.00	PALLIATIVE RADIATION THERAPY**	0	0	0	0	0
45.00	PALLIATIVE CHEMOTHERAPY**	0	0	0	0	0
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)**	0	0	0	0	0
NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM *	0	0	0	0	0
61.00	VOLUNTEER PROGRAM *	0	0	0	0	0
62.00	FUNDRAISING*	0	0	0	0	0
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS*	0	0	0	0	0
64.00	PALLIATIVE CARE PROGRAM*	0	0	0	0	0
65.00	OTHER PHYSICIAN SERVICES*	0	0	0	0	0
66.00	RESIDENTIAL CARE*	0	0	0	0	0
67.00	ADVERTISING*	0	0	0	0	0
68.00	TELEHEALTH/TELEMONITORING*	0	0	0	0	0
69.00	THRIFT STORE*	0	0	0	0	0
70.00	NURSING FACILITY ROOM & BOARD*	0	0	0	0	0
71.00	OTHER NONREIMBURSABLE (SPECIFY)*	0	6,018	6,018	0	6,018
100.00	TOTAL	225,200	296,546	521,746	-48,226	473,520

* Transfer the amounts in column 7 to Wkst. 0-5, column 1, line as appropriate.

** See instructions. Do not transfer the amounts in column 7 to Wkst. 0-5.

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS

Provider CCN: 15-0086

Period: From 01/01/2017

Worksheet 0

Hospice CCN: 15-1531

To 12/31/2017

Date/Time Prepared: 5/29/2018 2:11 pm

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)	Hospice I
		6.00	7.00	
GENERAL SERVICE COST CENTERS				
1.00	CAP REL COSTS-BLDG & FIXT*	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP*	0	506	2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT*	0	0	3.00
4.00	ADMINISTRATIVE & GENERAL*	0	86,618	4.00
5.00	PLANT OPERATION & MAINTENANCE*	0	0	5.00
6.00	LAUNDRY & LINEN SERVICE*	0	0	6.00
7.00	HOUSEKEEPING*	0	0	7.00
8.00	DIETARY*	0	0	8.00
9.00	NURSING ADMINISTRATION*	0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES*	0	0	10.00
11.00	MEDICAL RECORDS*	0	20,092	11.00
12.00	STAFF TRANSPORTATION*	0	0	12.00
13.00	VOLUNTEER SERVICE COORDINATION*	0	0	13.00
14.00	PHARMACY*	0	0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES*	0	12,000	15.00
16.00	OTHER GENERAL SERVICE*	0	198,169	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES			17.00
DIRECT PATIENT CARE SERVICE COST CENTERS				
25.00	INPATIENT CARE-CONTRACTED**	0	0	25.00
26.00	PHYSICIAN SERVICES**	0	0	26.00
27.00	NURSE PRACTITIONER**	0	0	27.00
28.00	REGISTERED NURSE**	0	106,184	28.00
29.00	LPN/LVN**	0	0	29.00
30.00	PHYSICAL THERAPY**	0	0	30.00
31.00	OCCUPATIONAL THERAPY**	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY**	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES**	0	24,977	33.00
34.00	SPIRITUAL COUNSELING**	0	10,472	34.00
35.00	DIETARY COUNSELING**	0	0	35.00
36.00	COUNSELING - OTHER**	0	0	36.00
37.00	HOSPICE AIDE & HOME MAKER SERVICES**	0	7,926	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN**	0	0	38.00
39.00	PATIENT TRANSPORTATION**	0	0	39.00
40.00	IMAGING SERVICES**	0	0	40.00
41.00	LABS & DIAGNOSTICS**	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE**	0	558	42.00
42.50	DRUGS CHARGED TO PATIENTS**	0	0	42.50
43.00	OUTPATIENT SERVICES**	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY**	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY**	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)**	0	0	46.00
NONREIMBURSABLE COST CENTERS				
60.00	BEREAVEMENT PROGRAM *	0	0	60.00
61.00	VOLUNTEER PROGRAM *	0	0	61.00
62.00	FUNDRAISING*	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS*	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM*	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES*	0	0	65.00
66.00	RESIDENTIAL CARE*	0	0	66.00
67.00	ADVERTISING*	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING*	0	0	68.00
69.00	THRIFT STORE*	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD*	0	0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)*	-6,016	2	71.00
100.00	TOTAL	-6,016	467,504	100.00

* Transfer the amounts in column 7 to Wkst. 0-5, column 1, line as appropriate.

