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: 15-1331	Period: From 01/01/2017 To 12/31/2017	Worksheet S Parts I-III Date/Time Prepared: 5/22/2018 2:22 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 5/22/2018 Time: 2:22 pm
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by HARRISON COUNTY HOSPITAL (15-1331) 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	381,360	-691,969	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	2,037	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
200.00	Total	0	383,397	-691,969	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: 15-1331 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-2 Part I | Date/Time Prepared: 5/22/2018 1:57 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 245 ATWOOD ST.	PO Box:			1.00
2.00	City: CORYDON	State: IN	Zip Code: 47112-	County: HARRISON	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	HARRISON COUNTY HOSPITAL	151331	31140	1	12/15/2005	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	HARRISON COUNTY SWING BEDS	15Z331	15999		08/14/2011	N	O	O	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	HARRISON COUNTY HHA	157242	15999		12/23/1992	N	P	N	12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	01/01/2017	12/31/2017	20.00
21.00	Type of Control (see instructions)	9		21.00
	Inpatient PPS Information			
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	N	N	22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	N	N	22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N	22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.	N	N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	2	N	23.00

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	0	0	0	0	0	0	24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0		25.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1331 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-2 Part I Date/Time Prepared: 5/22/2018 1:57 pm

		Urban/Rural S	Date of Geogr	
		1.00	2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	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

		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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1331 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-2 Part I | Date/Time Prepared: 5/22/2018 1:57 pm

		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).						61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.06

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1331 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-2 Part I Date/Time Prepared: 5/22/2018 1:57 pm

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

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

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

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

5/22/2018 1:57 pm

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-1331	Period: From 01/01/2017 To 12/31/2017	Worksheet S-2 Part I Date/Time Prepared: 5/22/2018 1:57 pm

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

		V	XIX	
		1.00	2.00	
	Title V and XIX Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. 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.	N	Y	N	Y	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: 15-1331 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-2 Part I Date/Time Prepared: 5/22/2018 1:57 pm

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

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

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	518,892	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	5.01	122.00
	Transplant Center Information			
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	N		140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1331 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-2 Part I | Date/Time Prepared: 5/22/2018 1:57 pm

	1.00	2.00	3.00	
	If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.			
141.00	Name:	Contractor's Name:	Contractor's Number:	141.00
142.00	Street:	PO Box:		142.00
143.00	City:	State:	Zip Code:	143.00

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

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

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

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

		1.00	
	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)	1	168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)		168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	9.99	169.00

		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	01/01/2017	12/31/2017	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: 15-1331 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-2 Part II | Date/Time Prepared: 5/22/2018 1:57 pm

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

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

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

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

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

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	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	04/04/2018	Y	04/04/2018	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: 15-1331 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-2 Part II Date/Time Prepared: 5/22/2018 1:57 pm

		Description		Y/N	Y/N	
		0		1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
	Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions				N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				N	27.00
	Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				N	31.00
	Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				N	33.00
	Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				N	35.00
				Y/N	Date	
				1.00	2.00	
	Home Office Costs					
36.00	Were home office costs claimed on the cost report?			N		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			N		37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.			N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			N		40.00
		1.00		2.00		
	Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	TODD		SCHIAVONE		41.00
42.00	Enter the employer/company name of the cost report preparer.	BLUE AND COMPANY				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	502.992.3506		TSCHIAVONE@BLUEANDCO.COM		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-1331	Period: From 01/01/2017 To 12/31/2017	Worksheet S-2 Part II Date/Time Prepared: 5/22/2018 1:57 pm

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-1331 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-3 Part I Date/Time Prepared: 5/22/2018 1:57 pm

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	21	7,665	104,856.00	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	104,856.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	4	1,460	10,248.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		25	9,125	115,104.00	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						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		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: 15-1331 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-3 Part I | Date/Time Prepared: 5/22/2018 1:57 pm

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	2,018	40	4,369			1.00
2.00	HMO and other (see instructions)	224	730				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	20	0	20			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	2,038	40	4,389			7.00
8.00	INTENSIVE CARE UNIT	241	5	427			8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY		0	878			13.00
14.00	Total (see instructions)	2,279	45	5,694	0.00	485.05	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	3,334	218	4,500	0.00	8.58	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	0	0	0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	493.63	27.00
28.00	Observation Bed Days		311	1,428			28.00
29.00	Ambulance Trips	2,072					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: 15-1331 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-3 Part I | Date/Time Prepared: 5/22/2018 1:57 pm

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	606	57	1,442	1.00
2.00	HMO and other (see instructions)			64	494		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	606	57	1,442	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						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01

HOME HEALTH AGENCY STATISTICAL DATA | Provider CCN: 15-1331 | Component CCN: 15-7242 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-4 | Date/Time Prepared: 5/22/2018 1:57 pm

Home Health Agency I | PPS

					1.00		
0.00	County				HARRISON		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	748	0	583	1,331	1.00
2.00	Unduplicated Census Count (see instructions)	0.00	122.00	0.00	95.00	217.00	2.00
				Number of Employees (Full Time Equivalent)			
		Enter the number of hours in your normal work week		Staff	Contract	Total	
		0		1.00	2.00	3.00	
	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES						
3.00	Administrator and Assistant Administrator(s)		40.00	0.00	0.00	0.00	3.00
4.00	Director(s) and Assistant Director(s)			1.00	0.00	1.00	4.00
5.00	Other Administrative Personnel			0.00	0.00	0.00	5.00
6.00	Direct Nursing Service			2.24	0.00	2.24	6.00
7.00	Nursing Supervisor			0.00	0.00	0.00	7.00
8.00	Physical Therapy Service			1.73	0.00	1.73	8.00
9.00	Physical Therapy Supervisor			0.00	0.00	0.00	9.00
10.00	Occupational Therapy Service			0.45	0.00	0.45	10.00
11.00	Occupational Therapy Supervisor			0.00	0.00	0.00	11.00
12.00	Speech Pathology Service			0.00	0.00	0.00	12.00
13.00	Speech Pathology Supervisor			0.00	0.00	0.00	13.00
14.00	Medical Social Service			0.00	0.00	0.00	14.00
15.00	Medical Social Service Supervisor			0.00	0.00	0.00	15.00
16.00	Home Health Aide			0.75	0.00	0.75	16.00
17.00	Home Health Aide Supervisor			0.00	0.00	0.00	17.00
18.00	OTHER: CLERICAL / PCA			2.13	0.00	2.13	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.			2			19.00
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).			31140			20.00
20.01				99915			20.01
		Full Episodes					
		Without Outliers	With Outliers	LUPA Episodes	PEP Only Episodes	Total (cols. 1-4)	
		1.00	2.00	3.00	4.00	5.00	
	PPS ACTIVITY DATA						
21.00	Skilled Nursing Visits	1,023	307	46	23	1,399	21.00
22.00	Skilled Nursing Visit Charges	127,770	38,250	5,750	2,875	174,645	22.00
23.00	Physical Therapy Visits	653	29	9	17	708	23.00
24.00	Physical Therapy Visit Charges	92,544	4,146	1,188	2,424	100,302	24.00
25.00	Occupational Therapy Visits	268	11	1	8	288	25.00
26.00	Occupational Therapy Visit Charges	35,645	1,469	134	1,068	38,316	26.00
27.00	Speech Pathology Visits	0	0	0	0	0	27.00
28.00	Speech Pathology Visit Charges	0	0	0	0	0	28.00
29.00	Medical Social Service Visits	0	0	0	0	0	29.00
30.00	Medical Social Service Visit Charges	0	0	0	0	0	30.00
31.00	Home Health Aide Visits	711	207	10	11	939	31.00
32.00	Home Health Aide Visit Charges	39,365	11,845	550	605	52,365	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	2,655	554	66	59	3,334	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)	295,324	55,710	7,622	6,972	365,628	35.00
36.00	Total Number of Episodes (standard/non outlier)	142		27	5	174	36.00
37.00	Total Number of Outlier Episodes		12		1	13	37.00
38.00	Total Non-Routine Medical Supply Charges	29,858	16,237	6,041	246	52,382	38.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 15-1331 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-10 | Date/Time Prepared: 5/22/2018 1:57 pm

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.253829	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	6,328,039	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?	N	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	202,552	5.00
6.00	Medicaid charges	35,861,243	6.00
7.00	Medicaid cost (line 1 times line 6)	9,102,623	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)	2,572,032	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)	2,572,032	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)	394,032	504,817	898,849	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	100,017	504,817	604,834	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)	100,017	504,817	604,834	23.00

		1.00	
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	6,164,683	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	739,956	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	1,138,393	27.01
28.00	Non-Medicare bad debt expense (see instructions)	5,026,290	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	1,674,255	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	2,279,089	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	4,851,121	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1331 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A | Date/Time Prepared: 5/22/2018 1:57 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		2,031,178	2,031,178	215,105	2,246,283	1.00
1.01	00101	MOB		861,837	861,837	0	861,837	1.01
1.02	00102	AMB DEPR		0	0	66,628	66,628	1.02
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		1,026,161	1,026,161	0	1,026,161	2.00
2.01	00201	AMB EQUIP		0	0	109,339	109,339	2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	178,599	5,788,854	5,967,453	0	5,967,453	4.00
5.01	00590	ADMINISTRATIVE & GENERAL	1,513,249	3,898,863	5,412,112	0	5,412,112	5.01
5.02	00570	ADMITTING	450,169	47,121	497,290	0	497,290	5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	428,370	617,615	1,045,985	0	1,045,985	5.03
7.00	00700	OPERATION OF PLANT	248,824	1,371,184	1,620,008	0	1,620,008	7.00
7.01	00701	AMB PLANT OPS	0	0	0	0	0	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	25,533	268,532	294,065	0	294,065	8.00
9.00	00900	HOUSEKEEPING	453,991	181,242	635,233	0	635,233	9.00
10.00	01000	DIETARY	394,716	352,490	747,206	-385,409	361,797	10.00
11.00	01100	CAFETERIA	0	0	0	385,409	385,409	11.00
13.00	01300	NURSING ADMINISTRATION	658,401	81,016	739,417	0	739,417	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	247,422	1,725,491	1,972,913	-1,634,144	338,769	14.00
15.00	01500	PHARMACY	633,399	98,401	731,800	757,865	1,489,665	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	271,508	14,816	286,324	0	286,324	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,029,113	177,041	3,206,154	-205,594	3,000,560	30.00
31.00	03100	INTENSIVE CARE UNIT	449,484	32,589	482,073	-3,469	478,604	31.00
43.00	04300	NURSERY	0	274	274	174,315	174,589	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	992,877	424,957	1,417,834	-221,073	1,196,761	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	225,842	928,862	1,154,704	-11,667	1,143,037	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,228,103	943,019	2,171,122	-129,199	2,041,923	54.00
60.00	06000	LABORATORY	787,645	1,271,784	2,059,429	-184,974	1,874,455	60.00
65.00	06500	RESPIRATORY THERAPY	0	543,618	543,618	-55,022	488,596	65.00
66.00	06600	PHYSICAL THERAPY	259,273	7,408	266,681	-2,244	264,437	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	44,873	44,873	0	44,873	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	1,810	1,810	68.00
69.00	06900	ELECTROCARDIOLOGY	333,362	31,059	364,421	34,296	398,717	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	1,445,265	1,445,265	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	976,084	976,084	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	355,638	2,119,400	2,475,038	-841,526	1,633,512	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	21,676	81,774	103,450	-31,337	72,113	90.00
90.01	09001	SENIOR CARE	130,571	150,215	280,786	0	280,786	90.01
91.00	09100	EMERGENCY	1,506,046	542,859	2,048,905	-8,176	2,040,729	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1,974,381	667,478	2,641,859	-237,177	2,404,682	95.00
101.00	10100	HOME HEALTH AGENCY	485,659	138,201	623,860	0	623,860	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		215,105	215,105	-215,105	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	17,283,851	26,685,317	43,969,168	0	43,969,168	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	7,829,747	2,845,770	10,675,517	0	10,675,517	192.00
194.00	07950	MARKETING	66,404	336,985	403,389	0	403,389	194.00
194.01	07951	PHYSICIAN BILLING	543,890	101,930	645,820	0	645,820	194.01
194.02	07952	MOB	0	0	0	0	0	194.02
194.03	07953	FOUNDATION	0	0	0	0	0	194.03
200.00		TOTAL (SUM OF LINES 118 through 199)	25,723,892	29,970,002	55,693,894	0	55,693,894	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1331 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A | Date/Time Prepared: 5/22/2018 1:57 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	-33,447	2,212,836		1.00
1.01	00101	MOB	0	861,837		1.01
1.02	00102	AMB DEPR	0	66,628		1.02
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	-18,192	1,007,969		2.00
2.01	00201	AMB EQUIP	0	109,339		2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	5,967,453		4.00
5.01	00590	ADMINISTRATIVE & GENERAL	-1,463,407	3,948,705		5.01
5.02	00570	ADMITTING	0	497,290		5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	1,045,985		5.03
7.00	00700	OPERATION OF PLANT	0	1,620,008		7.00
7.01	00701	AMB PLANT OPS	0	0		7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	294,065		8.00
9.00	00900	HOUSEKEEPING	0	635,233		9.00
10.00	01000	DIETARY	0	361,797		10.00
11.00	01100	CAFETERIA	-138,732	246,677		11.00
13.00	01300	NURSING ADMINISTRATION	-9,978	729,439		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	338,769		14.00
15.00	01500	PHARMACY	0	1,489,665		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-22,685	-22,685		16.00
17.00	01700	SOCIAL SERVICE	0	286,324		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	3,000,560		30.00
31.00	03100	INTENSIVE CARE UNIT	0	478,604		31.00
43.00	04300	NURSERY	0	174,589		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	1,196,761		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	-1,149,666	-6,629		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,041,923		54.00
60.00	06000	LABORATORY	-2,539	1,871,916		60.00
65.00	06500	RESPIRATORY THERAPY	0	488,596		65.00
66.00	06600	PHYSICAL THERAPY	0	264,437		66.00
67.00	06700	OCCUPATIONAL THERAPY	-1,464	43,409		67.00
68.00	06800	SPEECH PATHOLOGY	0	1,810		68.00
69.00	06900	ELECTROCARDIOLOGY	0	398,717		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,445,265		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	976,084		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,633,512		73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	72,113		90.00
90.01	09001	SENIOR CARE	0	280,786		90.01
91.00	09100	EMERGENCY	0	2,040,729		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	-34,737	2,369,945		95.00
101.00	10100	HOME HEALTH AGENCY	0	623,860		101.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-2,874,847	41,094,321		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	10,675,517		192.00
194.00	07950	MARKETING	0	403,389		194.00
194.01	07951	PHYSICIAN BILLING	0	645,820		194.01
194.02	07952	MOB	0	0		194.02
194.03	07953	FOUNDATION	0	0		194.03
200.00		TOTAL (SUM OF LINES 118 through 199)	-2,874,847	52,819,047		200.00

