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: 15-1329	Period: From 01/01/2017 To 12/31/2017	Worksheet S Parts I-III Date/Time Prepared: 5/17/2018 8:02 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 5/17/2018 Time: 8:02 am
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by MARGARET MARY COMMUNITY HOSPITAL (15-1329) 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	280,623	-388,002	0	70,398	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
9.00	HOME HEALTH AGENCY I	0	0	1		0	9.00
10.00	RURAL HEALTH CLINIC I	0		30,790		0	10.00
200.00	Total	0	280,623	-357,211	0	70,398	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: 15-1329 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-2 Part I | Date/Time Prepared: 5/17/2018 8:01 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 321 MITCHELL	PO Box:			1.00
2.00	City: BATESVILLE	State: IN	Zip Code: 47006-	County: RIPLEY	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	MARGARET MARY COMMUNITY HOSPITAL	151329	99915	1	01/07/1966	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									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	MARGARET MARY COMMUNITY HOSPITAL	157143	99915		03/01/1985	N	P	N	12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice	MARGARET MARY COMMUNITY HOSPITAL	151551	99915		12/31/2003				14.00
15.00	Hospital-Based Health Clinic - RHC	MARGARET MARY COMMUNITY HOSPITAL	158511	99915		09/03/2013	N	O	N	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: 1.00	To: 2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	01/01/2017	12/31/2017	20.00
21.00	Type of Control (see instructions)	2		21.00
	Inpatient PPS Information			
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	N		22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	N	N	22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N	22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or “N” for no.	N	N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	0		23.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1329 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-2 Part I | Date/Time Prepared: 5/17/2018 8:01 am

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

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1329 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-2 Part I | Date/Time Prepared: 5/17/2018 8:01 am

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1329 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-2 Part I Date/Time Prepared: 5/17/2018 8:01 am

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1329 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-2 Part I | Date/Time Prepared: 5/17/2018 8:01 am

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

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

		V	XIX	
		1.00	2.00	
	Title V and XIX Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.06
	Rural Providers			
105.00	Does this hospital qualify as a CAH?	Y		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N		106.00
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II.	N		107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1329 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-2 Part I Date/Time Prepared: 5/17/2018 8:01 am

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

		1.00	
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration)for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.	N	110.00

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-1329	Period: From 01/01/2017 To 12/31/2017	Worksheet S-2 Part I Date/Time Prepared: 5/17/2018 8:01 am

		1.00	2.00	
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	N		140.00

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

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

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

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

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-1329	Period: From 01/01/2017 To 12/31/2017	Worksheet S-2 Part I Date/Time Prepared: 5/17/2018 8:01 am

		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: 15-1329 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-2 Part II | Date/Time Prepared: 5/17/2018 8:01 am

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

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

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

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

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

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	Y	04/09/2018	Y	04/09/2018	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-1329 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-2 Part II Date/Time Prepared: 5/17/2018 8:01 am

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

		1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)		
	Capital Related Cost		
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions	N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.	N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions	N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.	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.	Y	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.	KYLE	SMITH	41.00
42.00	Enter the employer/company name of the cost report preparer.	BLUE & CO., LLC		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317-713-7957	KCSMITH@BLUEANDCO.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-1329	Period: From 01/01/2017 To 12/31/2017	Worksheet S-2 Part II Date/Time Prepared: 5/17/2018 8:01 am

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-1329 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-3 Part I Date/Time Prepared: 5/17/2018 8:01 am

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	18	6,570	97,560.00	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)		18	6,570	97,560.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	7	2,555	6,720.00	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	104,280.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	101.00				0	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	116.00	0	0			24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	88.00				0	26.00
26.25	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: 15-1329 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-3 Part I | Date/Time Prepared: 5/17/2018 8:01 am

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	1,618	55	4,065			1.00
2.00	HMO and other (see instructions)	488	308				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,618	55	4,065			7.00
8.00	INTENSIVE CARE UNIT	175	1	280			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	986			13.00
14.00	Total (see instructions)	1,793	56	5,331	0.00	554.83	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	5,947	635	10,306	0.00	22.00	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	0	0	0	0.00	0.00	24.00
24.10	HOSPICE (non-distinct part)	0	0	0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	1,261	800	4,113	0.00	9.98	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	586.81	27.00
28.00	Observation Bed Days		5	786			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-1329 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-3 Part I | Date/Time Prepared: 5/17/2018 8:01 am

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	613	22	1,600	1.00
2.00	HMO and other (see instructions)			145	119		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	613	22	1,600	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0.00					22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	0.00					24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	0.00					26.00
26.25	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: 15-1329 | Component CCN: 15-7143 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-4 | Date/Time Prepared: 5/17/2018 8:01 am

Home Health Agency I | PPS

					1.00		
0.00	County						0.00
		Title V	Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	5.00	
	HOME HEALTH AGENCY STATISTICAL DATA						
1.00	Home Health Aide Hours	0	0	0	0	0	1.00
2.00	Unduplicated Census Count (see instructions)	0.00	284.00	0.00	0.00	0.00	2.00
				Number of Employees (Full Time Equivalent)			
		Enter the number of hours in your normal work week		Staff	Contract	Total	
		0		1.00	2.00	3.00	
	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES						
3.00	Administrator and Assistant Administrator(s)		40.00	0.00	0.00	0.00	3.00
4.00	Director(s) and Assistant Director(s)			0.00	0.00	0.00	4.00
5.00	Other Administrative Personnel			6.82	0.00	6.82	5.00
6.00	Direct Nursing Service			7.64	0.00	7.64	6.00
7.00	Nursing Supervisor			0.00	0.00	0.00	7.00
8.00	Physical Therapy Service			4.48	0.00	4.48	8.00
9.00	Physical Therapy Supervisor			0.00	0.00	0.00	9.00
10.00	Occupational Therapy Service			1.77	0.00	1.77	10.00
11.00	Occupational Therapy Supervisor			0.00	0.00	0.00	11.00
12.00	Speech Pathology Service			0.03	0.00	0.03	12.00
13.00	Speech Pathology Supervisor			0.00	0.00	0.00	13.00
14.00	Medical Social Service			0.18	0.00	0.18	14.00
15.00	Medical Social Service Supervisor			0.00	0.00	0.00	15.00
16.00	Home Health Aide			1.09	0.00	1.09	16.00
17.00	Home Health Aide Supervisor			0.00	0.00	0.00	17.00
18.00	Other (specify)			0.00	0.00	0.00	18.00
	HOME HEALTH AGENCY CBSA CODES						
19.00	Enter in column 1 the number of CBSAs where you provided services during the cost reporting period.			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).			99915			20.00
20.01				17140			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	2,163	590	54	20	2,827	21.00
22.00	Skilled Nursing Visit Charges	363,384	99,120	9,072	3,360	474,936	22.00
23.00	Physical Therapy Visits	1,369	348	20	33	1,770	23.00
24.00	Physical Therapy Visit Charges	276,538	70,296	4,040	6,666	357,540	24.00
25.00	Occupational Therapy Visits	494	222	3	9	728	25.00
26.00	Occupational Therapy Visit Charges	106,704	47,952	648	1,944	157,248	26.00
27.00	Speech Pathology Visits	21	15	0	0	36	27.00
28.00	Speech Pathology Visit Charges	4,578	3,270	0	0	7,848	28.00
29.00	Medical Social Service Visits	6	1	0	0	7	29.00
30.00	Medical Social Service Visit Charges	1,920	320	0	0	2,240	30.00
31.00	Home Health Aide Visits	290	289	0	0	579	31.00
32.00	Home Health Aide Visit Charges	28,710	28,611	0	0	57,321	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	4,343	1,465	77	62	5,947	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)	781,834	249,569	13,760	11,970	1,057,133	35.00
36.00	Total Number of Episodes (standard/non outlier)	298		29	3	330	36.00
37.00	Total Number of Outlier Episodes		44		2	46	37.00
38.00	Total Non-Routine Medical Supply Charges	34,903	8,686	673	344	44,606	38.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 15-1329 | Component CCN: 15-8511 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-8 | Date/Time Prepared: 5/17/2018 8:01 am

RHC I | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			112 N. BUCKEYE ST.		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	OSGOOD		IN	47037	2.00
					1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0	3.00
			Grant Award		Date	
			1.00		2.00	
	Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)					4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)					5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)					6.00
7.00	Appalachian Regional Commission					7.00
8.00	Look-Alikes					8.00
9.00	OTHER (SPECIFY)					9.00
				1.00	2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N	0	10.00
		Sunday		Monday		Tuesday
		from	to	from	to	from
		1.00	2.00	3.00	4.00	5.00
	Facility hours of operations (1)					
11.00	CLINIC			08:00	16:30	08:00	11.00
					1.00	2.00	
12.00	Have you received an approval for an exception to the productivity standard?				N		12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.				N	0	13.00
				Provider name		CCN number
				1.00		2.00	
14.00	RHC/FQHC name, CCN number						14.00
		Y/N	V	XVIII	XIX	Total Visits	
		1.00	2.00	3.00	4.00	5.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)						15.00
			County				
			4.00				
2.00	City, State, ZIP Code, County						2.00
		Tuesday	Wednesday		Thursday		
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)						
11.00	CLINIC	16:30	08:00	16:30	08:00	16:30	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 15-1329 | Component CCN: 15-8511 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-8 | Date/Time Prepared: 5/17/2018 8:01 am

RHC I | Cost

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

HOSPITAL-BASED HOSPICE IDENTIFICATION DATA

Provider CCN: 15-1329
Hospice CCN: 15-1551

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

Worksheet S-9 PARTS I THROUGH IV Date/Time Prepared: 5/17/2018 8:01 am

Hospice I

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

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

		Title XVIII	Title XIX	Other	Total (sum of cols. 1 through 3)	
		1.00	2.00	3.00	4.00	
	PART III - ENROLLMENT DAYS FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2015					
10.00	Hospice Continuous Home Care	0	0	0	0	10.00
11.00	Hospice Routine Home Care	12,385	265	1,481	14,131	11.00
12.00	Hospice Inpatient Respite Care	16	0	8	24	12.00
13.00	Hospice General Inpatient Care	6	0	1	7	13.00
14.00	Total Hospice Days	12,407	265	1,490	14,162	14.00
	PART IV - CONTRACTED STATISTICAL DATA FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2015					
15.00	Hospice Inpatient Respite Care	0	0	0	0	15.00
16.00	Hospice General Inpatient Care	0	0	0	0	16.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 15-1329 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-10 | Date/Time Prepared: 5/17/2018 8:01 am

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.362027	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	5,807,163	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	N	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?		4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	16,919,214	6.00
7.00	Medicaid cost (line 1 times line 6)	6,125,212	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)	318,049	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)	318,049	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
	Uncompensated Care (see instructions for each line)				
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	2,062,032	0	2,062,032	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	746,511	0	746,511	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)	746,511	0	746,511	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)	5,730,671	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	748,153	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	1,151,005	27.01
28.00	Non-Medicare bad debt expense (see instructions)	4,579,666	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	2,060,815	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	2,807,326	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	3,125,375	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1329 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A | Date/Time Prepared: 5/17/2018 8:01 am