** See instructions. Do not transfer the amounts in column 7 to Wkst. 0-5.

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS FOR HOSPICE ROUTINE HOME CARE	Provider CCN: 15-0086 Hospice CCN: 15-1531	Period: From 01/01/2017 To 12/31/2017	Worksheet 0-2 Date/Time Prepared: 5/29/2018 2:11 pm
--	---	---	---

		SALARIES	OTHER	SUBTOTAL (col. 1 + col. 2)	Hospice I RECLASSIFI - CATIONS	SUBTOTAL	
		1.00	2.00	3.00	4.00	5.00	
DIRECT PATIENT CARE SERVICE COST CENTERS							
25.00	INPATIENT CARE-CONTRACTED						25.00
26.00	PHYSICIAN SERVICES	0	0	0	0	0	26.00
27.00	NURSE PRACTITIONER	0	0	0	0	0	27.00
28.00	REGISTERED NURSE	80,904	0	80,904	0	80,904	28.00
29.00	LPN/LVN	0	0	0	0	0	29.00
30.00	PHYSICAL THERAPY	0	0	0	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	19,030	0	19,030	0	19,030	33.00
34.00	SPIRITUAL COUNSELING	7,979	0	7,979	0	7,979	34.00
35.00	DIETARY COUNSELING	0	0	0	0	0	35.00
36.00	COUNSELING - OTHER	0	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOME MAKER SERVICES	6,039	0	6,039	0	6,039	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	0	0	0	38.00
39.00	PATIENT TRANSPORTATION	0	0	0	0	0	39.00
40.00	IMAGING SERVICES	0	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	0	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	48,784	48,784	-48,226	558	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	42.50
43.00	OUTPATIENT SERVICES	0	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	0	0	0	46.00
100.00	TOTAL *	113,952	48,784	162,736	-48,226	114,510	100.00

* Transfer the amount in column 7 to Wkst. 0-5, column 1, line 51.

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)	
		6.00	7.00	
DIRECT PATIENT CARE SERVICE COST CENTERS				
25.00	INPATIENT CARE-CONTRACTED			25.00
26.00	PHYSICIAN SERVICES	0	0	26.00
27.00	NURSE PRACTITIONER	0	0	27.00
28.00	REGISTERED NURSE	0	80,904	28.00
29.00	LPN/LVN	0	0	29.00
30.00	PHYSICAL THERAPY	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0	19,030	33.00
34.00	SPIRITUAL COUNSELING	0	7,979	34.00
35.00	DIETARY COUNSELING	0	0	35.00
36.00	COUNSELING - OTHER	0	0	36.00
37.00	HOSPICE AIDE & HOME MAKER SERVICES	0	6,039	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	38.00
39.00	PATIENT TRANSPORTATION	0	0	39.00
40.00	IMAGING SERVICES	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	558	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0	42.50
43.00	OUTPATIENT SERVICES	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	46.00
100.00	TOTAL *	0	114,510	100.00

* Transfer the amount in column 7 to Wkst. 0-5, column 1, line 51.

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS FOR HOSPICE GENERAL INPATIENT CARE	Provider CCN: 15-0086 Hospice CCN: 15-1531	Period: From 01/01/2017 To 12/31/2017	Worksheet 0-4 Date/Time Prepared: 5/29/2018 2:11 pm
--	---	---	---

		SALARIES	OTHER	SUBTOTAL (col. 1 + col. 2)	Hospice I RECLASSIFI- CATIONS	SUBTOTAL	
		1.00	2.00	3.00	4.00	5.00	
DIRECT PATIENT CARE SERVICE COST CENTERS							
25.00	INPATIENT CARE-CONTRACTED		0	0	0	0	25.00
26.00	PHYSICIAN SERVICES	0	0	0	0	0	26.00
27.00	NURSE PRACTITIONER	0	0	0	0	0	27.00
28.00	REGISTERED NURSE	25,280	0	25,280	0	25,280	28.00
29.00	LPN/LVN	0	0	0	0	0	29.00
30.00	PHYSICAL THERAPY	0	0	0	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	5,947	0	5,947	0	5,947	33.00
34.00	SPIRITUAL COUNSELING	2,493	0	2,493	0	2,493	34.00
35.00	DIETARY COUNSELING	0	0	0	0	0	35.00
36.00	COUNSELING - OTHER	0	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOME MAKER SERVICES	1,887	0	1,887	0	1,887	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	0	0	0	38.00
39.00	PATIENT TRANSPORTATION	0	0	0	0	0	39.00
40.00	IMAGING SERVICES	0	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	0	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	0	0	0	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	42.50
43.00	OUTPATIENT SERVICES	0	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	0	0	0	46.00
100.00	TOTAL *	35,607	0	35,607	0	35,607	100.00

* Transfer the amount in column 7 to Wkst. 0-5, column 1, line 53.