RECLASSIFICATIONS | Provider CCN: 15-1331 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-6 | Date/Time Prepared: 5/22/2018 1:57 pm

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - EKG				
1.00	ELECTROCARDIOLOGY	69.00	15,872	21,652	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
	TOTALS		15,872	21,652	
	B - INTEREST				
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	215,105	1.00
	TOTALS		0	215,105	
	C - CAFETERIA				
1.00	CAFETERIA	11.00	203,595	181,814	1.00
	TOTALS		203,595	181,814	
	D - NURSERY				
1.00	NURSERY	43.00	174,362	0	1.00
	TOTALS		174,362	0	
	E - AMBULANCE CAPITAL				
1.00	AMB DEPR	1.02	0	66,628	1.00
2.00	AMB EQUIP	2.01	0	109,339	2.00
	TOTALS		0	175,967	
	F - IMPLANTABLE DEVICES				
1.00	IMPL. DEV. CHARGED TO PATIENT	72.00	0	976,084	1.00
	TOTALS		0	976,084	
	G - PHARMACY				
1.00	PHARMACY	15.00	355,638	402,227	1.00
	TOTALS		355,638	402,227	
	H - SPEECH PATHOLOGY				
1.00	SPEECH PATHOLOGY	68.00	1,763	47	1.00
	TOTALS		1,763	47	
	I - SUPPLIES				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	2,421,349	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
	TOTALS		0	2,421,349	
500.00	Grand Total: Increases		751,230	4,394,245	500.00

RECLASSIFICATIONS | Provider CCN: 15-1331 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-6 | Date/Time Prepared: 5/22/2018 1:57 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - EKG						
1.00	INTENSIVE CARE UNIT	31.00	387	0	0		1.00
2.00	LABORATORY	60.00	14,837	0	0		2.00
3.00	EMERGENCY	91.00	577	0	0		3.00
4.00	AMBULANCE SERVICES	95.00	71	0	0		4.00
5.00	RESPIRATORY THERAPY	65.00	0	21,652	0		5.00
	TOTALS		15,872	21,652			
	B - INTEREST						
1.00	INTEREST EXPENSE	113.00	0	215,105	11		1.00
	TOTALS		0	215,105			
	C - CAFETERIA						
1.00	DIETARY	10.00	203,595	181,814	0		1.00
	TOTALS		203,595	181,814			
	D - NURSERY						
1.00	ADULTS & PEDIATRICS	30.00	174,362	0	0		1.00
	TOTALS		174,362	0			
	E - AMBULANCE CAPITAL						
1.00	AMBULANCE SERVICES	95.00	0	175,967	9		1.00
2.00		0.00	0	0	9		2.00
	TOTALS		0	175,967			
	F - IMPLANTABLE DEVICES						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	976,084	0		1.00
	TOTALS		0	976,084			
	G - PHARMACY						
1.00	DRUGS CHARGED TO PATIENTS	73.00	355,638	402,227	0		1.00
	TOTALS		355,638	402,227			
	H - SPEECH PATHOLOGY						
1.00	PHYSICAL THERAPY	66.00	1,763	47	0		1.00
	TOTALS		1,763	47			
	I - SUPPLIES						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	1,634,144	0		1.00
2.00	ADULTS & PEDIATRICS	30.00	0	31,232	0		2.00
3.00	INTENSIVE CARE UNIT	31.00	0	3,082	0		3.00
4.00	NURSERY	43.00	0	47	0		4.00
5.00	OPERATING ROOM	50.00	0	221,073	0		5.00
6.00	ANESTHESIOLOGY	53.00	0	11,667	0		6.00
7.00	RADIOLOGY-DIAGNOSTIC	54.00	0	129,199	0		7.00
8.00	LABORATORY	60.00	0	170,137	0		8.00
9.00	RESPIRATORY THERAPY	65.00	0	33,370	0		9.00
10.00	PHYSICAL THERAPY	66.00	0	434	0		10.00
11.00	ELECTROCARDIOLOGY	69.00	0	3,228	0		11.00
12.00	DRUGS CHARGED TO PATIENTS	73.00	0	83,661	0		12.00
13.00	CLINIC	90.00	0	31,337	0		13.00
14.00	EMERGENCY	91.00	0	7,599	0		14.00
15.00	AMBULANCE SERVICES	95.00	0	61,139	0		15.00
	TOTALS		0	2,421,349			
500.00	Grand Total: Decreases		751,230	4,394,245			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1331 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-7 Part I | Date/Time Prepared: 5/22/2018 1:57 pm

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	3,001,138	0	0	0	0	1.00
2.00	Land Improvements	3,379,433	0	0	0	0	2.00
3.00	Buildings and Fixtures	36,161,293	4,245,385	0	4,245,385	0	3.00
4.00	Building Improvements	799,691	3,509,712	0	3,509,712	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	26,949,530	1,175,456	0	1,175,456	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	70,291,085	8,930,553	0	8,930,553	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	70,291,085	8,930,553	0	8,930,553	0	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	3,001,138	0	1.00
2.00	Land Improvements	3,379,433	0	2.00
3.00	Buildings and Fixtures	40,406,678	0	3.00
4.00	Building Improvements	4,309,403	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	28,124,986	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	79,221,638	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	79,221,638	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1331 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-7 Part II | Date/Time Prepared: 5/22/2018 1:57 pm

	Cost Center Description	SUMMARY OF CAPITAL: Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1,988,556	0	0	42,622	0	1.00
1.01	MOB	364,439	73,492	242,671	14,040	0	1.01
1.02	AMB DEPR	0	0	0	0	0	1.02
2.00	NEW CAP REL COSTS-MVBLE EQUIP	1,026,161	0	0	0	0	2.00
2.01	AMB EQUIP	0	0	0	0	0	2.01
3.00	Total (sum of lines 1-2)	3,379,156	73,492	242,671	56,662	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
		14.00	15.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2			
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	2,031,178	1.00
1.01	MOB	167,195	861,837	1.01
1.02	AMB DEPR	0	0	1.02
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	1,026,161	2.00
2.01	AMB EQUIP	0	0	2.01
3.00	Total (sum of lines 1-2)	167,195	3,919,176	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1331 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-7 Part III Date/Time Prepared: 5/22/2018 1:57 pm

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	COMPUTATION OF RATIOS: Capitalized Leases	COMPUTATION OF RATIOS: Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	ALLOCATION OF OTHER CAPITAL: Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	51,096,652	0	51,096,652	0.644984	0	1.00
1.01	MOB	0	0	0	0.000000	0	1.01
1.02	AMB DEPR	0	0	0	0.000000	0	1.02
2.00	NEW CAP REL COSTS-MVBLE EQUIP	28,124,986	0	28,124,986	0.355016	0	2.00
2.01	AMB EQUIP	0	0	0	0.000000	0	2.01
3.00	Total (sum of lines 1-2)	79,221,638	0	79,221,638	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	ALLOCATION OF OTHER CAPITAL: Other Capital-Related Costs	ALLOCATION OF OTHER CAPITAL: Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	SUMMARY OF CAPITAL: Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	1,976,497	0	1.00
1.01	MOB	0	0	0	364,439	73,492	1.01
1.02	AMB DEPR	0	0	0	66,628	0	1.02
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	1,007,969	0	2.00
2.01	AMB EQUIP	0	0	0	109,339	0	2.01
3.00	Total (sum of lines 1-2)	0	0	0	3,524,872	73,492	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	SUMMARY OF CAPITAL: Insurance (see instructions)	SUMMARY OF CAPITAL: Taxes (see instructions)	SUMMARY OF CAPITAL: Other Capital-Related Costs (see instructions)	SUMMARY OF CAPITAL: Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	193,717	42,622	0	0	2,212,836	1.00
1.01	MOB	242,671	14,040	0	167,195	861,837	1.01
1.02	AMB DEPR	0	0	0	0	66,628	1.02
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	1,007,969	2.00
2.01	AMB EQUIP	0	0	0	0	109,339	2.01
3.00	Total (sum of lines 1-2)	436,388	56,662	0	167,195	4,258,609	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1331 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-8 | Date/Time Prepared: 5/22/2018 1:57 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-21,388	NEW CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
1.01	Investment income - MOB (chapter 2)		0	MOB	1.01	0	1.01
1.02	Investment income - AMB DEPR (chapter 2)		0	AMB DEPR	1.02	0	1.02
2.00	Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
2.01	Investment income - AMB EQUIP (chapter 2)		0	AMB EQUIP	2.01	0	2.01
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	-284,322			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	0			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-138,732	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-22,685	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - NEW CAP REL COSTS-BLDG & FIXT		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
26.01	Depreciation - MOB		0	MOB	1.01	0	26.01
26.02	Depreciation - AMB DEPR		0	AMB DEPR	1.02	0	26.02
27.00	Depreciation - NEW CAP REL COSTS-MVBLE EQUIP		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
27.01	Depreciation - AMB EQUIP		0	AMB EQUIP	2.01	0	27.01
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1331 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-8 | Date/Time Prepared: 5/22/2018 1:57 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	-1,464	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	-15,431	NEW CAP REL COSTS-MVBLE EQUIP	2.00	9	32.00
33.00	MISCELLANEOUS INCOME - OTHER A&G	B	-64,814	ADMINISTRATIVE & GENERAL	5.01	0	33.00
33.01	MISCELLANEOUS INCOME - LABORATORY	B	-78	LABORATORY	60.00	0	33.01
33.02	MISCELLANEOUS INCOME - AMBULANCE SER	B	-21,020	AMBULANCE SERVICES	95.00	0	33.02
34.00	UNNECESSARY BORROWING	A	-12,059	NEW CAP REL COSTS-BLDG & FIXT	1.00	9	34.00
35.00	PATIENT TELEPHONE - DEPRECIATION	A	-2,761	NEW CAP REL COSTS-MVBLE EQUIP	2.00	9	35.00
35.01	PATIENT TELEPHONE - EXPENSES	A	-7,851	ADMINISTRATIVE & GENERAL	5.01	0	35.01
36.00	CRNA EXPENSES	A	-891,500	ANESTHESIOLOGY	53.00	0	36.00
37.00	LOBBYING DUES	A	-5,230	ADMINISTRATIVE & GENERAL	5.01	0	37.00
38.00	NONALLOWABLE EXPENSES - HAF FEES	A	-1,385,512	ADMINISTRATIVE & GENERAL	5.01	0	38.00
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-2,874,847				50.00

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 15-1331 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-8-2 | Date/Time Prepared: 5/22/2018 1:57 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	13.00	NURSING ADMINISTRATION	9,978	9,978	0	0	0	1.00
2.00	53.00	ANESTHESIOLOGY	258,166	258,166	0	0	0	2.00
3.00	60.00	LABORATORY	24,605	2,461	22,144	0	0	3.00
4.00	91.00	EMERGENCY	322,543	0	322,543	0	0	4.00
5.00	95.00	AMBULANCE SERVICES	13,717	13,717	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			629,009	284,322	344,687		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	13.00	NURSING ADMINISTRATION	0	0	0	0	0	1.00
2.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	2.00
3.00	60.00	LABORATORY	0	0	0	0	0	3.00
4.00	91.00	EMERGENCY	0	0	0	0	0	4.00
5.00	95.00	AMBULANCE SERVICES	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	13.00	NURSING ADMINISTRATION	0	0	0	9,978		1.00
2.00	53.00	ANESTHESIOLOGY	0	0	0	258,166		2.00
3.00	60.00	LABORATORY	0	0	0	2,461		3.00
4.00	91.00	EMERGENCY	0	0	0	0		4.00
5.00	95.00	AMBULANCE SERVICES	0	0	0	13,717		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	284,322		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 15-1331 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-8-3 Parts I-VI Date/Time Prepared: 5/22/2018 1:57 pm

		Respiratory Therapy	Cost
		1.00	
	PART I - GENERAL INFORMATION		
1.00	Total number of weeks worked (excluding aides) (see instructions)	52	1.00
2.00	Line 1 multiplied by 15 hours per week	780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)	0	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	5.50	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	12,500.80	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	63.70	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)	31.85	31.85	0.00			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)						12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)						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)	796,301	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)	796,301	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)	796,301	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)	796,301	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)	0	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)	0	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)	0	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

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 15-1331 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-8-3 Parts I-VI Date/Time Prepared: 5/22/2018 1:57 pm

		Respiratory Therapy	Cost	
			1.00	
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)		0	45.00
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)	63.70	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)		796,301	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)		796,301	63.00
64.00	Total cost of outside supplier services (from your records)		481,085	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		0	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		0	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

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 15-1331 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-8-3 Parts I-VI Date/Time Prepared: 5/22/2018 1:57 pm

		Occupational Therapy	Cost	
			1.00	
	PART I - GENERAL INFORMATION			
1.00	Total number of weeks worked (excluding aides) (see instructions)		26	1.00
2.00	Line 1 multiplied by 15 hours per week		390	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)		0	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		5.50	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	565.07	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	76.82	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)	38.41	38.41	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	0	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)	43,409	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)	43,409	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)	43,409	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)	43,409	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)	0	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)	0	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)	0	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

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 15-1331 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 5/22/2018 1:57 pm