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		3,072,983	3,072,983	-10,989	3,061,994	1.00
1.01	00101	NEW CAP REL COSTS-OFFSITE BLDG		773,121	773,121	10,989	784,110	1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		4,497,062	4,497,062	-292,137	4,204,925	2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP OFFSIT		0	0	292,137	292,137	2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	178,994	12,136,603	12,315,597	0	12,315,597	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	6,477,897	7,957,475	14,435,372	356,228	14,791,600	5.00
7.00	00700	OPERATION OF PLANT	0	1,312,969	1,312,969	-147	1,312,822	7.00
7.01	00701	OPERATION OF PLANT -OFFSITE	0	208,151	208,151	0	208,151	7.01
7.02	00702	OPERATION OF PLANT - HOSPITAL & OFFS	485,708	14,514	500,222	0	500,222	7.02
8.00	00800	LAUNDRY & LINEN SERVICE	101,092	82,129	183,221	-11,756	171,465	8.00
9.00	00900	HOUSEKEEPING	950,216	306,196	1,256,412	0	1,256,412	9.00
10.00	01000	DIETARY	791,863	540,103	1,331,966	-1,224,197	107,769	10.00
11.00	01100	CAFETERIA	0	0	0	1,177,736	1,177,736	11.00
13.00	01300	NURSING ADMINISTRATION	587,781	9,508	597,289	-1	597,288	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	369,671	369,671	-369,617	54	14.00
15.00	01500	PHARMACY	597,048	2,685,977	3,283,025	-923	3,282,102	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,178,664	206,665	1,385,329	-4,274	1,381,055	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,705,206	348,516	3,053,722	489,441	3,543,163	30.00
31.00	03100	INTENSIVE CARE UNIT	296,730	13,830	310,560	-6,954	303,606	31.00
43.00	04300	NURSERY	0	1,957	1,957	641,364	643,321	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,387,428	2,826,812	4,214,240	-2,303,114	1,911,126	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,236,701	247,588	1,484,289	-1,337,277	147,012	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,066,815	6,763,475	9,830,290	-224,051	9,606,239	54.00
60.00	06000	LABORATORY	1,517,376	2,271,724	3,789,100	-38,631	3,750,469	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	473,434	112,211	585,645	-27,270	558,375	65.00
66.00	06600	PHYSICAL THERAPY	1,070,372	82,925	1,153,297	-16,942	1,136,355	66.00
67.00	06700	OCCUPATIONAL THERAPY	389,730	17,511	407,241	-8,109	399,132	67.00
68.00	06800	SPEECH PATHOLOGY	174,217	3,881	178,098	-1,063	177,035	68.00
69.00	06900	ELECTROCARDIOLOGY	598,123	339,631	937,754	-23,085	914,669	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	2,385,725	2,385,725	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	1,571,438	1,571,438	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	801,046	103,581	904,627	0	904,627	88.00
90.00	09000	CLINIC	1,564,326	677,225	2,241,551	-204,575	2,036,976	90.00
90.01	09001	WOUND CLINC	227,347	376,210	603,557	-370,524	233,033	90.01
91.00	09100	EMERGENCY	1,921,525	2,446,623	4,368,148	-88,393	4,279,755	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	1,592,122	198,029	1,790,151	0	1,790,151	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		0	0	0	0	113.00
116.00	11600	HOSPICE	679,762	386,977	1,066,739	0	1,066,739	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	31,051,523	51,391,833	82,443,356	361,029	82,804,385	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	8,679,729	2,021,566	10,701,295	0	10,701,295	192.00
192.01	19201	PEDIATRICS	597,751	55,974	653,725	0	653,725	192.01
192.02	19202	BROOKVILLE	932,698	133,237	1,065,935	0	1,065,935	192.02
192.03	19203	RADIOLOGY - OSGOOD	28,160	309	28,469	0	28,469	192.03
192.04	19204	ENT	181,852	37,884	219,736	0	219,736	192.04
194.00	07950	COMMUNITY RELATIONS	345,160	805,156	1,150,316	-361,029	789,287	194.00
194.01	07951	COMMUNITY BENEFITS	448,922	183,055	631,977	0	631,977	194.01
194.02	07952	OTHER NON-REIMBURSABLE	0	0	0	0	0	194.02
194.03	07953	EMS	12,637	48,692	61,329	0	61,329	194.03
200.00		TOTAL (SUM OF LINES 118 through 199)	42,278,432	54,677,706	96,956,138	0	96,956,138	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1329 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A | Date/Time Prepared: 5/17/2018 8:01 am

		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	-828,857	2,233,137		1.00
1.01	00101	NEW CAP REL COSTS-OFFSITE BLDG	0	784,110		1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	-185,751	4,019,174		2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP OFFSIT	0	292,137		2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	12,315,597		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-2,830,282	11,961,318		5.00
7.00	00700	OPERATION OF PLANT	-28,133	1,284,689		7.00
7.01	00701	OPERATION OF PLANT -OFFSITE	0	208,151		7.01
7.02	00702	OPERATION OF PLANT - HOSPITAL & OFFS	0	500,222		7.02
8.00	00800	LAUNDRY & LINEN SERVICE	-378	171,087		8.00
9.00	00900	HOUSEKEEPING	0	1,256,412		9.00
10.00	01000	DIETARY	-23,048	84,721		10.00
11.00	01100	CAFETERIA	-337,107	840,629		11.00
13.00	01300	NURSING ADMINISTRATION	0	597,288		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	54		14.00
15.00	01500	PHARMACY	0	3,282,102		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-4,855	1,376,200		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-1,214,992	2,328,171		30.00
31.00	03100	INTENSIVE CARE UNIT	0	303,606		31.00
43.00	04300	NURSERY	0	643,321		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-75,000	1,836,126		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	147,012		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-1,221,779	8,384,460		54.00
60.00	06000	LABORATORY	0	3,750,469		60.00
60.01	06001	BLOOD LABORATORY	0	0		60.01
65.00	06500	RESPIRATORY THERAPY	0	558,375		65.00
66.00	06600	PHYSICAL THERAPY	-10,820	1,125,535		66.00
67.00	06700	OCCUPATIONAL THERAPY	-1,725	397,407		67.00
68.00	06800	SPEECH PATHOLOGY	0	177,035		68.00
69.00	06900	ELECTROCARDIOLOGY	-179,044	735,625		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2,385,725		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	1,571,438		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	904,627		88.00
90.00	09000	CLINIC	-844,170	1,192,806		90.00
90.01	09001	WOUND CLINC	0	233,033		90.01
91.00	09100	EMERGENCY	-1,851,840	2,427,915		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY	0	1,790,151		101.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
116.00	11600	HOSPICE	0	1,066,739		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-9,637,781	73,166,604		118.00
		NONREIMBURSABLE COST CENTERS				
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	10,701,295		192.00
192.01	19201	PEDIATRICS	0	653,725		192.01
192.02	19202	BROOKVILLE	0	1,065,935		192.02
192.03	19203	RADIOLOGY - OSGOOD	0	28,469		192.03
192.04	19204	ENT	0	219,736		192.04
194.00	07950	COMMUNITY RELATIONS	0	789,287		194.00
194.01	07951	COMMUNITY BENEFITS	0	631,977		194.01
194.02	07952	OTHER NON-REIMBURSABLE	0	0		194.02
194.03	07953	EMS	0	61,329		194.03
200.00		TOTAL (SUM OF LINES 118 through 199)	-9,637,781	87,318,357		200.00

RECLASSIFICATIONS | Provider CCN: 15-1329 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-6 | Date/Time Prepared: 5/17/2018 8:01 am

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - CAFETERIA					
1.00	CAFETERIA	11.00	700,172	477,564		1.00
	0		700,172	477,564		
	B - OB RECLASS					
1.00	ADULTS & PEDIATRICS	30.00	528,670	59,991		1.00
2.00	NURSERY	43.00	576,002	65,362		2.00
	0		1,104,672	125,353		
	C - COMMUNITY RELATIONS					
1.00	ADMINISTRATIVE & GENERAL	5.00	120,806	240,223		1.00
	0		120,806	240,223		
	D - OFFSITE BUILDING DEPR RECLASS					
1.00	NEW CAP REL COSTS-OFFSITE BLDG	1.01	0	10,989		1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP OFFSIT	2.01	0	292,137		2.00
	0		0	303,126		
	E - IMPLANTABLE SUPPLIES RECLASS					
1.00	IMPL. DEV. CHARGED TO PATIENT	72.00	0	1,571,438		1.00
2.00		0.00	0	0		2.00
	0		0	1,571,438		
	G - CENTRAL SUPPLY RECLASS					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	2,385,725		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
16.00		0.00	0	0		16.00
17.00		0.00	0	0		17.00
18.00		0.00	0	0		18.00
19.00		0.00	0	0		19.00
20.00		0.00	0	0		20.00
21.00		0.00	0	0		21.00
22.00		0.00	0	0		22.00
	0		0	2,385,725		
500.00	Grand Total: Increases		1,925,650	5,103,429		500.00

RECLASSIFICATIONS | Provider CCN: 15-1329 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-6 | Date/Time Prepared: 5/17/2018 8:01 am

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - CAFETERIA						
1.00	DIETARY	10.00	700,172	477,564	0		1.00
	0		700,172	477,564			
	B - OB RECLASS						
1.00	DELIVERY ROOM & LABOR ROOM	52.00	1,104,672	125,353	0		1.00
2.00		0.00	0	0	0		2.00
	0		1,104,672	125,353			
	C - COMMUNITY RELATIONS						
1.00	COMMUNITY RELATIONS	194.00	120,806	240,223	0		1.00
	0		120,806	240,223			
	D - OFFSITE BUILDING DEPR RECLASS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	10,989	9		1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	292,137	9		2.00
	0		0	303,126			
	E - IMPLANTABLE SUPPLIES RECLASS						
1.00	OPERATING ROOM	50.00	0	1,567,274	0		1.00
2.00	CLINIC	90.00	0	4,164	0		2.00
	0		0	1,571,438			
	G - CENTRAL SUPPLY RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	4,801	0		1.00
2.00	OPERATION OF PLANT	7.00	0	147	0		2.00
3.00	LAUNDRY & LINEN SERVICE	8.00	0	11,756	0		3.00
4.00	DIETARY	10.00	0	46,461	0		4.00
5.00	NURSING ADMINISTRATION	13.00	0	1	0		5.00
6.00	CENTRAL SERVICES & SUPPLY	14.00	0	369,617	0		6.00
7.00	PHARMACY	15.00	0	923	0		7.00
8.00	MEDICAL RECORDS & LIBRARY	16.00	0	4,274	0		8.00
9.00	ADULTS & PEDIATRICS	30.00	0	99,220	0		9.00
10.00	INTENSIVE CARE UNIT	31.00	0	6,954	0		10.00
11.00	OPERATING ROOM	50.00	0	735,840	0		11.00
12.00	DELIVERY ROOM & LABOR ROOM	52.00	0	107,252	0		12.00
13.00	RADIOLOGY-DIAGNOSTIC	54.00	0	224,051	0		13.00
14.00	LABORATORY	60.00	0	38,631	0		14.00
15.00	RESPIRATORY THERAPY	65.00	0	27,270	0		15.00
16.00	PHYSICAL THERAPY	66.00	0	16,942	0		16.00
17.00	OCCUPATIONAL THERAPY	67.00	0	8,109	0		17.00
18.00	SPEECH PATHOLOGY	68.00	0	1,063	0		18.00
19.00	ELECTROCARDIOLOGY	69.00	0	23,085	0		19.00
20.00	CLINIC	90.00	0	200,411	0		20.00
21.00	WOUND CLINC	90.01	0	370,524	0		21.00
22.00	EMERGENCY	91.00	0	88,393	0		22.00
	0		0	2,385,725			
500.00	Grand Total: Decreases		1,925,650	5,103,429			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1329 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-7 Part I | Date/Time Prepared: 5/17/2018 8:01 am

		Beginning Balances	Acquisitions: Purchases	Acquisitions: Donation	Acquisitions: Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	2,553,658	0	0	0	0	1.00
2.00	Land Improvements	468,364	89,381	0	89,381	0	2.00
3.00	Buildings and Fixtures	76,061,360	4,526,629	0	4,526,629	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	6,341,285	0	0	0	1,005	5.00
6.00	Movable Equipment	52,060,884	15,973,699	0	15,973,699	9,142,278	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	137,485,551	20,589,709	0	20,589,709	9,143,283	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	137,485,551	20,589,709	0	20,589,709	9,143,283	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	2,553,658	0	1.00
2.00	Land Improvements	557,745	0	2.00
3.00	Buildings and Fixtures	80,587,989	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	6,340,280	0	5.00
6.00	Movable Equipment	58,892,305	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	148,931,977	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	148,931,977	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1329 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-7 Part II Date/Time Prepared: 5/17/2018 8:01 am

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	NEW CAP REL COSTS-BLDG & FIXT	2,048,108	0	1,024,875	0	0	1.00
1.01	NEW CAP REL COSTS-OFFSITE BLDG	773,121	0	0	0	0	1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	4,497,062	0	0	0	0	2.00
2.01	NEW CAP REL COSTS-MVBLE EQUIP OFFSIT	0	0	0	0	0	2.01
3.00	Total (sum of lines 1-2)	7,318,291	0	1,024,875	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL		
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
		14.00	15.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2			
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	3,072,983	1.00
1.01	NEW CAP REL COSTS-OFFSITE BLDG	0	773,121	1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	4,497,062	2.00
2.01	NEW CAP REL COSTS-MVBLE EQUIP OFFSIT	0	0	2.01
3.00	Total (sum of lines 1-2)	0	8,343,166	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1329 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-7 Part III Date/Time Prepared: 5/17/2018 8:01 am