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)	
		6.00	7.00	
DIRECT PATIENT CARE SERVICE COST CENTERS				
25.00	INPATIENT CARE-CONTRACTED	0	0	25.00
26.00	PHYSICIAN SERVICES	0	0	26.00
27.00	NURSE PRACTITIONER	0	0	27.00
28.00	REGISTERED NURSE	0	25,280	28.00
29.00	LPN/LVN	0	0	29.00
30.00	PHYSICAL THERAPY	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0	5,947	33.00
34.00	SPIRITUAL COUNSELING	0	2,493	34.00
35.00	DIETARY COUNSELING	0	0	35.00
36.00	COUNSELING - OTHER	0	0	36.00
37.00	HOSPICE AIDE & HOME MAKER SERVICES	0	1,887	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	38.00
39.00	PATIENT TRANSPORTATION	0	0	39.00
40.00	IMAGING SERVICES	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0	42.50
43.00	OUTPATIENT SERVICES	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	46.00
100.00	TOTAL *	0	35,607	100.00

* Transfer the amount in column 7 to Wkst. 0-5, column 1, line 53.

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

Provider CCN: 15-0086

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

Worksheet 0-5

Hospice CCN: 15-1531

Date/Time Prepared: 5/29/2018 2:11 pm

Descriptions		Hospice I		TOTAL EXPENSES (sum of cols. 1 + 2)	
		HOSPICE DIRECT EXPENSES (see instructions)	GENERAL SERVICE EXPENSES FROM WKST B PART I (see instructions)		
		1.00	2.00	3.00	
GENERAL SERVICE COST CENTERS					
1.00	CAP REL COSTS-BLDG & FIXT	0	3,938	3,938	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	506	2,440	2,946	2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	0	78,114	78,114	3.00
4.00	ADMINISTRATIVE & GENERAL	86,618	55,898	142,516	4.00
5.00	PLANT OPERATION & MAINTENANCE	0	10,629	10,629	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0	6.00
7.00	HOUSEKEEPING	0	2,954	2,954	7.00
8.00	DIETARY	0	0	0	8.00
9.00	NURSING ADMINISTRATION	0	0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	0	0	10.00
11.00	MEDICAL RECORDS	20,092	9,696	29,788	11.00
12.00	STAFF TRANSPORTATION	0	0	0	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0	0	0	13.00
14.00	PHARMACY	0	0	0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	12,000	0	12,000	15.00
16.00	OTHER GENERAL SERVICE	198,169	0	198,169	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0	0	0	17.00
LEVEL OF CARE					
50.00	HOSPICE CONTINUOUS HOME CARE	0	0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	114,510	0	114,510	51.00
52.00	HOSPICE INPATIENT RESPIRE CARE	0	0	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	35,607	0	35,607	53.00
NONREIMBURSABLE COST CENTERS					
60.00	BEREAVEMENT PROGRAM	0	0	0	60.00
61.00	VOLUNTEER PROGRAM	0	0	0	61.00
62.00	FUNDRAISING	0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES	0	0	0	65.00
66.00	RESIDENTIAL CARE	0	0	0	66.00
67.00	ADVERTISING	0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING	0	0	0	68.00
69.00	THRIFT STORE	0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD	0	0	0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	2	0	2	71.00
99.00	NEGATIVE COST CENTER	0	0	0	99.00
100.00	TOTAL	467,504	163,669	631,173	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN: 15-0086

Period: From 01/01/2017

Worksheet 0-6

Hospice CCN: 15-1531

To 12/31/2017

Part I
Date/Time Prepared:
5/29/2018 2:11 pm

Descriptions	Hospice I				SUBTOTAL	
	TOTAL EXPENSES	CAP REL BLDG & FIX	CAP REL MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT		
	0	1.00	2.00	3.00	3A	
GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	3,938	3,938			1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2,946		2,946		2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	78,114	0	0	78,114	3.00
4.00	ADMINISTRATIVE & GENERAL	142,516	0	0	0	4.00
5.00	PLANT OPERATION & MAINTENANCE	10,629	0	0	0	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0	0	6.00
7.00	HOUSEKEEPING	2,954	0	0	0	7.00
8.00	DIETARY	0	0	0	0	8.00
9.00	NURSING ADMINISTRATION	0	0	0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	0	0	0	10.00
11.00	MEDICAL RECORDS	29,788	0	0	0	11.00
12.00	STAFF TRANSPORTATION	0	0	0	0	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0	0	0	0	13.00
14.00	PHARMACY	0	0	0	0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	12,000	0	0	0	15.00
16.00	OTHER GENERAL SERVICE	198,169	0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES		0	0		17.00
LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0			0	50.00
51.00	HOSPICE ROUTINE HOME CARE	114,510			59,517	51.00
52.00	HOSPICE INPATIENT RESPIRE CARE	0	0	0	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	35,607	3,938	2,946	18,597	53.00
NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0	0	0	0	60.00
61.00	VOLUNTEER PROGRAM	0	0	0	0	61.00
62.00	FUNDRAISING	0	0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0	0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES	0	0	0	0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	66.00
67.00	ADVERTISING	0	0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING	0	0	0	0	68.00
69.00	THRIFT STORE	0	0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD	0				70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	2	0	0	0	71.00
99.00	NEGATIVE COST CENTER	0	0	0	0	99.00
100.00	TOTAL	631,173	3,938	2,946	78,114	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN: 15-0086

