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: 15-1324	Period: From 01/01/2017 To 12/31/2017	Worksheet S Parts I-III Date/Time Prepared: 5/31/2018 3:08 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 5/31/2018 Time: 3:08 am
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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

PART II - CERTIFICATION

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

CERTIFICATION BY CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by FRANCISCAN HEALTH RENSSELAER (15-1324) for the cost reporting period beginning 01/01/2017 and ending 12/31/2017 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

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

_____
Title

_____
Date

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	461,460	-3,001,680	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	34,787	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
10.00	RURAL HEALTH CLINIC I	0		6,872		0	10.00
10.03	RURAL HEALTH CLINIC IV	0		46,497		0	10.03
200.00	Total	0	496,247	-2,948,311	0	0	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1324 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-2 Part I Date/Time Prepared: 5/31/2018 2:46 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 1104 EAST GRACE STREET	PO Box:			1.00
2.00	City: RENSSELAER	State: IN	Zip Code: 47978-	County: JASPER	2.00

		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
	Hospital and Hospital-Based Component Identification:									
3.00	Hospital	FRANCISCAN HEALTH RENSSELAER	151324	23844	1	02/03/2005	N	O	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	FRANCISCAN HEALTH RENSSELAER	15Z324	99915		12/31/2005	N	O	N	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA	FRANCISCAN HEALTH RENSSELAER	157149	99915		05/13/1985	N	P	N	12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice	FRANCISCAN HEALTH RENSSELAER	151519	99915		03/12/1993				14.00
15.00	Hospital-Based Health Clinic - RHC	WHEATFIELD CLINIC	153990	99915		10/07/1999	N	O	N	15.00
15.03	Hospital-Based Health Clinic - RHC IV	BROOK	158502	99915		01/01/2005	N	O	N	15.03
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)	1		21.00
	Inpatient PPS Information			
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	N	N	22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	N	N	22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N	22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or “N” for no.	N	N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	0		23.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1324 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-2 Part I Date/Time Prepared: 5/31/2018 2:46 am

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

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1324 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-2 Part I | Date/Time Prepared: 5/31/2018 2:46 am

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1324 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-2 Part I | Date/Time Prepared: 5/31/2018 2:46 am

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

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

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

		1.00	2.00	3.00	
	Inpatient Psychiatric Facility PPS				
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	N			70.00
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0	71.00
	Inpatient Rehabilitation Facility PPS				
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	N			75.00
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: 15-1324	Period: From 01/01/2017 To 12/31/2017	Worksheet S-2 Part I Date/Time Prepared: 5/31/2018 2:46 am

		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	Y	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.06
	Rural Providers			
105.00	Does this hospital qualify as a CAH?	Y		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N		106.00
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II.	N		107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	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.	Y	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: 15-1324 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-2 Part I | Date/Time Prepared: 5/31/2018 2:46 am

		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:	141,168	0	0	118.01

		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	Y	5.00	122.00
	Transplant Center Information			
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	158014	140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1324 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-2 Part I | Date/Time Prepared: 5/31/2018 2:46 am

		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: FRANCISCAN ALLIANCE, INC.	Contractor's Name: WPS		Contractor's Number: 08101	141.00
142.00	Street: 1515 DRAGOON TRAIL	PO Box: 1290			142.00
143.00	City: MISHAWAKA	State: IN		Zip Code: 46546-1290	143.00

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

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

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

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

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

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

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

		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	08/05/2017	11/03/2017	170.00

		1.00	2.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)	N	0	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-1324 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-2 Part II | Date/Time Prepared: 5/31/2018 2:46 am

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

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

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

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

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

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	N		N		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	04/10/2018	Y	04/10/2018	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-1324 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-2 Part II Date/Time Prepared: 5/31/2018 2:46 am

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

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

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

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	STEVE	HOWELL	41.00
42.00	Enter the employer/company name of the cost report preparer.	FRANCISCAN ALLIANCE		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	765-428-5927	STEVEN.HOWELL@FRANCISCANALLIANCE.ORG	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-1324	Period: From 01/01/2017 To 12/31/2017	Worksheet S-2 Part II Date/Time Prepared: 5/31/2018 2:46 am

		3.00		
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	MANAGER REIMBURSEMENT		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: 15-1324 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-3 Part I Date/Time Prepared: 5/31/2018 2:46 am

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	21	7,665	30,696.00	0	1.00
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		21	7,665	30,696.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	4	1,460	4,632.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)		25	9,125	35,328.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	101.00				0	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	116.00	0	0			24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	88.00				0	26.00
26.03	RURAL HEALTH CLINIC IV	88.03				0	26.03
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		25				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00
33.01	LTCH site neutral days and discharges						33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-1324 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-3 Part I | Date/Time Prepared: 5/31/2018 2:46 am

	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)	763	123	1,279			1.00
2.00	HMO and other (see instructions)	30	0				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	209	0	209			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	13			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	972	123	1,501			7.00
8.00	INTENSIVE CARE UNIT	108	18	193			8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	1,080	141	1,694	0.00	177.60	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	2,656	0	6,432	0.00	15.80	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	3,082	90	3,378	0.00	5.37	24.00
24.10	HOSPICE (non-distinct part)	0	0	0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	300	1,449	3,002	0.00	3.97	26.00
26.03	RURAL HEALTH CLINIC IV	905	1,605	4,553	0.00	4.92	26.03
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	207.66	27.00
28.00	Observation Bed Days		89	611			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-1324 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-3 Part I | Date/Time Prepared: 5/31/2018 2:46 am

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	262	44	433	1.00
2.00	HMO and other (see instructions)			8	0		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				0		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	262	44	433	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0.00					22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	0.00					24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	0.00					26.00
26.03	RURAL HEALTH CLINIC IV	0.00					26.03
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

HOME HEALTH AGENCY STATISTICAL DATA | Provider CCN: 15-1324 | Component CCN: 15-7149 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-4 | Date/Time Prepared: 5/31/2018 2:46 am

Home Health Agency I | PPS

		1.00	
0.00	County	JASPER	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	1,974	0	5,287	7,261	1.00
2.00	Unduplicated Census Count (see instructions)	0.00	138.00	0.00	0.00	0.00	2.00

		Enter the number of hours in your normal work week	Number of Employees (Full Time Equivalent)			
			Staff	Contract	Total	
		0	1.00	2.00	3.00	
	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES					
3.00	Administrator and Assistant Administrator(s)	0.00	0.00	0.00	0.00	3.00
4.00	Director(s) and Assistant Director(s)		1.02	0.00	1.02	4.00
5.00	Other Administrative Personnel		5.26	0.00	5.26	5.00
6.00	Direct Nursing Service		4.35	0.00	4.35	6.00
7.00	Nursing Supervisor		0.00	0.00	0.00	7.00
8.00	Physical Therapy Service		0.62	0.00	0.62	8.00
9.00	Physical Therapy Supervisor		0.21	0.00	0.21	9.00
10.00	Occupational Therapy Service		0.41	0.00	0.41	10.00
11.00	Occupational Therapy Supervisor		0.16	0.00	0.16	11.00
12.00	Speech Pathology Service		0.18	0.00	0.18	12.00
13.00	Speech Pathology Supervisor		0.00	0.00	0.00	13.00
14.00	Medical Social Service		0.00	0.00	0.00	14.00
15.00	Medical Social Service Supervisor		0.00	0.00	0.00	15.00
16.00	Home Health Aide		3.49	0.00	3.49	16.00
17.00	Home Health Aide Supervisor		0.00	0.00	0.00	17.00
18.00	PRIVATE DUTY		0.10	0.00	0.10	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.		3			19.00
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).		23844			20.00
20.01			29200			20.01
20.02			99915			20.02

		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	609	118	34	48	809	21.00
22.00	Skilled Nursing Visit Charges	220,504	43,234	12,238	17,962	293,938	22.00
23.00	Physical Therapy Visits	779	93	16	25	913	23.00
24.00	Physical Therapy Visit Charges	292,650	35,216	6,005	9,689	343,560	24.00
25.00	Occupational Therapy Visits	213	25	2	8	248	25.00
26.00	Occupational Therapy Visit Charges	79,667	9,459	742	2,968	92,836	26.00
27.00	Speech Pathology Visits	49	34	0	0	83	27.00
28.00	Speech Pathology Visit Charges	18,754	13,143	0	0	31,897	28.00
29.00	Medical Social Service Visits	7	0	0	0	7	29.00
30.00	Medical Social Service Visit Charges	3,036	0	0	0	3,036	30.00
31.00	Home Health Aide Visits	457	95	1	43	596	31.00
32.00	Home Health Aide Visit Charges	80,356	16,622	184	7,824	104,986	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	2,114	365	53	124	2,656	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)	694,967	117,674	19,169	38,443	870,253	35.00
36.00	Total Number of Episodes (standard/non outlier)	2,114		53	5	2,172	36.00
37.00	Total Number of Outlier Episodes		365		0	365	37.00
38.00	Total Non-Routine Medical Supply Charges	2,227	13,233	0	395	15,855	38.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 15-1324 | Component CCN: 15-3990 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-8 | Date/Time Prepared: 5/31/2018 2:46 am

RHC I | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			492 S BIERMA ST		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	WHEATFIELD		IN	47978	2.00
					1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0	3.00
			Grant Award		Date	
			1.00		2.00	
	Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)					4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)					5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)					6.00
7.00	Appalachian Regional Commission					7.00
8.00	Look-Alikes					8.00
9.00	OTHER (SPECIFY)					9.00
				1.00	2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N	0	10.00

		Sunday		Monday		Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
	Facility hours of operations (1)						
11.00	CLINIC			08:00	16:30	08:00	11.00

				1.00	2.00	
12.00	Have you received an approval for an exception to the productivity standard?			N		12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.			N	0	13.00
				Provider name	CCN number	
				1.00	2.00	
14.00	RHC/FQHC name, CCN number					14.00

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

			County				
			4.00				
2.00	City, State, ZIP Code, County		JASPER				2.00
		Tuesday	Wednesday		Thursday		
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)						
11.00	CLINIC	16:30	08:00	12:00	08:00	16:30	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 15-1324
Component CCN: 15-3990

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

Worksheet S-8
Date/Time Prepared:
5/31/2018 2:46 am

RHC I

Cost

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	CLINIC	08:00	16:30				11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 15-1324 | Component CCN: 15-8502 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-8 | Date/Time Prepared: 5/31/2018 2:46 am

RHC IV | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			420 E MAIN ST		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	BROOK		IN	47922	2.00
					1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0	3.00
			Grant Award		Date	
			1.00		2.00	
	Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)					4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)					5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)					6.00
7.00	Appalachian Regional Commission					7.00
8.00	Look-Alikes					8.00
9.00	OTHER (SPECIFY)					9.00
				1.00	2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N	0	10.00
		Sunday		Monday		Tuesday
		from	to	from	to	from
		1.00	2.00	3.00	4.00	5.00
	Facility hours of operations (1)					
11.00	CLINIC			08:00	16:30	08:00	11.00
					1.00	2.00	
12.00	Have you received an approval for an exception to the productivity standard?				N		12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.				N	0	13.00
				Provider name		CCN number	
				1.00		2.00	
14.00	RHC/FQHC name, CCN number						14.00
		Y/N	V	XVIII	XIX	Total Visits	
		1.00	2.00	3.00	4.00	5.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)						15.00
			County				
			4.00				
2.00	City, State, ZIP Code, County		JASPER				2.00
		Tuesday	Wednesday		Thursday		
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)						
11.00	CLINIC	16:30	08:00	16:30	08:00	16:30	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 15-1324 | Component CCN: 15-8502 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-8 | Date/Time Prepared: 5/31/2018 2:46 am

RHC IV | Cost

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	CLINIC	08:00	12:00				11.00

HOSPITAL-BASED HOSPICE IDENTIFICATION DATA

Provider CCN: 15-1324
Hospice CCN: 15-1519

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

Worksheet S-9
PARTS I THROUGH IV
Date/Time Prepared:
5/31/2018 2:46 am

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	3,074	90	238	3,402	11.00
12.00	Hospice Inpatient Respite Care	7	0	6	13	12.00
13.00	Hospice General Inpatient Care	1	0	52	53	13.00
14.00	Total Hospice Days	3,082	90	296	3,468	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: 15-1324 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-10 | Date/Time Prepared: 5/31/2018 2:46 am

		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)	0.514612	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	0	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	0	6.00
7.00	Medicaid cost (line 1 times line 6)	0	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)	0	8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone CHIP	0	9.00
10.00	Stand-alone CHIP charges	0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	0	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
	Uncompensated Care (see instructions for each line)				
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	0	0	0	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	0	0	0	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)	0	0	0	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?		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)	566,902	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	353,587	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	543,980	27.01
28.00	Non-Medicare bad debt expense (see instructions)	22,922	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	202,189	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	202,189	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	202,189	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1324 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A | Date/Time Prepared: 5/31/2018 2:46 am

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		3,492,206	3,492,206	54,326	3,546,532	1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	3,881,597	3,881,597	0	3,881,597	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	666,706	9,958,576	10,625,282	-54,326	10,570,956	5.00
7.00	00700	OPERATION OF PLANT	275,076	1,278,206	1,553,282	0	1,553,282	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	72,299	23,513	95,812	0	95,812	8.00
9.00	00900	HOUSEKEEPING	503,227	99,016	602,243	-31,470	570,773	9.00
10.00	01000	DIETARY	293,571	158,749	452,320	-235,663	216,657	10.00
11.00	01100	CAFETERIA	0	0	0	235,663	235,663	11.00
13.00	01300	NURSING ADMINISTRATION	282,802	7,642	290,444	0	290,444	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	36,837	380,559	417,396	0	417,396	14.00
15.00	01500	PHARMACY	390,646	1,822,908	2,213,554	0	2,213,554	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	834,946	834,946	0	834,946	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	871,943	8,256	880,199	0	880,199	30.00
31.00	03100	INTENSIVE CARE UNIT	574,764	7,139	581,903	0	581,903	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	425,917	559,603	985,520	31,470	1,016,990	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	761,109	613,421	1,374,530	0	1,374,530	54.00
60.00	06000	LABORATORY	0	1,526,662	1,526,662	0	1,526,662	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	50,118	50,118	0	50,118	63.00
65.00	06500	RESPIRATORY THERAPY	668,267	84,400	752,667	0	752,667	65.00
66.00	06600	PHYSICAL THERAPY	748,881	51,935	800,816	0	800,816	66.00
66.01	06601	WHEATFIELD PT	275,078	7,526	282,604	0	282,604	66.01
67.00	06700	OCCUPATIONAL THERAPY	150,016	436	150,452	0	150,452	67.00
67.01	06701	WHEATFIELD OT	80,162	5,077	85,239	0	85,239	67.01
68.00	06800	SPEECH PATHOLOGY	96,735	491	97,226	0	97,226	68.00
68.01	06801	WHEATFIELD ST	59,039	777	59,816	0	59,816	68.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	389,161	389,161	0	389,161	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	187,490	187,490	0	187,490	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	271,322	53,969	325,291	0	325,291	88.00
88.03	08801	RURAL HEALTH CLINIC IV	341,724	57,570	399,294	0	399,294	88.03
90.00	09000	CLINIC	1,007,936	109,472	1,117,408	0	1,117,408	90.00
91.00	09100	EMERGENCY	949,341	1,086,449	2,035,790	0	2,035,790	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	794,142	376,696	1,170,838	0	1,170,838	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	320,248	231,002	551,250	0	551,250	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	10,917,788	27,345,568	38,263,356	0	38,263,356	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	RENSSELAER HEALTH CENTER	0	0	0	0	0	192.01
194.00	07950	ALTERNACARE	669,765	17,190	686,955	0	686,955	194.00
194.01	07951	DME EQUIPMENT	0	0	0	0	0	194.01
194.02	07952	WHEATFIELD FITNESS	216,965	94,633	311,598	0	311,598	194.02
194.03	07957	JOHNSON FITNESS	381,697	22,135	403,832	0	403,832	194.03
194.04	07953	FOUNDATION	0	0	0	0	0	194.04
194.05	07954	MEALS ON WHEELS	0	0	0	0	0	194.05
194.06	07955	WATER LAB	0	0	0	0	0	194.06
194.07	07956	ADVERTISING	0	0	0	0	0	194.07
200.00		TOTAL (SUM OF LINES 118 through 199)	12,186,215	27,479,526	39,665,741	0	39,665,741	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1324 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A | Date/Time Prepared: 5/31/2018 2:46 am

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	520,659	4,067,191		1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	630,970	4,512,567		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-2,779,170	7,791,786		5.00
7.00	00700	OPERATION OF PLANT	0	1,553,282		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	95,812		8.00
9.00	00900	HOUSEKEEPING	-929	569,844		9.00
10.00	01000	DIETARY	-37,669	178,988		10.00
11.00	01100	CAFETERIA	-57,126	178,537		11.00
13.00	01300	NURSING ADMINISTRATION	142,242	432,686		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	-293,057	124,339		14.00
15.00	01500	PHARMACY	-18,420	2,195,134		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-432,419	402,527		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	880,199		30.00
31.00	03100	INTENSIVE CARE UNIT	0	581,903		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-426,549	590,441		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-3,693	1,370,837		54.00
60.00	06000	LABORATORY	-5,490	1,521,172		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	50,118		63.00
65.00	06500	RESPIRATORY THERAPY	-4,923	747,744		65.00
66.00	06600	PHYSICAL THERAPY	0	800,816		66.00
66.01	06601	WHEATFIELD PT	0	282,604		66.01
67.00	06700	OCCUPATIONAL THERAPY	0	150,452		67.00
67.01	06701	WHEATFIELD OT	0	85,239		67.01
68.00	06800	SPEECH PATHOLOGY	0	97,226		68.00
68.01	06801	WHEATFIELD ST	0	59,816		68.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	389,161		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	187,490		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	325,291		88.00
88.03	08801	RURAL HEALTH CLINIC IV	0	399,294		88.03
90.00	09000	CLINIC	0	1,117,408		90.00
91.00	09100	EMERGENCY	-150	2,035,640		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
		OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY	0	1,170,838		101.00
		SPECIAL PURPOSE COST CENTERS				
116.00	11600	HOSPICE	0	551,250		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-2,765,724	35,497,632		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0		192.00
192.01	19201	RENSSELAER HEALTH CENTER	0	0		192.01
194.00	07950	ALTERNACARE	0	686,955		194.00
194.01	07951	DME EQUIPMENT	0	0		194.01
194.02	07952	WHEATFIELD FITNESS	0	311,598		194.02
194.03	07957	JOHNSON FITNESS	0	403,832		194.03
194.04	07953	FOUNDATION	0	0		194.04
194.05	07954	MEALS ON WHEELS	0	0		194.05
194.06	07955	WATER LAB	0	0		194.06
194.07	07956	ADVERTISING	0	0		194.07
200.00		TOTAL (SUM OF LINES 118 through 199)	-2,765,724	36,900,017		200.00