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	COMPUTATION OF RATIOS: Capitalized Leases	COMPUTATION OF RATIOS: Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	ALLOCATION OF OTHER CAPITAL: Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	62,625,202	0	62,625,202	0.420495	0	1.00
1.01	NEW CAP REL COSTS-OFFSITE BLDG	19,152,954	0	19,152,954	0.128602	0	1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	67,153,821	0	67,153,821	0.450903	0	2.00
2.01	NEW CAP REL COSTS-MVBLE EQUIP OFFSIT	0	0	0	0.000000	0	2.01
3.00	Total (sum of lines 1-2)	148,931,977	0	148,931,977	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	2,037,119	0	1.00
1.01	NEW CAP REL COSTS-OFFSITE BLDG	0	0	0	784,110	0	1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	4,019,174	0	2.00
2.01	NEW CAP REL COSTS-MVBLE EQUIP OFFSIT	0	0	0	292,137	0	2.01
3.00	Total (sum of lines 1-2)	0	0	0	7,132,540	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	SUMMARY OF CAPITAL: Insurance (see instructions)	SUMMARY OF CAPITAL: Taxes (see instructions)	SUMMARY OF CAPITAL: Other Capital-Related Costs (see instructions)	SUMMARY OF CAPITAL: Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	196,018	0	0	0	2,233,137	1.00
1.01	NEW CAP REL COSTS-OFFSITE BLDG	0	0	0	0	784,110	1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	4,019,174	2.00
2.01	NEW CAP REL COSTS-MVBLE EQUIP OFFSIT	0	0	0	0	292,137	2.01
3.00	Total (sum of lines 1-2)	196,018	0	0	0	7,328,558	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1329 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-8 | Date/Time Prepared: 5/17/2018 8:01 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
1.01	Investment income - NEW CAP REL COSTS-OFFSITE BLDG (chapter 2)		0	NEW CAP REL COSTS-OFFSITE BLDG	1.01	0	1.01
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 - NEW CAP REL COSTS-MVBLE EQUIP OFFSIT (chapter 2)		0	NEW CAP REL COSTS-MVBLE EQUIP OFFSIT	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	-4,654,696			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		0		0.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts		0		0.00	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 - NEW CAP REL COSTS-OFFSITE BLDG		0	NEW CAP REL COSTS-OFFSITE BLDG	1.01	0	26.01

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1329 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-8 | Date/Time Prepared: 5/17/2018 8:01 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
27.00	Depreciation - NEW CAP REL COSTS-MVBLE EQUIP		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
27.01	Depreciation - NEW CAP REL COSTS-MVBLE EQUIP OFFSIT		0	NEW CAP REL COSTS-MVBLE EQUIP OFFSIT	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
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	A	-185,751	NEW CAP REL COSTS-MVBLE EQUIP	2.00	9	32.00
33.00	OTHEROPERATING GIRLS ON THE RUN REVE	B	-33,669	ADMINISTRATIVE & GENERAL	5.00	0	33.00
34.00	OTHEROPERATING OTHOP - INTERNAL SALE	B	2,099	ADMINISTRATIVE & GENERAL	5.00	0	34.00
35.00	MMCH OTHER OPERATING COMMBENEFITS SC	B	-8,233	ADMINISTRATIVE & GENERAL	5.00	0	35.00
36.00	OTHEROPERATING DIABETES PROGRAM	B	-34,549	ADMINISTRATIVE & GENERAL	5.00	0	36.00
37.00	OTHEROPERATING OTHOP-COMMUNITY CLASS	B	-5,430	ADMINISTRATIVE & GENERAL	5.00	0	37.00
38.00	OTHEROPERATING OTHOP-PURCHASE DISCOU	B	-88	ADMINISTRATIVE & GENERAL	5.00	0	38.00
40.00	OTHEROPERATING OTHOP - MISC REVENUE	B	-27,633	OPERATION OF PLANT	7.00	0	40.00
41.00	MMCH NON-OPERATING R NONOP - MISCELL	B	-500	OPERATION OF PLANT	7.00	0	41.00
43.00	OTHEROPERATING OTHOP - LAUNDRY SERVI	B	-378	LAUNDRY & LINEN SERVICE	8.00	0	43.00
44.00	OTHEROPERATING OTHOP - VENDING SALES	B	-4,264	DIETARY	10.00	0	44.00
45.00	OTHEROPERATING OTHOP - DIET SUPP/INS	B	-18,784	DIETARY	10.00	0	45.00
45.01	CAFETERIA OFFSET	B	-337,107	CAFETERIA	11.00	0	45.01
45.02	OTHEROPERATING OTHOP - MEDRED TRANSC	B	-4,855	MEDICAL RECORDS & LIBRARY	16.00	0	45.02
45.03	OTHEROPERATING OTHOP-PHYSICAL THERAP	B	-10,820	PHYSICAL THERAPY	66.00	0	45.03
45.04	OTHEROPERATING OTHOP-OCCUPATIONAL T	B	-1,725	OCCUPATIONAL THERAPY	67.00	0	45.04
45.05	INTEREST OFFSET	A	-828,857	NEW CAP REL COSTS-BLDG & FIXT	1.00	11	45.05
45.06	LOBBYING EXPENSE	A	-4,926	ADMINISTRATIVE & GENERAL	5.00	0	45.06
45.07	MEDICAL STAFF RETENTION COST	A	-118,614	ADMINISTRATIVE & GENERAL	5.00	0	45.07
45.08	MEDICAL STAFF PLACEMENT FEE	A	-132,642	ADMINISTRATIVE & GENERAL	5.00	0	45.08
45.09	PHYSICIAN RECRUITMENT	A	-62,709	ADMINISTRATIVE & GENERAL	5.00	0	45.09
45.10	HAF	A	-2,428,953	ADMINISTRATIVE & GENERAL	5.00	0	45.10
45.11	TELEPHONE & TV OFFSET	A	-2,568	ADMINISTRATIVE & GENERAL	5.00	0	45.11
45.12	BOUTIQUE OFFSET	A	-1,802	RADIOLOGY-DIAGNOSTIC	54.00	0	45.12
45.13	HOSPITALIST OFFSET	A	-730,327	ADULTS & PEDIATRICS	30.00	0	45.13
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-9,637,781				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: 15-1329 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-8-2 | Date/Time Prepared: 5/17/2018 8:01 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	ADULTS & PEDIATRICS	569,665	484,665	85,000	0	0	1.00
2.00	50.00	OPERATING ROOM	130,000	75,000	55,000	0	0	2.00
3.00	54.00	RADIOLOGY-DIAGNOSTIC	1,277,977	1,219,977	58,000	0	0	3.00
4.00	60.00	LABORATORY	64,880	0	64,880	0	0	4.00
5.00	69.00	ELECTROCARDIOLOGY	219,205	179,044	40,161	0	0	5.00
6.00	90.00	CLINIC	844,170	844,170	0	0	0	6.00
7.00	91.00	EMERGENCY	2,302,300	1,851,840	450,460	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			5,408,197	4,654,696	753,501		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	50.00	OPERATING ROOM	0	0	0	0	0	2.00
3.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	3.00
4.00	60.00	LABORATORY	0	0	0	0	0	4.00
5.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	5.00
6.00	90.00	CLINIC	0	0	0	0	0	6.00
7.00	91.00	EMERGENCY	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	30.00	ADULTS & PEDIATRICS	0	0	0	484,665		1.00
2.00	50.00	OPERATING ROOM	0	0	0	75,000		2.00
3.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	1,219,977		3.00
4.00	60.00	LABORATORY	0	0	0	0		4.00
5.00	69.00	ELECTROCARDIOLOGY	0	0	0	179,044		5.00
6.00	90.00	CLINIC	0	0	0	844,170		6.00
7.00	91.00	EMERGENCY	0	0	0	1,851,840		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	4,654,696		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1329 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part I Date/Time Prepared: 5/17/2018 8:01 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS NEW BLDG & FIXT	NEW OFFSITE BLDG	NEW MVBLE EQUIP	NEW MVBLE EQUIP OFFSIT	
			0	1.00	1.01	2.00	2.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	2,233,137	2,233,137				1.00
1.01	00101	NEW CAP REL COSTS-OFFSITE BLDG	784,110	0	784,110			1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	4,019,174			4,019,174		2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP OFFSIT	292,137			0	292,137	2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	12,315,597	9,622	0	17,318	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	11,961,318	372,007	267	669,534	99	5.00
7.00	00700	OPERATION OF PLANT	1,284,689	358,063	5,840	644,437	2,176	7.00
7.01	00701	OPERATION OF PLANT -OFFSITE	208,151	0	0	0	0	7.01
7.02	00702	OPERATION OF PLANT - HOSPITAL & OFFS	500,222	0	0	0	0	7.02
8.00	00800	LAUNDRY & LINEN SERVICE	171,087	24,853	0	44,731	0	8.00
9.00	00900	HOUSEKEEPING	1,256,412	28,428	1,057	51,164	394	9.00
10.00	01000	DIETARY	84,721	9,933	0	17,877	0	10.00
11.00	01100	CAFETERIA	840,629	75,832	0	136,481	0	11.00
13.00	01300	NURSING ADMINISTRATION	597,288	862	0	1,551	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	54	0	0	0	0	14.00
15.00	01500	PHARMACY	3,282,102	11,911	0	21,437	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,376,200	40,508	0	72,907	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,328,171	205,736	0	370,280	0	30.00
31.00	03100	INTENSIVE CARE UNIT	303,606	19,527	0	35,144	0	31.00
43.00	04300	NURSERY	643,321	10,385	0	18,691	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,836,126	44,309	0	79,747	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	147,012	21,731	0	39,111	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,384,460	270,348	0	486,570	0	54.00
60.00	06000	LABORATORY	3,750,469	49,170	0	88,495	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	558,375	37,598	0	67,668	0	65.00
66.00	06600	PHYSICAL THERAPY	1,125,535	79,350	0	142,813	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	397,407	16,517	0	29,727	0	67.00
68.00	06800	SPEECH PATHOLOGY	177,035	15,090	0	27,159	0	68.00
69.00	06900	ELECTROCARDIOLOGY	735,625	32,229	0	58,005	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,385,725	10,752	0	19,352	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1,571,438	56,531	0	101,744	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	904,627	0	60,560	0	22,563	88.00
90.00	09000	CLINIC	1,192,806	197,456	24,463	355,379	9,114	90.00
90.01	09001	WOUND CLINC	233,033	9,537	0	17,165	0	90.01
91.00	09100	EMERGENCY	2,427,915	129,537	0	233,139	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	1,790,151	48,251	2,543	86,842	947	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	1,066,739	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	73,166,604	2,186,073	94,730	3,934,468	35,293	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	10,701,295	240	533,661	432	198,828	192.00
192.01	19201	PEDIATRICS	653,725	26,492	0	47,681	0	192.01
192.02	19202	BROOKVILLE	1,065,935	0	155,719	0	58,016	192.02
192.03	19203	RADIOLOGY - OSGOOD	28,469	0	0	0	0	192.03
192.04	19204	ENT	219,736	0	0	0	0	192.04
194.00	07950	COMMUNITY RELATIONS	789,287	3,843	0	6,917	0	194.00
194.01	07951	COMMUNITY BENEFITS	631,977	16,489	0	29,676	0	194.01
194.02	07952	OTHER NON-REIMBURSABLE	0	0	0	0	0	194.02
194.03	07953	EMS	61,329	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)	87,318,357	2,233,137	784,110	4,019,174	292,137	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1329 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part I Date/Time Prepared: 5/17/2018 8:01 am

		Cost Center Description	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	OPERATION OF PLANT -OFFSITE	
			4.00	4A	5.00	7.00	7.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-OFFSITE BLDG						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP OFFSIT						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	12,342,537					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,934,581	14,937,806	14,937,806			5.00
7.00	00700	OPERATION OF PLANT	0	2,295,205	473,682	2,768,887		7.00
7.01	00701	OPERATION OF PLANT -OFFSITE	0	208,151	42,958	0	251,109	7.01
7.02	00702	OPERATION OF PLANT - HOSPITAL & OFFS	142,398	642,620	132,623	0	0	7.02
8.00	00800	LAUNDRY & LINEN SERVICE	29,638	270,309	55,786	46,079	0	8.00
9.00	00900	HOUSEKEEPING	278,581	1,616,036	333,516	52,706	303	9.00
10.00	01000	DIETARY	26,882	139,413	28,772	18,416	0	10.00
11.00	01100	CAFETERIA	205,274	1,258,216	259,669	140,594	0	11.00
13.00	01300	NURSING ADMINISTRATION	172,323	772,024	159,330	1,598	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	54	11	0	0	14.00
15.00	01500	PHARMACY	175,040	3,490,490	720,364	22,083	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	345,556	1,835,171	378,741	75,104	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	948,095	3,852,282	795,030	381,439	0	30.00
31.00	03100	INTENSIVE CARE UNIT	86,994	445,271	91,895	36,203	0	31.00
43.00	04300	NURSERY	168,870	841,267	173,620	19,254	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	406,761	2,366,943	488,487	82,151	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	38,708	246,562	50,885	40,289	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	899,117	10,040,495	2,072,147	501,234	0	54.00
60.00	06000	LABORATORY	444,858	4,332,992	894,239	91,162	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	138,799	802,440	165,607	69,707	0	65.00
66.00	06600	PHYSICAL THERAPY	313,807	1,661,505	342,900	147,117	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	114,259	557,910	115,141	30,623	0	67.00
68.00	06800	SPEECH PATHOLOGY	51,076	270,360	55,797	27,977	0	68.00
69.00	06900	ELECTROCARDIOLOGY	175,355	1,001,214	206,630	59,753	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2,415,829	498,576	19,935	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	1,729,713	356,976	104,810	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	234,847	1,222,597	252,318	0	17,380	88.00
90.00	09000	CLINIC	458,623	2,237,841	461,843	366,089	7,021	90.00
90.01	09001	WOUND CLINC	66,653	326,388	67,360	17,682	0	90.01
91.00	09100	EMERGENCY	563,345	3,353,936	692,182	240,165	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0				92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	466,772	2,395,506	494,382	89,459	730	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	199,290	1,266,029	261,282	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	9,086,502	68,832,575	11,122,749	2,681,629	25,434	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2,544,680	13,979,136	2,884,981	445	180,985	192.00
192.01	19201	PEDIATRICS	175,246	903,144	186,390	49,117	0	192.01
192.02	19202	BROOKVILLE	273,445	1,553,115	320,530	0	44,690	192.02
192.03	19203	RADIOLOGY - OSGOOD	8,256	36,725	7,579	0	0	192.03
192.04	19204	ENT	53,315	273,051	56,352	0	0	192.04
194.00	07950	COMMUNITY RELATIONS	65,775	865,822	178,687	7,125	0	194.00
194.01	07951	COMMUNITY BENEFITS	131,613	809,755	167,116	30,571	0	194.01
194.02	07952	OTHER NON-REIMBURSABLE	0	0	0	0	0	194.02
194.03	07953	EMS	3,705	65,034	13,422	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)	12,342,537	87,318,357	14,937,806	2,768,887	251,109	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1329 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part I | Date/Time Prepared: 5/17/2018 8:01 am