Period: From 01/01/2017

Worksheet 0-6

Hospice CCN: 15-1531

To 12/31/2017

Part I
Date/Time Prepared:
5/29/2018 2:11 pm

Descriptions	Hospice I					
	ADMINISTRATIVE & GENERAL	PLANT OPERATION & MAINTENANCE	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
	4.00	5.00	6.00	7.00	8.00	
GENERAL SERVICE COST CENTERS						
1.00 CAP REL COSTS-BLDG & FIXT						1.00
2.00 CAP REL COSTS-MVBLE EQUIP						2.00
3.00 EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00 ADMINISTRATIVE & GENERAL	142,516					4.00
5.00 PLANT OPERATION & MAINTENANCE	3,100	13,729				5.00
6.00 LAUNDRY & LINEN SERVICE	0	0	0			6.00
7.00 HOUSEKEEPING	862	0		3,816		7.00
8.00 DIETARY	0	0		0	0	8.00
9.00 NURSING ADMINISTRATION	0	0		0		9.00
10.00 ROUTINE MEDICAL SUPPLIES	0	0		0		10.00
11.00 MEDICAL RECORDS	8,688	0		0		11.00
12.00 STAFF TRANSPORTATION	0	0		0		12.00
13.00 VOLUNTEER SERVICE COORDINATION	0	0		0		13.00
14.00 PHARMACY	0	0		0		14.00
15.00 PHYSICIAN ADMINISTRATIVE SERVICES	3,500	0		0		15.00
16.00 OTHER GENERAL SERVICE	57,794	0		0		16.00
17.00 PATIENT/RESIDENTIAL CARE SERVICES	0	0		0		17.00
LEVEL OF CARE						
50.00 HOSPICE CONTINUOUS HOME CARE	0					50.00
51.00 HOSPICE ROUTINE HOME CARE	50,755					51.00
52.00 HOSPICE INPATIENT RESPIRE CARE	0	0	0	0	0	52.00
53.00 HOSPICE GENERAL INPATIENT CARE	17,816	13,729	0	3,816	0	53.00
NONREIMBURSABLE COST CENTERS						
60.00 BEREAVEMENT PROGRAM	0	0		0		60.00
61.00 VOLUNTEER PROGRAM	0	0		0		61.00
62.00 FUNDRAISING	0	0		0		62.00
63.00 HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0		0		63.00
64.00 PALLIATIVE CARE PROGRAM	0	0		0		64.00
65.00 OTHER PHYSICIAN SERVICES	0	0		0		65.00
66.00 RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00 ADVERTISING	0	0		0		67.00
68.00 TELEHEALTH/TELEMONITORING	0	0		0		68.00
69.00 THRIFT STORE	0	0		0		69.00
70.00 NURSING FACILITY ROOM & BOARD						70.00
71.00 OTHER NONREIMBURSABLE (SPECIFY)	1	0	0	0	0	71.00
99.00 NEGATIVE COST CENTER	0	0		0		99.00
100.00 TOTAL	142,516	13,729	0	3,816	0	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN: 15-0086