RECLASSIFICATIONS | Provider CCN: 15-1324 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-6 | Date/Time Prepared: 5/31/2018 2:46 am

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - CAFETERIA					
1.00	CAFETERIA	11.00	152,953	82,710		1.00
	0		152,953	82,710		
	B - PROPERTY INSURANCE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	54,326		1.00
	0		0	54,326		
	C - HOUSEKEEPING					
1.00	OPERATING ROOM	50.00	31,470	0		1.00
	0		31,470	0		
500.00	Grand Total: Increases		184,423	137,036		500.00

RECLASSIFICATIONS | Provider CCN: 15-1324 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-6 | Date/Time Prepared: 5/31/2018 2:46 am

	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	152,953	82,710	0		1.00
	0		152,953	82,710			
	B - PROPERTY INSURANCE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	54,326	12		1.00
	0		0	54,326			
	C - HOUSEKEEPING						
1.00	HOUSEKEEPING	9.00	31,470	0	0		1.00
	0		31,470	0			
500.00	Grand Total: Decreases		184,423	137,036			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1324 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-7 Part I | Date/Time Prepared: 5/31/2018 2:46 am

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	675,791	0	0	0	0	1.00
2.00	Land Improvements	484,426	0	0	0	0	2.00
3.00	Buildings and Fixtures	0	0	0	0	0	3.00
4.00	Building Improvements	16,471,346	474,634	0	474,634	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	7,048,087	3,794,715	0	3,794,715	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	24,679,650	4,269,349	0	4,269,349	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	24,679,650	4,269,349	0	4,269,349	0	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	675,791	0	1.00
2.00	Land Improvements	484,426	0	2.00
3.00	Buildings and Fixtures	0	0	3.00
4.00	Building Improvements	16,945,980	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	10,842,802	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	28,948,999	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	28,948,999	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1324 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-7 Part II | Date/Time Prepared: 5/31/2018 2:46 am

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	2,680,566	0	811,640	0	0	1.00
3.00	Total (sum of lines 1-2)	2,680,566	0	811,640	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL			
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)		
		14.00	15.00		
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2				
1.00	CAP REL COSTS-BLDG & FIXT	0	3,492,206		1.00
3.00	Total (sum of lines 1-2)	0	3,492,206		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1324 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-7 Part III Date/Time Prepared: 5/31/2018 2:46 am

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	COMPUTATION OF RATIOS: Capitalized Leases	COMPUTATION OF RATIOS: Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	ALLOCATION OF OTHER CAPITAL: Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	28,948,999	0	28,948,999	1.000000	0	1.00
3.00	Total (sum of lines 1-2)	28,948,999	0	28,948,999	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	ALLOCATION OF OTHER CAPITAL: Other Capital-Related Costs	ALLOCATION OF OTHER CAPITAL: Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	SUMMARY OF CAPITAL: Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	2,618,138	0	1.00
3.00	Total (sum of lines 1-2)	0	0	0	2,618,138	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	SUMMARY OF CAPITAL: Insurance (see instructions)	SUMMARY OF CAPITAL: Taxes (see instructions)	SUMMARY OF CAPITAL: Other Capital-Related Costs (see instructions)	SUMMARY OF CAPITAL: Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	780,295	54,326	0	614,432	4,067,191	1.00
3.00	Total (sum of lines 1-2)	780,295	54,326	0	614,432	4,067,191	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1324 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-8 | Date/Time Prepared: 5/31/2018 2:46 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-40,289	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	*** Cost Center Deleted ***	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-4,388			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	-579,181			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests		0		0.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-698	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	*** Cost Center Deleted ***	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	A	-13,600	CAP REL COSTS-BLDG & FIXT	1.00	9	32.00
33.00	HAF OFFSET	A	-1,456,724	ADMINISTRATIVE & GENERAL	5.00	0	33.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1324 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-8 | Date/Time Prepared: 5/31/2018 2:46 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
39.00	OTHER REVENUE	B	-57,267	CAP REL COSTS-BLDG & FIXT	1.00	9	39.00
40.00	OTHER REVENUE	B	-48,897	ADMINISTRATIVE & GENERAL	5.00	0	40.00
40.01	OTHER REVENUE	B	-929	HOUSEKEEPING	9.00	0	40.01
40.02	OTHER REVENUE	B	-37,669	DIETARY	10.00	0	40.02
40.03	OTHER REVENUE	B	-57,126	CAFETERIA	11.00	0	40.03
40.04	OTHER REVENUE	B	-11,892	NURSING ADMINISTRATION	13.00	0	40.04
40.05	OTHER REVENUE	B	-3,137	CENTRAL SERVICES & SUPPLY	14.00	0	40.05
40.06	OTHER REVENUE	B	-25,211	PHARMACY	15.00	0	40.06
40.07	OTHER REVENUE	B	-6,214	OPERATING ROOM	50.00	0	40.07
40.08	OTHER REVENUE	B	-3,693	RADIOLOGY-DIAGNOSTIC	54.00	0	40.08
40.09	OTHER REVENUE	B	-5,490	LABORATORY	60.00	0	40.09
40.10	OTHER REVENUE	B	-1,535	RESPIRATORY THERAPY	65.00	0	40.10
40.11	OTHER REVENUE	B	-150	EMERGENCY	91.00	0	40.11
41.00	LOBBYING	A	-738	ADMINISTRATIVE & GENERAL	5.00	0	41.00
42.00	ANESTHESIA	A	-419,335	OPERATING ROOM	50.00	0	42.00
43.00	DEPRECIATION CARRY FORWARD	A	8,439	CAP REL COSTS-BLDG & FIXT	1.00	9	43.00
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-2,765,724				50.00

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 15-1324 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-8-1 | Date/Time Prepared: 5/31/2018 2:46 am

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	1.00	CAP REL COSTS-BLDG & FIXT	ALLOWABLE NEW CAPITAL COSTS	614,432	0	1.00
2.00	1.00	CAP REL COSTS-BLDG & FIXT	INTEREST	8,944	0	2.00
3.00	5.00	ADMINISTRATIVE & GENERAL	ADMINISTRATIVE & GENERAL	4,989,814	6,770,278	3.00
4.00	13.00	NURSING ADMINISTRATION	NURSING ADMIN	0	1,330	4.00
4.01	14.00	CENTRAL SERVICES & SUPPLY	CENTRAL SUPPLY	0	289,920	4.01
4.02	15.00	PHARMACY	COVP / PHARMACY	17,913	66,360	4.02
4.03	16.00	MEDICAL RECORDS & LIBRARY	HIM	364,634	796,355	4.03
4.04	1.00	CAP REL COSTS-BLDG & FIXT	INTEREST	799,703	799,703	4.04
4.05	4.00	EMPLOYEE BENEFITS DEPARTMENT	SHARED SERVICES	630,970	0	4.05
4.06	5.00	ADMINISTRATIVE & GENERAL	SHARED SERVICES	507,653	0	4.06
4.07	13.00	NURSING ADMINISTRATION	SHARED SERVICES	155,464	0	4.07
4.08	15.00	PHARMACY	SHARED SERVICES	55,238	0	4.08
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			8,144,765	8,723,946	5.00

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

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

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

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

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

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 15-1324 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-8-1 | Date/Time Prepared: 5/31/2018 2:46 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	614,432	14		1.00
2.00	8,944	11		2.00
3.00	-1,780,464	0		3.00
4.00	-1,330	0		4.00
4.01	-289,920	0		4.01
4.02	-48,447	0		4.02
4.03	-431,721	0		4.03
4.04	0	11		4.04
4.05	630,970	0		4.05
4.06	507,653	0		4.06
4.07	155,464	0		4.07
4.08	55,238	0		4.08
5.00	-579,181			5.00

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

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

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

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

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

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 15-1324 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-8-2 | Date/Time Prepared: 5/31/2018 2:46 am

	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	5.00	ADMINISTRATIVE & GENERAL	164,109	0	164,109	0	0	1.00
2.00	50.00	OPERATING ROOM	1,000	1,000	0	0	0	2.00
3.00	60.00	LABORATORY	32,850	0	32,850	0	0	3.00
4.00	65.00	RESPIRATORY THERAPY	17,898	3,388	14,510	0	0	4.00
5.00	91.00	EMERGENCY	1,036,212	0	1,036,212	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			1,252,069	4,388	1,247,681		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	0	0	1.00
2.00	50.00	OPERATING ROOM	0	0	0	0	0	2.00
3.00	60.00	LABORATORY	0	0	0	0	0	3.00
4.00	65.00	RESPIRATORY THERAPY	0	0	0	0	0	4.00
5.00	91.00	EMERGENCY	0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	0		1.00
2.00	50.00	OPERATING ROOM	0	0	0	1,000		2.00
3.00	60.00	LABORATORY	0	0	0	0		3.00
4.00	65.00	RESPIRATORY THERAPY	0	0	0	3,388		4.00
5.00	91.00	EMERGENCY	0	0	0	0		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	4,388		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 15-1324 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 5/31/2018 2:46 am

Physical Therapy | Cost

						1.00	
	PART I - GENERAL INFORMATION						
1.00	Total number of weeks worked (excluding aides) (see instructions)					31	1.00
2.00	Line 1 multiplied by 15 hours per week					465	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					140	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00
7.00	Standard travel expense rate					0.00	7.00
8.00	Optional travel expense rate per mile					0.00	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	1,136.00	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	81.04	0.00	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	40.52	40.52	0.00			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	7,267	0			13.01
						1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION						
14.00	Supervisors (column 1, line 9 times column 1, line 10)					0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					92,061	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)					0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					92,061	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)					0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)					0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)					92,061	20.00
	If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.						
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)					0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					0	22.00
23.00	Total salary equivalency (see instructions)					92,061	23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE						
	Standard Travel Allowance						
24.00	Therapists (line 3 times column 2, line 11)					5,673	24.00
25.00	Assistants (line 4 times column 3, line 11)					0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					5,673	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					0	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					5,673	28.00
	Optional Travel Allowance and Optional Travel Expense						
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)					0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)					0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)					0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)					0	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE						
	Standard Travel Expense						
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00
	Optional Travel Allowance and Optional Travel Expense						
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.						
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 15-1324 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 5/31/2018 2:46 am

Physical Therapy — Cost

						1.00	
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00
		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	81.04	0.00	0.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00

		1.00		
	Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT			
57.00	Salary equivalency amount (from line 23)	92,061		57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	0		58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)	0		59.00
60.00	Overtime allowance (from column 5, line 56)	0		60.00
61.00	Equipment cost (see instructions)	0		61.00
62.00	Supplies (see instructions)	0		62.00
63.00	Total allowance (sum of lines 57-62)	92,061		63.00
64.00	Total cost of outside supplier services (from your records)	86,128		64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)	0		65.00
	LINE 33 CALCULATION			
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others	5,673		100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	0		100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	5,673		100.02
	LINE 34 CALCULATION			
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	0		101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0		101.01
101.02	Line 34 = sum of lines 27 and 31	0		101.02
	LINE 35 CALCULATION			
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0		102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others	0		102.01
102.02	Line 35 = sum of lines 31 and 32	0		102.02

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1324 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part I | Date/Time Prepared: 5/31/2018 2:46 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	
			0	1.00	4.00	4A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	4,067,191	4,067,191				1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4,512,567	0	4,512,567			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	7,791,786	429,973	246,882	8,468,641	8,468,641	5.00
7.00	00700	OPERATION OF PLANT	1,553,282	71,592	101,861	1,726,735	514,330	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	95,812	62,039	26,772	184,623	54,992	8.00
9.00	00900	HOUSEKEEPING	569,844	73,433	174,692	817,969	243,643	9.00
10.00	01000	DIETARY	178,988	69,865	52,071	300,924	89,634	10.00
11.00	01100	CAFETERIA	178,537	76,004	56,639	311,180	92,689	11.00
13.00	01300	NURSING ADMINISTRATION	432,686	15,462	104,722	552,870	164,680	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	124,339	0	13,641	137,980	41,099	14.00
15.00	01500	PHARMACY	2,195,134	38,673	144,657	2,378,464	708,456	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	402,527	52,370	0	454,897	135,497	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	880,199	391,568	322,881	1,594,648	474,987	30.00
31.00	03100	INTENSIVE CARE UNIT	581,903	29,005	212,836	823,744	245,363	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	590,441	440,064	169,371	1,199,876	357,399	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,370,837	369,239	281,839	2,021,915	602,254	54.00
60.00	06000	LABORATORY	1,521,172	94,535	0	1,615,707	481,259	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	50,118	7,673	0	57,791	17,214	63.00
65.00	06500	RESPIRATORY THERAPY	747,744	124,231	247,460	1,119,435	333,438	65.00
66.00	06600	PHYSICAL THERAPY	800,816	92,425	277,311	1,170,552	348,664	66.00
66.01	06601	WHEATFIELD PT	282,604	351,475	101,862	735,941	219,210	66.01
67.00	06700	OCCUPATIONAL THERAPY	150,452	38,175	55,551	244,178	72,732	67.00
67.01	06701	WHEATFIELD OT	85,239	75,582	29,684	190,505	56,744	67.01
68.00	06800	SPEECH PATHOLOGY	97,226	22,061	35,821	155,108	46,201	68.00
68.01	06801	WHEATFIELD ST	59,816	49,032	21,862	130,710	38,934	68.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	389,161	43,086	0	432,247	128,750	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	187,490	6,254	0	193,744	57,709	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	325,291	0	100,471	425,762	126,819	88.00
88.03	08801	RURAL HEALTH CLINIC IV	399,294	101,671	126,541	627,506	186,911	88.03
90.00	09000	CLINIC	1,117,408	172,150	373,238	1,662,796	495,285	90.00
91.00	09100	EMERGENCY	2,035,640	171,268	351,542	2,558,450	762,055	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	1,170,838	119,588	294,072	1,584,498	471,963	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	551,250	8,364	118,588	678,202	202,011	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	35,497,632	3,596,857	4,042,867	34,557,598	7,770,922	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	8,824	0	8,824	2,628	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	RENSSELAER HEALTH CENTER	0	0	0	0	0	192.01
194.00	07950	ALTERNACARE	686,955	320,820	248,015	1,255,790	374,053	194.00
194.01	07951	DME EQUIPMENT	0	0	0	0	0	194.01
194.02	07952	WHEATFIELD FITNESS	311,598	106,736	80,342	498,676	148,537	194.02
194.03	07957	JOHNSON FITNESS	403,832	0	141,343	545,175	162,387	194.03
194.04	07953	FOUNDATION	0	0	0	0	0	194.04
194.05	07954	MEALS ON WHEELS	0	0	0	0	0	194.05
194.06	07955	WATER LAB	0	21,255	0	21,255	6,331	194.06
194.07	07956	ADVERTISING	0	12,699	0	12,699	3,783	194.07
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	36,900,017	4,067,191	4,512,567	36,900,017	8,468,641	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1324 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part I Date/Time Prepared: 5/31/2018 2:46 am

		Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	2,241,065					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	38,992	278,607				8.00
9.00	00900	HOUSEKEEPING	46,154	19,531	1,127,297			9.00
10.00	01000	DIETARY	43,912	3,131	3,213	440,814		10.00
11.00	01100	CAFETERIA	47,770	0	559	0	452,198	11.00
13.00	01300	NURSING ADMINISTRATION	9,718	0	0	0	16,699	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	2,175	14.00
15.00	01500	PHARMACY	24,307	0	16,275	0	23,067	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	32,916	0	0	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	246,108	161,879	327,174	125,743	51,486	30.00
31.00	03100	INTENSIVE CARE UNIT	18,230	1,183	30,175	14,373	33,939	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	276,588	14,126	0	0	26,518	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	232,074	3,656	130,478	0	44,942	54.00
60.00	06000	LABORATORY	59,417	0	47,358	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	4,823	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	78,081	7,655	26,682	0	39,460	65.00
66.00	06600	PHYSICAL THERAPY	58,091	18,641	52,778	0	44,220	66.00
66.01	06601	WHEATFIELD PT	220,909	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	23,993	0	21,793	0	8,858	67.00
67.01	06701	WHEATFIELD OT	47,505	0	0	0	0	67.01
68.00	06800	SPEECH PATHOLOGY	13,866	0	12,601	0	5,712	68.00
68.01	06801	WHEATFIELD ST	30,818	0	0	0	0	68.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	27,080	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,931	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.03	08801	RURAL HEALTH CLINIC IV	63,902	0	0	0	0	88.03
90.00	09000	CLINIC	108,200	3,537	115,042	0	59,517	90.00
91.00	09100	EMERGENCY	107,645	6,253	96,811	0	56,057	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	75,164	0	87,172	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	5,257	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,945,451	239,592	968,111	140,116	412,650	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	5,546	0	279	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	RENSSELAER HEALTH CENTER	0	0	0	0	0	192.01
194.00	07950	ALTERNACARE	201,642	39,015	147,522	220,434	39,548	194.00
194.01	07951	DME EQUIPMENT	0	0	0	0	0	194.01
194.02	07952	WHEATFIELD FITNESS	67,085	0	0	0	0	194.02
194.03	07957	JOHNSON FITNESS	0	0	0	0	0	194.03
194.04	07953	FOUNDATION	0	0	0	0	0	194.04
194.05	07954	MEALS ON WHEELS	0	0	0	80,264	0	194.05
194.06	07955	WATER LAB	13,359	0	11,385	0	0	194.06
194.07	07956	ADVERTISING	7,982	0	0	0	0	194.07
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)	2,241,065	278,607	1,127,297	440,814	452,198	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1324 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part I Date/Time Prepared: 5/31/2018 2:46 am