		Cost Center Description	OPERATION OF PLANT - HOSPITAL & OFFS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
			7.02	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-OFFSITE BLDG						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP OFFSIT						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT -OFFSITE						7.01
7.02	00702	OPERATION OF PLANT - HOSPITAL & OFFS	775,243					7.02
8.00	00800	LAUNDRY & LINEN SERVICE	8,312	380,486				8.00
9.00	00900	HOUSEKEEPING	9,688	97,715	2,109,964			9.00
10.00	01000	DIETARY	3,322	170	13,085	203,178		10.00
11.00	01100	CAFETERIA	25,362	1,297	99,900	0	1,785,038	11.00
13.00	01300	NURSING ADMINISTRATION	288	0	1,135	0	51,531	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	3,189	0	0	0	14.00
15.00	01500	PHARMACY	3,984	0	15,691	0	47,070	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	13,548	0	53,366	0	138,497	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	68,810	42,832	271,035	192,890	315,339	30.00
31.00	03100	INTENSIVE CARE UNIT	6,531	2,579	25,724	10,288	34,267	31.00
43.00	04300	NURSERY	3,473	15,506	13,681	0	62,947	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	14,820	21,910	58,373	0	166,313	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	7,268	30,463	28,628	0	14,428	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	90,420	47,176	356,158	0	170,305	54.00
60.00	06000	LABORATORY	16,445	0	64,776	0	212,403	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	12,575	5,312	49,531	0	57,621	65.00
66.00	06600	PHYSICAL THERAPY	26,539	26,152	104,535	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	5,524	0	21,759	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	5,047	0	19,880	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	10,779	2,617	42,458	0	64,680	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,596	0	14,165	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	18,907	28,397	74,474	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	75,997	14,313	260,127	0	0	90.00
90.01	09001	WOUND CLINC	3,190	3,773	12,564	0	0	90.01
91.00	09100	EMERGENCY	43,325	25,984	170,651	0	227,535	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	17,173	0	67,642	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	494,923	369,385	1,839,338	203,178	1,562,936	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	201,279	11,101	208,940	0	108,542	192.00
192.01	19201	PEDIATRICS	8,861	0	34,901	0	40,565	192.01
192.02	19202	BROOKVILLE	63,380	0	0	0	0	192.02
192.03	19203	RADIOLOGY - OSGOOD	0	0	0	0	0	192.03
192.04	19204	ENT	0	0	0	0	0	192.04
194.00	07950	COMMUNITY RELATIONS	1,285	0	5,063	0	21,222	194.00
194.01	07951	COMMUNITY BENEFITS	5,515	0	21,722	0	49,929	194.01
194.02	07952	OTHER NON-REIMBURSABLE	0	0	0	0	0	194.02
194.03	07953	EMS	0	0	0	0	1,844	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)	775,243	380,486	2,109,964	203,178	1,785,038	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1329 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part I | Date/Time Prepared: 5/17/2018 8:01 am

		Cost Center Description	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	
			13.00	14.00	15.00	16.00	24.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-OFFSITE BLDG						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP OFFSIT						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT -OFFSITE						7.01
7.02	00702	OPERATION OF PLANT - HOSPITAL & OFFS						7.02
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	985,906					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	3,254				14.00
15.00	01500	PHARMACY	39,137	1	4,338,820			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	3	0	2,494,430		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	262,194	61	0	1,641,072	7,822,984	30.00
31.00	03100	INTENSIVE CARE UNIT	28,492	5	0	0	681,255	31.00
43.00	04300	NURSERY	52,339	0	0	0	1,182,087	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	1,398	0	183,800	3,384,195	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	11,997	67	0	0	430,587	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	141,604	211	0	334,779	13,754,529	54.00
60.00	06000	LABORATORY	176,607	828	0	0	5,789,452	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	47,910	63	0	0	1,210,766	65.00
66.00	06600	PHYSICAL THERAPY	0	11	0	0	2,308,759	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	5	0	0	730,962	67.00
68.00	06800	SPEECH PATHOLOGY	0	1	0	0	379,062	68.00
69.00	06900	ELECTROCARDIOLOGY	34,904	28	0	19,693	1,442,756	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	2,952,101	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	2,313,277	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	4,338,820	0	4,338,820	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	6	0	0	1,492,301	88.00
90.00	09000	CLINIC	0	121	0	91,900	3,515,252	90.00
90.01	09001	WOUND CLINC	0	217	0	0	431,174	90.01
91.00	09100	EMERGENCY	189,188	55	0	203,493	5,146,514	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	18	0	0	3,064,910	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	13	0	0	1,527,324	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	984,372	3,112	4,338,820	2,474,737	63,899,067	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	119	0	19,693	17,595,221	192.00
192.01	19201	PEDIATRICS	0	9	0	0	1,222,987	192.01
192.02	19202	BROOKVILLE	0	10	0	0	1,981,725	192.02
192.03	19203	RADIOLOGY - OSGOOD	0	0	0	0	44,304	192.03
192.04	19204	ENT	0	0	0	0	329,403	192.04
194.00	07950	COMMUNITY RELATIONS	0	0	0	0	1,079,204	194.00
194.01	07951	COMMUNITY BENEFITS	0	4	0	0	1,084,612	194.01
194.02	07952	OTHER NON-REIMBURSABLE	0	0	0	0	0	194.02
194.03	07953	EMS	1,534	0	0	0	81,834	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)	985,906	3,254	4,338,820	2,494,430	87,318,357	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1329 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part I | Date/Time Prepared: 5/17/2018 8:01 am

		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			25.00	26.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT				1.00
1.01	00101	NEW CAP REL COSTS-OFFSITE BLDG				1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP				2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP OFFSIT				2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
7.00	00700	OPERATION OF PLANT				7.00
7.01	00701	OPERATION OF PLANT -OFFSITE				7.01
7.02	00702	OPERATION OF PLANT - HOSPITAL & OFFS				7.02
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	7,822,984		30.00
31.00	03100	INTENSIVE CARE UNIT	0	681,255		31.00
43.00	04300	NURSERY	0	1,182,087		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	3,384,195		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	430,587		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	13,754,529		54.00
60.00	06000	LABORATORY	0	5,789,452		60.00
60.01	06001	BLOOD LABORATORY	0	0		60.01
65.00	06500	RESPIRATORY THERAPY	0	1,210,766		65.00
66.00	06600	PHYSICAL THERAPY	0	2,308,759		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	730,962		67.00
68.00	06800	SPEECH PATHOLOGY	0	379,062		68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,442,756		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2,952,101		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	2,313,277		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	4,338,820		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	1,492,301		88.00
90.00	09000	CLINIC	0	3,515,252		90.00
90.01	09001	WOUND CLINC	0	431,174		90.01
91.00	09100	EMERGENCY	0	5,146,514		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0			92.00
		OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY	0	3,064,910		101.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE				113.00
116.00	11600	HOSPICE	0	1,527,324		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	63,899,067		118.00
		NONREIMBURSABLE COST CENTERS				
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	17,595,221		192.00
192.01	19201	PEDIATRICS	0	1,222,987		192.01
192.02	19202	BROOKVILLE	0	1,981,725		192.02
192.03	19203	RADIOLOGY - OSGOOD	0	44,304		192.03
192.04	19204	ENT	0	329,403		192.04
194.00	07950	COMMUNITY RELATIONS	0	1,079,204		194.00
194.01	07951	COMMUNITY BENEFITS	0	1,084,612		194.01
194.02	07952	OTHER NON-REIMBURSABLE	0	0		194.02
194.03	07953	EMS	0	81,834		194.03
200.00		Cross Foot Adjustments	0	0		200.00
201.00		Negative Cost Centers	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	0	87,318,357		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1329 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part II Date/Time Prepared: 5/17/2018 8:01 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS NEW BLDG & FIXT	NEW OFFSITE BLDG	NEW MVBLE EQUIP	NEW MVBLE EQUIP OFFSIT	
			0	1.00	1.01	2.00	2.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-OFFSITE BLDG						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP OFFSIT						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	9,622	0	17,318	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	372,007	267	669,534	99	5.00
7.00	00700	OPERATION OF PLANT	0	358,063	5,840	644,437	2,176	7.00
7.01	00701	OPERATION OF PLANT -OFFSITE	0	0	0	0	0	7.01
7.02	00702	OPERATION OF PLANT - HOSPITAL & OFFS	0	0	0	0	0	7.02
8.00	00800	LAUNDRY & LINEN SERVICE	0	24,853	0	44,731	0	8.00
9.00	00900	HOUSEKEEPING	0	28,428	1,057	51,164	394	9.00
10.00	01000	DIETARY	0	9,933	0	17,877	0	10.00
11.00	01100	CAFETERIA	0	75,832	0	136,481	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	862	0	1,551	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	11,911	0	21,437	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	40,508	0	72,907	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	205,736	0	370,280	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	19,527	0	35,144	0	31.00
43.00	04300	NURSERY	0	10,385	0	18,691	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	44,309	0	79,747	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	21,731	0	39,111	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	270,348	0	486,570	0	54.00
60.00	06000	LABORATORY	0	49,170	0	88,495	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	37,598	0	67,668	0	65.00
66.00	06600	PHYSICAL THERAPY	0	79,350	0	142,813	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	16,517	0	29,727	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	15,090	0	27,159	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	32,229	0	58,005	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	10,752	0	19,352	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	56,531	0	101,744	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	60,560	0	22,563	88.00
90.00	09000	CLINIC	0	197,456	24,463	355,379	9,114	90.00
90.01	09001	WOUND CLINC	0	9,537	0	17,165	0	90.01
91.00	09100	EMERGENCY	0	129,537	0	233,139	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	48,251	2,543	86,842	947	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	2,186,073	94,730	3,934,468	35,293	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	240	533,661	432	198,828	192.00
192.01	19201	PEDIATRICS	0	26,492	0	47,681	0	192.01
192.02	19202	BROOKVILLE	0	0	155,719	0	58,016	192.02
192.03	19203	RADIOLOGY - OSGOOD	0	0	0	0	0	192.03
192.04	19204	ENT	0	0	0	0	0	192.04
194.00	07950	COMMUNITY RELATIONS	0	3,843	0	6,917	0	194.00
194.01	07951	COMMUNITY BENEFITS	0	16,489	0	29,676	0	194.01
194.02	07952	OTHER NON-REIMBURSABLE	0	0	0	0	0	194.02
194.03	07953	EMS	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	2,233,137	784,110	4,019,174	292,137	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1329 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part II | Date/Time Prepared: 5/17/2018 8:01 am