Period: From 01/01/2017

Worksheet 0-6

Hospice CCN: 15-1531

To 12/31/2017

Part I
Date/Time Prepared:
5/29/2018 2:11 pm

Descriptions	Hospice I					
	NURSING ADMINISTRATION	ROUTINE MEDICAL SUPPLIES	MEDICAL RECORDS	STAFF TRANSPORTATION	VOLUNTEER SERVICE COORDINATION	
	9.00	10.00	11.00	12.00	13.00	
GENERAL SERVICE COST CENTERS						
1.00						1.00
2.00						2.00
3.00						3.00
4.00						4.00
5.00						5.00
6.00						6.00
7.00						7.00
8.00						8.00
9.00		0				9.00
10.00		0	0			10.00
11.00			38,476			11.00
12.00				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
LEVEL OF CARE						
50.00		0	0	0	0	50.00
51.00		0	0	36,337	0	51.00
52.00		0	0	0	0	52.00
53.00		0	0	2,139	0	53.00
NONREIMBURSABLE COST CENTERS						
60.00		0			0	60.00
61.00		0			0	61.00
62.00		0			0	62.00
63.00		0			0	63.00
64.00		0			0	64.00
65.00		0			0	65.00
66.00		0			0	66.00
67.00		0			0	67.00
68.00		0			0	68.00
69.00		0			0	69.00
70.00						70.00
71.00		0			0	71.00
99.00		0	0	0	0	99.00
100.00		0	0	38,476	0	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN: 15-0086

Period: From 01/01/2017

Worksheet 0-6

Hospice CCN: 15-1531

To 12/31/2017

Part I
Date/Time Prepared:
5/29/2018 2:11 pm

Descriptions	Hospice I				TOTAL	
	PHARMACY	PHYSICIAN ADMINISTRATIVE SERVICES	OTHER GENERAL SERVICE	PATIENT/ RESIDENTIAL CARE SERVICES		
	14.00	15.00	16.00	17.00	18.00	
GENERAL SERVICE COST CENTERS						
1.00						1.00
2.00						2.00
3.00						3.00
4.00						4.00
5.00						5.00
6.00						6.00
7.00						7.00
8.00						8.00
9.00						9.00
10.00						10.00
11.00						11.00
12.00						12.00
13.00						13.00
14.00	0					14.00
15.00	0	15,500				15.00
16.00	0		255,963			16.00
17.00				0		17.00
LEVEL OF CARE						
50.00	0	0	0		0	50.00
51.00	0	14,638	195,023		470,780	51.00
52.00	0	0	0	0	0	52.00
53.00	0	862	60,940	0	160,390	53.00
NONREIMBURSABLE COST CENTERS						
60.00	0		0		0	60.00
61.00	0		0		0	61.00
62.00	0		0		0	62.00
63.00	0		0		0	63.00
64.00	0		0		0	64.00
65.00	0		0		0	65.00
66.00	0	0	0	0	0	66.00
67.00	0		0		0	67.00
68.00	0		0		0	68.00
69.00	0		0		0	69.00
70.00	0		0		0	70.00
71.00	0	0	0	0	3	71.00
99.00	0	0	0	0	0	99.00
100.00	0	15,500	255,963	0	631,173	100.00

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

Provider CCN: 15-0086

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

Worksheet 0-6
Part II
Date/Time Prepared:
5/29/2018 2:11 pm

Cost Center Descriptions		CAP REL BLDG & FIX (SQUARE FEET)	CAP REL MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	HOSPICE I RECONCILIATION	ADMINISTRATIVE & GENERAL (ACCUMULATED COSTS)	
		1.00	2.00	3.00	4A	4.00	
GENERAL SERVICE COST CENTERS							
1.00	CAP REL COSTS-BLDG & FIX	315					1.00
2.00	CAP REL COSTS-MVBLE EQUIP		315				2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	0	0	225,201			3.00
4.00	ADMINISTRATIVE & GENERAL	0	0	0	-142,516	488,657	4.00
5.00	PLANT OPERATION & MAINTENANCE	0	0	0	0	10,629	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0	0	0	6.00
7.00	HOUSEKEEPING	0	0	0	0	2,954	7.00
8.00	DIETARY	0	0	0	0	0	8.00
9.00	NURSING ADMINISTRATION	0	0	0	0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	0	0	0	0	10.00
11.00	MEDICAL RECORDS	0	0	0	0	29,788	11.00
12.00	STAFF TRANSPORTATION	0	0	0	0	0	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0	0	0	0	0	13.00
14.00	PHARMACY	0	0	0	0	0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0	0	0	12,000	15.00
16.00	OTHER GENERAL SERVICE	0	0	0	0	198,169	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0	0	0	0	0	17.00
LEVEL OF CARE							
50.00	HOSPICE CONTINUOUS HOME CARE			0	0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE			171,585	0	174,027	51.00
52.00	HOSPICE INPATIENT RESPIRE CARE	0	0	0	0	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	315	315	53,616	0	61,088	53.00
NONREIMBURSABLE COST CENTERS							
60.00	BEREAVEMENT PROGRAM	0	0	0	0	0	60.00
61.00	VOLUNTEER PROGRAM	0	0	0	0	0	61.00
62.00	FUNDRAISING	0	0	0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0	0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0	0	0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES	0	0	0	0	0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0	0	0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING	0	0	0	0	0	68.00
69.00	THRIFT STORE	0	0	0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD	0	0	0	0	0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	2	71.00
99.00	NEGATIVE COST CENTER						99.00
100.00	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)	3,938	2,946	78,114		142,516	100.00
101.00	UNIT COST MULTIPLIER	12.501587	9.352381	0.346863		0.291648	101.00