		Occupational Therapy	Cost	
			1.00	
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)		0	45.00
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)	76.82	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)		43,409	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)		43,409	63.00
64.00	Total cost of outside supplier services (from your records)		44,873	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)		1,464	65.00
	LINE 33 CALCULATION			
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others		0	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		0	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: 15-1331 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part I | Date/Time Prepared: 5/22/2018 1:57 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS				
				NEW BLDG & FIXT	MOB	AMB DEPR	NEW MVBLE EQUIP	
			0	1.00	1.01	1.02	2.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	2,212,836	2,212,836				1.00
1.01	00101	MOB	861,837	0	861,837			1.01
1.02	00102	AMB DEPR	66,628	0	0	66,628		1.02
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	1,007,969				1,007,969	2.00
2.01	00201	AMB EQUIP	109,339				0	2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	5,967,453	3,244	0	0	1,478	4.00
5.01	00590	ADMINISTRATIVE & GENERAL	3,948,705	322,714	4,929	0	146,999	5.01
5.02	00570	ADMITTING	497,290	0	0	0	0	5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	1,045,985	0	0	0	0	5.03
7.00	00700	OPERATION OF PLANT	1,620,008	254,447	0	0	115,903	7.00
7.01	00701	AMB PLANT OPS	0	0	0	0	0	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	294,065	14,857	0	0	6,767	8.00
9.00	00900	HOUSEKEEPING	635,233	31,822	0	0	14,495	9.00
10.00	01000	DIETARY	361,797	92,595	0	0	42,178	10.00
11.00	01100	CAFETERIA	246,677	46,257	0	0	21,071	11.00
13.00	01300	NURSING ADMINISTRATION	729,439	7,785	0	0	3,546	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	338,769	0	0	0	0	14.00
15.00	01500	PHARMACY	1,489,665	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-22,685	51,658	0	0	23,531	16.00
17.00	01700	SOCIAL SERVICE	286,324	3,114	0	0	1,418	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,000,560	376,333	0	0	171,425	30.00
31.00	03100	INTENSIVE CARE UNIT	478,604	46,987	0	0	21,403	31.00
43.00	04300	NURSERY	174,589	9,732	0	0	4,433	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,196,761	287,437	0	0	130,930	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	-6,629	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,041,923	150,595	0	0	68,598	54.00
60.00	06000	LABORATORY	1,871,916	79,150	0	0	36,054	60.00
65.00	06500	RESPIRATORY THERAPY	488,596	17,225	0	0	7,846	65.00
66.00	06600	PHYSICAL THERAPY	264,437	58,276	0	0	26,545	66.00
67.00	06700	OCCUPATIONAL THERAPY	43,409	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	1,810	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	398,717	29,584	0	0	13,476	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,445,265	70,651	0	0	32,182	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	976,084	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,633,512	19,885	0	0	9,058	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	72,113	0	40,563	0	0	90.00
90.01	09001	SENIOR CARE	280,786	0	29,423	0	0	90.01
91.00	09100	EMERGENCY	2,040,729	106,382	40,563	0	48,458	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	2,369,945	0	0	66,628	0	95.00
101.00	10100	HOME HEALTH AGENCY	623,860	0	28,744	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	41,094,321	2,080,730	144,222	66,628	947,794	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	13,219	0	0	6,021	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	10,675,517	107,306	0	0	48,879	192.00
194.00	07950	MARKETING	403,389	3,471	0	0	1,581	194.00
194.01	07951	PHYSICIAN BILLING	645,820	8,110	0	0	3,694	194.01
194.02	07952	MOB	0	0	717,615	0	0	194.02
194.03	07953	FOUNDATION	0	0	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	52,819,047	2,212,836	861,837	66,628	1,007,969	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1331 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part I | Date/Time Prepared: 5/22/2018 1:57 pm

		Cost Center Description	CAPITAL RELATED COSTS AMB EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	ADMITTING	
			2.01	4.00	4A	5.01	5.02	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	MOB						1.01
1.02	00102	AMB DEPR						1.02
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	AMB EQUIP	109,339					2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	5,972,175				4.00
5.01	00590	ADMINISTRATIVE & GENERAL	0	353,779	4,777,126	4,777,126		5.01
5.02	00570	ADMITTING	0	105,244	602,534	59,914	662,448	5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	100,148	1,146,133	113,968	0	5.03
7.00	00700	OPERATION OF PLANT	0	58,172	2,048,530	203,700	0	7.00
7.01	00701	AMB PLANT OPS	0	0	0	0	0	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	5,969	321,658	31,985	0	8.00
9.00	00900	HOUSEKEEPING	0	106,138	787,688	78,325	0	9.00
10.00	01000	DIETARY	0	44,682	541,252	53,820	0	10.00
11.00	01100	CAFETERIA	0	47,598	361,603	35,957	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	153,926	894,696	88,966	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	57,844	396,613	39,438	0	14.00
15.00	01500	PHARMACY	0	231,225	1,720,890	171,120	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	52,504	5,221	0	16.00
17.00	01700	SOCIAL SERVICE	0	63,475	354,331	35,234	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	667,407	4,215,725	419,199	54,205	30.00
31.00	03100	INTENSIVE CARE UNIT	0	104,993	651,987	64,832	4,844	31.00
43.00	04300	NURSERY	0	40,764	229,518	22,823	6,707	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	232,123	1,847,251	183,685	49,489	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	52,799	46,170	4,591	7,712	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	287,116	2,548,232	253,389	177,108	54.00
60.00	06000	LABORATORY	0	180,673	2,167,793	215,559	104,730	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	513,667	51,078	6,479	65.00
66.00	06600	PHYSICAL THERAPY	0	60,203	409,461	40,716	9,991	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	43,409	4,316	1,247	67.00
68.00	06800	SPEECH PATHOLOGY	0	412	2,222	221	352	68.00
69.00	06900	ELECTROCARDIOLOGY	0	81,647	523,424	52,048	31,186	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	1,548,098	153,938	31,094	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	976,084	97,059	10,642	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	1,662,455	165,310	34,244	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	5,068	117,744	11,708	862	90.00
90.01	09001	SENIOR CARE	0	30,526	340,735	33,882	3,025	90.01
91.00	09100	EMERGENCY	0	351,961	2,588,093	257,352	89,135	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0			92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	109,339	461,570	3,007,482	299,055	36,771	95.00
101.00	10100	HOME HEALTH AGENCY	0	113,541	766,145	76,183	2,625	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	109,339	3,999,003	38,211,253	3,324,592	662,448	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	19,240	1,913	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	1,830,493	12,662,195	1,259,070	0	192.00
194.00	07950	MARKETING	0	15,524	423,965	42,158	0	194.00
194.01	07951	PHYSICIAN BILLING	0	127,155	784,779	78,036	0	194.01
194.02	07952	MOB	0	0	717,615	71,357	0	194.02
194.03	07953	FOUNDATION	0	0	0	0	0	194.03
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)	109,339	5,972,175	52,819,047	4,777,126	662,448	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1331 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part I Date/Time Prepared: 5/22/2018 1:57 pm

		Cost Center Description	CASHIERING/ACCOUNTS RECEIVABLE	OPERATION OF PLANT	AMB PLANT OPS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.03	7.00	7.01	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	MOB						1.01
1.02	00102	AMB DEPR						1.02
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	AMB EQUIP						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	ADMINISTRATIVE & GENERAL						5.01
5.02	00570	ADMITTING						5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	1,260,101					5.03
7.00	00700	OPERATION OF PLANT	0	2,252,230				7.00
7.01	00701	AMB PLANT OPS	0	0	0			7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	20,498	0	374,141		8.00
9.00	00900	HOUSEKEEPING	0	43,904	0	33,626	943,543	9.00
10.00	01000	DIETARY	0	127,752	0	24,803	55,095	10.00
11.00	01100	CAFETERIA	0	63,820	0	0	27,524	11.00
13.00	01300	NURSING ADMINISTRATION	0	10,741	0	0	4,632	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	71,272	0	0	30,737	16.00
17.00	01700	SOCIAL SERVICE	0	4,296	0	0	1,853	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	103,122	519,221	0	148,314	223,924	30.00
31.00	03100	INTENSIVE CARE UNIT	9,215	64,827	0	0	27,958	31.00
43.00	04300	NURSERY	12,760	13,426	0	0	5,790	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	94,151	396,570	0	20,626	171,029	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	14,672	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	336,769	207,773	0	39,892	89,606	54.00
60.00	06000	LABORATORY	199,242	109,201	0	0	47,095	60.00
65.00	06500	RESPIRATORY THERAPY	12,325	23,765	0	476	10,249	65.00
66.00	06600	PHYSICAL THERAPY	19,006	80,402	0	3,906	34,675	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,372	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	670	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	59,330	40,816	0	9,109	17,603	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	59,155	97,475	0	0	42,038	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	20,246	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	65,148	27,435	0	0	11,832	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,639	0	0	1,891	0	90.00
90.01	09001	SENIOR CARE	5,756	0	0	0	0	90.01
91.00	09100	EMERGENCY	169,575	146,773	0	71,934	63,299	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	69,955	0	0	13,096	0	95.00
101.00	10100	HOME HEALTH AGENCY	4,993	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,260,101	2,069,967	0	367,673	864,939	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	18,237	0	0	7,865	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	148,048	0	6,468	63,849	192.00
194.00	07950	MARKETING	0	4,789	0	0	2,065	194.00
194.01	07951	PHYSICIAN BILLING	0	11,189	0	0	4,825	194.01
194.02	07952	MOB	0	0	0	0	0	194.02
194.03	07953	FOUNDATION	0	0	0	0	0	194.03
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)	1,260,101	2,252,230	0	374,141	943,543	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1331 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part I | Date/Time Prepared: 5/22/2018 1:57 pm

		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	MOB						1.01
1.02	00102	AMB DEPR						1.02
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	AMB EQUIP						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	ADMINISTRATIVE & GENERAL						5.01
5.02	00570	ADMITTING						5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.03
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	AMB PLANT OPS						7.01
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	802,722					10.00
11.00	01100	CAFETERIA	0	488,904				11.00
13.00	01300	NURSING ADMINISTRATION	0	14,283	1,013,318			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	11,913	0	447,964		14.00
15.00	01500	PHARMACY	0	5,972	0	0	1,897,982	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	25,495	0	2,043	0	16.00
17.00	01700	SOCIAL SERVICE	0	6,081	0	435	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	618,099	104,195	465,744	10,750	0	30.00
31.00	03100	INTENSIVE CARE UNIT	60,409	14,704	65,728	3,272	0	31.00
43.00	04300	NURSERY	124,214	5,925	26,487	28	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	38,733	173,138	12,422	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	1,247	0	1,023	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	43,130	0	16,272	0	54.00
60.00	06000	LABORATORY	0	25,058	0	77,659	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	1,392	0	65.00
66.00	06600	PHYSICAL THERAPY	0	6,362	0	618	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	47	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	9,278	41,472	1,080	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	176,888	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	119,465	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	935	1,897,982	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	577	2,579	177	0	90.00
90.01	09001	SENIOR CARE	0	3,508	15,683	219	0	90.01
91.00	09100	EMERGENCY	0	49,773	222,487	10,770	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	12,516	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	802,722	366,281	1,013,318	447,964	1,897,982	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	99,218	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	1,559	0	0	0	192.00
194.00	07950	MARKETING	0	21,846	0	0	0	194.00
194.01	07951	PHYSICIAN BILLING	0	0	0	0	0	194.01
194.02	07952	MOB	0	0	0	0	0	194.02
194.03	07953	FOUNDATION	0	0	0	0	0	194.03
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)	802,722	488,904	1,013,318	447,964	1,897,982	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1331 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part I | Date/Time Prepared: 5/22/2018 1:57 pm

		Cost Center Description	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			16.00	17.00	24.00	25.00	26.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	MOB						1.01
1.02	00102	AMB DEPR						1.02
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	AMB EQUIP						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	ADMINISTRATIVE & GENERAL						5.01
5.02	00570	ADMITTING						5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.03
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	AMB PLANT OPS						7.01
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	187,272					16.00
17.00	01700	SOCIAL SERVICE	0	402,230				17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	15,325	309,719	7,207,542	0	7,207,542	30.00
31.00	03100	INTENSIVE CARE UNIT	1,369	30,270	999,415	0	999,415	31.00
43.00	04300	NURSERY	1,896	62,241	511,815	0	511,815	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	13,991	0	3,001,085	0	3,001,085	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	2,180	0	77,595	0	77,595	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	50,058	0	3,762,229	0	3,762,229	54.00
60.00	06000	LABORATORY	29,609	0	2,975,946	0	2,975,946	60.00
65.00	06500	RESPIRATORY THERAPY	1,832	0	621,263	0	621,263	65.00
66.00	06600	PHYSICAL THERAPY	2,824	0	607,961	0	607,961	66.00
67.00	06700	OCCUPATIONAL THERAPY	353	0	51,697	0	51,697	67.00
68.00	06800	SPEECH PATHOLOGY	100	0	3,612	0	3,612	68.00
69.00	06900	ELECTROCARDIOLOGY	8,817	0	794,163	0	794,163	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	8,791	0	2,117,477	0	2,117,477	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	3,009	0	1,226,505	0	1,226,505	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	9,681	0	3,875,022	0	3,875,022	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	244	0	137,421	0	137,421	90.00
90.01	09001	SENIOR CARE	855	0	403,663	0	403,663	90.01
91.00	09100	EMERGENCY	25,200	0	3,694,391	0	3,694,391	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	10,396	0	3,449,271	0	3,449,271	95.00
101.00	10100	HOME HEALTH AGENCY	742	0	850,688	0	850,688	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	187,272	402,230	36,368,761	0	36,368,761	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	146,473	0	146,473	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	14,141,189	0	14,141,189	192.00
194.00	07950	MARKETING	0	0	494,823	0	494,823	194.00
194.01	07951	PHYSICIAN BILLING	0	0	878,829	0	878,829	194.01
194.02	07952	MOB	0	0	788,972	0	788,972	194.02
194.03	07953	FOUNDATION	0	0	0	0	0	194.03
200.00		Cross Foot Adjustments			0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	187,272	402,230	52,819,047	0	52,819,047	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1331 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part II Date/Time Prepared: 5/22/2018 1:57 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS NEW BLDG & FIXT	MOB	AMB DEPR	NEW MVBLE EQUIP	
			0	1.00	1.01	1.02	2.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	MOB						1.01
1.02	00102	AMB DEPR						1.02
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	AMB EQUIP						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	3,244	0	0	1,478	4.00
5.01	00590	ADMINISTRATIVE & GENERAL	0	322,714	4,929	0	146,999	5.01
5.02	00570	ADMITTING	0	0	0	0	0	5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	0	0	0	0	5.03
7.00	00700	OPERATION OF PLANT	0	254,447	0	0	115,903	7.00
7.01	00701	AMB PLANT OPS	0	0	0	0	0	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	14,857	0	0	6,767	8.00
9.00	00900	HOUSEKEEPING	0	31,822	0	0	14,495	9.00
10.00	01000	DIETARY	0	92,595	0	0	42,178	10.00
11.00	01100	CAFETERIA	0	46,257	0	0	21,071	11.00
13.00	01300	NURSING ADMINISTRATION	0	7,785	0	0	3,546	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	51,658	0	0	23,531	16.00
17.00	01700	SOCIAL SERVICE	0	3,114	0	0	1,418	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	376,333	0	0	171,425	30.00
31.00	03100	INTENSIVE CARE UNIT	0	46,987	0	0	21,403	31.00
43.00	04300	NURSERY	0	9,732	0	0	4,433	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	287,437	0	0	130,930	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	150,595	0	0	68,598	54.00
60.00	06000	LABORATORY	0	79,150	0	0	36,054	60.00
65.00	06500	RESPIRATORY THERAPY	0	17,225	0	0	7,846	65.00
66.00	06600	PHYSICAL THERAPY	0	58,276	0	0	26,545	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	29,584	0	0	13,476	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	70,651	0	0	32,182	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	19,885	0	0	9,058	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	40,563	0	0	90.00
90.01	09001	SENIOR CARE	0	0	29,423	0	0	90.01
91.00	09100	EMERGENCY	0	106,382	40,563	0	48,458	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	66,628	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	28,744	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	2,080,730	144,222	66,628	947,794	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	13,219	0	0	6,021	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	107,306	0	0	48,879	192.00
194.00	07950	MARKETING	0	3,471	0	0	1,581	194.00
194.01	07951	PHYSICIAN BILLING	0	8,110	0	0	3,694	194.01
194.02	07952	MOB	0	0	717,615	0	0	194.02
194.03	07953	FOUNDATION	0	0	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	2,212,836	861,837	66,628	1,007,969	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1331 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part II | Date/Time Prepared: 5/22/2018 1:57 pm