		Cost Center Description	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	OPERATION OF PLANT -OFFSITE	
			2A	4.00	5.00	7.00	7.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-OFFSITE BLDG						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP OFFSIT						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	26,940	26,940				4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,041,907	4,223	1,046,130			5.00
7.00	00700	OPERATION OF PLANT	1,010,516	0	33,173	1,043,689		7.00
7.01	00701	OPERATION OF PLANT -OFFSITE	0	0	3,008	0	3,008	7.01
7.02	00702	OPERATION OF PLANT - HOSPITAL & OFFS	0	311	9,288	0	0	7.02
8.00	00800	LAUNDRY & LINEN SERVICE	69,584	65	3,907	17,369	0	8.00
9.00	00900	HOUSEKEEPING	81,043	608	23,357	19,867	4	9.00
10.00	01000	DIETARY	27,810	59	2,015	6,942	0	10.00
11.00	01100	CAFETERIA	212,313	448	18,185	52,995	0	11.00
13.00	01300	NURSING ADMINISTRATION	2,413	376	11,158	602	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	1	0	0	14.00
15.00	01500	PHARMACY	33,348	382	50,448	8,324	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	113,415	754	26,524	28,309	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	576,016	2,070	55,677	143,778	0	30.00
31.00	03100	INTENSIVE CARE UNIT	54,671	190	6,436	13,646	0	31.00
43.00	04300	NURSERY	29,076	369	12,159	7,258	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	124,056	888	34,209	30,965	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	60,842	84	3,564	15,186	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	756,918	1,963	145,115	188,932	0	54.00
60.00	06000	LABORATORY	137,665	971	62,625	34,362	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	105,266	303	11,598	26,275	0	65.00
66.00	06600	PHYSICAL THERAPY	222,163	685	24,014	55,453	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	46,244	249	8,063	11,543	0	67.00
68.00	06800	SPEECH PATHOLOGY	42,249	111	3,908	10,546	0	68.00
69.00	06900	ELECTROCARDIOLOGY	90,234	383	14,471	22,523	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	30,104	0	34,916	7,514	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	158,275	0	25,000	39,507	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	83,123	513	17,670	0	208	88.00
90.00	09000	CLINIC	586,412	1,001	32,344	137,991	84	90.00
90.01	09001	WOUND CLINC	26,702	146	4,717	6,665	0	90.01
91.00	09100	EMERGENCY	362,676	1,230	48,474	90,526	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0					92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	138,583	1,019	34,622	33,720	9	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	435	18,298	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	6,250,564	19,836	778,944	1,010,798	305	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	733,161	5,551	202,052	168	2,168	192.00
192.01	19201	PEDIATRICS	74,173	383	13,053	18,514	0	192.01
192.02	19202	BROOKVILLE	213,735	597	22,447	0	535	192.02
192.03	19203	RADIOLOGY - OSGOOD	0	18	531	0	0	192.03
192.04	19204	ENT	0	116	3,946	0	0	192.04
194.00	07950	COMMUNITY RELATIONS	10,760	144	12,514	2,686	0	194.00
194.01	07951	COMMUNITY BENEFITS	46,165	287	11,703	11,523	0	194.01
194.02	07952	OTHER NON-REIMBURSABLE	0	0	0	0	0	194.02
194.03	07953	EMS	0	8	940	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)	7,328,558	26,940	1,046,130	1,043,689	3,008	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1329 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part II Date/Time Prepared: 5/17/2018 8:01 am

		Cost Center Description	OPERATION OF PLANT - HOSPITAL & OFFS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
			7.02	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-OFFSITE BLDG						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP OFFSIT						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT -OFFSITE						7.01
7.02	00702	OPERATION OF PLANT - HOSPITAL & OFFS	9,599					7.02
8.00	00800	LAUNDRY & LINEN SERVICE	103	91,028				8.00
9.00	00900	HOUSEKEEPING	120	23,377	148,376			9.00
10.00	01000	DIETARY	41	41	920	37,828		10.00
11.00	01100	CAFETERIA	314	310	7,025	0	291,590	11.00
13.00	01300	NURSING ADMINISTRATION	4	0	80	0	8,418	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	763	0	0	0	14.00
15.00	01500	PHARMACY	49	0	1,103	0	7,689	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	168	0	3,753	0	22,624	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	852	10,247	19,060	35,913	51,508	30.00
31.00	03100	INTENSIVE CARE UNIT	81	617	1,809	1,915	5,598	31.00
43.00	04300	NURSERY	43	3,710	962	0	10,283	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	183	5,242	4,105	0	27,168	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	90	7,288	2,013	0	2,357	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,120	11,286	25,045	0	27,820	54.00
60.00	06000	LABORATORY	204	0	4,555	0	34,697	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	156	1,271	3,483	0	9,413	65.00
66.00	06600	PHYSICAL THERAPY	329	6,257	7,351	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	68	0	1,530	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	62	0	1,398	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	133	626	2,986	0	10,566	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	45	0	996	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	234	6,794	5,237	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	941	3,424	18,293	0	0	90.00
90.01	09001	WOUND CLINC	39	903	884	0	0	90.01
91.00	09100	EMERGENCY	536	6,216	12,000	0	37,168	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	213	0	4,757	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	6,128	88,372	129,345	37,828	255,309	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2,492	2,656	14,693	0	17,731	192.00
192.01	19201	PEDIATRICS	110	0	2,454	0	6,626	192.01
192.02	19202	BROOKVILLE	785	0	0	0	0	192.02
192.03	19203	RADIOLOGY - OSGOOD	0	0	0	0	0	192.03
192.04	19204	ENT	0	0	0	0	0	192.04
194.00	07950	COMMUNITY RELATIONS	16	0	356	0	3,467	194.00
194.01	07951	COMMUNITY BENEFITS	68	0	1,528	0	8,156	194.01
194.02	07952	OTHER NON-REIMBURSABLE	0	0	0	0	0	194.02
194.03	07953	EMS	0	0	0	0	301	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)	9,599	91,028	148,376	37,828	291,590	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1329 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part II Date/Time Prepared: 5/17/2018 8:01 am

		Cost Center Description	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	
			13.00	14.00	15.00	16.00	24.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-OFFSITE BLDG						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP OFFSIT						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT -OFFSITE						7.01
7.02	00702	OPERATION OF PLANT - HOSPITAL & OFFS						7.02
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	23,051					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	764				14.00
15.00	01500	PHARMACY	915	0	102,258			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1	0	195,548		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,131	14	0	128,649	1,029,915	30.00
31.00	03100	INTENSIVE CARE UNIT	666	1	0	0	85,630	31.00
43.00	04300	NURSERY	1,224	0	0	0	65,084	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	328	0	14,409	241,553	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	280	16	0	0	91,720	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,311	50	0	26,245	1,187,805	54.00
60.00	06000	LABORATORY	4,129	195	0	0	279,403	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	1,120	15	0	0	158,900	65.00
66.00	06600	PHYSICAL THERAPY	0	3	0	0	316,255	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1	0	0	67,698	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	58,274	68.00
69.00	06900	ELECTROCARDIOLOGY	816	7	0	1,544	144,289	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	73,575	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	235,047	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	102,258	0	102,258	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	1	0	0	101,515	88.00
90.00	09000	CLINIC	0	28	0	7,204	787,722	90.00
90.01	09001	WOUND CLINC	0	51	0	0	40,107	90.01
91.00	09100	EMERGENCY	4,423	13	0	15,953	579,215	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	4	0	0	212,927	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	3	0	0	18,736	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	23,015	731	102,258	194,004	5,877,628	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	28	0	1,544	982,244	192.00
192.01	19201	PEDIATRICS	0	2	0	0	115,315	192.01
192.02	19202	BROOKVILLE	0	2	0	0	238,101	192.02
192.03	19203	RADIOLOGY - OSGOOD	0	0	0	0	549	192.03
192.04	19204	ENT	0	0	0	0	4,062	192.04
194.00	07950	COMMUNITY RELATIONS	0	0	0	0	29,943	194.00
194.01	07951	COMMUNITY BENEFITS	0	1	0	0	79,431	194.01
194.02	07952	OTHER NON-REIMBURSABLE	0	0	0	0	0	194.02
194.03	07953	EMS	36	0	0	0	1,285	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)	23,051	764	102,258	195,548	7,328,558	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1329 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part II Date/Time Prepared: 5/17/2018 8:01 am

		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			25.00	26.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT				1.00
1.01	00101	NEW CAP REL COSTS-OFFSITE BLDG				1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP				2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP OFFSIT				2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
7.00	00700	OPERATION OF PLANT				7.00
7.01	00701	OPERATION OF PLANT -OFFSITE				7.01
7.02	00702	OPERATION OF PLANT - HOSPITAL & OFFS				7.02
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	1,029,915		30.00
31.00	03100	INTENSIVE CARE UNIT	0	85,630		31.00
43.00	04300	NURSERY	0	65,084		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	241,553		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	91,720		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,187,805		54.00
60.00	06000	LABORATORY	0	279,403		60.00
60.01	06001	BLOOD LABORATORY	0	0		60.01
65.00	06500	RESPIRATORY THERAPY	0	158,900		65.00
66.00	06600	PHYSICAL THERAPY	0	316,255		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	67,698		67.00
68.00	06800	SPEECH PATHOLOGY	0	58,274		68.00
69.00	06900	ELECTROCARDIOLOGY	0	144,289		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	73,575		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	235,047		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	102,258		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	101,515		88.00
90.00	09000	CLINIC	0	787,722		90.00
90.01	09001	WOUND CLINC	0	40,107		90.01
91.00	09100	EMERGENCY	0	579,215		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0			92.00
		OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY	0	212,927		101.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE				113.00
116.00	11600	HOSPICE	0	18,736		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	5,877,628		118.00
		NONREIMBURSABLE COST CENTERS				
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	982,244		192.00
192.01	19201	PEDIATRICS	0	115,315		192.01
192.02	19202	BROOKVILLE	0	238,101		192.02
192.03	19203	RADIOLOGY - OSGOOD	0	549		192.03
192.04	19204	ENT	0	4,062		192.04
194.00	07950	COMMUNITY RELATIONS	0	29,943		194.00
194.01	07951	COMMUNITY BENEFITS	0	79,431		194.01
194.02	07952	OTHER NON-REIMBURSABLE	0	0		194.02
194.03	07953	EMS	0	1,285		194.03
200.00		Cross Foot Adjustments	0	0		200.00
201.00		Negative Cost Centers	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	0	7,328,558		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1329 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B-1 | Date/Time Prepared: 5/17/2018 8:01 am

		Cost Center Description	CAPITAL RELATED COSTS					
			NEW BLDG & FIXT (SQUARE FEET)	NEW OFFSITE BLDG (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)	NEW MVBLE EQUIP OFFSIT (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	
			1.00	1.01	2.00	2.01	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	158,051					1.00
1.01	00101	NEW CAP REL COSTS-OFFSITE BLDG	0	67,535				1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP			158,051			2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP OFFSIT			0	67,535		2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	681	0	681	0	42,099,438	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	26,329	23	26,329	23	6,598,703	5.00
7.00	00700	OPERATION OF PLANT	25,342	503	25,342	503	0	7.00
7.01	00701	OPERATION OF PLANT -OFFSITE	0	0	0	0	0	7.01
7.02	00702	OPERATION OF PLANT - HOSPITAL & OFFS	0	0	0	0	485,708	7.02
8.00	00800	LAUNDRY & LINEN SERVICE	1,759	0	1,759	0	101,092	8.00
9.00	00900	HOUSEKEEPING	2,012	91	2,012	91	950,216	9.00
10.00	01000	DIETARY	703	0	703	0	91,691	10.00
11.00	01100	CAFETERIA	5,367	0	5,367	0	700,172	11.00
13.00	01300	NURSING ADMINISTRATION	61	0	61	0	587,781	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	843	0	843	0	597,048	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,867	0	2,867	0	1,178,664	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	14,561	0	14,561	0	3,233,876	30.00
31.00	03100	INTENSIVE CARE UNIT	1,382	0	1,382	0	296,730	31.00
43.00	04300	NURSERY	735	0	735	0	576,002	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,136	0	3,136	0	1,387,428	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,538	0	1,538	0	132,029	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	19,134	0	19,134	0	3,066,815	54.00
60.00	06000	LABORATORY	3,480	0	3,480	0	1,517,376	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	2,661	0	2,661	0	473,434	65.00
66.00	06600	PHYSICAL THERAPY	5,616	0	5,616	0	1,070,372	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,169	0	1,169	0	389,730	67.00
68.00	06800	SPEECH PATHOLOGY	1,068	0	1,068	0	174,217	68.00
69.00	06900	ELECTROCARDIOLOGY	2,281	0	2,281	0	598,123	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	761	0	761	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	4,001	0	4,001	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	5,216	0	5,216	801,046	88.00
90.00	09000	CLINIC	13,975	2,107	13,975	2,107	1,564,326	90.00
90.01	09001	WOUND CLINC	675	0	675	0	227,347	90.01
91.00	09100	EMERGENCY	9,168	0	9,168	0	1,921,525	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	3,415	219	3,415	219	1,592,122	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0	679,762	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	154,720	8,159	154,720	8,159	30,993,335	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	17	45,964	17	45,964	8,679,729	192.00
192.01	19201	PEDIATRICS	1,875	0	1,875	0	597,751	192.01
192.02	19202	BROOKVILLE	0	13,412	0	13,412	932,698	192.02
192.03	19203	RADIOLOGY - OSGOOD	0	0	0	0	28,160	192.03
192.04	19204	ENT	0	0	0	0	181,852	192.04
194.00	07950	COMMUNITY RELATIONS	272	0	272	0	224,354	194.00
194.01	07951	COMMUNITY BENEFITS	1,167	0	1,167	0	448,922	194.01
194.02	07952	OTHER NON-REIMBURSABLE	0	0	0	0	0	194.02
194.03	07953	EMS	0	0	0	0	12,637	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)	2,233,137	784,110	4,019,174	292,137	12,342,537	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	14.129218	11.610424	25.429602	4.325713	0.293176	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)					26,940	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)					0.000640	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1329 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B-1 | Date/Time Prepared: 5/17/2018 8:01 am