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

Provider CCN: 15-0086

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

Worksheet 0-6
Part II
Date/Time Prepared:
5/29/2018 2:11 pm

Cost Center Descriptions		Hospice I					
		PLANT OPERATION & MAINTENANCE (SQUARE FEET)	LAUNDRY & LINEN SERVICE (IN-FACILITY DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (IN-FACILITY DAYS)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	
		5.00	6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE	315					5.00
6.00	LAUNDRY & LINEN SERVICE	0	0				6.00
7.00	HOUSEKEEPING	0		315			7.00
8.00	DIETARY	0		0	0		8.00
9.00	NURSING ADMINISTRATION	0		0		0	9.00
10.00	ROUTINE MEDICAL SUPPLIES	0		0		0	10.00
11.00	MEDICAL RECORDS	0		0		0	11.00
12.00	STAFF TRANSPORTATION	0		0		0	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0		0		0	13.00
14.00	PHARMACY	0		0		0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0		0		0	15.00
16.00	OTHER GENERAL SERVICE	0		0		0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0		0		0	17.00
LEVEL OF CARE							
50.00	HOSPICE CONTINUOUS HOME CARE					0	50.00
51.00	HOSPICE ROUTINE HOME CARE					0	51.00
52.00	HOSPICE INPATIENT RESPIRE CARE	0	0	0	0	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	315	0	315	0	0	53.00
NONREIMBURSABLE COST CENTERS							
60.00	BEREAVEMENT PROGRAM	0		0		0	60.00
61.00	VOLUNTEER PROGRAM	0		0		0	61.00
62.00	FUNDRAISING	0		0		0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0		0		0	63.00
64.00	PALLIATIVE CARE PROGRAM	0		0		0	64.00
65.00	OTHER PHYSICIAN SERVICES	0		0		0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0		0		0	67.00
68.00	TELEHEALTH/TELEMONITORING	0		0		0	68.00
69.00	THRIFT STORE	0		0		0	69.00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER						99.00
100.00	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)	13,729	0	3,816	0	0	100.00
101.00	UNIT COST MULTIPLIER	43.584127	0.000000	12.114286	0.000000	0.000000	101.00

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

Provider CCN: 15-0086

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

Worksheet 0-6
Part II
Date/Time Prepared:
5/29/2018 2:11 pm

Cost Center Descriptions		Hospice I					
		ROUTINE MEDICAL SUPPLIES (PATIENT DAYS)	MEDICAL RECORDS (PATIENT DAYS)	STAFF TRANSPORTATION (MILEAGE)	VOLUNTEER SERVICE COORDINATION (HOURS OF SERVICE)	PHARMACY (CHARGES)	
		10.00	11.00	12.00	13.00	14.00	
GENERAL SERVICE COST CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5.00
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPING						7.00
8.00	DIETARY						8.00
9.00	NURSING ADMINISTRATION						9.00
10.00	ROUTINE MEDICAL SUPPLIES	0					10.00
11.00	MEDICAL RECORDS		4,568				11.00
12.00	STAFF TRANSPORTATION			0			12.00
13.00	VOLUNTEER SERVICE COORDINATION			0	0		13.00
14.00	PHARMACY			0	0	0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES			0	0	0	15.00
16.00	OTHER GENERAL SERVICE			0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES						17.00
LEVEL OF CARE							
50.00	HOSPICE CONTINUOUS HOME CARE	0	0	0	0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	0	4,314	0	0	0	51.00
52.00	HOSPICE INPATIENT RESPIRE CARE	0	0	0	0	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	254	0	0	0	53.00
NONREIMBURSABLE COST CENTERS							
60.00	BEREAVEMENT PROGRAM			0	0	0	60.00
61.00	VOLUNTEER PROGRAM			0	0	0	61.00
62.00	FUNDRAISING			0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS			0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM			0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES			0	0	0	65.00
66.00	RESIDENTIAL CARE			0	0	0	66.00
67.00	ADVERTISING			0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING			0	0	0	68.00
69.00	THRIFT STORE			0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD			0	0	0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)			0	0	0	71.00
99.00	NEGATIVE COST CENTER						99.00
100.00	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)	0	38,476	0	0	0	100.00
101.00	UNIT COST MULTIPLIER	0.000000	8.422942	0.000000	0.000000	0.000000	101.00