		Cost Center Description	CAPITAL RELATED COSTS AMB EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	ADMITTING	
			2.01	2A	4.00	5.01	5.02	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	MOB						1.01
1.02	00102	AMB DEPR						1.02
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	AMB EQUIP						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	4,722	4,722			4.00
5.01	00590	ADMINISTRATIVE & GENERAL	0	474,642	280	474,922		5.01
5.02	00570	ADMITTING	0	0	83	5,957	6,040	5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	0	79	11,331	0	5.03
7.00	00700	OPERATION OF PLANT	0	370,350	46	20,252	0	7.00
7.01	00701	AMB PLANT OPS	0	0	0	0	0	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	21,624	5	3,180	0	8.00
9.00	00900	HOUSEKEEPING	0	46,317	84	7,787	0	9.00
10.00	01000	DIETARY	0	134,773	35	5,351	0	10.00
11.00	01100	CAFETERIA	0	67,328	38	3,575	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	11,331	122	8,845	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	46	3,921	0	14.00
15.00	01500	PHARMACY	0	0	183	17,013	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	75,189	0	519	0	16.00
17.00	01700	SOCIAL SERVICE	0	4,532	50	3,503	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	547,758	528	41,677	492	30.00
31.00	03100	INTENSIVE CARE UNIT	0	68,390	83	6,446	44	31.00
43.00	04300	NURSERY	0	14,165	32	2,269	61	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	418,367	184	18,262	450	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	42	456	70	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	219,193	227	25,192	1,632	54.00
60.00	06000	LABORATORY	0	115,204	143	21,431	951	60.00
65.00	06500	RESPIRATORY THERAPY	0	25,071	0	5,078	59	65.00
66.00	06600	PHYSICAL THERAPY	0	84,821	48	4,048	91	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	429	11	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	22	3	68.00
69.00	06900	ELECTROCARDIOLOGY	0	43,060	65	5,175	283	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	102,833	0	15,304	282	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	9,650	97	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	28,943	0	16,435	311	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	40,563	4	1,164	8	90.00
90.01	09001	SENIOR CARE	0	29,423	24	3,369	27	90.01
91.00	09100	EMERGENCY	0	195,403	279	25,586	810	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0				92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	109,339	175,967	365	29,732	334	95.00
101.00	10100	HOME HEALTH AGENCY	0	28,744	90	7,574	24	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	109,339	3,348,713	3,165	330,533	6,040	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	19,240	0	190	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	156,185	1,444	125,156	0	192.00
194.00	07950	MARKETING	0	5,052	12	4,191	0	194.00
194.01	07951	PHYSICIAN BILLING	0	11,804	101	7,758	0	194.01
194.02	07952	MOB	0	717,615	0	7,094	0	194.02
194.03	07953	FOUNDATION	0	0	0	0	0	194.03
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)	109,339	4,258,609	4,722	474,922	6,040	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1331 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part II | Date/Time Prepared: 5/22/2018 1:57 pm

		Cost Center Description	CASHIERING/ACCOUNTS RECEIVABLE	OPERATION OF PLANT	AMB PLANT OPS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.03	7.00	7.01	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	MOB						1.01
1.02	00102	AMB DEPR						1.02
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	AMB EQUIP						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	ADMINISTRATIVE & GENERAL						5.01
5.02	00570	ADMITTING						5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	11,410					5.03
7.00	00700	OPERATION OF PLANT	0	390,648				7.00
7.01	00701	AMB PLANT OPS	0	0	0			7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	3,555	0	28,364		8.00
9.00	00900	HOUSEKEEPING	0	7,615	0	2,549	64,352	9.00
10.00	01000	DIETARY	0	22,159	0	1,880	3,758	10.00
11.00	01100	CAFETERIA	0	11,070	0	0	1,877	11.00
13.00	01300	NURSING ADMINISTRATION	0	1,863	0	0	316	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	12,362	0	0	2,096	16.00
17.00	01700	SOCIAL SERVICE	0	745	0	0	126	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	938	90,056	0	11,245	15,272	30.00
31.00	03100	INTENSIVE CARE UNIT	84	11,244	0	0	1,907	31.00
43.00	04300	NURSERY	116	2,329	0	0	395	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	856	68,785	0	1,564	11,665	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	133	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,013	36,038	0	3,024	6,111	54.00
60.00	06000	LABORATORY	1,812	18,941	0	0	3,212	60.00
65.00	06500	RESPIRATORY THERAPY	112	4,122	0	36	699	65.00
66.00	06600	PHYSICAL THERAPY	173	13,946	0	296	2,365	66.00
67.00	06700	OCCUPATIONAL THERAPY	22	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	6	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	540	7,080	0	691	1,201	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	538	16,907	0	0	2,867	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	184	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	593	4,759	0	0	807	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	15	0	0	143	0	90.00
90.01	09001	SENIOR CARE	52	0	0	0	0	90.01
91.00	09100	EMERGENCY	1,542	25,458	0	5,453	4,317	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	636	0	0	993	0	95.00
101.00	10100	HOME HEALTH AGENCY	45	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	11,410	359,034	0	27,874	58,991	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	3,163	0	0	536	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	25,679	0	490	4,355	192.00
194.00	07950	MARKETING	0	831	0	0	141	194.00
194.01	07951	PHYSICIAN BILLING	0	1,941	0	0	329	194.01
194.02	07952	MOB	0	0	0	0	0	194.02
194.03	07953	FOUNDATION	0	0	0	0	0	194.03
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)	11,410	390,648	0	28,364	64,352	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1331 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part II | Date/Time Prepared: 5/22/2018 1:57 pm

		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	MOB						1.01
1.02	00102	AMB DEPR						1.02
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	AMB EQUIP						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	ADMINISTRATIVE & GENERAL						5.01
5.02	00570	ADMITTING						5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.03
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	AMB PLANT OPS						7.01
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	167,956					10.00
11.00	01100	CAFETERIA	0	83,888				11.00
13.00	01300	NURSING ADMINISTRATION	0	2,451	24,928			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	2,044	0	6,011		14.00
15.00	01500	PHARMACY	0	1,025	0	0	18,221	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	4,374	0	27	0	16.00
17.00	01700	SOCIAL SERVICE	0	1,043	0	6	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	129,326	17,878	11,458	144	0	30.00
31.00	03100	INTENSIVE CARE UNIT	12,640	2,523	1,617	44	0	31.00
43.00	04300	NURSERY	25,990	1,017	652	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	6,646	4,259	167	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	214	0	14	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	7,400	0	218	0	54.00
60.00	06000	LABORATORY	0	4,300	0	1,042	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	19	0	65.00
66.00	06600	PHYSICAL THERAPY	0	1,092	0	8	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	8	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,592	1,020	14	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	2,375	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	1,603	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	13	18,221	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	99	63	2	0	90.00
90.01	09001	SENIOR CARE	0	602	386	3	0	90.01
91.00	09100	EMERGENCY	0	8,540	5,473	144	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	168	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	167,956	62,848	24,928	6,011	18,221	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	17,024	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	268	0	0	0	192.00
194.00	07950	MARKETING	0	3,748	0	0	0	194.00
194.01	07951	PHYSICIAN BILLING	0	0	0	0	0	194.01
194.02	07952	MOB	0	0	0	0	0	194.02
194.03	07953	FOUNDATION	0	0	0	0	0	194.03
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)	167,956	83,888	24,928	6,011	18,221	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1331 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part II | Date/Time Prepared: 5/22/2018 1:57 pm

		Cost Center Description	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			16.00	17.00	24.00	25.00	26.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	MOB						1.01
1.02	00102	AMB DEPR						1.02
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	AMB EQUIP						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	ADMINISTRATIVE & GENERAL						5.01
5.02	00570	ADMITTING						5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.03
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	AMB PLANT OPS						7.01
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	84,349					16.00
17.00	01700	SOCIAL SERVICE	0	10,005				17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,906	7,704	881,382	0	881,382	30.00
31.00	03100	INTENSIVE CARE UNIT	617	753	106,392	0	106,392	31.00
43.00	04300	NURSERY	855	1,548	49,429	0	49,429	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,305	0	537,510	0	537,510	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	983	0	1,912	0	1,912	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	22,514	0	324,562	0	324,562	54.00
60.00	06000	LABORATORY	13,343	0	180,379	0	180,379	60.00
65.00	06500	RESPIRATORY THERAPY	825	0	36,021	0	36,021	65.00
66.00	06600	PHYSICAL THERAPY	1,273	0	108,161	0	108,161	66.00
67.00	06700	OCCUPATIONAL THERAPY	159	0	621	0	621	67.00
68.00	06800	SPEECH PATHOLOGY	45	0	84	0	84	68.00
69.00	06900	ELECTROCARDIOLOGY	3,973	0	64,694	0	64,694	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,962	0	145,068	0	145,068	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1,356	0	12,890	0	12,890	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,363	0	74,445	0	74,445	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	110	0	42,171	0	42,171	90.00
90.01	09001	SENIOR CARE	385	0	34,271	0	34,271	90.01
91.00	09100	EMERGENCY	11,356	0	284,361	0	284,361	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	4,685	0	212,880	0	212,880	95.00
101.00	10100	HOME HEALTH AGENCY	334	0	36,811	0	36,811	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	84,349	10,005	3,134,044	0	3,134,044	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	40,153	0	40,153	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	313,577	0	313,577	192.00
194.00	07950	MARKETING	0	0	13,975	0	13,975	194.00
194.01	07951	PHYSICIAN BILLING	0	0	21,933	0	21,933	194.01
194.02	07952	MOB	0	0	724,709	0	724,709	194.02
194.03	07953	FOUNDATION	0	0	0	0	0	194.03
200.00		Cross Foot Adjustments			0	0	0	200.00
201.00		Negative Cost Centers	10,218	0	10,218	0	10,218	201.00
202.00		TOTAL (sum lines 118 through 201)	94,567	10,005	4,258,609	0	4,258,609	202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1331 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B-1 | Date/Time Prepared: 5/22/2018 1:57 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			NEW BLDG & FIXT (SQUARE FEET)	MOB (SQUARE FEET)	AMB DEPR (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)	AMB EQUIP (SQUARE FEET)	
			1.00	1.01	1.02	2.00	2.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	136,433					1.00
1.01	00101	MOB	0	34,271				1.01
1.02	00102	AMB DEPR	0	0	11,032			1.02
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP				136,433		2.00
2.01	00201	AMB EQUIP				0	11,032	2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	200	0	0	200	0	4.00
5.01	00590	ADMINISTRATIVE & GENERAL	19,897	196	0	19,897	0	5.01
5.02	00570	ADMITTING	0	0	0	0	0	5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	0	0	0	0	5.03
7.00	00700	OPERATION OF PLANT	15,688	0	0	15,688	0	7.00
7.01	00701	AMB PLANT OPS	0	0	0	0	0	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	916	0	0	916	0	8.00
9.00	00900	HOUSEKEEPING	1,962	0	0	1,962	0	9.00
10.00	01000	DIETARY	5,709	0	0	5,709	0	10.00
11.00	01100	CAFETERIA	2,852	0	0	2,852	0	11.00
13.00	01300	NURSING ADMINISTRATION	480	0	0	480	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,185	0	0	3,185	0	16.00
17.00	01700	SOCIAL SERVICE	192	0	0	192	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	23,203	0	0	23,203	0	30.00
31.00	03100	INTENSIVE CARE UNIT	2,897	0	0	2,897	0	31.00
43.00	04300	NURSERY	600	0	0	600	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	17,722	0	0	17,722	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	9,285	0	0	9,285	0	54.00
60.00	06000	LABORATORY	4,880	0	0	4,880	0	60.00
65.00	06500	RESPIRATORY THERAPY	1,062	0	0	1,062	0	65.00
66.00	06600	PHYSICAL THERAPY	3,593	0	0	3,593	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	1,824	0	0	1,824	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,356	0	0	4,356	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,226	0	0	1,226	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	1,613	0	0	0	90.00
90.01	09001	SENIOR CARE	0	1,170	0	0	0	90.01
91.00	09100	EMERGENCY	6,559	1,613	0	6,559	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	11,032	0	11,032	95.00
101.00	10100	HOME HEALTH AGENCY	0	1,143	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	128,288	5,735	11,032	128,288	11,032	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	815	0	0	815	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	6,616	0	0	6,616	0	192.00
194.00	07950	MARKETING	214	0	0	214	0	194.00
194.01	07951	PHYSICIAN BILLING	500	0	0	500	0	194.01
194.02	07952	MOB	0	28,536	0	0	0	194.02
194.03	07953	FOUNDATION	0	0	0	0	0	194.03
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)	2,212,836	861,837	66,628	1,007,969	109,339	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	16.219214	25.147705	6.039521	7.388015	9.911077	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)						204.00
205.00		Unit cost multiplier (Wkst. B, Part II)						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: 15-1331 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B-1 | Date/Time Prepared: 5/22/2018 1:57 pm