		Cost Center Description	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	
			13.00	14.00	15.00	16.00	24.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	743,967					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	181,254				14.00
15.00	01500	PHARMACY	0	6,560	3,157,129			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	442	0	623,752		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	150,639	514	145	163,476	3,296,799	30.00
31.00	03100	INTENSIVE CARE UNIT	99,297	175	0	25,077	1,291,556	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	77,585	2,099	5,113	62,712	2,022,016	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	82,028	9,347	755	81,688	3,209,137	54.00
60.00	06000	LABORATORY	0	55	118	15,897	2,219,811	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	8,653	0	0	88,481	63.00
65.00	06500	RESPIRATORY THERAPY	0	5,587	0	0	1,610,338	65.00
66.00	06600	PHYSICAL THERAPY	0	1,243	905	0	1,695,094	66.00
66.01	06601	WHEATFIELD PT	0	486	0	0	1,176,546	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	24	0	0	371,578	67.00
67.01	06701	WHEATFIELD OT	0	178	0	0	294,932	67.01
68.00	06800	SPEECH PATHOLOGY	0	2	0	0	233,490	68.00
68.01	06801	WHEATFIELD ST	0	51	0	0	200,513	68.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	85,565	0	0	673,642	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	35,534	0	0	290,918	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	2,969,168	0	2,969,168	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	717	28,882	0	582,180	88.00
88.03	08801	RURAL HEALTH CLINIC IV	0	693	55,333	0	934,345	88.03
90.00	09000	CLINIC	170,408	2,994	3,592	193,463	2,814,834	90.00
91.00	09100	EMERGENCY	164,010	2,025	522	81,439	3,835,267	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	6,963	0	0	2,225,760	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	5,057	91,681	0	982,208	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	743,967	174,964	3,156,214	623,752	33,018,613	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	17,277	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	RENSSELAER HEALTH CENTER	0	0	0	0	0	192.01
194.00	07950	ALTERNACARE	0	2,194	4	0	2,280,202	194.00
194.01	07951	DME EQUIPMENT	0	0	0	0	0	194.01
194.02	07952	WHEATFIELD FITNESS	0	3,298	541	0	718,137	194.02
194.03	07957	JOHNSON FITNESS	0	798	370	0	708,730	194.03
194.04	07953	FOUNDATION	0	0	0	0	0	194.04
194.05	07954	MEALS ON WHEELS	0	0	0	0	80,264	194.05
194.06	07955	WATER LAB	0	0	0	0	52,330	194.06
194.07	07956	ADVERTISING	0	0	0	0	24,464	194.07
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	743,967	181,254	3,157,129	623,752	36,900,017	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1324 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part I Date/Time Prepared: 5/31/2018 2:46 am

		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			25.00	26.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	3,296,799		30.00
31.00	03100	INTENSIVE CARE UNIT	0	1,291,556		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	2,022,016		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	3,209,137		54.00
60.00	06000	LABORATORY	0	2,219,811		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	88,481		63.00
65.00	06500	RESPIRATORY THERAPY	0	1,610,338		65.00
66.00	06600	PHYSICAL THERAPY	0	1,695,094		66.00
66.01	06601	WHEATFIELD PT	0	1,176,546		66.01
67.00	06700	OCCUPATIONAL THERAPY	0	371,578		67.00
67.01	06701	WHEATFIELD OT	0	294,932		67.01
68.00	06800	SPEECH PATHOLOGY	0	233,490		68.00
68.01	06801	WHEATFIELD ST	0	200,513		68.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	673,642		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	290,918		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,969,168		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	582,180		88.00
88.03	08801	RURAL HEALTH CLINIC IV	0	934,345		88.03
90.00	09000	CLINIC	0	2,814,834		90.00
91.00	09100	EMERGENCY	0	3,835,267		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0			92.00
		OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY	0	2,225,760		101.00
		SPECIAL PURPOSE COST CENTERS				
116.00	11600	HOSPICE	0	982,208		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	33,018,613		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	17,277		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0		192.00
192.01	19201	RENSSELAER HEALTH CENTER	0	0		192.01
194.00	07950	ALTERNACARE	0	2,280,202		194.00
194.01	07951	DME EQUIPMENT	0	0		194.01
194.02	07952	WHEATFIELD FITNESS	0	718,137		194.02
194.03	07957	JOHNSON FITNESS	0	708,730		194.03
194.04	07953	FOUNDATION	0	0		194.04
194.05	07954	MEALS ON WHEELS	0	80,264		194.05
194.06	07955	WATER LAB	0	52,330		194.06
194.07	07956	ADVERTISING	0	24,464		194.07
200.00		Cross Foot Adjustments	0	0		200.00
201.00		Negative Cost Centers	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	0	36,900,017		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1324 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part II Date/Time Prepared: 5/31/2018 2:46 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	
			0	1.00	2A	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	429,973	429,973	0	429,973	5.00
7.00	00700	OPERATION OF PLANT	0	71,592	71,592	0	26,113	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	62,039	62,039	0	2,792	8.00
9.00	00900	HOUSEKEEPING	0	73,433	73,433	0	12,370	9.00
10.00	01000	DIETARY	0	69,865	69,865	0	4,551	10.00
11.00	01100	CAFETERIA	0	76,004	76,004	0	4,706	11.00
13.00	01300	NURSING ADMINISTRATION	0	15,462	15,462	0	8,361	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	2,087	14.00
15.00	01500	PHARMACY	0	38,673	38,673	0	35,970	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	52,370	52,370	0	6,879	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	391,568	391,568	0	24,116	30.00
31.00	03100	INTENSIVE CARE UNIT	0	29,005	29,005	0	12,457	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	440,064	440,064	0	18,146	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	369,239	369,239	0	30,577	54.00
60.00	06000	LABORATORY	0	94,535	94,535	0	24,434	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	7,673	7,673	0	874	63.00
65.00	06500	RESPIRATORY THERAPY	0	124,231	124,231	0	16,929	65.00
66.00	06600	PHYSICAL THERAPY	0	92,425	92,425	0	17,702	66.00
66.01	06601	WHEATFIELD PT	0	351,475	351,475	0	11,130	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	38,175	38,175	0	3,693	67.00
67.01	06701	WHEATFIELD OT	0	75,582	75,582	0	2,881	67.01
68.00	06800	SPEECH PATHOLOGY	0	22,061	22,061	0	2,346	68.00
68.01	06801	WHEATFIELD ST	0	49,032	49,032	0	1,977	68.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	43,086	43,086	0	6,537	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	6,254	6,254	0	2,930	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	6,439	88.00
88.03	08801	RURAL HEALTH CLINIC IV	0	101,671	101,671	0	9,490	88.03
90.00	09000	CLINIC	0	172,150	172,150	0	25,146	90.00
91.00	09100	EMERGENCY	0	171,268	171,268	0	38,699	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			0			92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	119,588	119,588	0	23,962	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	8,364	8,364	0	10,256	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	3,596,857	3,596,857	0	394,550	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	8,824	8,824	0	133	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	RENSSELAER HEALTH CENTER	0	0	0	0	0	192.01
194.00	07950	ALTERNACARE	0	320,820	320,820	0	18,991	194.00
194.01	07951	DME EQUIPMENT	0	0	0	0	0	194.01
194.02	07952	WHEATFIELD FITNESS	0	106,736	106,736	0	7,541	194.02
194.03	07957	JOHNSON FITNESS	0	0	0	0	8,245	194.03
194.04	07953	FOUNDATION	0	0	0	0	0	194.04
194.05	07954	MEALS ON WHEELS	0	0	0	0	0	194.05
194.06	07955	WATER LAB	0	21,255	21,255	0	321	194.06
194.07	07956	ADVERTISING	0	12,699	12,699	0	192	194.07
200.00		Cross Foot Adjustments			0			200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	4,067,191	4,067,191	0	429,973	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1324 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part II | Date/Time Prepared: 5/31/2018 2:46 am

		Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	97,705					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,700	66,531				8.00
9.00	00900	HOUSEKEEPING	2,012	4,664	92,479			9.00
10.00	01000	DIETARY	1,914	748	264	77,342		10.00
11.00	01100	CAFETERIA	2,083	0	46	0	82,839	11.00
13.00	01300	NURSING ADMINISTRATION	424	0	0	0	3,059	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	398	14.00
15.00	01500	PHARMACY	1,060	0	1,335	0	4,226	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,435	0	0	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	10,730	38,656	26,839	22,062	9,432	30.00
31.00	03100	INTENSIVE CARE UNIT	795	283	2,475	2,522	6,217	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	12,058	3,373	0	0	4,858	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	10,118	873	10,704	0	8,233	54.00
60.00	06000	LABORATORY	2,590	0	3,885	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	210	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	3,404	1,828	2,189	0	7,229	65.00
66.00	06600	PHYSICAL THERAPY	2,533	4,451	4,330	0	8,101	66.00
66.01	06601	WHEATFIELD PT	9,631	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	1,046	0	1,788	0	1,623	67.00
67.01	06701	WHEATFIELD OT	2,071	0	0	0	0	67.01
68.00	06800	SPEECH PATHOLOGY	605	0	1,034	0	1,046	68.00
68.01	06801	WHEATFIELD ST	1,344	0	0	0	0	68.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,181	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	171	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.03	08801	RURAL HEALTH CLINIC IV	2,786	0	0	0	0	88.03
90.00	09000	CLINIC	4,717	845	9,438	0	10,903	90.00
91.00	09100	EMERGENCY	4,693	1,493	7,942	0	10,269	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	3,277	0	7,151	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	229	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	84,817	57,214	79,420	24,584	75,594	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	242	0	23	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	RENSSELAER HEALTH CENTER	0	0	0	0	0	192.01
194.00	07950	ALTERNACARE	8,791	9,317	12,102	38,675	7,245	194.00
194.01	07951	DME EQUIPMENT	0	0	0	0	0	194.01
194.02	07952	WHEATFIELD FITNESS	2,925	0	0	0	0	194.02
194.03	07957	JOHNSON FITNESS	0	0	0	0	0	194.03
194.04	07953	FOUNDATION	0	0	0	0	0	194.04
194.05	07954	MEALS ON WHEELS	0	0	0	14,083	0	194.05
194.06	07955	WATER LAB	582	0	934	0	0	194.06
194.07	07956	ADVERTISING	348	0	0	0	0	194.07
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)	97,705	66,531	92,479	77,342	82,839	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1324 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part II Date/Time Prepared: 5/31/2018 2:46 am

		Cost Center Description	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	
			13.00	14.00	15.00	16.00	24.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	27,306					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	2,485				14.00
15.00	01500	PHARMACY	0	90	81,354			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	6	0	60,690		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,529	7	4	15,906	544,849	30.00
31.00	03100	INTENSIVE CARE UNIT	3,645	2	0	2,440	59,841	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,848	29	132	6,102	487,610	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,011	128	19	7,948	440,850	54.00
60.00	06000	LABORATORY	0	1	3	1,547	126,995	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	119	0	0	8,876	63.00
65.00	06500	RESPIRATORY THERAPY	0	77	0	0	155,887	65.00
66.00	06600	PHYSICAL THERAPY	0	17	23	0	129,582	66.00
66.01	06601	WHEATFIELD PT	0	7	0	0	372,243	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	46,325	67.00
67.01	06701	WHEATFIELD OT	0	2	0	0	80,536	67.01
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	27,092	68.00
68.01	06801	WHEATFIELD ST	0	1	0	0	52,354	68.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	1,174	0	0	51,978	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	487	0	0	9,842	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	76,511	0	76,511	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	10	744	0	7,193	88.00
88.03	08801	RURAL HEALTH CLINIC IV	0	9	1,426	0	115,382	88.03
90.00	09000	CLINIC	6,253	41	93	18,823	248,409	90.00
91.00	09100	EMERGENCY	6,020	28	13	7,924	248,349	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	95	0	0	154,073	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	69	2,362	0	21,280	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	27,306	2,399	81,330	60,690	3,466,057	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	9,222	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	RENSSELAER HEALTH CENTER	0	0	0	0	0	192.01
194.00	07950	ALTERNACARE	0	30	0	0	415,971	194.00
194.01	07951	DME EQUIPMENT	0	0	0	0	0	194.01
194.02	07952	WHEATFIELD FITNESS	0	45	14	0	117,261	194.02
194.03	07957	JOHNSON FITNESS	0	11	10	0	8,266	194.03
194.04	07953	FOUNDATION	0	0	0	0	0	194.04
194.05	07954	MEALS ON WHEELS	0	0	0	0	14,083	194.05
194.06	07955	WATER LAB	0	0	0	0	23,092	194.06
194.07	07956	ADVERTISING	0	0	0	0	13,239	194.07
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	27,306	2,485	81,354	60,690	4,067,191	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1324 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part II | Date/Time Prepared: 5/31/2018 2:46 am

		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			25.00	26.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	544,849		30.00
31.00	03100	INTENSIVE CARE UNIT	0	59,841		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	487,610		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	440,850		54.00
60.00	06000	LABORATORY	0	126,995		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	8,876		63.00
65.00	06500	RESPIRATORY THERAPY	0	155,887		65.00
66.00	06600	PHYSICAL THERAPY	0	129,582		66.00
66.01	06601	WHEATFIELD PT	0	372,243		66.01
67.00	06700	OCCUPATIONAL THERAPY	0	46,325		67.00
67.01	06701	WHEATFIELD OT	0	80,536		67.01
68.00	06800	SPEECH PATHOLOGY	0	27,092		68.00
68.01	06801	WHEATFIELD ST	0	52,354		68.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	51,978		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	9,842		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	76,511		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	7,193		88.00
88.03	08801	RURAL HEALTH CLINIC IV	0	115,382		88.03
90.00	09000	CLINIC	0	248,409		90.00
91.00	09100	EMERGENCY	0	248,349		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0			92.00
		OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY	0	154,073		101.00
		SPECIAL PURPOSE COST CENTERS				
116.00	11600	HOSPICE	0	21,280		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	3,466,057		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	9,222		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0		192.00
192.01	19201	RENSSELAER HEALTH CENTER	0	0		192.01
194.00	07950	ALTERNACARE	0	415,971		194.00
194.01	07951	DME EQUIPMENT	0	0		194.01
194.02	07952	WHEATFIELD FITNESS	0	117,261		194.02
194.03	07957	JOHNSON FITNESS	0	8,266		194.03
194.04	07953	FOUNDATION	0	0		194.04
194.05	07954	MEALS ON WHEELS	0	14,083		194.05
194.06	07955	WATER LAB	0	23,092		194.06
194.07	07956	ADVERTISING	0	13,239		194.07
200.00		Cross Foot Adjustments	0	0		200.00
201.00		Negative Cost Centers	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	0	4,067,191		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1324 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B-1 | Date/Time Prepared: 5/31/2018 2:46 am

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
			1.00	4.00	5A	5.00	7.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	106,009					1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	12,186,215				4.00
5.00	00500	ADMINISTRATIVE & GENERAL	11,207	666,706	-8,468,641	28,431,376		5.00
7.00	00700	OPERATION OF PLANT	1,866	275,076	0	1,726,735	92,936	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,617	72,299	0	184,623	1,617	8.00
9.00	00900	HOUSEKEEPING	1,914	471,757	0	817,969	1,914	9.00
10.00	01000	DIETARY	1,821	140,618	0	300,924	1,821	10.00
11.00	01100	CAFETERIA	1,981	152,953	0	311,180	1,981	11.00
13.00	01300	NURSING ADMINISTRATION	403	282,802	0	552,870	403	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	36,837	0	137,980	0	14.00
15.00	01500	PHARMACY	1,008	390,646	0	2,378,464	1,008	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,365	0	0	454,897	1,365	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	10,206	871,943	0	1,594,648	10,206	30.00
31.00	03100	INTENSIVE CARE UNIT	756	574,764	0	823,744	756	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	11,470	457,387	0	1,199,876	11,470	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	9,624	761,109	0	2,021,915	9,624	54.00
60.00	06000	LABORATORY	2,464	0	0	1,615,707	2,464	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	200	0	0	57,791	200	63.00
65.00	06500	RESPIRATORY THERAPY	3,238	668,267	0	1,119,435	3,238	65.00
66.00	06600	PHYSICAL THERAPY	2,409	748,881	0	1,170,552	2,409	66.00
66.01	06601	WHEATFIELD PT	9,161	275,078	0	735,941	9,161	66.01
67.00	06700	OCCUPATIONAL THERAPY	995	150,016	0	244,178	995	67.00
67.01	06701	WHEATFIELD OT	1,970	80,162	0	190,505	1,970	67.01
68.00	06800	SPEECH PATHOLOGY	575	96,735	0	155,108	575	68.00
68.01	06801	WHEATFIELD ST	1,278	59,039	0	130,710	1,278	68.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,123	0	0	432,247	1,123	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	163	0	0	193,744	163	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	271,322	0	425,762	0	88.00
88.03	08801	RURAL HEALTH CLINIC IV	2,650	341,724	0	627,506	2,650	88.03
90.00	09000	CLINIC	4,487	1,007,936	0	1,662,796	4,487	90.00
91.00	09100	EMERGENCY	4,464	949,341	0	2,558,450	4,464	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	3,117	794,142	0	1,584,498	3,117	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	218	320,248	0	678,202	218	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	93,750	10,917,788	-8,468,641	26,088,957	80,677	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	230	0	0	8,824	230	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	RENSSELAER HEALTH CENTER	0	0	0	0	0	192.01
194.00	07950	ALTERNACARE	8,362	669,765	0	1,255,790	8,362	194.00
194.01	07951	DME EQUIPMENT	0	0	0	0	0	194.01
194.02	07952	WHEATFIELD FITNESS	2,782	216,965	0	498,676	2,782	194.02
194.03	07957	JOHNSON FITNESS	0	381,697	0	545,175	0	194.03
194.04	07953	FOUNDATION	0	0	0	0	0	194.04
194.05	07954	MEALS ON WHEELS	0	0	0	0	0	194.05
194.06	07955	WATER LAB	554	0	0	21,255	554	194.06
194.07	07956	ADVERTISING	331	0	0	12,699	331	194.07
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)	4,067,191	4,512,567		8,468,641	2,241,065	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	38.366469	0.370301		0.297863	24.114068	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)		0		429,973	97,705	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)		0.000000		0.015123	1.051315	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: 15-1324 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B-1 | Date/Time Prepared: 5/31/2018 2:46 am