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

Provider CCN: 15-0086

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

Worksheet 0-6
Part II
Date/Time Prepared:
5/29/2018 2:11 pm

Cost Center Descriptions		PHYSICIAN ADMINISTRATIVE SERVICES (PATIENT DAYS)	OTHER GENERAL SERVICE (SPECIFY BASIS)	PATIENT/ RESIDENTIAL CARE SERVICES (IN-FACILITY DAYS)	Hospice I	
		15.00	16.00	17.00		
GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT					1.00
2.00	CAP REL COSTS-MVBLE EQUIP					2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT					3.00
4.00	ADMINISTRATIVE & GENERAL					4.00
5.00	PLANT OPERATION & MAINTENANCE					5.00
6.00	LAUNDRY & LINEN SERVICE					6.00
7.00	HOUSEKEEPING					7.00
8.00	DIETARY					8.00
9.00	NURSING ADMINISTRATION					9.00
10.00	ROUTINE MEDICAL SUPPLIES					10.00
11.00	MEDICAL RECORDS					11.00
12.00	STAFF TRANSPORTATION					12.00
13.00	VOLUNTEER SERVICE COORDINATION					13.00
14.00	PHARMACY					14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	4,568				15.00
16.00	OTHER GENERAL SERVICE		441,344			16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES			0		17.00
LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0	0			50.00
51.00	HOSPICE ROUTINE HOME CARE	4,314	336,268			51.00
52.00	HOSPICE INPATIENT RESPIRE CARE	0	0	0		52.00
53.00	HOSPICE GENERAL INPATIENT CARE	254	105,076	0		53.00
NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM			0		60.00
61.00	VOLUNTEER PROGRAM			0		61.00
62.00	FUNDRAISING			0		62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS			0		63.00
64.00	PALLIATIVE CARE PROGRAM			0		64.00
65.00	OTHER PHYSICIAN SERVICES			0		65.00
66.00	RESIDENTIAL CARE	0		0	0	66.00
67.00	ADVERTISING			0		67.00
68.00	TELEHEALTH/TELEMONITORING			0		68.00
69.00	THRIFT STORE			0		69.00
70.00	NURSING FACILITY ROOM & BOARD			0		70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER					99.00
100.00	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)	15,500	255,963	0		100.00
101.00	UNIT COST MULTIPLIER	3.393170	0.579963	0.000000		101.00

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

Provider CCN: 15-0086

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

Worksheet 0-7

Hospice CCN: 15-1531

Date/Time Prepared: 5/29/2018 2:11 pm

Cost Center Descriptions		From Wkst. C, Part I, Col. 9 line	Cost to Charge Ratio	Charges by LOC (from Provider Records)			
				HCHC	HRHC	HIRC	
				0	1.00	2.00	
ANCILLARY SERVICE COST CENTERS							
1.00	PHYSICAL THERAPY	66.00	0.451048	0	0	0	1.00
2.00	OCCUPATIONAL THERAPY	67.00	0.522963	0	0	0	2.00
3.00	SPEECH PATHOLOGY	68.00	0.594100	0	0	0	3.00
4.00	DRUGS CHARGED TO PATIENTS	73.00	0.473663	0	0	0	4.00
5.00	DURABLE MEDICAL EQUIP-RENTED	96.00					5.00
6.00	LABORATORY	60.00	0.220589	0	0	0	6.00
6.01	BLOOD LABORATORY	60.01	0.000000	0	0	0	6.01
7.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0.843778	0	0	0	7.00
8.00	OTHER OUTPATIENT SERVICE COST CENTER	93.00					8.00
9.00	RADIOLOGY-THERAPEUTIC	55.00	0.191103	0	0	0	9.00
10.00	OTHER ANCILLARY SERVICE COST CENTERS	76.00					10.00
11.00	Totals (sum of lines 1-11)						11.00
Cost Center Descriptions		Charges by LOC (from Provider Records)		Shared Service Costs by LOC			
		HGIP	HCHC (col. 1 x col. 2)	HRHC (col. 1 x col. 3)	HIRC (col. 1 x col. 4)	HGIP (col. 1 x col. 5)	
		5.00	6.00	7.00	8.00	9.00	
ANCILLARY SERVICE COST CENTERS							
1.00	PHYSICAL THERAPY	0	0	0	0	0	1.00
2.00	OCCUPATIONAL THERAPY	0	0	0	0	0	2.00
3.00	SPEECH PATHOLOGY	0	0	0	0	0	3.00
4.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	4.00
5.00	DURABLE MEDICAL EQUIP-RENTED						5.00
6.00	LABORATORY	0	0	0	0	0	6.00
6.01	BLOOD LABORATORY	0	0	0	0	0	6.01
7.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	7.00
8.00	OTHER OUTPATIENT SERVICE COST CENTER						8.00
9.00	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	9.00
10.00	OTHER ANCILLARY SERVICE COST CENTERS						10.00
11.00	Totals (sum of lines 1-11)		0	0	0	0	11.00