	Cost Center Description	CAPITAL RELATED COSTS					
		NEW BLDG & FIXT (SQUARE FEET)	NEW OFFSITE BLDG (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)	NEW MVBLE EQUIP OFFSIT (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	
		1.00	1.01	2.00	2.01	4.00	
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1329 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B-1 | Date/Time Prepared: 5/17/2018 8:01 am

		Cost Center Description	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	OPERATION OF PLANT -OFFSITE (SQUARE FEET)	OPERATION OF PLANT - HOSPITAL & OFFS (SQUARE FEET)	
			5A	5.00	7.00	7.01	7.02	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-OFFSITE BLDG						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP OFFSIT						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-14,937,806	72,380,551				5.00
7.00	00700	OPERATION OF PLANT	0	2,295,205	105,699			7.00
7.01	00701	OPERATION OF PLANT -OFFSITE	0	208,151	0	75,361		7.01
7.02	00702	OPERATION OF PLANT - HOSPITAL & OFFS	0	642,620	0	0	164,051	7.02
8.00	00800	LAUNDRY & LINEN SERVICE	0	270,309	1,759	0	1,759	8.00
9.00	00900	HOUSEKEEPING	0	1,616,036	2,012	91	2,050	9.00
10.00	01000	DIETARY	0	139,413	703	0	703	10.00
11.00	01100	CAFETERIA	0	1,258,216	5,367	0	5,367	11.00
13.00	01300	NURSING ADMINISTRATION	0	772,024	61	0	61	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	54	0	0	0	14.00
15.00	01500	PHARMACY	0	3,490,490	843	0	843	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,835,171	2,867	0	2,867	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	3,852,282	14,561	0	14,561	30.00
31.00	03100	INTENSIVE CARE UNIT	0	445,271	1,382	0	1,382	31.00
43.00	04300	NURSERY	0	841,267	735	0	735	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	2,366,943	3,136	0	3,136	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	246,562	1,538	0	1,538	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	10,040,495	19,134	0	19,134	54.00
60.00	06000	LABORATORY	0	4,332,992	3,480	0	3,480	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	802,440	2,661	0	2,661	65.00
66.00	06600	PHYSICAL THERAPY	0	1,661,505	5,616	0	5,616	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	557,910	1,169	0	1,169	67.00
68.00	06800	SPEECH PATHOLOGY	0	270,360	1,068	0	1,068	68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,001,214	2,281	0	2,281	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2,415,829	761	0	761	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	1,729,713	4,001	0	4,001	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	1,222,597	0	5,216	0	88.00
90.00	09000	CLINIC	0	2,237,841	13,975	2,107	16,082	90.00
90.01	09001	WOUND CLINC	0	326,388	675	0	675	90.01
91.00	09100	EMERGENCY	0	3,353,936	9,168	0	9,168	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	2,395,506	3,415	219	3,634	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	1,266,029	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-14,937,806	53,894,769	102,368	7,633	104,732	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	13,979,136	17	54,316	42,593	192.00
192.01	19201	PEDIATRICS	0	903,144	1,875	0	1,875	192.01
192.02	19202	BROOKVILLE	0	1,553,115	0	13,412	13,412	192.02
192.03	19203	RADIOLOGY - OSGOOD	0	36,725	0	0	0	192.03
192.04	19204	ENT	0	273,051	0	0	0	192.04
194.00	07950	COMMUNITY RELATIONS	0	865,822	272	0	272	194.00
194.01	07951	COMMUNITY BENEFITS	0	809,755	1,167	0	1,167	194.01
194.02	07952	OTHER NON-REIMBURSABLE	0	0	0	0	0	194.02
194.03	07953	EMS	0	65,034	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)		14,937,806	2,768,887	251,109	775,243	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)		0.206379	26.195962	3.332082	4.725622	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)		1,046,130	1,043,689	3,008	9,599	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)		0.014453	9.874162	0.039915	0.058512	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1329 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B-1 | Date/Time Prepared: 5/17/2018 8:01 am

	Cost Center Description	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	OPERATION OF PLANT -OFFSITE (SQUARE FEET)	OPERATION OF PLANT - HOSPITAL & OFFS (SQUARE FEET)	
		5A	5.00	7.00	7.01	7.02	
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1329 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B-1 | Date/Time Prepared: 5/17/2018 8:01 am

		Cost Center Description	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (HOURS OF SERVICE)	NURSING ADMINISTRATION (HOURS OF SERVICE)	
			8.00	9.00	10.00	11.00	13.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-OFFSITE BLDG						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP OFFSIT						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT -OFFSITE						7.01
7.02	00702	OPERATION OF PLANT - HOSPITAL & OFFS						7.02
8.00	00800	LAUNDRY & LINEN SERVICE	363,971					8.00
9.00	00900	HOUSEKEEPING	93,474	113,355				9.00
10.00	01000	DIETARY	163	703	13,548			10.00
11.00	01100	CAFETERIA	1,241	5,367	0	464,557		11.00
13.00	01300	NURSING ADMINISTRATION	0	61	0	13,411	308,589	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3,051	0	0	0	0	14.00
15.00	01500	PHARMACY	0	843	0	12,250	12,250	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	2,867	0	36,044	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	40,973	14,561	12,862	82,067	82,067	30.00
31.00	03100	INTENSIVE CARE UNIT	2,467	1,382	686	8,918	8,918	31.00
43.00	04300	NURSERY	14,833	735	0	16,382	16,382	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	20,959	3,136	0	43,283	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	29,141	1,538	0	3,755	3,755	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	45,128	19,134	0	44,322	44,322	54.00
60.00	06000	LABORATORY	0	3,480	0	55,278	55,278	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	5,081	2,661	0	14,996	14,996	65.00
66.00	06600	PHYSICAL THERAPY	25,017	5,616	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,169	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	1,068	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	2,503	2,281	0	16,833	10,925	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	761	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	27,164	4,001	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	13,692	13,975	0	0	0	90.00
90.01	09001	WOUND CLINC	3,609	675	0	0	0	90.01
91.00	09100	EMERGENCY	24,856	9,168	0	59,216	59,216	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	3,634	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	353,352	98,816	13,548	406,755	308,109	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	10,619	11,225	0	28,248	0	192.00
192.01	19201	PEDIATRICS	0	1,875	0	10,557	0	192.01
192.02	19202	BROOKVILLE	0	0	0	0	0	192.02
192.03	19203	RADIOLOGY - OSGOOD	0	0	0	0	0	192.03
192.04	19204	ENT	0	0	0	0	0	192.04
194.00	07950	COMMUNITY RELATIONS	0	272	0	5,523	0	194.00
194.01	07951	COMMUNITY BENEFITS	0	1,167	0	12,994	0	194.01
194.02	07952	OTHER NON-REIMBURSABLE	0	0	0	0	0	194.02
194.03	07953	EMS	0	0	0	480	480	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)	380,486	2,109,964	203,178	1,785,038	985,906	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	1.045374	18.613771	14.996900	3.842452	3.194884	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	91,028	148,376	37,828	291,590	23,051	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.250097	1.308950	2.792146	0.627673	0.074698	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: 15-1329 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B-1 | Date/Time Prepared: 5/17/2018 8:01 am

		Cost Center Description	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (100% PHARMACY)	MEDICAL RECORDS & LIBRARY (TIME SPENT)		
			14.00	15.00	16.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	NEW CAP REL COSTS-OFFSITE BLDG					1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP OFFSIT					2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
7.01	00701	OPERATION OF PLANT -OFFSITE					7.01
7.02	00702	OPERATION OF PLANT - HOSPITAL & OFFS					7.02
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	5,550,268				14.00
15.00	01500	PHARMACY	923	100			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,274	0	760		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	104,388	0	500		30.00
31.00	03100	INTENSIVE CARE UNIT	8,476	0	0		31.00
43.00	04300	NURSERY	0	0	0		43.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	2,384,914	0	56		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	115,184	0	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	360,195	0	102		54.00
60.00	06000	LABORATORY	1,413,300	0	0		60.00
60.01	06001	BLOOD LABORATORY	0	0	0		60.01
65.00	06500	RESPIRATORY THERAPY	107,088	0	0		65.00
66.00	06600	PHYSICAL THERAPY	18,451	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	8,544	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	1,063	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	47,277	0	6		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	100	0		73.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	10,000	0	0		88.00
90.00	09000	CLINIC	206,361	0	28		90.00
90.01	09001	WOUND CLINC	370,747	0	0		90.01
91.00	09100	EMERGENCY	94,607	0	62		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
		OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY	30,504	0	0		101.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
116.00	11600	HOSPICE	21,566	0	0		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	5,307,862	100	754		118.00
		NONREIMBURSABLE COST CENTERS					
192.00	19200	PHYSICIANS' PRIVATE OFFICES	202,471	0	6		192.00
192.01	19201	PEDIATRICS	15,766	0	0		192.01
192.02	19202	BROOKVILLE	17,221	0	0		192.02
192.03	19203	RADIOLOGY - OSGOOD	84	0	0		192.03
192.04	19204	ENT	0	0	0		192.04
194.00	07950	COMMUNITY RELATIONS	22	0	0		194.00
194.01	07951	COMMUNITY BENEFITS	6,842	0	0		194.01
194.02	07952	OTHER NON-REIMBURSABLE	0	0	0		194.02
194.03	07953	EMS	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)	3,254	4,338,820	2,494,430		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000586	43,388.200000	3,282.144737		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	764	102,258	195,548		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000138	1,022.580000	257.300000		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: 15-1329 | Period: From 01/01/2017 To 12/31/2017 | Worksheet C Part I Date/Time Prepared: 5/17/2018 8:01 am

Title XVIII | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,822,984		7,822,984	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	681,255		681,255	0	0	31.00
43.00	04300	NURSERY	1,182,087		1,182,087	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,384,195		3,384,195	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	430,587		430,587	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	13,754,529		13,754,529	0	0	54.00
60.00	06000	LABORATORY	5,789,452		5,789,452	0	0	60.00
60.01	06001	BLOOD LABORATORY	0		0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	1,210,766	0	1,210,766	0	0	65.00
66.00	06600	PHYSICAL THERAPY	2,308,759	0	2,308,759	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	730,962	0	730,962	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	379,062	0	379,062	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	1,442,756		1,442,756	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,952,101		2,952,101	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	2,313,277		2,313,277	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,338,820		4,338,820	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,492,301		1,492,301	0	0	88.00
90.00	09000	CLINIC	3,515,252		3,515,252	0	0	90.00
90.01	09001	WOUND CLINC	431,174		431,174	0	0	90.01
91.00	09100	EMERGENCY	5,146,514		5,146,514	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,267,543		1,267,543		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	3,064,910		3,064,910		0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	1,527,324		1,527,324		0	116.00
200.00		Subtotal (see instructions)	65,166,610	0	65,166,610	0	0	200.00
201.00		Less Observation Beds	1,267,543		1,267,543		0	201.00
202.00		Total (see instructions)	63,899,067	0	63,899,067	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1329 | Period: From 01/01/2017 To 12/31/2017 | Worksheet C Part I Date/Time Prepared: 5/17/2018 8:01 am

Title XVIII | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,196,035		5,196,035			30.00
31.00	03100	INTENSIVE CARE UNIT	551,189		551,189			31.00
43.00	04300	NURSERY	2,518,792		2,518,792			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,677,475	13,166,172	16,843,647	0.200918	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	262,104	43,647	305,751	1.408293	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,468,539	59,839,805	61,308,344	0.224350	0.000000	54.00
60.00	06000	LABORATORY	2,942,229	25,954,700	28,896,929	0.200348	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	0.000000	60.01
65.00	06500	RESPIRATORY THERAPY	3,368,769	1,354,668	4,723,437	0.256332	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	197,146	4,064,358	4,261,504	0.541771	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	117,126	1,300,349	1,417,475	0.515679	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	74,913	635,067	709,980	0.533905	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	422,425	4,414,313	4,836,738	0.298291	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,175,043	4,651,924	7,826,967	0.377170	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1,343,488	920,802	2,264,290	1.021635	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,455,331	9,689,912	13,145,243	0.330068	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	783,344	783,344			88.00
90.00	09000	CLINIC	131,812	6,150,643	6,282,455	0.559535	0.000000	90.00
90.01	09001	WOUND CLINC	20,906	1,853,640	1,874,546	0.230015	0.000000	90.01
91.00	09100	EMERGENCY	227,119	7,414,416	7,641,535	0.673492	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	9,530	853,372	862,902	1.468930	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	1,879,747	1,879,747			101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	2,372,559	2,372,559			116.00
200.00		Subtotal (see instructions)	29,159,971	147,343,438	176,503,409			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	29,159,971	147,343,438	176,503,409			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1329 | Period: From 01/01/2017 To 12/31/2017 | Worksheet C Part I Date/Time Prepared: 5/17/2018 8:01 am