		Cost Center Description	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVIC)	DIETARY (MEALS SERVED)	CAFETERIA (SALARIES)	NURSING ADMINISTRATION (NURSING SALARIES)	
			8.00	9.00	10.00	11.00	13.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE	278,110					8.00
9.00	00900	HOUSEKEEPING	19,496	80,695				9.00
10.00	01000	DIETARY	3,125	230	32,694			10.00
11.00	01100	CAFETERIA	0	40	0	7,658,126		11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	282,802	4,306,300	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	36,837	0	14.00
15.00	01500	PHARMACY	0	1,165	0	390,646	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	161,591	23,420	9,326	871,943	871,943	30.00
31.00	03100	INTENSIVE CARE UNIT	1,181	2,160	1,066	574,764	574,764	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	14,101	0	0	449,084	449,084	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,649	9,340	0	761,109	474,803	54.00
60.00	06000	LABORATORY	0	3,390	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	7,641	1,910	0	668,267	0	65.00
66.00	06600	PHYSICAL THERAPY	18,608	3,778	0	748,881	0	66.00
66.01	06601	WHEATFIELD PT	0	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	1,560	0	150,016	0	67.00
67.01	06701	WHEATFIELD OT	0	0	0	0	0	67.01
68.00	06800	SPEECH PATHOLOGY	0	902	0	96,735	0	68.00
68.01	06801	WHEATFIELD ST	0	0	0	0	0	68.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.03	08801	RURAL HEALTH CLINIC IV	0	0	0	0	0	88.03
90.00	09000	CLINIC	3,531	8,235	0	1,007,936	986,365	90.00
91.00	09100	EMERGENCY	6,242	6,930	0	949,341	949,341	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	6,240	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	239,165	69,300	10,392	6,988,361	4,306,300	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	20	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	RENSSELAER HEALTH CENTER	0	0	0	0	0	192.01
194.00	07950	ALTERNACARE	38,945	10,560	16,349	669,765	0	194.00
194.01	07951	DME EQUIPMENT	0	0	0	0	0	194.01
194.02	07952	WHEATFIELD FITNESS	0	0	0	0	0	194.02
194.03	07957	JOHNSON FITNESS	0	0	0	0	0	194.03
194.04	07953	FOUNDATION	0	0	0	0	0	194.04
194.05	07954	MEALS ON WHEELS	0	0	5,953	0	0	194.05
194.06	07955	WATER LAB	0	815	0	0	0	194.06
194.07	07956	ADVERTISING	0	0	0	0	0	194.07
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)	278,607	1,127,297	440,814	452,198	743,967	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	1.001787	13.969849	13.483024	0.059048	0.172762	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	66,531	92,479	77,342	82,839	27,306	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.239225	1.146031	2.365633	0.010817	0.006341	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: 15-1324 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B-1 | Date/Time Prepared: 5/31/2018 2:46 am

		Cost Center Description	CENTRAL SERVICES & SUPPLY (COSTED REQUISITIONS)	PHARMACY (COSTED REQUISITIONS)	MEDICAL RECORDS & LIBRARY (TIME SPENT)		
			14.00	15.00	16.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	953,711				14.00
15.00	01500	PHARMACY	34,518	1,680,656			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,327	0	74,945		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	2,703	77	19,642		30.00
31.00	03100	INTENSIVE CARE UNIT	919	0	3,013		31.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	11,045	2,722	7,535		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	49,181	402	9,815		54.00
60.00	06000	LABORATORY	291	63	1,910		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	45,528	0	0		63.00
65.00	06500	RESPIRATORY THERAPY	29,398	0	0		65.00
66.00	06600	PHYSICAL THERAPY	6,542	482	0		66.00
66.01	06601	WHEATFIELD PT	2,559	0	0		66.01
67.00	06700	OCCUPATIONAL THERAPY	124	0	0		67.00
67.01	06701	WHEATFIELD OT	939	0	0		67.01
68.00	06800	SPEECH PATHOLOGY	11	0	0		68.00
68.01	06801	WHEATFIELD ST	268	0	0		68.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	450,209	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	186,970	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,580,597	0		73.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	3,775	15,375	0		88.00
88.03	08801	RURAL HEALTH CLINIC IV	3,645	29,456	0		88.03
90.00	09000	CLINIC	15,755	1,912	23,245		90.00
91.00	09100	EMERGENCY	10,656	278	9,785		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
		OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY	36,636	0	0		101.00
		SPECIAL PURPOSE COST CENTERS					
116.00	11600	HOSPICE	26,611	48,805	0		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	920,610	1,680,169	74,945		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0		192.00
192.01	19201	RENSSELAER HEALTH CENTER	0	0	0		192.01
194.00	07950	ALTERNACARE	11,545	2	0		194.00
194.01	07951	DME EQUIPMENT	0	0	0		194.01
194.02	07952	WHEATFIELD FITNESS	17,355	288	0		194.02
194.03	07957	JOHNSON FITNESS	4,201	197	0		194.03
194.04	07953	FOUNDATION	0	0	0		194.04
194.05	07954	MEALS ON WHEELS	0	0	0		194.05
194.06	07955	WATER LAB	0	0	0		194.06
194.07	07956	ADVERTISING	0	0	0		194.07
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)	181,254	3,157,129	623,752		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.190051	1.878510	8.322797		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	2,485	81,354	60,690		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.002606	0.048406	0.809794		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: 15-1324 | Period: From 01/01/2017 To 12/31/2017 | Worksheet C Part I Date/Time Prepared: 5/31/2018 2:46 am

Title XVIII | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,296,799		3,296,799	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	1,291,556		1,291,556	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,022,016		2,022,016	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,209,137		3,209,137	0	0	54.00
60.00	06000	LABORATORY	2,219,811		2,219,811	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	88,481		88,481	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	1,610,338	0	1,610,338	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,695,094	0	1,695,094	0	0	66.00
66.01	06601	WHEATFIELD PT	1,176,546	0	1,176,546	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	371,578	0	371,578	0	0	67.00
67.01	06701	WHEATFIELD OT	294,932	0	294,932	0	0	67.01
68.00	06800	SPEECH PATHOLOGY	233,490	0	233,490	0	0	68.00
68.01	06801	WHEATFIELD ST	200,513	0	200,513	0	0	68.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	673,642		673,642	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	290,918		290,918	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,969,168		2,969,168	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	582,180		582,180	0	0	88.00
88.03	08801	RURAL HEALTH CLINIC IV	934,345		934,345	0	0	88.03
90.00	09000	CLINIC	2,814,834		2,814,834	0	0	90.00
91.00	09100	EMERGENCY	3,835,267		3,835,267	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	959,160		959,160		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	2,225,760		2,225,760		0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	982,208		982,208		0	116.00
200.00		Subtotal (see instructions)	33,977,773	0	33,977,773	0	0	200.00
201.00		Less Observation Beds	959,160		959,160		0	201.00
202.00		Total (see instructions)	33,018,613	0	33,018,613	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1324 | Period: From 01/01/2017 To 12/31/2017 | Worksheet C Part I Date/Time Prepared: 5/31/2018 2:46 am

Title XVIII | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,331,552		1,331,552			30.00
31.00	03100	INTENSIVE CARE UNIT	253,624		253,624			31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	307,229	2,850,801	3,158,030	0.640278	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	274,789	8,794,349	9,069,138	0.353852	0.000000	54.00
60.00	06000	LABORATORY	644,819	6,315,087	6,959,906	0.318943	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	37,201	159,801	197,002	0.449138	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	375,831	1,848,282	2,224,113	0.724036	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	70,742	1,901,074	1,971,816	0.859661	0.000000	66.00
66.01	06601	WHEATFIELD PT	0	1,232,059	1,232,059	0.954943	0.000000	66.01
67.00	06700	OCCUPATIONAL THERAPY	44,103	319,851	363,954	1.020948	0.000000	67.00
67.01	06701	WHEATFIELD OT	0	143,484	143,484	2.055504	0.000000	67.01
68.00	06800	SPEECH PATHOLOGY	5,348	148,748	154,096	1.515224	0.000000	68.00
68.01	06801	WHEATFIELD ST	0	99,120	99,120	2.022932	0.000000	68.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	861,715	3,827,185	4,688,900	0.143667	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	518,449	988,354	1,506,803	0.193070	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,470,950	13,733,497	15,204,447	0.195283	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	251,708	251,708			88.00
88.03	08801	RURAL HEALTH CLINIC IV	0	417,363	417,363			88.03
90.00	09000	CLINIC	98,785	3,586,340	3,685,125	0.763837	0.000000	90.00
91.00	09100	EMERGENCY	228,174	5,644,296	5,872,470	0.653093	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	77,245	1,358,531	1,435,776	0.668043	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	2,021,637	2,021,637			101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	1,920,040	1,920,040			116.00
200.00		Subtotal (see instructions)	6,600,556	57,561,607	64,162,163			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	6,600,556	57,561,607	64,162,163			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1324 | Period: From 01/01/2017 To 12/31/2017 | Worksheet C Part I Date/Time Prepared: 5/31/2018 2:46 am

Title XVIII | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	06000	LABORATORY	0.000000		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000		63.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
66.01	06601	WHEATFIELD PT	0.000000		66.01
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
67.01	06701	WHEATFIELD OT	0.000000		67.01
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
68.01	06801	WHEATFIELD ST	0.000000		68.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC			88.00
88.03	08801	RURAL HEALTH CLINIC IV			88.03
90.00	09000	CLINIC	0.000000		90.00
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
		OTHER REIMBURSABLE COST CENTERS			
101.00	10100	HOME HEALTH AGENCY			101.00
		SPECIAL PURPOSE COST CENTERS			
116.00	11600	HOSPICE			116.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1324 | Period: From 01/01/2017 To 12/31/2017 | Worksheet C Part I Date/Time Prepared: 5/31/2018 2:46 am

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,296,799		3,296,799	0	3,296,799	30.00
31.00	03100	INTENSIVE CARE UNIT	1,291,556		1,291,556	0	1,291,556	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,022,016		2,022,016	0	2,022,016	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,209,137		3,209,137	0	3,209,137	54.00
60.00	06000	LABORATORY	2,219,811		2,219,811	0	2,219,811	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	88,481		88,481	0	88,481	63.00
65.00	06500	RESPIRATORY THERAPY	1,610,338	0	1,610,338	0	1,610,338	65.00
66.00	06600	PHYSICAL THERAPY	1,695,094	0	1,695,094	0	1,695,094	66.00
66.01	06601	WHEATFIELD PT	1,176,546	0	1,176,546	0	1,176,546	66.01
67.00	06700	OCCUPATIONAL THERAPY	371,578	0	371,578	0	371,578	67.00
67.01	06701	WHEATFIELD OT	294,932	0	294,932	0	294,932	67.01
68.00	06800	SPEECH PATHOLOGY	233,490	0	233,490	0	233,490	68.00
68.01	06801	WHEATFIELD ST	200,513	0	200,513	0	200,513	68.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	673,642		673,642	0	673,642	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	290,918		290,918	0	290,918	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,969,168		2,969,168	0	2,969,168	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	582,180		582,180	0	582,180	88.00
88.03	08801	RURAL HEALTH CLINIC IV	934,345		934,345	0	934,345	88.03
90.00	09000	CLINIC	2,814,834		2,814,834	0	2,814,834	90.00
91.00	09100	EMERGENCY	3,835,267		3,835,267	0	3,835,267	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	959,160		959,160		959,160	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	2,225,760		2,225,760		2,225,760	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	982,208		982,208		982,208	116.00
200.00		Subtotal (see instructions)	33,977,773	0	33,977,773	0	33,977,773	200.00
201.00		Less Observation Beds	959,160		959,160		959,160	201.00
202.00		Total (see instructions)	33,018,613	0	33,018,613	0	33,018,613	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1324 | Period: From 01/01/2017 To 12/31/2017 | Worksheet C Part I Date/Time Prepared: 5/31/2018 2:46 am

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,331,552		1,331,552			30.00
31.00	03100	INTENSIVE CARE UNIT	253,624		253,624			31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	307,229	2,850,801	3,158,030	0.640278	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	274,789	8,794,349	9,069,138	0.353852	0.000000	54.00
60.00	06000	LABORATORY	644,819	6,315,087	6,959,906	0.318943	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	37,201	159,801	197,002	0.449138	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	375,831	1,848,282	2,224,113	0.724036	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	70,742	1,901,074	1,971,816	0.859661	0.000000	66.00
66.01	06601	WHEATFIELD PT	0	1,232,059	1,232,059	0.954943	0.000000	66.01
67.00	06700	OCCUPATIONAL THERAPY	44,103	319,851	363,954	1.020948	0.000000	67.00
67.01	06701	WHEATFIELD OT	0	143,484	143,484	2.055504	0.000000	67.01
68.00	06800	SPEECH PATHOLOGY	5,348	148,748	154,096	1.515224	0.000000	68.00
68.01	06801	WHEATFIELD ST	0	99,120	99,120	2.022932	0.000000	68.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	861,715	3,827,185	4,688,900	0.143667	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	518,449	988,354	1,506,803	0.193070	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,470,950	13,733,497	15,204,447	0.195283	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	251,708	251,708	2.312918	0.000000	88.00
88.03	08801	RURAL HEALTH CLINIC IV	0	417,363	417,363	2.238687	0.000000	88.03
90.00	09000	CLINIC	98,785	3,586,340	3,685,125	0.763837	0.000000	90.00
91.00	09100	EMERGENCY	228,174	5,644,296	5,872,470	0.653093	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	77,245	1,358,531	1,435,776	0.668043	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	2,021,637	2,021,637			101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	1,920,040	1,920,040			116.00
200.00		Subtotal (see instructions)	6,600,556	57,561,607	64,162,163			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	6,600,556	57,561,607	64,162,163			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1324 | Period: From 01/01/2017 To 12/31/2017 | Worksheet C Part I Date/Time Prepared: 5/31/2018 2:46 am

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	06000	LABORATORY	0.000000		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000		63.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
66.01	06601	WHEATFIELD PT	0.000000		66.01
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
67.01	06701	WHEATFIELD OT	0.000000		67.01
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
68.01	06801	WHEATFIELD ST	0.000000		68.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	0.000000		88.00
88.03	08801	RURAL HEALTH CLINIC IV	0.000000		88.03
90.00	09000	CLINIC	0.000000		90.00
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
		OTHER REIMBURSABLE COST CENTERS			
101.00	10100	HOME HEALTH AGENCY			101.00
		SPECIAL PURPOSE COST CENTERS			
116.00	11600	HOSPICE			116.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-1324 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part II Date/Time Prepared: 5/31/2018 2:46 am

Title XVIII | Hospital | Cost

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	487,610	3,158,030	0.154403	216,253	33,390	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	440,850	9,069,138	0.048610	134,611	6,543	54.00
60.00	06000	LABORATORY	126,995	6,959,906	0.018247	446,335	8,144	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	8,876	197,002	0.045055	27,156	1,224	63.00
65.00	06500	RESPIRATORY THERAPY	155,887	2,224,113	0.070090	226,921	15,905	65.00
66.00	06600	PHYSICAL THERAPY	129,582	1,971,816	0.065717	29,197	1,919	66.00
66.01	06601	WHEATFIELD PT	372,243	1,232,059	0.302131	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	46,325	363,954	0.127283	13,830	1,760	67.00
67.01	06701	WHEATFIELD OT	80,536	143,484	0.561289	0	0	67.01
68.00	06800	SPEECH PATHOLOGY	27,092	154,096	0.175812	2,185	384	68.00
68.01	06801	WHEATFIELD ST	52,354	99,120	0.528188	0	0	68.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	51,978	4,688,900	0.011085	620,498	6,878	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	9,842	1,506,803	0.006532	379,463	2,479	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	76,511	15,204,447	0.005032	853,954	4,297	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	7,193	251,708	0.028577	0	0	88.00
88.03	08801	RURAL HEALTH CLINIC IV	115,382	417,363	0.276455	0	0	88.03
90.00	09000	CLINIC	248,409	3,685,125	0.067409	50,477	3,403	90.00
91.00	09100	EMERGENCY	248,349	5,872,470	0.042290	115,156	4,870	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	158,517	1,435,776	0.110405	77,245	8,528	92.00
200.00		Total (lines 50 through 199)	2,844,531	58,635,310		3,193,281	99,724	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-1324 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part IV Date/Time Prepared: 5/31/2018 2:46 am

Title XVIII | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
66.01	06601	WHEATFIELD PT	0	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
67.01	06701	WHEATFIELD OT	0	0	0	0	0	67.01
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
68.01	06801	WHEATFIELD ST	0	0	0	0	0	68.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.03	08801	RURAL HEALTH CLINIC IV	0	0	0	0	0	88.03
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	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: 15-1324 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part IV | Date/Time Prepared: 5/31/2018 2:46 am

Title XVIII | Hospital | Cost

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	3,158,030	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	9,069,138	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	6,959,906	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	197,002	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	2,224,113	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	1,971,816	0.000000	66.00
66.01	06601	WHEATFIELD PT	0	0	0	1,232,059	0.000000	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	363,954	0.000000	67.00
67.01	06701	WHEATFIELD OT	0	0	0	143,484	0.000000	67.01
68.00	06800	SPEECH PATHOLOGY	0	0	0	154,096	0.000000	68.00
68.01	06801	WHEATFIELD ST	0	0	0	99,120	0.000000	68.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	4,688,900	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1,506,803	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	15,204,447	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	251,708	0.000000	88.00
88.03	08801	RURAL HEALTH CLINIC IV	0	0	0	417,363	0.000000	88.03
90.00	09000	CLINIC	0	0	0	3,685,125	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	5,872,470	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	1,435,776	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	58,635,310		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-1324 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part IV | Date/Time Prepared: 5/31/2018 2:46 am

Title XVIII | Hospital | Cost

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	216,253	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	134,611	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	446,335	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	27,156	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.000000	226,921	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	29,197	0	0	0	66.00
66.01	06601	WHEATFIELD PT	0.000000	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0.000000	13,830	0	0	0	67.00
67.01	06701	WHEATFIELD OT	0.000000	0	0	0	0	67.01
68.00	06800	SPEECH PATHOLOGY	0.000000	2,185	0	0	0	68.00
68.01	06801	WHEATFIELD ST	0.000000	0	0	0	0	68.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	620,498	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	379,463	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	853,954	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
88.03	08801	RURAL HEALTH CLINIC IV	0.000000	0	0	0	0	88.03
90.00	09000	CLINIC	0.000000	50,477	0	0	0	90.00
91.00	09100	EMERGENCY	0.000000	115,156	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	77,245	0	0	0	92.00
200.00		Total (lines 50 through 199)		3,193,281	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1324 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part V Date/Time Prepared: 5/31/2018 2:46 am

Title XVIII | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.640278	0	1,102,541	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.353852	0	2,908,991	0	0	54.00
60.00	06000	LABORATORY	0.318943	0	1,628,301	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.449138	0	124,811	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.724036	0	761,685	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.859661	0	676,742	0	0	66.00
66.01	06601	WHEATFIELD PT	0.954943	0	388,341	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	1.020948	0	62,432	0	0	67.00
67.01	06701	WHEATFIELD OT	2.055504	0	21,654	0	0	67.01
68.00	06800	SPEECH PATHOLOGY	1.515224	0	17,544	0	0	68.00
68.01	06801	WHEATFIELD ST	2.022932	0	5,842	0	0	68.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.143667	0	1,277,055	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.193070	0	437,601	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.195283	0	5,986,040	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
88.03	08801	RURAL HEALTH CLINIC IV	0.000000				0	88.03
90.00	09000	CLINIC	0.763837	0	1,440,058	0	0	90.00
91.00	09100	EMERGENCY	0.653093	0	1,454,024	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.668043	0	670,533	0	0	92.00
200.00		Subtotal (see instructions)		0	18,964,195	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	18,964,195	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1324 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part V Date/Time Prepared: 5/31/2018 2:46 am