		Cost Center Description	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM COST)	ADMITTING (GROSS CHARGES)	CASHIERING/ACCOUNTS RECEIVABLE (GROSS CHARGES)	
			4.00	5A.01	5.01	5.02	5.03	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	MOB						1.01
1.02	00102	AMB DEPR						1.02
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	AMB EQUIP						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	25,545,293					4.00
5.01	00590	ADMINISTRATIVE & GENERAL	1,513,249	-4,777,126	48,041,921			5.01
5.02	00570	ADMITTING	450,169	0	602,534	143,280,694		5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	428,370	0	1,146,133	0	143,280,694	5.03
7.00	00700	OPERATION OF PLANT	248,824	0	2,048,530	0	0	7.00
7.01	00701	AMB PLANT OPS	0	0	0	0	0	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	25,533	0	321,658	0	0	8.00
9.00	00900	HOUSEKEEPING	453,991	0	787,688	0	0	9.00
10.00	01000	DIETARY	191,121	0	541,252	0	0	10.00
11.00	01100	CAFETERIA	203,595	0	361,603	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	658,401	0	894,696	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	247,422	0	396,613	0	0	14.00
15.00	01500	PHARMACY	989,037	0	1,720,890	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	52,504	0	0	16.00
17.00	01700	SOCIAL SERVICE	271,508	0	354,331	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,854,751	0	4,215,725	11,725,081	11,725,081	30.00
31.00	03100	INTENSIVE CARE UNIT	449,097	0	651,987	1,047,774	1,047,774	31.00
43.00	04300	NURSERY	174,362	0	229,518	1,450,814	1,450,814	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	992,877	0	1,847,251	10,705,043	10,705,043	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	225,842	0	46,170	1,668,250	1,668,250	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,228,103	0	2,548,232	38,296,666	38,296,666	54.00
60.00	06000	LABORATORY	772,808	0	2,167,793	22,654,053	22,654,053	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	513,667	1,401,373	1,401,373	65.00
66.00	06600	PHYSICAL THERAPY	257,510	0	409,461	2,161,044	2,161,044	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	43,409	269,707	269,707	67.00
68.00	06800	SPEECH PATHOLOGY	1,763	0	2,222	76,236	76,236	68.00
69.00	06900	ELECTROCARDIOLOGY	349,234	0	523,424	6,745,920	6,745,920	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	1,548,098	6,725,940	6,725,940	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	976,084	2,302,010	2,302,010	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	1,662,455	7,407,374	7,407,374	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	21,676	0	117,744	186,377	186,377	90.00
90.01	09001	SENIOR CARE	130,571	0	340,735	654,445	654,445	90.01
91.00	09100	EMERGENCY	1,505,469	0	2,588,093	19,280,859	19,280,859	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1,974,310	0	3,007,482	7,953,988	7,953,988	95.00
101.00	10100	HOME HEALTH AGENCY	485,659	0	766,145	567,740	567,740	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	17,105,252	-4,777,126	33,434,127	143,280,694	143,280,694	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	19,240	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	7,829,747	0	12,662,195	0	0	192.00
194.00	07950	MARKETING	66,404	0	423,965	0	0	194.00
194.01	07951	PHYSICIAN BILLING	543,890	0	784,779	0	0	194.01
194.02	07952	MOB	0	0	717,615	0	0	194.02
194.03	07953	FOUNDATION	0	0	0	0	0	194.03
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)	5,972,175		4,777,126	662,448	1,260,101	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.233788		0.099437	0.004623	0.008795	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	4,722		474,922	6,040	11,410	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000185		0.009886	0.000042	0.000080	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: 15-1331 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B-1 | Date/Time Prepared: 5/22/2018 1:57 pm

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	AMB PLANT OPS (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (TOTAL PATIENT DAYS)	
			7.00	7.01	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	MOB						1.01
1.02	00102	AMB DEPR						1.02
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	AMB EQUIP						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	ADMINISTRATIVE & GENERAL						5.01
5.02	00570	ADMITTING						5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.03
7.00	00700	OPERATION OF PLANT	100,648					7.00
7.01	00701	AMB PLANT OPS	0	11,032				7.01
8.00	00800	LAUNDRY & LINEN SERVICE	916	0	216,097			8.00
9.00	00900	HOUSEKEEPING	1,962	0	19,422	97,770		9.00
10.00	01000	DIETARY	5,709	0	14,326	5,709	5,674	10.00
11.00	01100	CAFETERIA	2,852	0	0	2,852	0	11.00
13.00	01300	NURSING ADMINISTRATION	480	0	0	480	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,185	0	0	3,185	0	16.00
17.00	01700	SOCIAL SERVICE	192	0	0	192	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	23,203	0	85,663	23,203	4,369	30.00
31.00	03100	INTENSIVE CARE UNIT	2,897	0	0	2,897	427	31.00
43.00	04300	NURSERY	600	0	0	600	878	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	17,722	0	11,913	17,722	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	9,285	0	23,041	9,285	0	54.00
60.00	06000	LABORATORY	4,880	0	0	4,880	0	60.00
65.00	06500	RESPIRATORY THERAPY	1,062	0	275	1,062	0	65.00
66.00	06600	PHYSICAL THERAPY	3,593	0	2,256	3,593	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	1,824	0	5,261	1,824	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,356	0	0	4,356	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,226	0	0	1,226	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	1,092	0	0	90.00
90.01	09001	SENIOR CARE	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	6,559	0	41,548	6,559	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	11,032	7,564	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	92,503	11,032	212,361	89,625	5,674	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	815	0	0	815	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	6,616	0	3,736	6,616	0	192.00
194.00	07950	MARKETING	214	0	0	214	0	194.00
194.01	07951	PHYSICIAN BILLING	500	0	0	500	0	194.01
194.02	07952	MOB	0	0	0	0	0	194.02
194.03	07953	FOUNDATION	0	0	0	0	0	194.03
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)	2,252,230	0	374,141	943,543	802,722	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	22.377295	0.000000	1.731357	9.650639	141.473740	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	390,648	0	28,364	64,352	167,956	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	3.881329	0.000000	0.131256	0.658198	29.600987	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: 15-1331 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B-1 | Date/Time Prepared: 5/22/2018 1:57 pm

		Cost Center Description	CAFETERIA (HOURS OF SERVICE)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (TIME SPENT)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	MOB						1.01
1.02	00102	AMB DEPR						1.02
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	AMB EQUIP						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	ADMINISTRATIVE & GENERAL						5.01
5.02	00570	ADMITTING						5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.03
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	AMB PLANT OPS						7.01
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	31,354					11.00
13.00	01300	NURSING ADMINISTRATION	916	14,538				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	764	0	3,660,082			14.00
15.00	01500	PHARMACY	383	0	0	100		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,635	0	16,693	0	143,280,694	16.00
17.00	01700	SOCIAL SERVICE	390	0	3,552	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,682	6,682	87,832	0	11,725,081	30.00
31.00	03100	INTENSIVE CARE UNIT	943	943	26,731	0	1,047,774	31.00
43.00	04300	NURSERY	380	380	227	0	1,450,814	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,484	2,484	101,495	0	10,705,043	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	80	0	8,356	0	1,668,250	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,766	0	132,950	0	38,296,666	54.00
60.00	06000	LABORATORY	1,607	0	634,514	0	22,654,053	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	11,373	0	1,401,373	65.00
66.00	06600	PHYSICAL THERAPY	408	0	5,050	0	2,161,044	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	269,707	67.00
68.00	06800	SPEECH PATHOLOGY	3	0	0	0	76,236	68.00
69.00	06900	ELECTROCARDIOLOGY	595	595	8,826	0	6,745,920	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	1,445,265	0	6,725,940	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	976,084	0	2,302,010	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	7,636	100	7,407,374	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	37	37	1,448	0	186,377	90.00
90.01	09001	SENIOR CARE	225	225	1,792	0	654,445	90.01
91.00	09100	EMERGENCY	3,192	3,192	87,999	0	19,280,859	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	102,259	0	7,953,988	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	567,740	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	23,490	14,538	3,660,082	100	143,280,694	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	6,363	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	100	0	0	0	0	192.00
194.00	07950	MARKETING	1,401	0	0	0	0	194.00
194.01	07951	PHYSICIAN BILLING	0	0	0	0	0	194.01
194.02	07952	MOB	0	0	0	0	0	194.02
194.03	07953	FOUNDATION	0	0	0	0	0	194.03
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)	488,904	1,013,318	447,964	1,897,982	187,272	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	15.593034	69.701334	0.122392	18,979.820000	0.001307	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	83,888	24,928	6,011	18,221	94,567	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	2.675512	1.714679	0.001642	182.210000	0.000589	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: 15-1331 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B-1 | Date/Time Prepared: 5/22/2018 1:57 pm

		Cost Center Description	SOCIAL SERVICE (TOTAL PATIENT DAYS)		
			17.00		
		GENERAL SERVICE COST CENTERS			
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT			1.00
1.01	00101	MOB			1.01
1.02	00102	AMB DEPR			1.02
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP			2.00
2.01	00201	AMB EQUIP			2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.01	00590	ADMINISTRATIVE & GENERAL			5.01
5.02	00570	ADMITTING			5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE			5.03
7.00	00700	OPERATION OF PLANT			7.00
7.01	00701	AMB PLANT OPS			7.01
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
17.00	01700	SOCIAL SERVICE	5,674		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	4,369		30.00
31.00	03100	INTENSIVE CARE UNIT	427		31.00
43.00	04300	NURSERY	878		43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0		52.00
53.00	05300	ANESTHESIOLOGY	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0		54.00
60.00	06000	LABORATORY	0		60.00
65.00	06500	RESPIRATORY THERAPY	0		65.00
66.00	06600	PHYSICAL THERAPY	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0		67.00
68.00	06800	SPEECH PATHOLOGY	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0		73.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0		90.00
90.01	09001	SENIOR CARE	0		90.01
91.00	09100	EMERGENCY	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0		95.00
101.00	10100	HOME HEALTH AGENCY	0		101.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	5,674		118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0		192.00
194.00	07950	MARKETING	0		194.00
194.01	07951	PHYSICIAN BILLING	0		194.01
194.02	07952	MOB	0		194.02
194.03	07953	FOUNDATION	0		194.03
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)	402,230		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	70.890025		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	10,005		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	1.763306		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: 15-1331 | Period: From 01/01/2017 To 12/31/2017 | Worksheet C Part I Date/Time Prepared: 5/22/2018 1:57 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,207,542		7,207,542	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	999,415		999,415	0	0	31.00
43.00	04300	NURSERY	511,815		511,815	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,001,085		3,001,085	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0		0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	77,595		77,595	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,762,229		3,762,229	0	0	54.00
60.00	06000	LABORATORY	2,975,946		2,975,946	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	621,263	0	621,263	0	0	65.00
66.00	06600	PHYSICAL THERAPY	607,961	0	607,961	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	51,697	0	51,697	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	3,612	0	3,612	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	794,163		794,163	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,117,477		2,117,477	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1,226,505		1,226,505	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,875,022		3,875,022	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	137,421		137,421	0	0	90.00
90.01	09001	SENIOR CARE	403,663		403,663	0	0	90.01
91.00	09100	EMERGENCY	3,694,391		3,694,391	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,769,363		1,769,363		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	3,449,271		3,449,271	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	850,688		850,688		0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	38,138,124	0	38,138,124	0	0	200.00
201.00		Less Observation Beds	1,769,363		1,769,363		0	201.00
202.00		Total (see instructions)	36,368,761	0	36,368,761	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1331 | Period: From 01/01/2017 To 12/31/2017 | Worksheet C Part I Date/Time Prepared: 5/22/2018 1:57 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	8,596,993		8,596,993			30.00
31.00	03100	INTENSIVE CARE UNIT	1,047,774		1,047,774			31.00
43.00	04300	NURSERY	1,450,814		1,450,814			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,717,401	7,987,642	10,705,043	0.280343	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0.000000	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	436,000	1,232,250	1,668,250	0.046513	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,283,806	36,012,860	38,296,666	0.098239	0.000000	54.00
60.00	06000	LABORATORY	3,551,692	19,102,361	22,654,053	0.131365	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	946,148	455,225	1,401,373	0.443325	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	603,310	1,557,734	2,161,044	0.281327	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	73,067	196,640	269,707	0.191678	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	53,945	22,291	76,236	0.047379	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	516,576	6,229,344	6,745,920	0.117725	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,937,634	3,788,306	6,725,940	0.314822	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1,386,029	915,981	2,302,010	0.532797	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,252,786	5,154,588	7,407,374	0.523130	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	186,377	186,377	0.737328	0.000000	90.00
90.01	09001	SENIOR CARE	0	654,445	654,445	0.616802	0.000000	90.01
91.00	09100	EMERGENCY	566,904	18,713,955	19,280,859	0.191609	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	8,726	3,119,362	3,128,088	0.565637	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	7,953,988	7,953,988	0.433653	0.000000	95.00
101.00	10100	HOME HEALTH AGENCY	0	567,740	567,740			101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	29,429,605	113,851,089	143,280,694			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	29,429,605	113,851,089	143,280,694			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1331 | Period: From 01/01/2017 To 12/31/2017 | Worksheet C Part I Date/Time Prepared: 5/22/2018 1:57 pm