Title XVIII | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
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
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	06000	LABORATORY	0.000000		60.00
60.01	06001	BLOOD LABORATORY	0.000000		60.01
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
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			
88.00	08800	RURAL HEALTH CLINIC			88.00
90.00	09000	CLINIC	0.000000		90.00
90.01	09001	WOUND CLINC	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			
101.00	10100	HOME HEALTH AGENCY			101.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
116.00	11600	HOSPICE			116.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1329 | Period: From 01/01/2017 To 12/31/2017 | Worksheet C Part I Date/Time Prepared: 5/17/2018 8:01 am

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,822,984		7,822,984	0	7,822,984	30.00
31.00	03100	INTENSIVE CARE UNIT	681,255		681,255	0	681,255	31.00
43.00	04300	NURSERY	1,182,087		1,182,087	0	1,182,087	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,384,195		3,384,195	0	3,384,195	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	430,587		430,587	0	430,587	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	13,754,529		13,754,529	0	13,754,529	54.00
60.00	06000	LABORATORY	5,789,452		5,789,452	0	5,789,452	60.00
60.01	06001	BLOOD LABORATORY	0		0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	1,210,766	0	1,210,766	0	1,210,766	65.00
66.00	06600	PHYSICAL THERAPY	2,308,759	0	2,308,759	0	2,308,759	66.00
67.00	06700	OCCUPATIONAL THERAPY	730,962	0	730,962	0	730,962	67.00
68.00	06800	SPEECH PATHOLOGY	379,062	0	379,062	0	379,062	68.00
69.00	06900	ELECTROCARDIOLOGY	1,442,756		1,442,756	0	1,442,756	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,952,101		2,952,101	0	2,952,101	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	2,313,277		2,313,277	0	2,313,277	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,338,820		4,338,820	0	4,338,820	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,492,301		1,492,301	0	1,492,301	88.00
90.00	09000	CLINIC	3,515,252		3,515,252	0	3,515,252	90.00
90.01	09001	WOUND CLINC	431,174		431,174	0	431,174	90.01
91.00	09100	EMERGENCY	5,146,514		5,146,514	0	5,146,514	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,267,543		1,267,543		1,267,543	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	3,064,910		3,064,910		3,064,910	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	1,527,324		1,527,324		1,527,324	116.00
200.00		Subtotal (see instructions)	65,166,610	0	65,166,610	0	65,166,610	200.00
201.00		Less Observation Beds	1,267,543		1,267,543		1,267,543	201.00
202.00		Total (see instructions)	63,899,067	0	63,899,067	0	63,899,067	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1329 | Period: From 01/01/2017 To 12/31/2017 | Worksheet C Part I Date/Time Prepared: 5/17/2018 8:01 am

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,196,035		5,196,035			30.00
31.00	03100	INTENSIVE CARE UNIT	551,189		551,189			31.00
43.00	04300	NURSERY	2,518,792		2,518,792			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,677,475	13,166,172	16,843,647	0.200918	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	262,104	43,647	305,751	1.408293	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,468,539	59,839,805	61,308,344	0.224350	0.000000	54.00
60.00	06000	LABORATORY	2,942,229	25,954,700	28,896,929	0.200348	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	0.000000	60.01
65.00	06500	RESPIRATORY THERAPY	3,368,769	1,354,668	4,723,437	0.256332	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	197,146	4,064,358	4,261,504	0.541771	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	117,126	1,300,349	1,417,475	0.515679	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	74,913	635,067	709,980	0.533905	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	422,425	4,414,313	4,836,738	0.298291	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,175,043	4,651,924	7,826,967	0.377170	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1,343,488	920,802	2,264,290	1.021635	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,455,331	9,689,912	13,145,243	0.330068	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	783,344	783,344	1.905039	0.000000	88.00
90.00	09000	CLINIC	131,812	6,150,643	6,282,455	0.559535	0.000000	90.00
90.01	09001	WOUND CLINC	20,906	1,853,640	1,874,546	0.230015	0.000000	90.01
91.00	09100	EMERGENCY	227,119	7,414,416	7,641,535	0.673492	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	9,530	853,372	862,902	1.468930	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	1,879,747	1,879,747			101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	2,372,559	2,372,559			116.00
200.00		Subtotal (see instructions)	29,159,971	147,343,438	176,503,409			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	29,159,971	147,343,438	176,503,409			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1329 | Period: From 01/01/2017 To 12/31/2017 | Worksheet C Part I Date/Time Prepared: 5/17/2018 8:01 am

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
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
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	06000	LABORATORY	0.000000		60.00
60.01	06001	BLOOD LABORATORY	0.000000		60.01
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
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			
88.00	08800	RURAL HEALTH CLINIC	0.000000		88.00
90.00	09000	CLINIC	0.000000		90.00
90.01	09001	WOUND CLINC	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			
101.00	10100	HOME HEALTH AGENCY			101.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
116.00	11600	HOSPICE			116.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-1329 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part II Date/Time Prepared: 5/17/2018 8:01 am

Title XVIII | Hospital | Cost

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	241,553	16,843,647	0.014341	961,317	13,786	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	91,720	305,751	0.299983	1,321	396	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,187,805	61,308,344	0.019374	762,328	14,769	54.00
60.00	06000	LABORATORY	279,403	28,896,929	0.009669	1,457,745	14,095	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	158,900	4,723,437	0.033641	2,049,994	68,964	65.00
66.00	06600	PHYSICAL THERAPY	316,255	4,261,504	0.074212	118,377	8,785	66.00
67.00	06700	OCCUPATIONAL THERAPY	67,698	1,417,475	0.047760	73,697	3,520	67.00
68.00	06800	SPEECH PATHOLOGY	58,274	709,980	0.082078	58,280	4,784	68.00
69.00	06900	ELECTROCARDIOLOGY	144,289	4,836,738	0.029832	252,426	7,530	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	73,575	7,826,967	0.009400	1,136,462	10,683	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	235,047	2,264,290	0.103806	549,195	57,010	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	102,258	13,145,243	0.007779	1,652,521	12,855	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	101,515	783,344	0.129592	0	0	88.00
90.00	09000	CLINIC	787,722	6,282,455	0.125384	107,312	13,455	90.00
90.01	09001	WOUND CLINC	40,107	1,874,546	0.021396	16,113	345	90.01
91.00	09100	EMERGENCY	579,215	7,641,535	0.075798	34,090	2,584	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	166,875	862,902	0.193388	5,541	1,072	92.00
200.00		Total (lines 50 through 199)	4,632,211	163,985,087		9,236,719	234,633	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-1329 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part IV Date/Time Prepared: 5/17/2018 8:01 am

Title XVIII | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
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						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CLINC	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
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: 15-1329 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part IV Date/Time Prepared: 5/17/2018 8:01 am

Title XVIII | Hospital | Cost

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	16,843,647	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	305,751	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	61,308,344	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	28,896,929	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0.000000	60.01
65.00	06500	RESPIRATORY THERAPY	0	0	0	4,723,437	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	4,261,504	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,417,475	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	709,980	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	4,836,738	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	7,826,967	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	2,264,290	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	13,145,243	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	783,344	0.000000	88.00
90.00	09000	CLINIC	0	0	0	6,282,455	0.000000	90.00
90.01	09001	WOUND CLINC	0	0	0	1,874,546	0.000000	90.01
91.00	09100	EMERGENCY	0	0	0	7,641,535	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	862,902	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	163,985,087		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-1329 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part IV | Date/Time Prepared: 5/17/2018 8:01 am

Title XVIII | Hospital | Cost

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	961,317	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	1,321	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	762,328	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	1,457,745	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0.000000	2,049,994	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	118,377	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	73,697	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	58,280	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	252,426	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	1,136,462	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000	549,195	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	1,652,521	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
90.00	09000	CLINIC	0.000000	107,312	0	0	0	90.00
90.01	09001	WOUND CLINC	0.000000	16,113	0	0	0	90.01
91.00	09100	EMERGENCY	0.000000	34,090	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	5,541	0	0	0	92.00
200.00		Total (lines 50 through 199)		9,236,719	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1329 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part V Date/Time Prepared: 5/17/2018 8:01 am

Title XVIII | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.200918	0	2,952,400	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.408293	0	1,650	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.224350	0	21,373,199	4,364	0	54.00
60.00	06000	LABORATORY	0.200348	0	7,214,662	0	0	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0.256332	0	423,582	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.541771	0	1,171,778	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.515679	0	267,029	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.533905	0	30,113	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.298291	0	1,754,599	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.377170	0	1,266,287	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1.021635	0	294,040	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.330068	0	3,618,055	1,041	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
90.00	09000	CLINIC	0.559535	0	2,033,938	0	0	90.00
90.01	09001	WOUND CLINC	0.230015	0	844,914	124	0	90.01
91.00	09100	EMERGENCY	0.673492	0	1,921,764	910	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.468930	0	422,224	0	0	92.00
200.00		Subtotal (see instructions)		0	45,590,234	6,439	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	45,590,234	6,439	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1329 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part V Date/Time Prepared: 5/17/2018 8:01 am

Title XVIII | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	593,190	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,324	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,795,077	979		54.00
60.00	06000	LABORATORY	1,445,443	0		60.00
60.01	06001	BLOOD LABORATORY	0	0		60.01
65.00	06500	RESPIRATORY THERAPY	108,578	0		65.00
66.00	06600	PHYSICAL THERAPY	634,835	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	137,701	0		67.00
68.00	06800	SPEECH PATHOLOGY	16,077	0		68.00
69.00	06900	ELECTROCARDIOLOGY	523,381	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	477,605	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	300,402	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,194,204	344		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
90.00	09000	CLINIC	1,138,059	0		90.00
90.01	09001	WOUND CLINC	194,343	29		90.01
91.00	09100	EMERGENCY	1,294,293	613		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	620,218	0		92.00
200.00		Subtotal (see instructions)	13,475,730	1,965		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	13,475,730	1,965		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1329 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-1 | Date/Time Prepared: 5/17/2018 8:01 am

Title XVIII | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	4,851	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	4,851	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)	4,065	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	1,618	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	7,822,984	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	7,822,984	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)	7,822,984	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)	1,612.65	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	2,609,268	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)	2,609,268	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1329 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-1 | Date/Time Prepared: 5/17/2018 8:01 am

Title XVIII | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	681,255	280	2,433.05	175	425,784	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)	3,022,127	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	6,057,179	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	786	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,612.65	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,267,543	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1329 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-1 | Date/Time Prepared: 5/17/2018 8:01 am

Title XVIII | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	1,029,915	7,822,984	0.131652	1,267,543	166,875	90.00
91.00	Nursing School cost	0	7,822,984	0.000000	1,267,543	0	91.00
92.00	Allied health cost	0	7,822,984	0.000000	1,267,543	0	92.00
93.00	All other Medical Education	0	7,822,984	0.000000	1,267,543	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1329 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-1 | Date/Time Prepared: 5/17/2018 8:01 am

Title XIX | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	4,851	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	4,851	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)	4,065	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	55	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	986	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	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	7,822,984	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	7,822,984	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)	7,822,984	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)	1,612.65	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	88,696	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)	88,696	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1329 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-1 | Date/Time Prepared: 5/17/2018 8:01 am

Title XIX | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	1,182,087	986	1,198.87	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	681,255	280	2,433.05	1	2,433	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)	91,015	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	182,144	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	786	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,612.65	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,267,543	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1329 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-1 | Date/Time Prepared: 5/17/2018 8:01 am

Title XIX | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	1,029,915	7,822,984	0.131652	1,267,543	166,875	90.00
91.00	Nursing School cost	0	7,822,984	0.000000	1,267,543	0	91.00
92.00	Allied health cost	0	7,822,984	0.000000	1,267,543	0	92.00
93.00	All other Medical Education	0	7,822,984	0.000000	1,267,543	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1329 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-3 | Date/Time Prepared: 5/17/2018 8:01 am

Title XVIII | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		1,710,252		30.00
31.00	03100	INTENSIVE CARE UNIT		334,419		31.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.200918	961,317	193,146	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.408293	1,321	1,860	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.224350	762,328	171,028	54.00
60.00	06000	LABORATORY	0.200348	1,457,745	292,056	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0.256332	2,049,994	525,479	65.00
66.00	06600	PHYSICAL THERAPY	0.541771	118,377	64,133	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.515679	73,697	38,004	67.00
68.00	06800	SPEECH PATHOLOGY	0.533905	58,280	31,116	68.00
69.00	06900	ELECTROCARDIOLOGY	0.298291	252,426	75,296	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.377170	1,136,462	428,639	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1.021635	549,195	561,077	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.330068	1,652,521	545,444	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000	CLINIC	0.559535	107,312	60,045	90.00
90.01	09001	WOUND CLINC	0.230015	16,113	3,706	90.01
91.00	09100	EMERGENCY	0.673492	34,090	22,959	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.468930	5,541	8,139	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		9,236,719	3,022,127	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)		9,236,719		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1329 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-3 | Date/Time Prepared: 5/17/2018 8:01 am