Title XVIII | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	705,933	0		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,029,352	0		54.00
60.00	06000	LABORATORY	519,335	0		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	56,057	0		63.00
65.00	06500	RESPIRATORY THERAPY	551,487	0		65.00
66.00	06600	PHYSICAL THERAPY	581,769	0		66.00
66.01	06601	WHEATFIELD PT	370,844	0		66.01
67.00	06700	OCCUPATIONAL THERAPY	63,740	0		67.00
67.01	06701	WHEATFIELD OT	44,510	0		67.01
68.00	06800	SPEECH PATHOLOGY	26,583	0		68.00
68.01	06801	WHEATFIELD ST	11,818	0		68.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	183,471	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	84,488	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,168,972	0		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
88.03	08801	RURAL HEALTH CLINIC IV	0	0		88.03
90.00	09000	CLINIC	1,099,970	0		90.00
91.00	09100	EMERGENCY	949,613	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	447,945	0		92.00
200.00		Subtotal (see instructions)	7,895,887	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	7,895,887	0		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-1324 | Component CCN: 15-Z324 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part V | Date/Time Prepared: 5/31/2018 2:46 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.640278	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.353852	0	0	0	0	54.00
60.00	06000	LABORATORY	0.318943	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.449138	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.724036	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.859661	0	0	0	0	66.00
66.01	06601	WHEATFIELD PT	0.954943	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	1.020948	0	0	0	0	67.00
67.01	06701	WHEATFIELD OT	2.055504	0	0	0	0	67.01
68.00	06800	SPEECH PATHOLOGY	1.515224	0	0	0	0	68.00
68.01	06801	WHEATFIELD ST	2.022932	0	0	0	0	68.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.143667	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.193070	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.195283	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
88.03	08801	RURAL HEALTH CLINIC IV	0.000000				0	88.03
90.00	09000	CLINIC	0.763837	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.653093	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.668043	0	0	0	0	92.00
200.00		Subtotal (see instructions)		0	0	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-1324 | Component CCN: 15-Z324 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part V | Date/Time Prepared: 5/31/2018 2:46 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
60.00	06000	LABORATORY	0	0		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0		63.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
66.01	06601	WHEATFIELD PT	0	0		66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
67.01	06701	WHEATFIELD OT	0	0		67.01
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
68.01	06801	WHEATFIELD ST	0	0		68.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
88.03	08801	RURAL HEALTH CLINIC IV	0	0		88.03
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
200.00		Subtotal (see instructions)	0	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	0		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1324 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part V Date/Time Prepared: 5/31/2018 2:46 am

Title XIX | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.640278	0	22,980	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.353852	0	89,647	0	0	54.00
60.00	06000	LABORATORY	0.318943	0	71,385	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.449138	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.724036	0	9,986	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.859661	0	11,108	0	0	66.00
66.01	06601	WHEATFIELD PT	0.954943	0	13,093	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	1.020948	0	12,150	0	0	67.00
67.01	06701	WHEATFIELD OT	2.055504	0	9,949	0	0	67.01
68.00	06800	SPEECH PATHOLOGY	1.515224	0	5,611	0	0	68.00
68.01	06801	WHEATFIELD ST	2.022932	0	9,718	0	0	68.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.143667	0	19,359	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.193070	0	797	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.195283	0	172,437	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	2.312918				0	88.00
88.03	08801	RURAL HEALTH CLINIC IV	2.238687				0	88.03
90.00	09000	CLINIC	0.763837	0	21,857	0	0	90.00
91.00	09100	EMERGENCY	0.653093	0	99,793	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.668043	0	22,083	0	0	92.00
200.00		Subtotal (see instructions)		0	591,953	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	591,953	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1324 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part V Date/Time Prepared: 5/31/2018 2:46 am

Title XIX | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	14,714	0		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	31,722	0		54.00
60.00	06000	LABORATORY	22,768	0		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0		63.00
65.00	06500	RESPIRATORY THERAPY	7,230	0		65.00
66.00	06600	PHYSICAL THERAPY	9,549	0		66.00
66.01	06601	WHEATFIELD PT	12,503	0		66.01
67.00	06700	OCCUPATIONAL THERAPY	12,405	0		67.00
67.01	06701	WHEATFIELD OT	20,450	0		67.01
68.00	06800	SPEECH PATHOLOGY	8,502	0		68.00
68.01	06801	WHEATFIELD ST	19,659	0		68.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,781	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	154	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	33,674	0		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
88.03	08801	RURAL HEALTH CLINIC IV	0	0		88.03
90.00	09000	CLINIC	16,695	0		90.00
91.00	09100	EMERGENCY	65,174	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	14,752	0		92.00
200.00		Subtotal (see instructions)	292,732	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	292,732	0		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1324 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-1 | Date/Time Prepared: 5/31/2018 2:46 am

Title XVIII | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	2,112	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,890	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	1,279	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	209	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	13	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)	763	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)	209	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	134.09	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	3,296,799	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)	1,743	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)	329,835	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	2,966,964	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)	2,966,964	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)	1,569.82	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,197,773	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	1,197,773	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1324 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-1 | Date/Time Prepared: 5/31/2018 2:46 am

Title XVIII | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	1,291,556	193	6,692.00	108	722,736	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)	1,042,014	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	2,962,523	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)	328,092	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)	328,092	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)	611	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,569.82	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	959,160	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1324 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-1 | Date/Time Prepared: 5/31/2018 2:46 am

Title XVIII | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	544,849	3,296,799	0.165266	959,160	158,517	90.00
91.00	Nursing School cost	0	3,296,799	0.000000	959,160	0	91.00
92.00	Allied health cost	0	3,296,799	0.000000	959,160	0	92.00
93.00	All other Medical Education	0	3,296,799	0.000000	959,160	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1324 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-1 | Date/Time Prepared: 5/31/2018 2:46 am

Title XIX | Hospital | Cost

	Cost Center Description		
		1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	2,112	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,890	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	1,279	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	209	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	13	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)	123	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	134.09	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	3,296,799	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)	1,743	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)	329,835	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	2,966,964	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)	2,966,964	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)	1,569.82	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	193,088	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)	193,088	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1324 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-1 | Date/Time Prepared: 5/31/2018 2:46 am

Title XIX | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	1,291,556	193	6,692.00	18	120,456	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)	11,571	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	325,115	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)	611	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,569.82	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	959,160	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1324 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-1 | Date/Time Prepared: 5/31/2018 2:46 am

Title XIX | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	544,849	3,296,799	0.165266	959,160	158,517	90.00
91.00	Nursing School cost	0	3,296,799	0.000000	959,160	0	91.00
92.00	Allied health cost	0	3,296,799	0.000000	959,160	0	92.00
93.00	All other Medical Education	0	3,296,799	0.000000	959,160	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1324 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-3 | Date/Time Prepared: 5/31/2018 2:46 am

Title XVIII | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		746,191		30.00
31.00	03100	INTENSIVE CARE UNIT		149,040		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.640278	216,253	138,462	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.353852	134,611	47,632	54.00
60.00	06000	LABORATORY	0.318943	446,335	142,355	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.449138	27,156	12,197	63.00
65.00	06500	RESPIRATORY THERAPY	0.724036	226,921	164,299	65.00
66.00	06600	PHYSICAL THERAPY	0.859661	29,197	25,100	66.00
66.01	06601	WHEATFIELD PT	0.954943	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	1.020948	13,830	14,120	67.00
67.01	06701	WHEATFIELD OT	2.055504	0	0	67.01
68.00	06800	SPEECH PATHOLOGY	1.515224	2,185	3,311	68.00
68.01	06801	WHEATFIELD ST	2.022932	0	0	68.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.143667	620,498	89,145	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.193070	379,463	73,263	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.195283	853,954	166,763	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
88.03	08801	RURAL HEALTH CLINIC IV	0.000000		0	88.03
90.00	09000	CLINIC	0.763837	50,477	38,556	90.00
91.00	09100	EMERGENCY	0.653093	115,156	75,208	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.668043	77,245	51,603	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		3,193,281	1,042,014	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		3,193,281		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1324 | Component CCN: 15-Z324 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-3 | Date/Time Prepared: 5/31/2018 2:46 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.640278	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.353852	2,030	718	54.00
60.00	06000	LABORATORY	0.318943	10,631	3,391	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.449138	2,400	1,078	63.00
65.00	06500	RESPIRATORY THERAPY	0.724036	32,321	23,402	65.00
66.00	06600	PHYSICAL THERAPY	0.859661	25,757	22,142	66.00
66.01	06601	WHEATFIELD PT	0.954943	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	1.020948	23,806	24,305	67.00
67.01	06701	WHEATFIELD OT	2.055504	0	0	67.01
68.00	06800	SPEECH PATHOLOGY	1.515224	1,912	2,897	68.00
68.01	06801	WHEATFIELD ST	2.022932	0	0	68.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.143667	15,002	2,155	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.193070	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.195283	159,808	31,208	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
88.03	08801	RURAL HEALTH CLINIC IV	0.000000		0	88.03
90.00	09000	CLINIC	0.763837	0	0	90.00
91.00	09100	EMERGENCY	0.653093	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.668043	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		273,667	111,296	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		273,667		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1324 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-3 | Date/Time Prepared: 5/31/2018 2:46 am

Title XIX | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		6,483		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.640278	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.353852	4,667	1,651	54.00
60.00	06000	LABORATORY	0.318943	4,878	1,556	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.449138	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.724036	832	602	65.00
66.00	06600	PHYSICAL THERAPY	0.859661	0	0	66.00
66.01	06601	WHEATFIELD PT	0.954943	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	1.020948	0	0	67.00
67.01	06701	WHEATFIELD OT	2.055504	0	0	67.01
68.00	06800	SPEECH PATHOLOGY	1.515224	0	0	68.00
68.01	06801	WHEATFIELD ST	2.022932	0	0	68.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.143667	1,954	281	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.193070	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.195283	11,997	2,343	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	2.312918	0	0	88.00
88.03	08801	RURAL HEALTH CLINIC IV	2.238687	0	0	88.03
90.00	09000	CLINIC	0.763837	5,024	3,838	90.00
91.00	09100	EMERGENCY	0.653093	1,991	1,300	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.668043	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		31,343	11,571	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		31,343		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1324	Period: From 01/01/2017 To 12/31/2017	Worksheet E Part B Date/Time Prepared: 5/31/2018 2:46 am
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	7,895,887	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	OPPS payments	0	3.00
4.00	Outlier payment (see instructions)	0	4.00
4.01	Outlier reconciliation amount (see instructions)	0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	7,895,887	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	0	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (see instructions)	7,974,846	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	0	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	82,277	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	3,471,848	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	4,420,721	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	4,420,721	30.00
31.00	Primary payer payments	4,504	31.00
32.00	Subtotal (line 30 minus line 31)	4,416,217	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)	515,214	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	334,889	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	459,420	36.00
37.00	Subtotal (see instructions)	4,751,106	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		39.50
39.97	Demonstration payment adjustment amount before sequestration	0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	4,751,106	40.00
40.01	Sequestration adjustment (see instructions)	95,022	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
41.00	Interim payments	7,657,764	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	-3,001,680	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: 15-1324 | Period: From 01/01/2017 To 12/31/2017 | Worksheet E-1 Part I Date/Time Prepared: 5/31/2018 2:46 am

Title XVIII | Hospital | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,655,943		7,385,964	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	08/18/2017	269,500	08/18/2017	107,900	3.01
3.02		09/27/2017	311,900	09/27/2017	163,900	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)		581,400		271,800	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		2,237,343		7,657,764	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		461,460		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		3,001,680	6.02
7.00	Total Medicare program liability (see instructions)		2,698,803		4,656,084	7.00

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 15-1324 | Component CCN: 15-Z324 | Period: From 01/01/2017 To 12/31/2017 | Worksheet E-1 Part I | Date/Time Prepared: 5/31/2018 2:46 am

Title XVIII | Swing Beds - SNF | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		315,390		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER	08/21/2017	48,600		0	3.01
3.02		09/27/2017	35,000		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)		83,600		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		398,990		0	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		34,787		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		433,777		0	7.00

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

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-1324	Period: From 01/01/2017 To 12/31/2017	Worksheet E-1 Part II Date/Time Prepared: 5/31/2018 2:46 am
	Title XVIII	Hospital	Cost

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

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

Provider CCN: 15-1324 | Component CCN: 15-Z324 | Period: From 01/01/2017 To 12/31/2017 | Worksheet E-2 | Date/Time Prepared: 5/31/2018 2:46 am

Title XVIII | Swing Beds - SNF | Cost

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	331,373	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)			2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202, for Part B) (For CAH, see instructions)	112,409	0	3.00
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)		0.00	4.00
5.00	Program days	209	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)		0	6.00
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	443,782	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	443,782	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0	0	11.00
12.00	Subtotal (line 10 minus line 11)	443,782	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	1,152	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)	442,630	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)			16.50
16.55	Rural community hospital demonstration project (§410A Demonstration) payment adjustment (see instructions)	0		16.55
16.99	Demonstration payment adjustment amount before sequestration	0	0	16.99
17.00	Allowable bad debts (see instructions)	0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (see instructions)	442,630	0	19.00
19.01	Sequestration adjustment (see instructions)	8,853	0	19.01
19.02	Demonstration payment adjustment amount after sequestration)	0	0	19.02
20.00	Interim payments	398,990	0	20.00
21.00	Tentative settlement (for contractor use only)	0	0	21.00
22.00	Balance due provider/program (line 19 minus lines 19.01, 20, and 21)	34,787	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	23.00
	Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment			
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
	Cost Reimbursement			
201.00	Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital))			201.00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))			202.00
203.00	Total (sum of lines 201 and 202)			203.00
204.00	Medicare swing-bed SNF discharges (see instructions)			204.00
	Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)			
205.00	Medicare swing-bed SNF target amount			205.00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)			206.00
	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement			
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)			208.00
209.00	Adjustment to Medicare swing-bed SNF PPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
	Comparision of PPS versus Cost Reimbursement			
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see instructions)			215.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1324	Period: From 01/01/2017 To 12/31/2017	Worksheet E-3 Part V Date/Time Prepared: 5/31/2018 2:46 am
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	2,962,523	1.00
2.00	Nursing and Allied Health Managed Care payment (see instructions)	0	2.00
3.00	Organ acquisition	0	3.00
4.00	Subtotal (sum of lines 1 through 3)	2,962,523	4.00
5.00	Primary payer payments	4,650	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	2,987,498	6.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
7.00	Routine service charges	0	7.00
8.00	Ancillary service charges	0	8.00
9.00	Organ acquisition charges, net of revenue	0	9.00
10.00	Total reasonable charges	0	10.00
	Customary charges		
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)	0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)	0.000000	13.00
14.00	Total customary charges (see instructions)	0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)	0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)	0	16.00
17.00	Cost of physicians' services in a teaching hospital (see instructions)	0	17.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)	0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)	2,987,498	19.00
20.00	Deductibles (exclude professional component)	250,012	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	2,737,486	22.00
23.00	Coinsurance	2,303	23.00
24.00	Subtotal (line 22 minus line 23)	2,735,183	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	28,766	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	18,698	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	24,010	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	2,753,881	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	29.50
29.99	Demonstration payment adjustment amount before sequestration	0	29.99
30.00	Subtotal (see instructions)	2,753,881	30.00
30.01	Sequestration adjustment (see instructions)	55,078	30.01
30.02	Demonstration payment adjustment amount after sequestration	0	30.02
31.00	Interim payments	2,237,343	31.00
32.00	Tentative settlement (for contractor use only)	0	32.00
33.00	Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32)	461,460	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-1324 | Period: From 01/01/2017 To 12/31/2017 | Worksheet E-3 Part VII | Date/Time Prepared: 5/31/2018 2:46 am

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	325,115		1.00
2.00	Medical and other services		292,732	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	325,115	292,732	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)	325,115	292,732	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	0		8.00
9.00	Ancillary service charges	31,343	591,953	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)	31,343	591,953	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)	31,343	591,953	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	0	299,221	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	293,772	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)	325,115	292,732	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)	325,115	292,732	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30.00	Excess of reasonable cost (from line 18)	293,772	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	325,115	292,732	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	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)	325,115	292,732	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	325,115	292,732	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)	325,115	292,732	40.00
41.00	Interim payments	325,115	292,732	41.00
42.00	Balance due provider/program (line 40 minus line 41)	0	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: 15-1324 | Period: From 01/01/2017 To 12/31/2017 | Worksheet G | Date/Time Prepared: 5/31/2018 2:46 am

		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	164,782	0	0	0	1.00
2.00	Temporary investments	928,580	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	6,412,747	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-2,730,788	0	0	0	6.00
7.00	Inventory	908,924	0	0	0	7.00
8.00	Prepaid expenses	0	0	0	0	8.00
9.00	Other current assets	145,056	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)	5,829,301	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	675,791	0	0	0	12.00
13.00	Land improvements	484,426	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	16,945,980	0	0	0	15.00
16.00	Accumulated depreciation	0	0	0	0	16.00
17.00	Leasehold improvements	663,147	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	10,842,802	0	0	0	23.00
24.00	Accumulated depreciation	-6,151,625	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	23,460,521	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	83,413	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	83,413	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	29,373,235	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	2,044,748	0	0	0	37.00
38.00	Salaries, wages, and fees payable	928,459	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	64,854	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	2,994,730	0	0	0	43.00
44.00	Other current liabilities	14,345,638	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	20,378,429	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	20,900,616	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	77,124	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	20,977,740	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	41,356,169	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	-11,982,934				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)	-11,982,934	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	29,373,235	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-1324 | Period: From 01/01/2017 To 12/31/2017 | Worksheet G-1 | Date/Time Prepared: 5/31/2018 2:46 am