Title XVIII | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
43.00	04300	NURSERY			43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	06000	LABORATORY	0.000000		60.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0.000000		90.00
90.01	09001	SENIOR CARE	0.000000		90.01
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0.000000		95.00
101.00	10100	HOME HEALTH AGENCY			101.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1331 | Period: From 01/01/2017 To 12/31/2017 | Worksheet C Part I Date/Time Prepared: 5/22/2018 1:57 pm

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,207,542		7,207,542	0	7,207,542	30.00
31.00	03100	INTENSIVE CARE UNIT	999,415		999,415	0	999,415	31.00
43.00	04300	NURSERY	511,815		511,815	0	511,815	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,001,085		3,001,085	0	3,001,085	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0		0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	77,595		77,595	0	77,595	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,762,229		3,762,229	0	3,762,229	54.00
60.00	06000	LABORATORY	2,975,946		2,975,946	0	2,975,946	60.00
65.00	06500	RESPIRATORY THERAPY	621,263	0	621,263	0	621,263	65.00
66.00	06600	PHYSICAL THERAPY	607,961	0	607,961	0	607,961	66.00
67.00	06700	OCCUPATIONAL THERAPY	51,697	0	51,697	0	51,697	67.00
68.00	06800	SPEECH PATHOLOGY	3,612	0	3,612	0	3,612	68.00
69.00	06900	ELECTROCARDIOLOGY	794,163		794,163	0	794,163	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,117,477		2,117,477	0	2,117,477	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1,226,505		1,226,505	0	1,226,505	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,875,022		3,875,022	0	3,875,022	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	137,421		137,421	0	137,421	90.00
90.01	09001	SENIOR CARE	403,663		403,663	0	403,663	90.01
91.00	09100	EMERGENCY	3,694,391		3,694,391	0	3,694,391	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,769,363		1,769,363		1,769,363	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	3,449,271		3,449,271	0	3,449,271	95.00
101.00	10100	HOME HEALTH AGENCY	850,688		850,688		850,688	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	38,138,124	0	38,138,124	0	38,138,124	200.00
201.00		Less Observation Beds	1,769,363		1,769,363		1,769,363	201.00
202.00		Total (see instructions)	36,368,761	0	36,368,761	0	36,368,761	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1331 | Period: From 01/01/2017 To 12/31/2017 | Worksheet C Part I Date/Time Prepared: 5/22/2018 1:57 pm

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	8,596,993		8,596,993			30.00
31.00	03100	INTENSIVE CARE UNIT	1,047,774		1,047,774			31.00
43.00	04300	NURSERY	1,450,814		1,450,814			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,717,401	7,987,642	10,705,043	0.280343	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0.000000	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	436,000	1,232,250	1,668,250	0.046513	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,283,806	36,012,860	38,296,666	0.098239	0.000000	54.00
60.00	06000	LABORATORY	3,551,692	19,102,361	22,654,053	0.131365	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	946,148	455,225	1,401,373	0.443325	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	603,310	1,557,734	2,161,044	0.281327	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	73,067	196,640	269,707	0.191678	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	53,945	22,291	76,236	0.047379	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	516,576	6,229,344	6,745,920	0.117725	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,937,634	3,788,306	6,725,940	0.314822	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1,386,029	915,981	2,302,010	0.532797	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,252,786	5,154,588	7,407,374	0.523130	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	186,377	186,377	0.737328	0.000000	90.00
90.01	09001	SENIOR CARE	0	654,445	654,445	0.616802	0.000000	90.01
91.00	09100	EMERGENCY	566,904	18,713,955	19,280,859	0.191609	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	8,726	3,119,362	3,128,088	0.565637	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	7,953,988	7,953,988	0.433653	0.000000	95.00
101.00	10100	HOME HEALTH AGENCY	0	567,740	567,740			101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	29,429,605	113,851,089	143,280,694			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	29,429,605	113,851,089	143,280,694			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1331 | Period: From 01/01/2017 To 12/31/2017 | Worksheet C Part I Date/Time Prepared: 5/22/2018 1:57 pm

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
43.00	04300	NURSERY			43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	06000	LABORATORY	0.000000		60.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0.000000		90.00
90.01	09001	SENIOR CARE	0.000000		90.01
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0.000000		95.00
101.00	10100	HOME HEALTH AGENCY			101.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-1331 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part II Date/Time Prepared: 5/22/2018 1:57 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	537,510	10,705,043	0.050211	563,810	28,309	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0	0	52.00
53.00	05300	ANESTHESIOLOGY	1,912	1,668,250	0.001146	111,500	128	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	324,562	38,296,666	0.008475	940,878	7,974	54.00
60.00	06000	LABORATORY	180,379	22,654,053	0.007962	1,434,010	11,418	60.00
65.00	06500	RESPIRATORY THERAPY	36,021	1,401,373	0.025704	609,177	15,658	65.00
66.00	06600	PHYSICAL THERAPY	108,161	2,161,044	0.050050	415,664	20,804	66.00
67.00	06700	OCCUPATIONAL THERAPY	621	269,707	0.002302	48,563	112	67.00
68.00	06800	SPEECH PATHOLOGY	84	76,236	0.001102	2,106	2	68.00
69.00	06900	ELECTROCARDIOLOGY	64,694	6,745,920	0.009590	265,762	2,549	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	145,068	6,725,940	0.021568	1,439,242	31,042	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	12,890	2,302,010	0.005599	600,401	3,362	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	74,445	7,407,374	0.010050	1,053,008	10,583	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	42,171	186,377	0.226267	0	0	90.00
90.01	09001	SENIOR CARE	34,271	654,445	0.052367	0	0	90.01
91.00	09100	EMERGENCY	284,361	19,280,859	0.014748	87,354	1,288	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	216,368	3,128,088	0.069169	1,078	75	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	2,063,518	123,663,385		7,572,553	133,304	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-1331 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part IV Date/Time Prepared: 5/22/2018 1:57 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	SENIOR CARE	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-1331 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part IV Date/Time Prepared: 5/22/2018 1:57 pm

Title XVIII | Hospital | Cost

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	10,705,043	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	1,668,250	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	38,296,666	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	22,654,053	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	1,401,373	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	2,161,044	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	269,707	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	76,236	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	6,745,920	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	6,725,940	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	2,302,010	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	7,407,374	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	186,377	0.000000	90.00
90.01	09001	SENIOR CARE	0	0	0	654,445	0.000000	90.01
91.00	09100	EMERGENCY	0	0	0	19,280,859	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	3,128,088	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	123,663,385		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-1331 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part IV Date/Time Prepared: 5/22/2018 1:57 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	563,810	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	111,500	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	940,878	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	1,434,010	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	609,177	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	415,664	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	48,563	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	2,106	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	265,762	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	1,439,242	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000	600,401	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	1,053,008	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	SENIOR CARE	0.000000	0	0	0	0	90.01
91.00	09100	EMERGENCY	0.000000	87,354	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	1,078	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)		7,572,553	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1331 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part V Date/Time Prepared: 5/22/2018 1:57 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.280343	0	1,718,119	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.046513	0	280,500	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.098239	0	12,133,740	0	0	54.00
60.00	06000	LABORATORY	0.131365	0	5,415,434	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.443325	0	271,387	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.281327	0	390,037	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.191678	0	58,947	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.047379	0	8,279	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.117725	0	2,263,991	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.314822	0	917,137	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.532797	0	214,527	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.523130	0	2,256,722	1,161	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.737328	0	33,818	0	0	90.00
90.01	09001	SENIOR CARE	0.616802	0	607,220	0	0	90.01
91.00	09100	EMERGENCY	0.191609	0	5,215,327	1,021	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.565637	0	1,152,847	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.433653		0			95.00
200.00		Subtotal (see instructions)		0	32,938,032	2,182	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	32,938,032	2,182	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1331 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part V Date/Time Prepared: 5/22/2018 1:57 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	481,663	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	13,047	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,192,006	0		54.00
60.00	06000	LABORATORY	711,398	0		60.00
65.00	06500	RESPIRATORY THERAPY	120,313	0		65.00
66.00	06600	PHYSICAL THERAPY	109,728	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	11,299	0		67.00
68.00	06800	SPEECH PATHOLOGY	392	0		68.00
69.00	06900	ELECTROCARDIOLOGY	266,528	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	288,735	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	114,299	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,180,559	607		73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	24,935	0		90.00
90.01	09001	SENIOR CARE	374,535	0		90.01
91.00	09100	EMERGENCY	999,304	196		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	652,093	0		92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	6,540,834	803		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	6,540,834	803		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-1331 | Component CCN: 15-Z331 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part V Date/Time Prepared: 5/22/2018 1:57 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.280343	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.046513	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.098239	0	0	0	0	54.00
60.00	06000	LABORATORY	0.131365	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.443325	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.281327	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.191678	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.047379	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.117725	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.314822	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.532797	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.523130	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.737328	0	0	0	0	90.00
90.01	09001	SENIOR CARE	0.616802	0	0	0	0	90.01
91.00	09100	EMERGENCY	0.191609	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.565637	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.433653		0			95.00
200.00		Subtotal (see instructions)		0	0	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1331 | Component CCN: 15-Z331 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part V Date/Time Prepared: 5/22/2018 1:57 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
			6.00	7.00	
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
60.00	06000	LABORATORY	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0	0	90.00
90.01	09001	SENIOR CARE	0	0	90.01
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0		95.00
200.00		Subtotal (see instructions)	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1331 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part V Date/Time Prepared: 5/22/2018 1:57 pm

Title XIX | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.280343	0	0	82,076	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.046513	0	0	11,250	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.098239	0	0	499,600	0	54.00
60.00	06000	LABORATORY	0.131365	0	0	328,509	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.443325	0	0	3,244	0	65.00
66.00	06600	PHYSICAL THERAPY	0.281327	0	0	18,471	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.191678	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.047379	0	0	351	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.117725	0	0	44,539	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.314822	0	0	52,647	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.532797	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.523130	0	0	97,036	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.737328	0	0	0	0	90.00
90.01	09001	SENIOR CARE	0.616802	0	0	0	0	90.01
91.00	09100	EMERGENCY	0.191609	0	0	475,946	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.565637	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.433653	0	0			95.00
200.00		Subtotal (see instructions)		0	0	1,613,669	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	1,613,669	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1331 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part V Date/Time Prepared: 5/22/2018 1:57 pm

Title XIX | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	23,009		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	523		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	49,080		54.00
60.00	06000	LABORATORY	0	43,155		60.00
65.00	06500	RESPIRATORY THERAPY	0	1,438		65.00
66.00	06600	PHYSICAL THERAPY	0	5,196		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	17		68.00
69.00	06900	ELECTROCARDIOLOGY	0	5,243		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	16,574		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	50,762		73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
90.01	09001	SENIOR CARE	0	0		90.01
91.00	09100	EMERGENCY	0	91,196		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	0	286,193		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	286,193		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1331 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-1 | Date/Time Prepared: 5/22/2018 1:57 pm

Title XVIII | Hospital

	Cost Center Description	Cost	
		1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	5,817	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	5,797	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)	4,369	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	20	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	2,018	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)	20	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	155.02	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	7,207,542	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	24,781	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	7,182,761	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)	7,182,761	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)	1,239.05	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	2,500,403	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)	2,500,403	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1331 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-1 | Date/Time Prepared: 5/22/2018 1:57 pm

Title XVIII | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	999,415	427	2,340.55	241	564,073	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)	2,212,957	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	5,277,433	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)	24,781	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)	24,781	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	1,428	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,239.05	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,769,363	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1331 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-1 | Date/Time Prepared: 5/22/2018 1:57 pm

Title XVIII | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	881,382	7,207,542	0.122286	1,769,363	216,368	90.00
91.00	Nursing School cost	0	7,207,542	0.000000	1,769,363	0	91.00
92.00	Allied health cost	0	7,207,542	0.000000	1,769,363	0	92.00
93.00	All other Medical Education	0	7,207,542	0.000000	1,769,363	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1331 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-3 | Date/Time Prepared: 5/22/2018 1:57 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		2,901,503		30.00
31.00	03100	INTENSIVE CARE UNIT		632,866		31.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.280343	563,810	158,060	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.046513	111,500	5,186	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.098239	940,878	92,431	54.00
60.00	06000	LABORATORY	0.131365	1,434,010	188,379	60.00
65.00	06500	RESPIRATORY THERAPY	0.443325	609,177	270,063	65.00
66.00	06600	PHYSICAL THERAPY	0.281327	415,664	116,938	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.191678	48,563	9,308	67.00
68.00	06800	SPEECH PATHOLOGY	0.047379	2,106	100	68.00
69.00	06900	ELECTROCARDIOLOGY	0.117725	265,762	31,287	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.314822	1,439,242	453,105	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.532797	600,401	319,892	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.523130	1,053,008	550,860	73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.737328	0	0	90.00
90.01	09001	SENIOR CARE	0.616802	0	0	90.01
91.00	09100	EMERGENCY	0.191609	87,354	16,738	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.565637	1,078	610	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		7,572,553	2,212,957	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)		7,572,553		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1331 | Component CCN: 15-Z331 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-3 | Date/Time Prepared: 5/22/2018 1:57 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.280343	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.046513	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.098239	0	0	54.00
60.00	06000	LABORATORY	0.131365	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.443325	2,267	1,005	65.00
66.00	06600	PHYSICAL THERAPY	0.281327	11,648	3,277	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.191678	3,912	750	67.00
68.00	06800	SPEECH PATHOLOGY	0.047379	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.117725	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.314822	5,369	1,690	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.532797	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.523130	4,807	2,515	73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.737328	0	0	90.00
90.01	09001	SENIOR CARE	0.616802	0	0	90.01
91.00	09100	EMERGENCY	0.191609	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.565637	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		28,003	9,237	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)		28,003		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1331 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-3 | Date/Time Prepared: 5/22/2018 1:57 pm