CALCULATION OF HOSPITAL-BASED HOSPICE PER DIEM COST

Provider CCN: 15-0086

Period: From 01/01/2017

Worksheet 0-8

Hospice CCN: 15-1531

To 12/31/2017

Date/Time Prepared: 5/29/2018 2:11 pm

		Hospice I		
		TITLE XVII MEDI CARE	TITLE XIX MEDI CAID	TOTAL
		1.00	2.00	3.00
HOSPICE CONTINUOUS HOME CARE				
1.00	Total cost (Wkst. 0-6, Part I, col. 18, line 50 plus Wkst. 0-7, col. 6, line 11)			0
2.00	Total unduplicated days (Wkst. S-9, col. 4, line 10)			0
3.00	Total average cost per diem (line 1 divided by line 2)			0.00
4.00	Unduplicated program days (Wkst. S-9 col. as appropriate, line 10)	0	0	0
5.00	Program cost (line 3 times line 4)	0	0	0
HOSPICE ROUTINE HOME CARE				
6.00	Total cost (Wkst. 0-6, Part I, col. 18, line 51 plus Wkst. 0-7, col. 7, line 11)			470,780
7.00	Total unduplicated days (Wkst. S-9, col. 4, line 11)			4,314
8.00	Total average cost per diem (line 6 divided by line 7)			109.13
9.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 11)	3,628	139	3,767
10.00	Program cost (line 8 times line 9)	395,924	15,169	411,093
HOSPICE INPATIENT RESPITE CARE				
11.00	Total cost (Wkst. 0-6, Part I, col. 18, line 52 plus Wkst. 0-7, col. 8, line 11)			0
12.00	Total unduplicated days (Wkst. S-9, col. 4, line 12)			0
13.00	Total average cost per diem (line 11 divided by line 12)			0.00
14.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 12)	0	0	0
15.00	Program cost (line 13 times line 14)	0	0	0
HOSPICE GENERAL INPATIENT CARE				
16.00	Total cost (Wkst. 0-6, Part I, col. 18, line 53 plus Wkst. 0-7, col. 9, line 11)			160,390
17.00	Total unduplicated days (Wkst. S-9, col. 4, line 13)			254
18.00	Total average cost per diem (line 16 divided by line 17)			631.46
19.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 13)	211	24	235
20.00	Program cost (line 18 times line 19)	133,238	15,155	148,393
TOTAL HOSPICE CARE				
21.00	Total cost (sum of line 1 + line 6 + line 11 + line 16)			631,170
22.00	Total unduplicated days (Wkst. S-9, col. 4, line 14)			4,568
23.00	Average cost per diem (line 21 divided by line 22)			138.17

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 15-0086	Period: From 01/01/2017 To 12/31/2017	Worksheet L Parts I-III Date/Time Prepared: 5/29/2018 2:11 pm
		Title XVIII	Hospital	PPS
				1.00
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		966,883	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		26,345	2.00
2.01	Model 4 BPCI Capital DRG outlier payments		0	2.01
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)		36.33	3.00
4.00	Number of interns & residents (see instructions)		0.00	4.00
5.00	Indirect medical education percentage (see instructions)		0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)		0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		0.00	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		0.00	8.00
9.00	Sum of lines 7 and 8		0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)		0.00	10.00
11.00	Disproportionate share adjustment (see instructions)		0	11.00
12.00	Total prospective capital payments (see instructions)		993,228	12.00
				1.00
PART II - PAYMENT UNDER REASONABLE COST				
1.00	Program inpatient routine capital cost (see instructions)		0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)		0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)		0	3.00
4.00	Capital cost payment factor (see instructions)		0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)		0	5.00
				1.00
PART III - COMPUTATION OF EXCEPTION PAYMENTS				
1.00	Program inpatient capital costs (see instructions)		0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)		0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)		0	3.00
4.00	Applicable exception percentage (see instructions)		0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)		0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)		0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)		0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)		0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)		0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)		0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)		0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)		0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)		0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)		0	14.00
15.00	Current year allowable operating and capital payment (see instructions)		0	15.00
16.00	Current year operating and capital costs (see instructions)		0	16.00
17.00	Current year exception offset amount (see instructions)		0	17.00