		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		-1,640,406		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-7,622,940				2.00
3.00	Total (sum of line 1 and line 2)		-9,263,346		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)		-9,263,346		0		11.00
12.00	EQUITY TRANSFERS TO/ FROM AFFILIATES	2,719,588		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)		2,719,588		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		-11,982,934		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	EQUITY TRANSFERS TO/ FROM AFFILIATES		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: 15-1324 | Period: From 01/01/2017 To 12/31/2017 | Worksheet G-2 Parts I & II | Date/Time Prepared: 5/31/2018 2:46 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	1,331,552		1,331,552	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	1,331,552		1,331,552	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	253,624		253,624	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)	253,624		253,624	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	1,585,176		1,585,176	17.00
18.00	Ancillary services	4,611,176	42,361,692	46,972,868	18.00
19.00	Outpatient services	326,959	10,666,412	10,993,371	19.00
20.00	RURAL HEALTH CLINIC	0	251,708	251,708	20.00
20.03	RURAL HEALTH CLINIC IV	0	417,363	417,363	20.03
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		2,021,637	2,021,637	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	1,920,040	1,920,040	26.00
27.00	NRCC REVENUE	889,434	64,131	953,565	27.00
27.01	CRNA PROFESSIONAL FEES	26,785	135,528	162,313	27.01
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	7,439,530	57,838,511	65,278,041	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		39,665,741		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)		39,665,741		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 15-1324	Period: From 01/01/2017 To 12/31/2017	Worksheet G-3 Date/Time Prepared: 5/31/2018 2:46 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	65,278,041	1.00
2.00	Less contractual allowances and discounts on patients' accounts	34,062,926	2.00
3.00	Net patient revenues (line 1 minus line 2)	31,215,115	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	39,665,741	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-8,450,626	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	OTHER OPERATING REVENUE	639,424	24.00
24.01	OTHER NON-OPERATING REVENUE	188,262	24.01
25.00	Total other income (sum of lines 6-24)	827,686	25.00
26.00	Total (line 5 plus line 25)	-7,622,940	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)	-7,622,940	29.00

ANALYSIS OF HOSPITAL-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 15-1324 | HHA CCN: 15-7149 | Period: From 01/01/2017 To 12/31/2017 | Worksheet H | Date/Time Prepared: 5/31/2018 2:46 am

Home Health Agency I | PPS

		Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased Services	Other Costs	Total (sum of cols. 1 thru 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures			0		0	0	1.00
2.00	Capital Related - Movable Equipment			0		0	0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0	0	0	3.00
4.00	Transportation	0	0	0	0	0	0	4.00
5.00	Administrative and General	300,099	0	4,036	152,281	19,425	475,841	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	283,609	0	18,724	0	0	302,333	6.00
7.00	Physical Therapy	66,111	0	6,241	116,144	0	188,496	7.00
8.00	Occupational Therapy	43,066	0	4,874	0	0	47,940	8.00
9.00	Speech Pathology	12,752	0	1,933	0	0	14,685	9.00
10.00	Medical Social Services	0	0	0	0	335	335	10.00
11.00	Home Health Aide	88,128	0	20,623	0	0	108,751	11.00
12.00	Supplies (see instructions)	0	0	0	0	31,912	31,912	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	377	0	168	0	0	545	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	794,142	0	56,599	268,425	51,672	1,170,838	24.00

		Reclassification	Reclassified Trial Balance (col. 6 + col.7)	Adjustments	Net Expenses for Allocation (col. 8 + col. 9)			
		7.00	8.00	9.00	10.00			
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0	0	0			1.00
2.00	Capital Related - Movable Equipment	0	0	0	0			2.00
3.00	Plant Operation & Maintenance	0	0	0	0			3.00
4.00	Transportation	0	0	0	0			4.00
5.00	Administrative and General	0	475,841	0	475,841			5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	302,333	0	302,333			6.00
7.00	Physical Therapy	0	188,496	0	188,496			7.00
8.00	Occupational Therapy	0	47,940	0	47,940			8.00
9.00	Speech Pathology	0	14,685	0	14,685			9.00
10.00	Medical Social Services	0	335	0	335			10.00
11.00	Home Health Aide	0	108,751	0	108,751			11.00
12.00	Supplies (see instructions)	0	31,912	0	31,912			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	545	0	545			17.00
18.00	Clinic	0	0	0	0			18.00
19.00	Health Promotion Activities	0	0	0	0			19.00
20.00	Day Care Program	0	0	0	0			20.00
21.00	Home Delivered Meals Program	0	0	0	0			21.00
22.00	Homemaker Service	0	0	0	0			22.00
23.00	All Others (specify)	0	0	0	0			23.00
23.50	Telemedicine	0	0	0	0			23.50
24.00	Total (sum of lines 1-23)	0	1,170,838	0	1,170,838			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: 15-1324 HHA CCN: 15-7149 | Period: From 01/01/2017 To 12/31/2017 | Worksheet H-1 Part I Date/Time Prepared: 5/31/2018 2:46 am

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		Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Capital Related Costs: Bldgs & Fixtures	Capital Related Costs: Movable Equipment	Plant Operation & Maintenance	Transportation	Subtotal (cols. 0-4)	
		0	1.00	2.00	3.00	4.00	4A.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0				0	1.00
2.00	Capital Related - Movable Equipment	0		0			0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0		0	3.00
4.00	Transportation	0	0	0	0	0		4.00
5.00	Administrative and General	475,841	0	0	0	0	475,841	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	302,333	0	0	0	0	302,333	6.00
7.00	Physical Therapy	188,496	0	0	0	0	188,496	7.00
8.00	Occupational Therapy	47,940	0	0	0	0	47,940	8.00
9.00	Speech Pathology	14,685	0	0	0	0	14,685	9.00
10.00	Medical Social Services	335	0	0	0	0	335	10.00
11.00	Home Health Aide	108,751	0	0	0	0	108,751	11.00
12.00	Supplies (see instructions)	31,912	0	0	0	0	31,912	12.00
13.00	Drugs	0	0	0	0		0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	545	0	0	0	0	545	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	1,170,838	0	0	0	0	1,170,838	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	475,841			5.00
	HHA REIMBURSABLE SERVICES				
6.00	Skilled Nursing Care	206,998	509,331		6.00
7.00	Physical Therapy	129,057	317,553		7.00
8.00	Occupational Therapy	32,823	80,763		8.00
9.00	Speech Pathology	10,054	24,739		9.00
10.00	Medical Social Services	229	564		10.00
11.00	Home Health Aide	74,458	183,209		11.00
12.00	Supplies (see instructions)	21,849	53,761		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	373	918		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)		1,170,838		24.00

COST ALLOCATION - HHA STATISTICAL BASIS | Provider CCN: 15-1324 | HHA CCN: 15-7149 | Period: From 01/01/2017 To 12/31/2017 | Worksheet H-1 Part II Date/Time Prepared: 5/31/2018 2:46 am

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		Capital Related Costs						
		Bldgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)	Plant Operation & Maintenance (SQUARE FEET)	Transportation (MILEAGE)	Reconciliation	Administrative & General (ACCUM. COST)	
		1.00	2.00	3.00	4.00	5A.00	5.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0				0		1.00
2.00	Capital Related - Movable Equipment		0			0		2.00
3.00	Plant Operation & Maintenance	0	0	0		0		3.00
4.00	Transportation (see instructions)	0	0	0	0			4.00
5.00	Administrative and General	0	0	0	0	-475,841	694,997	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	0	302,333	6.00
7.00	Physical Therapy	0	0	0	0	0	188,496	7.00
8.00	Occupational Therapy	0	0	0	0	0	47,940	8.00
9.00	Speech Pathology	0	0	0	0	0	14,685	9.00
10.00	Medical Social Services	0	0	0	0	0	335	10.00
11.00	Home Health Aide	0	0	0	0	0	108,751	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	31,912	12.00
13.00	Drugs	0	0	0		0	0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	545	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	0	0	0	0	-475,841	694,997	24.00
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0	0		475,841	25.00
26.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000		0.684666	26.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 15-1324 HHA CCN: 15-7149

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

Worksheet H-2 Part I Date/Time Prepared: 5/31/2018 2:46 am

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	Cost Center Description	HHA Trial Balance (1)	CAPITAL RELATED COSTS BLDG & FIXT	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	
		0	1.00	4.00	4A	5.00	7.00	
1.00	Administrative and General	0	119,588	294,072	413,660	123,214	75,164	1.00
2.00	Skilled Nursing Care	509,331	0	0	509,331	151,712	0	2.00
3.00	Physical Therapy	317,553	0	0	317,553	94,587	0	3.00
4.00	Occupational Therapy	80,763	0	0	80,763	24,056	0	4.00
5.00	Speech Pathology	24,739	0	0	24,739	7,369	0	5.00
6.00	Medical Social Services	564	0	0	564	168	0	6.00
7.00	Home Health Aide	183,209	0	0	183,209	54,571	0	7.00
8.00	Supplies (see instructions)	53,761	0	0	53,761	16,013	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	918	0	0	918	273	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)	1,170,838	119,588	294,072	1,584,498	471,963	75,164	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.				0.000000			21.00

	Cost Center Description	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
		8.00	9.00	10.00	11.00	13.00	14.00	
1.00	Administrative and General	0	87,172	0	0	0	6,963	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	87,172	0	0	0	6,963	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: 15-1324 | Period: From 01/01/2017 To 12/31/2017 | Worksheet H-2 Part I | Date/Time Prepared: 5/31/2018 2:46 am

HHA CCN: 15-7149 | Home Health Agency I | PPS

	Cost Center Description	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	Allocated HHA A&G (see Part II)	
		15.00	16.00	24.00	25.00	26.00	27.00	
1.00	Administrative and General	0	0	706,173	0	706,173		1.00
2.00	Skilled Nursing Care	0	0	661,043	0	661,043	307,196	2.00
3.00	Physical Therapy	0	0	412,140	0	412,140	191,527	3.00
4.00	Occupational Therapy	0	0	104,819	0	104,819	48,711	4.00
5.00	Speech Pathology	0	0	32,108	0	32,108	14,921	5.00
6.00	Medical Social Services	0	0	732	0	732	340	6.00
7.00	Home Health Aide	0	0	237,780	0	237,780	110,500	7.00
8.00	Supplies (see instructions)	0	0	69,774	0	69,774	32,425	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	1,191	0	1,191	553	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	0	0	2,225,760	0	2,225,760	706,173	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.						0.464714	21.00

	Cost Center Description	Total HHA Costs	
		28.00	
1.00	Administrative and General		1.00
2.00	Skilled Nursing Care	968,239	2.00
3.00	Physical Therapy	603,667	3.00
4.00	Occupational Therapy	153,530	4.00
5.00	Speech Pathology	47,029	5.00
6.00	Medical Social Services	1,072	6.00
7.00	Home Health Aide	348,280	7.00
8.00	Supplies (see instructions)	102,199	8.00
9.00	Drugs	0	9.00
10.00	DME	0	10.00
11.00	Home Dialysis Aide Services	0	11.00
12.00	Respiratory Therapy	0	12.00
13.00	Private Duty Nursing	1,744	13.00
14.00	Clinic	0	14.00
15.00	Health Promotion Activities	0	15.00
16.00	Day Care Program	0	16.00
17.00	Home Delivered Meals Program	0	17.00
18.00	Homemaker Service	0	18.00
19.00	All Others (specify)	0	19.00
19.50	Telemedicine	0	19.50
20.00	Total (sum of lines 1-19) (2)	2,225,760	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 STATISTICAL BASIS

Provider CCN: 15-1324 HHA CCN: 15-7149

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

Worksheet H-2 Part II Date/Time Prepared: 5/31/2018 2:46 am

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	Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	
		1.00	4.00	5A	5.00	7.00	8.00	
1.00	Administrative and General	3,117	794,142	0	413,660	3,117	0	1.00
2.00	Skilled Nursing Care	0	0	0	509,331	0	0	2.00
3.00	Physical Therapy	0	0	0	317,553	0	0	3.00
4.00	Occupational Therapy	0	0	0	80,763	0	0	4.00
5.00	Speech Pathology	0	0	0	24,739	0	0	5.00
6.00	Medical Social Services	0	0	0	564	0	0	6.00
7.00	Home Health Aide	0	0	0	183,209	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	53,761	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	918	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)	3,117	794,142		1,584,498	3,117	0	20.00
21.00	Total cost to be allocated	119,588	294,072		471,963	75,164	0	21.00
22.00	Unit cost multiplier	38.366378	0.370302		0.297863	24.114212	0.000000	22.00

	Cost Center Description	HOUSEKEEPING (HOURS OF SERVIC)	DIETARY (MEALS SERVED)	CAFETERIA (SALARIES)	NURSING ADMINISTRATION (NURSING SALARIES)	CENTRAL SERVICES & SUPPLY (COSTED REQUISITIONS)	PHARMACY (COSTED REQUISITIONS)	
		9.00	10.00	11.00	13.00	14.00	15.00	
1.00	Administrative and General	6,240	0	0	0	36,636	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)	6,240	0	0	0	36,636	0	20.00
21.00	Total cost to be allocated	87,172	0	0	0	6,963	0	21.00
22.00	Unit cost multiplier	13.969872	0.000000	0.000000	0.000000	0.190059	0.000000	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 15-1324
HHA CCN: 15-7149

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

Worksheet H-2
Part II
Date/Time Prepared:
5/31/2018 2:46 am

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

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 15-1324 | HHA CCN: 15-7149 | Period: From 01/01/2017 To 12/31/2017 | Worksheet H-3 Part I | Date/Time Prepared: 5/31/2018 2:46 am

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	968,239		968,239	2,344	413.07	1.00
2.00	Physical Therapy	3.00	603,667	0	603,667	1,334	452.52	2.00
3.00	Occupational Therapy	4.00	153,530	0	153,530	411	373.55	3.00
4.00	Speech Pathology	5.00	47,029	0	47,029	134	350.96	4.00
5.00	Medical Social Services	6.00	1,072		1,072	16	67.00	5.00
6.00	Home Health Aide	7.00	348,280		348,280	2,193	158.81	6.00
7.00	Total (sum of lines 1-6)		2,121,817	0	2,121,817	6,432		7.00

	Cost Center Description	Cost Limits	CBSA No. (1)	Part A	Program Visits Part B Not Subject to Deductibles & Coinsurance	Part B Subject to Deductibles		
		0	1.00	2.00	3.00	4.00	5.00	
	Limitation Cost Computation							
8.00	Skilled Nursing Care		23844	0	765			8.00
8.01	Skilled Nursing Care		29200	0	11			8.01
8.02	Skilled Nursing Care		99915	0	33			8.02
9.00	Physical Therapy		23844	0	844			9.00
9.01	Physical Therapy		29200	0	11			9.01
9.02	Physical Therapy		99915	0	58			9.02
10.00	Occupational Therapy		23844	0	227			10.00
10.01	Occupational Therapy		29200	0	7			10.01
10.02	Occupational Therapy		99915	0	14			10.02
11.00	Speech Pathology		23844	0	83			11.00
11.01	Speech Pathology		29200	0	0			11.01
11.02	Speech Pathology		99915	0	0			11.02
12.00	Medical Social Services		23844	0	6			12.00
12.01	Medical Social Services		29200	0	0			12.01
12.02	Medical Social Services		99915	0	1			12.02
13.00	Home Health Aide		23844	0	562			13.00
13.01	Home Health Aide		29200	0	34			13.01
13.02	Home Health Aide		99915	0	0			13.02
14.00	Total (sum of lines 8-13)			0	2,656			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	102,199	0	102,199	0	0.000000	15.00
16.00	Cost of Drugs	9.00	0	0	0	0	0.000000	16.00

	Cost Center Description	Program Visits Part A	Program Visits Part B Not Subject to Deductibles & Coinsurance	Program Visits Part B Subject to Deductibles & Coinsurance	Cost of Services Part A	Cost of Services Part B Not Subject to Deductibles & Coinsurance	Cost of Services Part B Subject to Deductibles & Coinsurance	
		6.00	7.00	8.00	9.00	10.00	11.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	0	809		0	334,174		1.00
2.00	Physical Therapy	0	913		0	413,151		2.00
3.00	Occupational Therapy	0	248		0	92,640		3.00
4.00	Speech Pathology	0	83		0	29,130		4.00
5.00	Medical Social Services	0	7		0	469		5.00
6.00	Home Health Aide	0	596		0	94,651		6.00
7.00	Total (sum of lines 1-6)	0	2,656		0	964,215		7.00

APPORTIONMENT OF PATIENT SERVICE COSTS | Provider CCN: 15-1324 HHA CCN: 15-7149 | Period: From 01/01/2017 To 12/31/2017 | Worksheet H-3 Part I Date/Time Prepared: 5/31/2018 2:46 am

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	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
9.00	Physical Therapy							9.00
9.01	Physical Therapy							9.01
9.02	Physical Therapy							9.02
10.00	Occupational Therapy							10.00
10.01	Occupational Therapy							10.01
10.02	Occupational Therapy							10.02
11.00	Speech Pathology							11.00
11.01	Speech Pathology							11.01
11.02	Speech Pathology							11.02
12.00	Medical Social Services							12.00
12.01	Medical Social Services							12.01
12.02	Medical Social Services							12.02
13.00	Home Health Aide							13.00
13.01	Home Health Aide							13.01
13.02	Home Health Aide							13.02
14.00	Total (sum of lines 8-13)							14.00

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

	Cost Center Description	Total Program Cost (sum of cols. 9-10)	
		12.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION		
	Cost Per Visit Computation		
1.00	Skilled Nursing Care	334,174	1.00
2.00	Physical Therapy	413,151	2.00
3.00	Occupational Therapy	92,640	3.00
4.00	Speech Pathology	29,130	4.00
5.00	Medical Social Services	469	5.00
6.00	Home Health Aide	94,651	6.00
7.00	Total (sum of lines 1-6)	964,215	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
9.00	Physical Therapy		9.00
9.01	Physical Therapy		9.01
9.02	Physical Therapy		9.02
10.00	Occupational Therapy		10.00
10.01	Occupational Therapy		10.01
10.02	Occupational Therapy		10.02
11.00	Speech Pathology		11.00
11.01	Speech Pathology		11.01
11.02	Speech Pathology		11.02
12.00	Medical Social Services		12.00
12.01	Medical Social Services		12.01
12.02	Medical Social Services		12.02
13.00	Home Health Aide		13.00
13.01	Home Health Aide		13.01
13.02	Home Health Aide		13.02
14.00	Total (sum of lines 8-13)		14.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 15-1324 | HHA CCN: 15-7149 | Period: From 01/01/2017 To 12/31/2017 | Worksheet H-3 Part II | Date/Time Prepared: 5/31/2018 2:46 am