Title XIX | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		263,094		30.00
31.00	03100	INTENSIVE CARE UNIT		26,340		31.00
43.00	04300	NURSERY		96,593		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.280343	39,080	10,956	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.046513	6,500	302	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.098239	36,317	3,568	54.00
60.00	06000	LABORATORY	0.131365	84,573	11,110	60.00
65.00	06500	RESPIRATORY THERAPY	0.443325	30,401	13,478	65.00
66.00	06600	PHYSICAL THERAPY	0.281327	2,920	821	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.191678	361	69	67.00
68.00	06800	SPEECH PATHOLOGY	0.047379	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.117725	9,502	1,119	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.314822	73,196	23,044	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.532797	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.523130	40,857	21,374	73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.737328	0	0	90.00
90.01	09001	SENIOR CARE	0.616802	0	0	90.01
91.00	09100	EMERGENCY	0.191609	9,018	1,728	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.565637	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		332,725	87,569	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)		332,725		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1331 | Component CCN: 15-Z331 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-3 | Date/Time Prepared: 5/22/2018 1:57 pm

Title XIX | 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
43.00	04300	NURSERY		0		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.280343	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.046513	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.098239	0	0	54.00
60.00	06000	LABORATORY	0.131365	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.443325	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.281327	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.191678	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.047379	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.117725	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.314822	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.532797	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.523130	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.737328	0	0	90.00
90.01	09001	SENIOR CARE	0.616802	0	0	90.01
91.00	09100	EMERGENCY	0.191609	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.565637	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		0	0	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)		0		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1331	Period: From 01/01/2017 To 12/31/2017	Worksheet E Part B Date/Time Prepared: 5/22/2018 1:57 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	6,541,637	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)	6,541,637	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)	6,607,053	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)	63,052	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	5,510,415	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)	1,033,586	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)	1,033,586	30.00
31.00	Primary payer payments	885	31.00
32.00	Subtotal (line 30 minus line 31)	1,032,701	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)	1,058,470	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	688,006	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	727,326	36.00
37.00	Subtotal (see instructions)	1,720,707	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)	1,720,707	40.00
40.01	Sequestration adjustment (see instructions)	34,414	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
41.00	Interim payments	2,378,262	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	-691,969	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: 15-1331 | Period: From 01/01/2017 To 12/31/2017 | Worksheet E-1 Part I Date/Time Prepared: 5/22/2018 1:57 pm

Title XVIII | Hospital | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		4,327,124		2,378,262	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		4,327,124		2,378,262	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		381,360		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		691,969	6.02
7.00	Total Medicare program liability (see instructions)		4,708,484		1,686,293	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: 15-1331 | Component CCN: 15-Z331 | Period: From 01/01/2017 To 12/31/2017 | Worksheet E-1 Part I | Date/Time Prepared: 5/22/2018 1:57 pm

Title XVIII | Swing Beds - SNF | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		31,634		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		31,634		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		2,037		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		33,671		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: 15-1331	Period: From 01/01/2017 To 12/31/2017	Worksheet E-1 Part II Date/Time Prepared: 5/22/2018 1:57 pm
	Title XVIII	Hospital	Cost

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

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

Provider CCN: 15-1331 | Component CCN: 15-Z331 | Period: From 01/01/2017 To 12/31/2017 | Worksheet E-2 | Date/Time Prepared: 5/22/2018 1:57 pm

Title XVIII | Swing Beds - SNF | Cost

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	25,029	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)	9,329	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	20	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)	34,358	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	34,358	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)	34,358	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	0	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)	34,358	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)	34,358	0	19.00
19.01	Sequestration adjustment (see instructions)	687	0	19.01
19.02	Demonstration payment adjustment amount after sequestration)	0	0	19.02
20.00	Interim payments	31,634	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)	2,037	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 - SWING BEDS	Provider CCN: 15-1331 Component CCN: 15-Z331	Period: From 01/01/2017 To 12/31/2017	Worksheet E-2 Date/Time Prepared: 5/22/2018 1:57 pm
	Title XIX	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)	0		1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)	0		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)	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	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)	0		8.00
9.00	Primary payer payments (see instructions)	0		9.00
10.00	Subtotal (line 8 minus line 9)	0		10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0		11.00
12.00	Subtotal (line 10 minus line 11)	0		12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	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)	0		15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	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)			16.55
16.99	Demonstration payment adjustment amount before sequestration	0		16.99
17.00	Allowable bad debts (see instructions)	0		17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0		17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0		18.00
19.00	Total (see instructions)	0		19.00
19.01	Sequestration adjustment (see instructions)	0		19.01
19.02	Demonstration payment adjustment amount after sequestration)	0		19.02
20.00	Interim payments	0		20.00
21.00	Tentative settlement (for contractor use only)	0		21.00
22.00	Balance due provider/program (line 19 minus lines 19.01, 20, and 21)	0		22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	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: 15-1331	Period: From 01/01/2017 To 12/31/2017	Worksheet E-3 Part V Date/Time Prepared: 5/22/2018 1:57 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	5,277,433	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)	5,277,433	4.00
5.00	Primary payer payments	13,017	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	5,317,190	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)	5,317,190	19.00
20.00	Deductibles (exclude professional component)	564,564	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	4,752,626	22.00
23.00	Coinsurance	0	23.00
24.00	Subtotal (line 22 minus line 23)	4,752,626	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	79,923	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	51,950	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	37,352	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	4,804,576	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)	4,804,576	30.00
30.01	Sequestration adjustment (see instructions)	96,092	30.01
30.02	Demonstration payment adjustment amount after sequestration	0	30.02
31.00	Interim payments	4,327,124	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)	381,360	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	34.00

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

Provider CCN: 15-1331 | Period: From 01/01/2017 To 12/31/2017 | Worksheet G | Date/Time Prepared: 5/22/2018 1:57 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	1,593,029	0	0	0	1.00
2.00	Temporary investments	3,700,431	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	26,167,166	0	0	0	4.00
5.00	Other receivable	940,174	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-18,590,469	0	0	0	6.00
7.00	Inventory	1,117,279	0	0	0	7.00
8.00	Prepaid expenses	824,766	0	0	0	8.00
9.00	Other current assets	14,827	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)	15,767,203	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	3,001,138	0	0	0	12.00
13.00	Land improvements	3,379,433	0	0	0	13.00
14.00	Accumulated depreciation	-2,262,011	0	0	0	14.00
15.00	Buildings	40,406,678	0	0	0	15.00
16.00	Accumulated depreciation	-20,405,347	0	0	0	16.00
17.00	Leasehold improvements	4,309,403	0	0	0	17.00
18.00	Accumulated depreciation	-1,940,030	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	28,124,986	0	0	0	23.00
24.00	Accumulated depreciation	-24,758,221	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)	29,856,029	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	8,730,176	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	1,407,057	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	10,137,233	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	55,760,465	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	2,502,120	0	0	0	37.00
38.00	Salaries, wages, and fees payable	2,415,137	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	31,308	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	4,948,565	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	6,508,178	0	0	0	47.00
48.00	Unsecured loans	4,883,000	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	11,391,178	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	16,339,743	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	39,420,722				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)	39,420,722	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	55,760,465	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-1331 | Period: From 01/01/2017 To 12/31/2017 | Worksheet G-1 | Date/Time Prepared: 5/22/2018 1:57 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		41,011,699		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-1,590,977				2.00
3.00	Total (sum of line 1 and line 2)		39,420,722		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)		39,420,722		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		39,420,722		0		19.00

		Endowment Fund	Plant Fund			
		6.00	7.00	8.00		
1.00	Fund balances at beginning of period	0		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)					2.00
3.00	Total (sum of line 1 and line 2)	0		0		3.00
4.00	Additions (credit adjustments) (specify)		0			4.00
5.00			0			5.00
6.00			0			6.00
7.00			0			7.00
8.00			0			8.00
9.00			0			9.00
10.00	Total additions (sum of line 4-9)	0		0		10.00
11.00	Subtotal (line 3 plus line 10)	0		0		11.00
12.00	Deductions (debit adjustments) (specify)		0			12.00
13.00			0			13.00
14.00			0			14.00
15.00			0			15.00
16.00			0			16.00
17.00			0			17.00
18.00	Total deductions (sum of lines 12-17)	0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0		19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 15-1331 | Period: From 01/01/2017 To 12/31/2017 | Worksheet G-2 Parts I & II Date/Time Prepared: 5/22/2018 1:57 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	8,398,680		8,398,680	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)	8,398,680		8,398,680	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	1,098,691		1,098,691	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)	1,098,691		1,098,691	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	9,497,371		9,497,371	17.00
18.00	Ancillary services	19,463,038	122,627,417	142,090,455	18.00
19.00	Outpatient services	0	9,976	9,976	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		567,740	567,740	22.00
23.00	AMBULANCE SERVICES	0	7,953,988	7,953,988	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	28,960,409	131,159,121	160,119,530	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		55,693,894		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)		55,693,894		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 15-1331 | Period: From 01/01/2017 To 12/31/2017 | Worksheet G-3 | Date/Time Prepared: 5/22/2018 1:57 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	160,119,530	1.00
2.00	Less contractual allowances and discounts on patients' accounts	108,939,040	2.00
3.00	Net patient revenues (line 1 minus line 2)	51,180,490	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	55,693,894	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-4,513,404	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	14,754	6.00
7.00	Income from investments	412,180	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	4,094	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	138,732	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	22,685	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	229,139	22.00
23.00	Governmental appropriations	59,499	23.00
24.00	OTHER OPERATING INCOME	1,089,322	24.00
24.01	MOB	952,022	24.01
25.00	Total other income (sum of lines 6-24)	2,922,427	25.00
26.00	Total (line 5 plus line 25)	-1,590,977	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-1,590,977	29.00

ANALYSIS OF HOSPITAL-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 15-1331 HHA CCN: 15-7242 | Period: From 01/01/2017 To 12/31/2017 | Worksheet H Date/Time Prepared: 5/22/2018 1:57 pm

Home Health Agency I | PPS

		Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased Services	Other Costs	Total (sum of cols. 1 thru 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures			0		0	0	1.00
2.00	Capital Related - Movable Equipment			0		0	0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0	0	0	3.00
4.00	Transportation	0	0	0	0	0	0	4.00
5.00	Administrative and General	107,398	0	0	0	100,417	207,815	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	154,846	0	10,188	0	0	165,034	6.00
7.00	Physical Therapy	140,272	0	7,410	0	0	147,682	7.00
8.00	Occupational Therapy	26,198	0	2,050	0	0	28,248	8.00
9.00	Speech Pathology	0	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	0	10.00
11.00	Home Health Aide	56,945	0	8,616	0	0	65,561	11.00
12.00	Supplies (see instructions)	0	0	0	0	9,520	9,520	12.00
13.00	Drugs	0	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	485,659	0	28,264	0	109,937	623,860	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	207,815	0	207,815			5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	165,034	0	165,034			6.00
7.00	Physical Therapy	0	147,682	0	147,682			7.00
8.00	Occupational Therapy	0	28,248	0	28,248			8.00
9.00	Speech Pathology	0	0	0	0			9.00
10.00	Medical Social Services	0	0	0	0			10.00
11.00	Home Health Aide	0	65,561	0	65,561			11.00
12.00	Supplies (see instructions)	0	9,520	0	9,520			12.00
13.00	Drugs	0	0	0	0			13.00
14.00	DME	0	0	0	0			14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0			15.00
16.00	Respiratory Therapy	0	0	0	0			16.00
17.00	Private Duty Nursing	0	0	0	0			17.00
18.00	Clinic	0	0	0	0			18.00
19.00	Health Promotion Activities	0	0	0	0			19.00
20.00	Day Care Program	0	0	0	0			20.00
21.00	Home Delivered Meals Program	0	0	0	0			21.00
22.00	Homemaker Service	0	0	0	0			22.00
23.00	All Others (specify)	0	0	0	0			23.00
23.50	Telemedicine	0	0	0	0			23.50
24.00	Total (sum of lines 1-23)	0	623,860	0	623,860			24.00

Column, 6 line 24 should agree with the Worksheet A, column 3, line 101, or subscript as applicable.
5/22/2018 1:57 pm

COST ALLOCATION - HHA GENERAL SERVICE COST | Provider CCN: 15-1331 HHA CCN: 15-7242 | Period: From 01/01/2017 To 12/31/2017 | Worksheet H-1 Part I Date/Time Prepared: 5/22/2018 1:57 pm

Home Health Agency I | PPS

		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	207,815	0	0	0	0	207,815	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	165,034	0	0	0	0	165,034	6.00
7.00	Physical Therapy	147,682	0	0	0	0	147,682	7.00
8.00	Occupational Therapy	28,248	0	0	0	0	28,248	8.00
9.00	Speech Pathology	0	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	0	10.00
11.00	Home Health Aide	65,561	0	0	0	0	65,561	11.00
12.00	Supplies (see instructions)	9,520	0	0	0	0	9,520	12.00
13.00	Drugs	0	0	0	0		0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	623,860	0	0	0	0	623,860	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	207,815			5.00
	HHA REIMBURSABLE SERVICES				
6.00	Skilled Nursing Care	82,435	247,469		6.00
7.00	Physical Therapy	73,767	221,449		7.00
8.00	Occupational Therapy	14,110	42,358		8.00
9.00	Speech Pathology	0	0		9.00
10.00	Medical Social Services	0	0		10.00
11.00	Home Health Aide	32,748	98,309		11.00
12.00	Supplies (see instructions)	4,755	14,275		12.00
13.00	Drugs	0	0		13.00
14.00	DME	0	0		14.00
	HHA NONREIMBURSABLE SERVICES				
15.00	Home Dialysis Aide Services	0	0		15.00
16.00	Respiratory Therapy	0	0		16.00
17.00	Private Duty Nursing	0	0		17.00
18.00	Clinic	0	0		18.00
19.00	Health Promotion Activities	0	0		19.00
20.00	Day Care Program	0	0		20.00
21.00	Home Delivered Meals Program	0	0		21.00
22.00	Homemaker Service	0	0		22.00
23.00	All Others (specify)	0	0		23.00
23.50	Telemedicine	0	0		23.50
24.00	Total (sum of lines 1-23)		623,860		24.00

COST ALLOCATION - HHA STATISTICAL BASIS | Provider CCN: 15-1331 HHA CCN: 15-7242 | Period: From 01/01/2017 To 12/31/2017 | Worksheet H-1 Part II Date/Time Prepared: 5/22/2018 1:57 pm