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	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	0.859661	0	0	col. 2, line 2.00		1.00
1.01	Physical Therapy 1	66.01	0.954943	0	0	col. 2, line 2.01		1.01
2.00	Occupational Therapy	67.00	1.020948	0	0	col. 2, line 3.00		2.00
2.01	Occupational Therapy 1	67.01	2.055504	0	0	col. 2, line 3.01		2.01
3.00	Speech Pathology	68.00	1.515224	0	0	col. 2, line 4.00		3.00
3.01	Speech Pathology 1	68.01	2.022932	0	0	col. 2, line 4.01		3.01
4.00	Cost of Medical Supplies	71.00	0.143667	0	0	col. 2, line 15.00		4.00
5.00	Cost of Drugs	73.00	0.195283	0	0	col. 2, line 16.00		5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT

Provider CCN: 15-1324 | HHA CCN: 15-7149 | Period: From 01/01/2017 To 12/31/2017 | Worksheet H-4 Part I-II | Date/Time Prepared: 5/31/2018 2:46 am

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

		Part A Services	Part B Services	
		1.00	2.00	
	PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT			
10.00	Total reasonable cost (see instructions)	0	0	10.00
11.00	Total PPS Reimbursement - Full Episodes without Outliers	0	379,617	11.00
12.00	Total PPS Reimbursement - Full Episodes with Outliers	0	36,591	12.00
13.00	Total PPS Reimbursement - LUPA Episodes	0	8,855	13.00
14.00	Total PPS Reimbursement - PEP Episodes	0	7,817	14.00
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers	0	9,150	15.00
16.00	Total PPS Outlier Reimbursement - PEP Episodes	0	4,143	16.00
17.00	Total Other Payments	0	0	17.00
18.00	DME Payments	0	0	18.00
19.00	Oxygen Payments	0	0	19.00
20.00	Prosthetic and Orthotic Payments	0	0	20.00
21.00	Part B deductibles billed to Medicare patients (exclude coinsurance)		0	21.00
22.00	Subtotal (sum of lines 10 thru 20 minus line 21)	0	446,173	22.00
23.00	Excess reasonable cost (from line 8)	0	0	23.00
24.00	Subtotal (line 22 minus line 23)	0	446,173	24.00
25.00	Coinsurance billed to program patients (from your records)		0	25.00
26.00	Net cost (line 24 minus line 25)	0	446,173	26.00
27.00	Reimbursable bad debts (from your records)			27.00
28.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)			28.00
29.00	Total costs - current cost reporting period (line 26 plus line 27)	0	446,173	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	0	30.50
30.99	Demonstration payment adjustment amount before sequestration	0	0	30.99
31.00	Subtotal (see instructions)	0	446,173	31.00
31.01	Sequestration adjustment (see instructions)	0	0	31.01
31.02	Demonstration payment adjustment amount after sequestration	0	0	31.02
32.00	Interim payments (see instructions)	0	446,173	32.00
33.00	Tentative settlement (for contractor use only)	0	0	33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 32, and 33)	0	0	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	35.00

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

Provider CCN: 15-1324 | HHA CCN: 15-7149 | Period: From 01/01/2017 To 12/31/2017 | Worksheet H-5 | Date/Time Prepared: 5/31/2018 2:46 am

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		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		446,173	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		446,173	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		446,173	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: 15-1324 | Hospice CCN: 15-1519 | Period: From 01/01/2017 To 12/31/2017 | Worksheet O | Date/Time Prepared: 5/31/2018 2:46 am

Hospice I

		SALARIES	OTHER	SUBTOTAL (col. 1 plus col. 2)	RECLASSIFI-CATIONS	SUBTOTAL	
		1.00	2.00	3.00	4.00	5.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT*		0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP*		0	0	0	0	2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT*	0	0	0	0	0	3.00
4.00	ADMINISTRATIVE & GENERAL*	146,261	34,434	180,695	0	180,695	4.00
5.00	PLANT OPERATION & MAINTENANCE*	0	0	0	0	0	5.00
6.00	LAUNDRY & LINEN SERVICE*	0	0	0	0	0	6.00
7.00	HOUSEKEEPING*	0	0	0	0	0	7.00
8.00	DIETARY*	0	0	0	0	0	8.00
9.00	NURSING ADMINISTRATION*	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	0	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	0	15.00
16.00	OTHER GENERAL SERVICE*	0	0	0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES						17.00
	DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED**		0	0	0	0	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**	173,987	331	174,318	0	174,318	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**	0	0	0	0	0	33.00
34.00	SPIRITUAL COUNSELING**	0	0	0	0	0	34.00
35.00	DIETARY COUNSELING**	0	821	821	0	821	35.00
36.00	COUNSELING - OTHER**	0	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES**	0	0	0	0	0	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN**	0	36,469	36,469	0	36,469	38.00
39.00	PATIENT TRANSPORTATION**	0	22,046	22,046	0	22,046	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	1,787	1,787	0	1,787	42.00
42.50	DRUGS CHARGED TO PATIENTS**	0	45,533	45,533	0	45,533	42.50
43.00	OUTPATIENT SERVICES**	0	89,581	89,581	0	89,581	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
	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	0	71.00
100.00	TOTAL	320,248	231,002	551,250	0	551,250	100.00

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

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS

Provider CCN: 15-1324 | Hospice CCN: 15-1519 | Period: From 01/01/2017 To 12/31/2017 | Worksheet O | Date/Time Prepared: 5/31/2018 2:46 am

Hospice I

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)		
		6.00	7.00		
	GENERAL SERVICE COST CENTERS				
1.00	CAP REL COSTS-BLDG & FIXT*	0	0		1.00
2.00	CAP REL COSTS-MVBLE EQUIP*	0	0		2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT*	0	0		3.00
4.00	ADMINISTRATIVE & GENERAL*	0	180,695		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	0		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	0		15.00
16.00	OTHER GENERAL SERVICE*	0	0		16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES				17.00
	DIRECT PATIENT CARE SERVICE COST CENTERS				
25.00	INPATIENT CARE-CONTRACTED**	0	0		25.00
26.00	PHYSICIAN SERVICES**	0	0		26.00
27.00	NURSE PRACTITIONER**	0	0		27.00
28.00	REGISTERED NURSE**	0	174,318		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	0		33.00
34.00	SPIRITUAL COUNSELING**	0	0		34.00
35.00	DIETARY COUNSELING**	0	821		35.00
36.00	COUNSELING - OTHER**	0	0		36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES**	0	0		37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN**	0	36,469		38.00
39.00	PATIENT TRANSPORTATION**	0	22,046		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	1,787		42.00
42.50	DRUGS CHARGED TO PATIENTS**	0	45,533		42.50
43.00	OUTPATIENT SERVICES**	0	89,581		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)*	0	0		71.00
100.00	TOTAL	0	551,250		100.00

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

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

Provider CCN: 15-1324 Hospice CCN: 15-1519

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

Worksheet O-2 Date/Time Prepared: 5/31/2018 2:46 am

Hospice I

		SALARIES	OTHER	SUBTOTAL (col. 1 + col. 2)	RECLASSIFI-CATIONS	SUBTOTAL	
		1.00	2.00	3.00	4.00	5.00	
	DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED						25.00
26.00	PHYSICIAN SERVICES	0	0	0	0	0	26.00
27.00	NURSE PRACTITIONER	0	0	0	0	0	27.00
28.00	REGISTERED NURSE	172,580	0	172,580	0	172,580	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	0	0	0	0	0	33.00
34.00	SPIRITUAL COUNSELING	0	0	0	0	0	34.00
35.00	DIETARY COUNSELING	0	821	821	0	821	35.00
36.00	COUNSELING - OTHER	0	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	0	0	0	0	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	36,469	36,469	0	36,469	38.00
39.00	PATIENT TRANSPORTATION	0	22,046	22,046	0	22,046	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	1,787	1,787	0	1,787	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	45,533	45,533	0	45,533	42.50
43.00	OUTPATIENT SERVICES	0	89,581	89,581	0	89,581	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 *	172,580	196,237	368,817	0	368,817	100.00

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

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)		
		6.00	7.00		
	DIRECT PATIENT CARE SERVICE COST CENTERS				
25.00	INPATIENT CARE-CONTRACTED				25.00
26.00	PHYSICIAN SERVICES	0	0		26.00
27.00	NURSE PRACTITIONER	0	0		27.00
28.00	REGISTERED NURSE	0	172,580		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	0		33.00
34.00	SPIRITUAL COUNSELING	0	0		34.00
35.00	DIETARY COUNSELING	0	821		35.00
36.00	COUNSELING - OTHER	0	0		36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	0		37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	36,469		38.00
39.00	PATIENT TRANSPORTATION	0	22,046		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	1,787		42.00
42.50	DRUGS CHARGED TO PATIENTS	0	45,533		42.50
43.00	OUTPATIENT SERVICES	0	89,581		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	368,817		100.00

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

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

Provider CCN: 15-1324 Hospice CCN: 15-1519

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

Worksheet O-3 Date/Time Prepared: 5/31/2018 2:46 am

Hospice I

		SALARIES	OTHER	SUBTOTAL (col. 1 + col. 2)	RECLASSIFI-CATIONS	SUBTOTAL	
		1.00	2.00	3.00	4.00	5.00	
	DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED		0	0	0	0	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	1,231	290	1,521	0	1,521	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	0	0	0	0	0	33.00
34.00	SPIRITUAL COUNSELING	0	0	0	0	0	34.00
35.00	DIETARY COUNSELING	0	0	0	0	0	35.00
36.00	COUNSELING - OTHER	0	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	0	0	0	0	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 *	1,231	290	1,521	0	1,521	100.00

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

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)		
		6.00	7.00		
	DIRECT PATIENT CARE SERVICE COST CENTERS				
25.00	INPATIENT CARE-CONTRACTED	0	0		25.00
26.00	PHYSICIAN SERVICES	0	0		26.00
27.00	NURSE PRACTITIONER	0	0		27.00
28.00	REGISTERED NURSE	0	1,521		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	0		33.00
34.00	SPIRITUAL COUNSELING	0	0		34.00
35.00	DIETARY COUNSELING	0	0		35.00
36.00	COUNSELING - OTHER	0	0		36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	0		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	1,521		100.00

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

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

Provider CCN: 15-1324 Hospice CCN: 15-1519 | Period: From 01/01/2017 To 12/31/2017 | Worksheet O-4 | Date/Time Prepared: 5/31/2018 2:46 am

Hospice I

		SALARIES	OTHER	SUBTOTAL (col. 1 + col. 2)	RECLASSIFI-CATIONS	SUBTOTAL	
		1.00	2.00	3.00	4.00	5.00	
	DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED		0	0	0	0	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	176	41	217	0	217	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	0	0	0	0	0	33.00
34.00	SPIRITUAL COUNSELING	0	0	0	0	0	34.00
35.00	DIETARY COUNSELING	0	0	0	0	0	35.00
36.00	COUNSELING - OTHER	0	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	0	0	0	0	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 *	176	41	217	0	217	100.00

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

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)		
		6.00	7.00		
	DIRECT PATIENT CARE SERVICE COST CENTERS				
25.00	INPATIENT CARE-CONTRACTED	0	0		25.00
26.00	PHYSICIAN SERVICES	0	0		26.00
27.00	NURSE PRACTITIONER	0	0		27.00
28.00	REGISTERED NURSE	0	217		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	0		33.00
34.00	SPIRITUAL COUNSELING	0	0		34.00
35.00	DIETARY COUNSELING	0	0		35.00
36.00	COUNSELING - OTHER	0	0		36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	0		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	217		100.00

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

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

Provider CCN: 15-1324 Hospice CCN: 15-1519

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

Worksheet O-5

Date/Time Prepared: 5/31/2018 2:46 am

Hospice I

	Descriptions	HOSPICE DIRECT EXPENSES (see instructions)	GENERAL SERVICE EXPENSES FROM WKST B PART I (see instructions)	TOTAL EXPENSES (sum of cols. 1 + 2)	
		1.00	2.00	3.00	
	GENERAL SERVICE COST CENTERS				
1.00	CAP REL COSTS-BLDG & FIXT	0	8,364	8,364	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	0	118,588	118,588	3.00
4.00	ADMINISTRATIVE & GENERAL	180,695	202,011	382,706	4.00
5.00	PLANT OPERATION & MAINTENANCE	0	5,257	5,257	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0	6.00
7.00	HOUSEKEEPING	0	0	0	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	5,057	5,057	10.00
11.00	MEDICAL RECORDS	0	0	0	11.00
12.00	STAFF TRANSPORTATION	0		0	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0		0	13.00
14.00	PHARMACY	0	91,681	91,681	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0		0	15.00
16.00	OTHER GENERAL SERVICE	0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES		0	0	17.00
	LEVEL OF CARE				
50.00	HOSPICE CONTINUOUS HOME CARE	0		0	50.00
51.00	HOSPICE ROUTINE HOME CARE	368,817		368,817	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	1,521		1,521	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	217		217	53.00
	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)	0		0	71.00
99.00	NEGATIVE COST CENTER	0		0	99.00
100.00	TOTAL	551,250	430,958	982,208	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN: 15-1324
Hospice CCN: 15-1519

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

Worksheet O-6 Part I
Date/Time Prepared: 5/31/2018 2:46 am

Hospice I

	Descriptions	TOTAL EXPENSES	CAP REL BLDG & FIX	CAP REL MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	SUBTOTAL	
		0	1.00	2.00	3.00	3A	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	8,364	8,364				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0		0			2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	118,588	0	0	118,588		3.00
4.00	ADMINISTRATIVE & GENERAL	382,706	8,364	0	118,588	509,658	4.00
5.00	PLANT OPERATION & MAINTENANCE	5,257	0	0	0	5,257	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0	0	0	6.00
7.00	HOUSEKEEPING	0	0	0	0	0	7.00
8.00	DIETARY	0	0	0	0	0	8.00
9.00	NURSING ADMINISTRATION	0	0	0	0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES	5,057	0	0	0	5,057	10.00
11.00	MEDICAL RECORDS	0	0	0	0	0	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	91,681	0	0	0	91,681	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0	0	0	0	15.00
16.00	OTHER GENERAL SERVICE	0	0	0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES		0	0		0	17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0			0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	368,817			0	368,817	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	1,521	0	0	0	1,521	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	217	0	0	0	217	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	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER	0	0	0	0		99.00
100.00	TOTAL	982,208	8,364	0	118,588	982,208	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN: 15-1324
Hospice CCN: 15-1519

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

Worksheet O-6 Part I
Date/Time Prepared: 5/31/2018 2:46 am

Hospice I

	Descriptions	ADMINISTRATIVE & GENERAL	PLANT OPERATION & MAINTENANCE	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		4.00	5.00	6.00	7.00	8.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL	509,658					4.00
5.00	PLANT OPERATION & MAINTENANCE	5,670	10,927				5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0			6.00
7.00	HOUSEKEEPING	0	0		0		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	5,454	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	98,880	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	397,780					51.00
52.00	HOSPICE INPATIENT RESPITE CARE	1,640	0	0	0	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	234	10,927	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	0	0	66.00
67.00	ADVERTISING	0	0		0		67.00
68.00	TELEHEALTH/TELEMONITORING	0	0		0		68.00
69.00	THRIFT STORE	0	0		0		69.00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER	0	0	0	0	0	99.00
100.00	TOTAL	509,658	10,927	0	0	0	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN: 15-1324 Hospice CCN: 15-1519

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

Worksheet O-6 Part I Date/Time Prepared: 5/31/2018 2:46 am

Hospice I

	Descriptions	NURSING ADMINISTRATION	ROUTINE MEDICAL SUPPLIES	MEDICAL RECORDS	STAFF TRANSPORTATION	VOLUNTEER SERVICE COORDINATION	
		9.00	10.00	11.00	12.00	13.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5.00
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPING						7.00
8.00	DIETARY						8.00
9.00	NURSING ADMINISTRATION	0					9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	10,511				10.00
11.00	MEDICAL RECORDS	0		0			11.00
12.00	STAFF TRANSPORTATION	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						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	10,311	0	0	0	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	39	0	0	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	161	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						70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0			0	0	71.00
99.00	NEGATIVE COST CENTER	0	0	0	0	0	99.00
100.00	TOTAL	0	10,511	0	0	0	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN: 15-1324
Hospice CCN: 15-1519

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

Worksheet O-6 Part I
Date/Time Prepared: 5/31/2018 2:46 am

Hospice I

	Descriptions	PHARMACY	PHYSICIAN ADMINISTRATIVE SERVICES	OTHER GENERAL SERVICE	PATIENT/ RESIDENTIAL CARE SERVICES	TOTAL	
		14.00	15.00	16.00	17.00	18.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5.00
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPING						7.00
8.00	DIETARY						8.00
9.00	NURSING ADMINISTRATION						9.00
10.00	ROUTINE MEDICAL SUPPLIES						10.00
11.00	MEDICAL RECORDS						11.00
12.00	STAFF TRANSPORTATION						12.00
13.00	VOLUNTEER SERVICE COORDINATION						13.00
14.00	PHARMACY	190,561					14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0				15.00
16.00	OTHER GENERAL SERVICE	0		0			16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES				0		17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0	0	0		0	50.00
51.00	HOSPICE ROUTINE HOME CARE	186,836	0	0		963,744	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	734	0	0	0	3,934	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	2,991	0	0	0	14,530	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					0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER	0	0	0	0	0	99.00
100.00	TOTAL	190,561	0	0	0	982,208	100.00

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

Provider CCN: 15-1324
Hospice CCN: 15-1519

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

Worksheet O-6
Part II
Date/Time Prepared:
5/31/2018 2:46 am

Hospice I

	Cost Center Descriptions	CAP REL BLDG & FIX (SQUARE FEET)	CAP REL MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	RECONCILIATION	ADMINISTRATIVE & GENERAL (ACCUMULATED COSTS)	
		1.00	2.00	3.00	4A	4.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	249					1.00
2.00	CAP REL COSTS-MVBLE EQUIP		0				2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	0	0	320,248			3.00
4.00	ADMINISTRATIVE & GENERAL	249	0	320,248	-509,658	472,550	4.00
5.00	PLANT OPERATION & MAINTENANCE	0	0	0	0	5,257	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0	0	0	6.00
7.00	HOUSEKEEPING	0	0	0	0	0	7.00
8.00	DIETARY	0	0	0	0	0	8.00
9.00	NURSING ADMINISTRATION	0	0	0	0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	0	0	0	5,057	10.00
11.00	MEDICAL RECORDS	0	0	0	0	0	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	91,681	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0	0	0	0	15.00
16.00	OTHER GENERAL SERVICE	0	0	0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0	0		0	0	17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE			0	0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE			0	0	368,817	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0	0	0	1,521	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	0	0	217	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		70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER						99.00
100.00	COST TO BE ALLOCATED (per Wkst. O-6, Part I)	8,364	0	118,588		509,658	100.00
101.00	UNIT COST MULTIPLIER	33.590361	0.000000	0.370301		1.078527	101.00

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

Provider CCN: 15-1324
Hospice CCN: 15-1519

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

Worksheet O-6
Part II
Date/Time Prepared:
5/31/2018 2:46 am

Hospice I

	Cost Center Descriptions	PLANT OPERATION & MAINTENANCE (SQUARE FEET)	LAUNDRY & LINEN SERVICE (IN-FACILITY DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (IN-FACILITY DAYS)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	
		5.00	6.00	7.00	8.00	9.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE	249					5.00
6.00	LAUNDRY & LINEN SERVICE	0	0				6.00
7.00	HOUSEKEEPING	0		0			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			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 RESPITE CARE	0	0	0	0	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	249	0	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	0	0	66.00
67.00	ADVERTISING	0		0		0	67.00
68.00	TELEHEALTH/TELEMONITORING	0		0		0	68.00
69.00	THRIFT STORE	0		0		0	69.00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER						99.00
100.00	COST TO BE ALLOCATED (per Wkst. O-6, Part I)	10,927	0	0	0	0	100.00
101.00	UNIT COST MULTIPLIER	43.883534	0.000000	0.000000	0.000000	0.000000	101.00

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

Provider CCN: 15-1324
Hospice CCN: 15-1519

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

Worksheet O-6
Part II
Date/Time Prepared:
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Hospice I

	Cost Center Descriptions	ROUTINE MEDICAL SUPPLIES (PATIENT DAYS)	MEDICAL RECORDS (PATIENT DAYS)	STAFF TRANSPORTATION (MILEAGE)	VOLUNTEER SERVICE COORDINATION (HOURS OF SERVICE)	PHARMACY (CHARGES)	
		10.00	11.00	12.00	13.00	14.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5.00
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPING						7.00
8.00	DIETARY						8.00
9.00	NURSING ADMINISTRATION						9.00
10.00	ROUTINE MEDICAL SUPPLIES	3,468					10.00
11.00	MEDICAL RECORDS		0				11.00
12.00	STAFF TRANSPORTATION			0			12.00
13.00	VOLUNTEER SERVICE COORDINATION			0	0		13.00
14.00	PHARMACY			0	0	48,805	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	3,402	0	0	0	47,851	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	13	0	0	0	188	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	53	0	0	0	766	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM			0	0	0	60.00
61.00	VOLUNTEER PROGRAM			0	0	0	61.00
62.00	FUNDRAISING			0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS			0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM			0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES			0	0	0	65.00
66.00	RESIDENTIAL CARE			0	0	0	66.00
67.00	ADVERTISING			0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING			0	0	0	68.00
69.00	THRIFT STORE			0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)			0	0	0	71.00
99.00	NEGATIVE COST CENTER						99.00
100.00	COST TO BE ALLOCATED (per Wkst. O-6, Part I)	10,511	0	0	0	190,561	100.00
101.00	UNIT COST MULTIPLIER	3.030854	0.000000	0.000000	0.000000	3.904538	101.00

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

Provider CCN: 15-1324
Hospice CCN: 15-1519

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

Worksheet O-6
Part II
Date/Time Prepared:
5/31/2018 2:46 am

Hospice I

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

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

Provider CCN: 15-1324 Hospice CCN: 15-1519

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

Worksheet O-7

Date/Time Prepared: 5/31/2018 2:46 am

Hospice I

	Cost Center Descriptions	From Wkst. C, Part I, Col. 9 line	Cost to Charge Ratio	Charges by LOC (from Provider Records) HCHC	HRHC	HIRC	
		0	1.00	2.00	3.00	4.00	
	ANCILLARY SERVICE COST CENTERS						
1.00	PHYSICAL THERAPY	66.00	0.859661	0	0	0	1.00
1.01	WHEATFIELD PT	66.01	0.954943	0	0	0	1.01
2.00	OCCUPATIONAL THERAPY	67.00	1.020948	0	0	0	2.00
2.01	WHEATFIELD OT	67.01	2.055504	0	0	0	2.01
3.00	SPEECH PATHOLOGY	68.00	1.515224	0	0	0	3.00
3.01	WHEATFIELD ST	68.01	2.022932	0	0	0	3.01
4.00	DRUGS CHARGED TO PATIENTS	73.00	0.195283	0	0	0	4.00
5.00	DURABLE MEDICAL EQUIP-RENTED	96.00					5.00
6.00	LABORATORY	60.00	0.318943	0	0	0	6.00
7.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0.143667	0	0	0	7.00
8.00	OTHER OUTPATIENT SERVICE COST CENTER	93.00					8.00
9.00	RADIOLOGY-THERAPEUTIC	55.00					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) HGIP	Shared Service Costs by LOC HCHC (col. 1 x col. 2)	HRHC (col. 1 x col. 3)	HIRC (col. 1 x col. 4)	HGIP (col. 1 x col. 5)	
		5.00	6.00	7.00	8.00	9.00	
	ANCILLARY SERVICE COST CENTERS						
1.00	PHYSICAL THERAPY	0	0	0	0	0	1.00
1.01	WHEATFIELD PT	0	0	0	0	0	1.01
2.00	OCCUPATIONAL THERAPY	0	0	0	0	0	2.00
2.01	WHEATFIELD OT	0	0	0	0	0	2.01
3.00	SPEECH PATHOLOGY	0	0	0	0	0	3.00
3.01	WHEATFIELD ST	0	0	0	0	0	3.01
4.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	4.00
5.00	DURABLE MEDICAL EQUIP-RENTED						5.00
6.00	LABORATORY	0	0	0	0	0	6.00
7.00	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	7.00
8.00	OTHER OUTPATIENT SERVICE COST CENTER						8.00
9.00	RADIOLOGY-THERAPEUTIC						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: 15-1324 | Hospice CCN: 15-1519 | Period: From 01/01/2017 To 12/31/2017 | Worksheet O-8 | Date/Time Prepared: 5/31/2018 2:46 am

Hospice I

		TITLE XVIII MEDICARE	TITLE XIX MEDICAID	TOTAL	
		1.00	2.00	3.00	
	HOSPICE CONTINUOUS HOME CARE				
1.00	Total cost (Wkst. O-6, Part I, col. 18, line 50 plus Wkst. O-7, col. 6, line 11)			0	1.00
2.00	Total unduplicated days (Wkst. S-9, col. 4, line 10)			0	2.00
3.00	Total average cost per diem (line 1 divided by line 2)			0.00	3.00
4.00	Unduplicated program days (Wkst. S-9 col. as appropriate, line 10)	0	0		4.00
5.00	Program cost (line 3 times line 4)	0	0		5.00
	HOSPICE ROUTINE HOME CARE				
6.00	Total cost (Wkst. O-6, Part I, col. 18, line 51 plus Wkst. O-7, col. 7, line 11)			963,744	6.00
7.00	Total unduplicated days (Wkst. S-9, col. 4, line 11)			3,402	7.00
8.00	Total average cost per diem (line 6 divided by line 7)			283.29	8.00
9.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 11)	3,074	90		9.00
10.00	Program cost (line 8 times line 9)	870,833	25,496		10.00
	HOSPICE INPATIENT RESPITE CARE				
11.00	Total cost (Wkst. O-6, Part I, col. 18, line 52 plus Wkst. O-7, col. 8, line 11)			3,934	11.00
12.00	Total unduplicated days (Wkst. S-9, col. 4, line 12)			13	12.00
13.00	Total average cost per diem (line 11 divided by line 12)			302.62	13.00
14.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 12)	7	0		14.00
15.00	Program cost (line 13 times line 14)	2,118	0		15.00
	HOSPICE GENERAL INPATIENT CARE				
16.00	Total cost (Wkst. O-6, Part I, col. 18, line 53 plus Wkst. O-7, col. 9, line 11)			14,530	16.00
17.00	Total unduplicated days (Wkst. S-9, col. 4, line 13)			53	17.00
18.00	Total average cost per diem (line 16 divided by line 17)			274.15	18.00
19.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 13)	1	0		19.00
20.00	Program cost (line 18 times line 19)	274	0		20.00
	TOTAL HOSPICE CARE				
21.00	Total cost (sum of line 1 + line 6 + line 11 + line 16)			982,208	21.00
22.00	Total unduplicated days (Wkst. S-9, col. 4, line 14)			3,468	22.00
23.00	Average cost per diem (line 21 divided by line 22)			283.22	23.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1324 | Component CCN: 15-3990 | Period: From 01/01/2017 To 12/31/2017 | Worksheet M-1 | Date/Time Prepared: 5/31/2018 2:46 am

RHC I | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	56,154	0	56,154	0	56,154	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	108,751	0	108,751	0	108,751	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	75,172	0	75,172	0	75,172	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	240,077	0	240,077	0	240,077	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	15,838	15,838	0	15,838	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	15,838	15,838	0	15,838	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	240,077	15,838	255,915	0	255,915	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
25.01	Telehealth	0	0	0	0	0	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	0	0	0	0	29.00
30.00	Administrative Costs	31,245	38,131	69,376	0	69,376	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	31,245	38,131	69,376	0	69,376	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	271,322	53,969	325,291	0	325,291	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1324 | Component CCN: 15-3990 | Period: From 01/01/2017 To 12/31/2017 | Worksheet M-1 | Date/Time Prepared: 5/31/2018 2:46 am

RHC I | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	56,154		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	108,751		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	75,172		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	0		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	240,077		10.00
11.00	Physician Services Under Agreement	0	0		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	0		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0		14.00
15.00	Medical Supplies	0	15,838		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	15,838		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	255,915		22.00
	COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
25.01	Telehealth	0	0		25.01
25.02	Chronic Care Management	0	0		25.02
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs				27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	0		29.00
30.00	Administrative Costs	0	69,376		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	69,376		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	325,291		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1324 | Component CCN: 15-8502 | Period: From 01/01/2017 To 12/31/2017 | Worksheet M-1 | Date/Time Prepared: 5/31/2018 2:46 am

RHC IV | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	56,154	0	56,154	0	56,154	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	148,831	0	148,831	0	148,831	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	116,440	0	116,440	0	116,440	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	321,425	0	321,425	0	321,425	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	36	36	0	36	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	36	36	0	36	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	321,425	36	321,461	0	321,461	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
25.01	Telehealth	0	0	0	0	0	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	0	0	0	0	29.00
30.00	Administrative Costs	20,299	57,534	77,833	0	77,833	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	20,299	57,534	77,833	0	77,833	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	341,724	57,570	399,294	0	399,294	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1324 | Component CCN: 15-8502 | Period: From 01/01/2017 To 12/31/2017 | Worksheet M-1 | Date/Time Prepared: 5/31/2018 2:46 am

RHC IV | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	56,154		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	148,831		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	116,440		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	0		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	321,425		10.00
11.00	Physician Services Under Agreement	0	0		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	0		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0		14.00
15.00	Medical Supplies	0	36		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	36		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	321,461		22.00
	COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
25.01	Telehealth	0	0		25.01
25.02	Chronic Care Management	0	0		25.02
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs				27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	0		29.00
30.00	Administrative Costs	0	77,833		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	77,833		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	399,294		32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 15-1324 | Component CCN: 15-3990 | Period: From 01/01/2017 To 12/31/2017 | Worksheet M-2 | Date/Time Prepared: 5/31/2018 2:46 am

RHC I | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	0.29	526	4,200	1,218		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	1.09	2,476	2,100	2,289		3.00
4.00	Subtotal (sum of lines 1 through 3)	1.38	3,002		3,507	3,507	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	1.38	3,002			3,507	8.00
9.00	Physician Services Under Agreements		0			0	9.00
						1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)					255,915	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					255,915	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					1.000000	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					69,376	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					256,889	15.00
16.00	Total overhead (sum of lines 14 and 15)					326,265	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					326,265	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					326,265	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					582,180	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 15-1324 | Component CCN: 15-8502 | Period: From 01/01/2017 To 12/31/2017 | Worksheet M-2 | Date/Time Prepared: 5/31/2018 2:46 am

RHC IV | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	0.29	673	4,200	1,218		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	1.40	3,880	2,100	2,940		3.00
4.00	Subtotal (sum of lines 1 through 3)	1.69	4,553		4,158	4,553	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	1.69	4,553			4,553	8.00
9.00	Physician Services Under Agreements		0			0	9.00
						1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)					321,461	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					321,461	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					1.000000	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					77,833	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					535,051	15.00
16.00	Total overhead (sum of lines 14 and 15)					612,884	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					612,884	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					612,884	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					934,345	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 15-1324 Component CCN: 15-3990	Period: From 01/01/2017 To 12/31/2017	Worksheet M-3 Date/Time Prepared: 5/31/2018 2:46 am
	Title XVIII	RHC I	Cost

				1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES				
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			582,180	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			11,977	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			570,203	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			3,507	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)			0	5.00
6.00	Total adjusted visits (line 4 plus line 5)			3,507	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			162.59	7.00
		Calculation of Limit (1)			
		Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)		
		1.00	2.00		
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	0.00	0.00		8.00
9.00	Rate for Program covered visits (see instructions)	162.59	162.59		9.00
	CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	0	300		10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	48,777		11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0		12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0		13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0		14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)				15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *	0	48,777		16.00
16.01	Total program charges (see instructions)(from contractor's records)		23,825		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		1,425		16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		2,917		16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)		34,781		16.04
16.05	Total program cost (see instructions)	0	37,698		16.05
17.00	Primary payer amounts		0		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		2,384		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		4,003		19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		37,698		20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		5,597		21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		43,295		22.00
23.00	Allowable bad debts (see instructions)		0		23.00
23.01	Adjusted reimbursable bad debts (see instructions)		0		23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0		24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0		25.50
25.99	Demonstration payment adjustment amount before sequestration		0		25.99
26.00	Net reimbursable amount (see instructions)		43,295		26.00
26.01	Sequestration adjustment (see instructions)		866		26.01
26.02	Demonstration payment adjustment amount after sequestration		0		26.02
27.00	Interim payments		35,557		27.00
28.00	Tentative settlement (for contractor use only)		0		28.00
29.00	Balance due component/program (line 26 minus lines 26.01, 26.02, 27, and 28)		6,872		29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0		30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 15-1324 Component CCN: 15-8502	Period: From 01/01/2017 To 12/31/2017	Worksheet M-3 Date/Time Prepared: 5/31/2018 2:46 am
	Title XVIII	RHC IV	Cost

				1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES				
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			934,345	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			30,798	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			903,547	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			4,553	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)			0	5.00
6.00	Total adjusted visits (line 4 plus line 5)			4,553	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			198.45	7.00
		Calculation of Limit (1)			
		Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)		
		1.00	2.00		
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	0.00	0.00		8.00
9.00	Rate for Program covered visits (see instructions)	198.45	198.45		9.00
	CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	0	905		10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	179,597		11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0		12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0		13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0		14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)				15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *	0	179,597		16.00
16.01	Total program charges (see instructions)(from contractor's records)		69,205		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		5,105		16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		13,248		16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)		125,596		16.04
16.05	Total program cost (see instructions)	0	138,844		16.05
17.00	Primary payer amounts		0		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		9,354		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		10,949		19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		138,844		20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		20,133		21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		158,977		22.00
23.00	Allowable bad debts (see instructions)		0		23.00
23.01	Adjusted reimbursable bad debts (see instructions)		0		23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0		24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0		25.50
25.99	Demonstration payment adjustment amount before sequestration		0		25.99
26.00	Net reimbursable amount (see instructions)		158,977		26.00
26.01	Sequestration adjustment (see instructions)		3,180		26.01
26.02	Demonstration payment adjustment amount after sequestration		0		26.02
27.00	Interim payments		109,300		27.00
28.00	Tentative settlement (for contractor use only)		0		28.00
29.00	Balance due component/program (line 26 minus lines 26.01, 26.02, 27, and 28)		46,497		29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0		30.00

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

Provider CCN: 15-1324 | Component CCN: 15-3990 | Period: From 01/01/2017 To 12/31/2017 | Worksheet M-4 | Date/Time Prepared: 5/31/2018 2:46 am

Title XVIII | RHC I | Cost

		Pneumococcal	Influenza	
		1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	240,077	240,077	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000877	0.003111	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	211	747	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	2,478	1,829	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	2,689	2,576	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	255,915	255,915	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	326,265	326,265	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.010507	0.010066	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	3,428	3,284	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	6,117	5,860	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	31	110	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	197.32	53.27	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	20	31	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	3,946	1,651	14.00
15.00	Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2)		11,977	15.00
16.00	Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3, line 21)		5,597	16.00

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

Provider CCN: 15-1324 | Component CCN: 15-8502 | Period: From 01/01/2017 To 12/31/2017 | Worksheet M-4 | Date/Time Prepared: 5/31/2018 2:46 am

Title XVIII | RHC IV | Cost

		Pneumococcal	Influenza	
		1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	321,425	321,425	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.002581	0.005856	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	830	1,882	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	5,356	2,528	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	6,186	4,410	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	321,461	321,461	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	612,884	612,884	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.019243	0.013719	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	11,794	8,408	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	17,980	12,818	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	67	152	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	268.36	84.33	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	48	86	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	12,881	7,252	14.00
15.00	Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2)		30,798	15.00
16.00	Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3, line 21)		20,133	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 15-1324 Component CCN: 15-3990	Period: From 01/01/2017 To 12/31/2017	Worksheet M-5 Date/Time Prepared: 5/31/2018 2:46 am
		RHC I	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		35,557	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00
	Program to Provider			
3.01			0	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
	Provider to Program			
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		35,557	4.00
	TO BE COMPLETED BY CONTRACTOR			
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			5.00
	Program to Provider			
5.01			0	5.01
5.02			0	5.02
5.03			0	5.03
	Provider to Program			
5.50			0	5.50
5.51			0	5.51
5.52			0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00
6.01	SETTLEMENT TO PROVIDER		6,872	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		42,429	7.00

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

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 15-1324 Component CCN: 15-8502	Period: From 01/01/2017 To 12/31/2017	Worksheet M-5 Date/Time Prepared: 5/31/2018 2:46 am
		RHC IV	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		109,300	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00
	Program to Provider			
3.01			0	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
	Provider to Program			
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		109,300	4.00
	TO BE COMPLETED BY CONTRACTOR			
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			5.00
	Program to Provider			
5.01			0	5.01
5.02			0	5.02
5.03			0	5.03
	Provider to Program			
5.50			0	5.50
5.51			0	5.51
5.52			0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00
6.01	SETTLEMENT TO PROVIDER		46,497	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		155,797	7.00

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