Home Health Agency I | PPS

		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	-207,815	416,045	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	0	165,034	6.00
7.00	Physical Therapy	0	0	0	0	0	147,682	7.00
8.00	Occupational Therapy	0	0	0	0	0	28,248	8.00
9.00	Speech Pathology	0	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	0	10.00
11.00	Home Health Aide	0	0	0	0	0	65,561	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	9,520	12.00
13.00	Drugs	0	0	0		0	0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	0	0	0	0	-207,815	416,045	24.00
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0	0		207,815	25.00
26.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000		0.499501	26.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 15-1331 | HHA CCN: 15-7242 | Period: From 01/01/2017 To 12/31/2017 | Worksheet H-2 Part I | Date/Time Prepared: 5/22/2018 1:57 pm

Home Health Agency I | PPS

	Cost Center Description	HHA Trial Balance (1)	CAPITAL RELATED COSTS NEW BLDG & FIXT	MOB	AMB DEPR	NEW MVBLE EQUIP	AMB EQUIP	
		0	1.00	1.01	1.02	2.00	2.01	
1.00	Administrative and General	0	0	28,744	0	0	0	1.00
2.00	Skilled Nursing Care	247,469	0	0	0	0	0	2.00
3.00	Physical Therapy	221,449	0	0	0	0	0	3.00
4.00	Occupational Therapy	42,358	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	98,309	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	14,275	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)	623,860	0	28,744	0	0	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

	Cost Center Description	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	ADMITTING	CASHIERING/ACCOUNTS RECEIVABLE	OPERATION OF PLANT	
		4.00	4A	5.01	5.02	5.03	7.00	
1.00	Administrative and General	113,541	142,285	14,148	2,625	4,993	0	1.00
2.00	Skilled Nursing Care	0	247,469	24,608	0	0	0	2.00
3.00	Physical Therapy	0	221,449	22,020	0	0	0	3.00
4.00	Occupational Therapy	0	42,358	4,212	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	98,309	9,776	0	0	0	7.00
8.00	Supplies (see instructions)	0	14,275	1,419	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)	113,541	766,145	76,183	2,625	4,993	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.		0.000000					21.00

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 15-1331 HHA CCN: 15-7242 | Period: From 01/01/2017 To 12/31/2017 | Worksheet H-2 Part I Date/Time Prepared: 5/22/2018 1:57 pm

Home Health Agency I | PPS

	Cost Center Description	AMB PLANT OPS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
		7.01	8.00	9.00	10.00	11.00	13.00	
1.00	Administrative and General	0	0	0	0	0	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	0	0	0	0	0	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

	Cost Center Description	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
		14.00	15.00	16.00	17.00	24.00	25.00	
1.00	Administrative and General	0	0	742	0	164,793	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	272,077	0	2.00
3.00	Physical Therapy	0	0	0	0	243,469	0	3.00
4.00	Occupational Therapy	0	0	0	0	46,570	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	108,085	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	15,694	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	0	0	742	0	850,688	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 15-1331 | HHA CCN: 15-7242 | Period: From 01/01/2017 To 12/31/2017 | Worksheet H-2 Part I | Date/Time Prepared: 5/22/2018 1:57 pm

Home Health Agency I | PPS

	Cost Center Description	Subtotal	Allocated HHA A&G (see Part II)	Total HHA Costs			
		26.00	27.00	28.00			
1.00	Administrative and General	164,793					1.00
2.00	Skilled Nursing Care	272,077	65,368	337,445			2.00
3.00	Physical Therapy	243,469	58,496	301,965			3.00
4.00	Occupational Therapy	46,570	11,189	57,759			4.00
5.00	Speech Pathology	0	0	0			5.00
6.00	Medical Social Services	0	0	0			6.00
7.00	Home Health Aide	108,085	25,969	134,054			7.00
8.00	Supplies (see instructions)	15,694	3,771	19,465			8.00
9.00	Drugs	0	0	0			9.00
10.00	DME	0	0	0			10.00
11.00	Home Dialysis Aide Services	0	0	0			11.00
12.00	Respiratory Therapy	0	0	0			12.00
13.00	Private Duty Nursing	0	0	0			13.00
14.00	Clinic	0	0	0			14.00
15.00	Health Promotion Activities	0	0	0			15.00
16.00	Day Care Program	0	0	0			16.00
17.00	Home Delivered Meals Program	0	0	0			17.00
18.00	Homemaker Service	0	0	0			18.00
19.00	All Others (specify)	0	0	0			19.00
19.50	Telemedicine	0	0	0			19.50
20.00	Total (sum of lines 1-19) (2)	850,688	164,793	850,688			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.		0.240260				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: 15-1331 | HHA CCN: 15-7242 | Period: From 01/01/2017 To 12/31/2017 | Worksheet H-2 Part II | Date/Time Prepared: 5/22/2018 1:57 pm

Home Health Agency I | PPS

	Cost Center Description	CAPITAL RELATED COSTS						
		NEW BLDG & FIXT (SQUARE FEET)	MOB (SQUARE FEET)	AMB DEPR (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)	AMB EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	
		1.00	1.01	1.02	2.00	2.01	4.00	
1.00	Administrative and General	0	1,143	0	0	0	485,659	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	0	1,143	0	0	0	485,659	20.00
21.00	Total cost to be allocated	0	28,744	0	0	0	113,541	21.00
22.00	Unit cost multiplier	0.000000	25.147857	0.000000	0.000000	0.000000	0.233787	22.00

	Cost Center Description	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM COST)	ADMITTING (GROSS CHARGES)	CASHIERING/ACCOUNTS RECEIVABLE (GROSS CHARGES)	OPERATION OF PLANT (SQUARE FEET)	AMB PLANT OPS (SQUARE FEET)	
		5A.01	5.01	5.02	5.03	7.00	7.01	
1.00	Administrative and General	0	142,285	567,740	567,740	0	0	1.00
2.00	Skilled Nursing Care	0	247,469	0	0	0	0	2.00
3.00	Physical Therapy	0	221,449	0	0	0	0	3.00
4.00	Occupational Therapy	0	42,358	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	98,309	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	14,275	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)		766,145	567,740	567,740	0	0	20.00
21.00	Total cost to be allocated		76,183	2,625	4,993	0	0	21.00
22.00	Unit cost multiplier		0.099437	0.004624	0.008795	0.000000	0.000000	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 15-1331 | HHA CCN: 15-7242 | Period: From 01/01/2017 To 12/31/2017 | Worksheet H-2 Part II | Date/Time Prepared: 5/22/2018 1:57 pm

Home Health Agency I | PPS

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

	Cost Center Description	PHARMACY (TIME SPENT)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TOTAL PATIENT DAYS)				
		15.00	16.00	17.00				
1.00	Administrative and General	0	567,740	0				1.00
2.00	Skilled Nursing Care	0	0	0				2.00
3.00	Physical Therapy	0	0	0				3.00
4.00	Occupational Therapy	0	0	0				4.00
5.00	Speech Pathology	0	0	0				5.00
6.00	Medical Social Services	0	0	0				6.00
7.00	Home Health Aide	0	0	0				7.00
8.00	Supplies (see instructions)	0	0	0				8.00
9.00	Drugs	0	0	0				9.00
10.00	DME	0	0	0				10.00
11.00	Home Dialysis Aide Services	0	0	0				11.00
12.00	Respiratory Therapy	0	0	0				12.00
13.00	Private Duty Nursing	0	0	0				13.00
14.00	Clinic	0	0	0				14.00
15.00	Health Promotion Activities	0	0	0				15.00
16.00	Day Care Program	0	0	0				16.00
17.00	Home Delivered Meals Program	0	0	0				17.00
18.00	Homemaker Service	0	0	0				18.00
19.00	All Others (specify)	0	0	0				19.00
19.50	Telemedicine	0	0	0				19.50
20.00	Total (sum of lines 1-19)	0	567,740	0				20.00
21.00	Total cost to be allocated	0	742	0				21.00
22.00	Unit cost multiplier	0.000000	0.001307	0.000000				22.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 15-1331 | HHA CCN: 15-7242 | Period: From 01/01/2017 To 12/31/2017 | Worksheet H-3 Part I | Date/Time Prepared: 5/22/2018 1:57 pm

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	337,445		337,445	1,647	204.88	1.00
2.00	Physical Therapy	3.00	301,965	0	301,965	951	317.52	2.00
3.00	Occupational Therapy	4.00	57,759	0	57,759	355	162.70	3.00
4.00	Speech Pathology	5.00	0	0	0	0	0.00	4.00
5.00	Medical Social Services	6.00	0		0	0	0.00	5.00
6.00	Home Health Aide	7.00	134,054		134,054	1,547	86.65	6.00
7.00	Total (sum of lines 1-6)		831,223	0	831,223	4,500		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		31140	0	1,115			8.00
8.01	Skilled Nursing Care		99915	0	284			8.01
9.00	Physical Therapy		31140	0	580			9.00
9.01	Physical Therapy		99915	0	128			9.01
10.00	Occupational Therapy		31140	0	256			10.00
10.01	Occupational Therapy		99915	0	32			10.01
11.00	Speech Pathology		31140	0	0			11.00
11.01	Speech Pathology		99915	0	0			11.01
12.00	Medical Social Services		31140	0	0			12.00
12.01	Medical Social Services		99915	0	0			12.01
13.00	Home Health Aide		31140	0	765			13.00
13.01	Home Health Aide		99915	0	174			13.01
14.00	Total (sum of lines 8-13)			0	3,334			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	19,465	0	19,465	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	Part B Not Subject to Deductibles & Coinsurance	Part B Subject to Deductibles & Coinsurance	
		6.00	7.00	8.00	9.00	10.00	11.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	0	1,399		0	286,627		1.00
2.00	Physical Therapy	0	708		0	224,804		2.00
3.00	Occupational Therapy	0	288		0	46,858		3.00
4.00	Speech Pathology	0	0		0	0		4.00
5.00	Medical Social Services	0	0		0	0		5.00
6.00	Home Health Aide	0	939		0	81,364		6.00
7.00	Total (sum of lines 1-6)	0	3,334		0	639,653		7.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 15-1331 HHA CCN: 15-7242 | Period: From 01/01/2017 To 12/31/2017 | Worksheet H-3 Part I Date/Time Prepared: 5/22/2018 1:57 pm

Title XVIII | Home Health Agency I | PPS

	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
9.00	Physical Therapy							9.00
9.01	Physical Therapy							9.01
10.00	Occupational Therapy							10.00
10.01	Occupational Therapy							10.01
11.00	Speech Pathology							11.00
11.01	Speech Pathology							11.01
12.00	Medical Social Services							12.00
12.01	Medical Social Services							12.01
13.00	Home Health Aide							13.00
13.01	Home Health Aide							13.01
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	286,627						1.00
2.00	Physical Therapy	224,804						2.00
3.00	Occupational Therapy	46,858						3.00
4.00	Speech Pathology	0						4.00
5.00	Medical Social Services	0						5.00
6.00	Home Health Aide	81,364						6.00
7.00	Total (sum of lines 1-6)	639,653						7.00

	Cost Center Description							
		12.00						
	Limitation Cost Computation							
8.00	Skilled Nursing Care							8.00
8.01	Skilled Nursing Care							8.01
9.00	Physical Therapy							9.00
9.01	Physical Therapy							9.01
10.00	Occupational Therapy							10.00
10.01	Occupational Therapy							10.01
11.00	Speech Pathology							11.00
11.01	Speech Pathology							11.01
12.00	Medical Social Services							12.00
12.01	Medical Social Services							12.01
13.00	Home Health Aide							13.00
13.01	Home Health Aide							13.01
14.00	Total (sum of lines 8-13)							14.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 15-1331 HHA CCN: 15-7242 | Period: From 01/01/2017 To 12/31/2017 | Worksheet H-3 Part II Date/Time Prepared: 5/22/2018 1:57 pm

Title XVIII | Home Health Agency I | PPS

	Cost Center Description	From Wkst. C, Part I, col. 9, line	Cost to Charge Ratio	Total HHA Charge (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)	Transfer to Part I as Indicated		
		0	1.00	2.00	3.00	4.00		
	PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS							
1.00	Physical Therapy	66.00	0.281327	0	0	col. 2, line 2.00		1.00
2.00	Occupational Therapy	67.00	0.191678	0	0	col. 2, line 3.00		2.00
3.00	Speech Pathology	68.00	0.047379	0	0	col. 2, line 4.00		3.00
4.00	Cost of Medical Supplies	71.00	0.314822	0	0	col. 2, line 15.00		4.00
5.00	Cost of Drugs	73.00	0.523130	0	0	col. 2, line 16.00		5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1331 HHA CCN: 15-7242	Period: From 01/01/2017 To 12/31/2017	Worksheet H-4 Part I-II Date/Time Prepared: 5/22/2018 1:57 pm
	Title XVIII	Home Health Agency I	PPS

		Part A	Part B		
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
		1.00	2.00	3.00	
	PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES				
	Reasonable Cost of Part A & Part B Services				
1.00	Reasonable cost of services (see instructions)	0	0	0	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	371,509	11.00
12.00	Total PPS Reimbursement - Full Episodes with Outliers	0	29,315	12.00
13.00	Total PPS Reimbursement - LUPA Episodes	0	9,007	13.00
14.00	Total PPS Reimbursement - PEP Episodes	0	5,874	14.00
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers	0	11,128	15.00
16.00	Total PPS Outlier Reimbursement - PEP Episodes	0	69	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	426,902	22.00
23.00	Excess reasonable cost (from line 8)	0	0	23.00
24.00	Subtotal (line 22 minus line 23)	0	426,902	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	426,902	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	426,902	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	426,902	31.00
31.01	Sequestration adjustment (see instructions)	0	8,538	31.01
31.02	Demonstration payment adjustment amount after sequestration	0	0	31.02
32.00	Interim payments (see instructions)	0	418,364	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: 15-1331 | HHA CCN: 15-7242 | Period: From 01/01/2017 To 12/31/2017 | Worksheet H-5 | Date/Time Prepared: 5/22/2018 1:57 pm

Home Health Agency I | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		0		418,364	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		418,364	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		418,364	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00