Title XIX | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		7,337		30.00
31.00	03100	INTENSIVE CARE UNIT		1,279		31.00
43.00	04300	NURSERY		32,743		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.200918	14,037	2,820	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.408293	41,884	58,985	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.224350	4,451	999	54.00
60.00	06000	LABORATORY	0.200348	17,436	3,493	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0.256332	12,196	3,126	65.00
66.00	06600	PHYSICAL THERAPY	0.541771	174	94	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.515679	110	57	67.00
68.00	06800	SPEECH PATHOLOGY	0.533905	157	84	68.00
69.00	06900	ELECTROCARDIOLOGY	0.298291	981	293	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.377170	20,800	7,845	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1.021635	5,131	5,242	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.330068	16,999	5,611	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	1.905039	0	0	88.00
90.00	09000	CLINIC	0.559535	185	104	90.00
90.01	09001	WOUND CLINC	0.230015	17	4	90.01
91.00	09100	EMERGENCY	0.673492	3,352	2,258	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.468930	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		137,910	91,015	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)		137,910		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1329	Period: From 01/01/2017 To 12/31/2017	Worksheet E Part B Date/Time Prepared: 5/17/2018 8:01 am
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	13,477,695	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)	13,477,695	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)	13,612,472	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)	159,546	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	7,626,996	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	5,825,930	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	5,825,930	30.00
31.00	Primary payer payments	3,315	31.00
32.00	Subtotal (line 30 minus line 31)	5,822,615	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)	1,092,911	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	710,392	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	588,575	36.00
37.00	Subtotal (see instructions)	6,533,007	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)	6,533,007	40.00
40.01	Sequestration adjustment (see instructions)	130,660	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
41.00	Interim payments	6,790,349	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	-388,002	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: 15-1329 | Period: From 01/01/2017 To 12/31/2017 | Worksheet E-1 Part I Date/Time Prepared: 5/17/2018 8:01 am

Title XVIII | Hospital | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		4,927,913		6,790,349	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	07/27/2017	218,600		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)		218,600		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		5,146,513		6,790,349	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		280,623		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		388,002	6.02
7.00	Total Medicare program liability (see instructions)		5,427,136		6,402,347	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: 15-1329	Period: From 01/01/2017 To 12/31/2017	Worksheet E-1 Part II Date/Time Prepared: 5/17/2018 8:01 am
	Title XVIII	Hospital	Cost

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

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1329	Period: From 01/01/2017 To 12/31/2017	Worksheet E-3 Part V Date/Time Prepared: 5/17/2018 8:01 am
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	6,057,179	1.00
2.00	Nursing and Allied Health Managed Care payment (see instructions)	0	2.00
3.00	Organ acquisition	0	3.00
4.00	Subtotal (sum of lines 1 through 3)	6,057,179	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	6,117,751	6.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
7.00	Routine service charges	0	7.00
8.00	Ancillary service charges	0	8.00
9.00	Organ acquisition charges, net of revenue	0	9.00
10.00	Total reasonable charges	0	10.00
	Customary charges		
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)	0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)	0.000000	13.00
14.00	Total customary charges (see instructions)	0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)	0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)	0	16.00
17.00	Cost of physicians' services in a teaching hospital (see instructions)	0	17.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)	0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)	6,117,751	19.00
20.00	Deductibles (exclude professional component)	615,644	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	5,502,107	22.00
23.00	Coinsurance	1,974	23.00
24.00	Subtotal (line 22 minus line 23)	5,500,133	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	58,094	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	37,761	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	27,036	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	5,537,894	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)	5,537,894	30.00
30.01	Sequestration adjustment (see instructions)	110,758	30.01
30.02	Demonstration payment adjustment amount after sequestration	0	30.02
31.00	Interim payments	5,146,513	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)	280,623	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1329	Period: From 01/01/2017 To 12/31/2017	Worksheet E-3 Part VII Date/Time Prepared: 5/17/2018 8:01 am
	Title XIX	Hospital	Cost

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	182,144		1.00
2.00	Medical and other services		0	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	182,144	0	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	182,144	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	41,359		8.00
9.00	Ancillary service charges	137,910	0	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	179,269	0	12.00
	CUSTOMARY CHARGES			
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	179,269	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	0	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	2,875	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	182,144	0	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.			
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0		24.00
25.00	Capital exception payments (see instructions)	0		25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	182,144	0	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30.00	Excess of reasonable cost (from line 18)	2,875	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	182,144	0	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	182,144	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	182,144	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	182,144	0	40.00
41.00	Interim payments	111,746	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	70,398	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 15-1329 | Period: From 01/01/2017 To 12/31/2017 | Worksheet G | Date/Time Prepared: 5/17/2018 8:01 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	3,335,168	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	33,672,379	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-19,092,902	0	0	0	6.00
7.00	Inventory	1,063,357	0	0	0	7.00
8.00	Prepaid expenses	1,834,378	0	0	0	8.00
9.00	Other current assets	400,408	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)	21,212,788	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	2,553,658	0	0	0	12.00
13.00	Land improvements	557,745	0	0	0	13.00
14.00	Accumulated depreciation	-410,431	0	0	0	14.00
15.00	Buildings	80,587,989	0	0	0	15.00
16.00	Accumulated depreciation	-42,861,573	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	6,340,280	0	0	0	19.00
20.00	Accumulated depreciation	-6,163,103	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	58,892,305	0	0	0	23.00
24.00	Accumulated depreciation	-36,246,568	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)	63,250,302	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	82,670,632	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	82,670,632	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	167,133,722	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	2,504,486	0	0	0	37.00
38.00	Salaries, wages, and fees payable	0	0	0	0	38.00
39.00	Payroll taxes payable	6,567,697	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	3,388,898	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	12,461,081	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	26,709,584	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	26,709,584	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	39,170,665	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	127,963,057				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)	127,963,057	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	167,133,722	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-1329 | Period: From 01/01/2017 To 12/31/2017 | Worksheet G-1 | Date/Time Prepared: 5/17/2018 8:01 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		114,623,023		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		13,340,034				2.00
3.00	Total (sum of line 1 and line 2)		127,963,057		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)		127,963,057		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)		127,963,057		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: 15-1329 | Period: From 01/01/2017 To 12/31/2017 | Worksheet G-2 Parts I & II Date/Time Prepared: 5/17/2018 8:01 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	7,714,827		7,714,827	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)	7,714,827		7,714,827	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	551,189		551,189	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)	551,189		551,189	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	8,266,016		8,266,016	17.00
18.00	Ancillary services	20,504,588	126,035,717	146,540,305	18.00
19.00	Outpatient services	389,367	16,272,071	16,661,438	19.00
20.00	RURAL HEALTH CLINIC	0	783,344	783,344	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		1,879,747	1,879,747	22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE	0	2,372,559	2,372,559	26.00
27.00	NON-PROVIDER BASED	0	19,220,551	19,220,551	27.00
27.01	PROFESSIONAL FEES	675,257	11,748,221	12,423,478	27.01
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	29,835,228	178,312,210	208,147,438	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		96,956,138		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)		96,956,138		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 15-1329 | Period: From 01/01/2017 To 12/31/2017 | Worksheet G-3 | Date/Time Prepared: 5/17/2018 8:01 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	208,147,438	1.00
2.00	Less contractual allowances and discounts on patients' accounts	109,435,921	2.00
3.00	Net patient revenues (line 1 minus line 2)	98,711,517	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	96,956,138	4.00
5.00	Net income from service to patients (line 3 minus line 4)	1,755,379	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER INCOME	1,193,399	24.00
24.01	CONTRIBUTIONS	327,602	24.01
24.02	GAIN ON DISPOSAL	-174,925	24.02
24.03	INVESTMENT RETURN	6,473,270	24.03
24.04	UNREALIZED GAIN, DERIVATIVE	335,985	24.04
24.05	UNREALIZED GAIN, INVESTMENTS	3,400,343	24.05
24.06	TEMPORARILY RESTRICTED ASSETS	28,981	24.06
25.00	Total other income (sum of lines 6-24)	11,584,655	25.00
26.00	Total (line 5 plus line 25)	13,340,034	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)	13,340,034	29.00

ANALYSIS OF HOSPITAL-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 15-1329 HHA CCN: 15-7143 | Period: From 01/01/2017 To 12/31/2017 | Worksheet H | Date/Time Prepared: 5/17/2018 8:01 am

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		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	429,837	0	0	0	198,029	627,866	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	503,033	0	0	0	0	503,033	6.00
7.00	Physical Therapy	426,676	0	0	0	0	426,676	7.00
8.00	Occupational Therapy	176,617	0	0	0	0	176,617	8.00
9.00	Speech Pathology	3,588	0	0	0	0	3,588	9.00
10.00	Medical Social Services	13,236	0	0	0	0	13,236	10.00
11.00	Home Health Aide	38,944	0	0	0	0	38,944	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	191	0	0	0	0	191	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)	1,592,122	0	0	0	198,029	1,790,151	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	627,866	0	627,866			5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	503,033	0	503,033			6.00
7.00	Physical Therapy	0	426,676	0	426,676			7.00
8.00	Occupational Therapy	0	176,617	0	176,617			8.00
9.00	Speech Pathology	0	3,588	0	3,588			9.00
10.00	Medical Social Services	0	13,236	0	13,236			10.00
11.00	Home Health Aide	0	38,944	0	38,944			11.00
12.00	Supplies (see instructions)	0	0	0	0			12.00
13.00	Drugs	0	0	0	0			13.00
14.00	DME	0	0	0	0			14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0			15.00
16.00	Respiratory Therapy	0	191	0	191			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	1,790,151	0	1,790,151			24.00

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

COST ALLOCATION - HHA GENERAL SERVICE COST | Provider CCN: 15-1329 | HHA CCN: 15-7143 | Period: From 01/01/2017 To 12/31/2017 | Worksheet H-1 Part I | Date/Time Prepared: 5/17/2018 8:01 am

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		Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Capital Related Costs: Bldgs & Fixtures	Capital Related Costs: Movable Equipment	Plant Operation & Maintenance	Transportation	Subtotal (cols. 0-4)	
		0	1.00	2.00	3.00	4.00	4A.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0				0	1.00
2.00	Capital Related - Movable Equipment	0		0			0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0		0	3.00
4.00	Transportation	0	0	0	0	0		4.00
5.00	Administrative and General	627,866	0	0	0	0	627,866	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	503,033	0	0	0	0	503,033	6.00
7.00	Physical Therapy	426,676	0	0	0	0	426,676	7.00
8.00	Occupational Therapy	176,617	0	0	0	0	176,617	8.00
9.00	Speech Pathology	3,588	0	0	0	0	3,588	9.00
10.00	Medical Social Services	13,236	0	0	0	0	13,236	10.00
11.00	Home Health Aide	38,944	0	0	0	0	38,944	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0		0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	191	0	0	0	0	191	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)	1,790,151	0	0	0	0	1,790,151	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	627,866		5.00
	HHA REIMBURSABLE SERVICES			
6.00	Skilled Nursing Care	271,738	774,771	6.00
7.00	Physical Therapy	230,490	657,166	7.00
8.00	Occupational Therapy	95,409	272,026	8.00
9.00	Speech Pathology	1,938	5,526	9.00
10.00	Medical Social Services	7,150	20,386	10.00
11.00	Home Health Aide	21,038	59,982	11.00
12.00	Supplies (see instructions)	0	0	12.00
13.00	Drugs	0	0	13.00
14.00	DME	0	0	14.00
	HHA NONREIMBURSABLE SERVICES			
15.00	Home Dialysis Aide Services	0	0	15.00
16.00	Respiratory Therapy	103	294	16.00
17.00	Private Duty Nursing	0	0	17.00
18.00	Clinic	0	0	18.00
19.00	Health Promotion Activities	0	0	19.00
20.00	Day Care Program	0	0	20.00
21.00	Home Delivered Meals Program	0	0	21.00
22.00	Homemaker Service	0	0	22.00
23.00	All Others (specify)	0	0	23.00
23.50	Telemedicine	0	0	23.50
24.00	Total (sum of lines 1-23)		1,790,151	24.00

COST ALLOCATION - HHA STATISTICAL BASIS | Provider CCN: 15-1329 | HHA CCN: 15-7143 | Period: From 01/01/2017 To 12/31/2017 | Worksheet H-1 Part II Date/Time Prepared: 5/17/2018 8:01 am

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		Capital Related Costs						
		Bldgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)	Plant Operation & Maintenance (SQUARE FEET)	Transportation (MILEAGE)	Reconciliation	Administrative & General (ACCUM. COST)	
		1.00	2.00	3.00	4.00	5A.00	5.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0				0		1.00
2.00	Capital Related - Movable Equipment		0			0		2.00
3.00	Plant Operation & Maintenance	0	0	0		0		3.00
4.00	Transportation (see instructions)	0	0	0	0			4.00
5.00	Administrative and General	0	0	0	0	-627,866	1,162,285	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	0	503,033	6.00
7.00	Physical Therapy	0	0	0	0	0	426,676	7.00
8.00	Occupational Therapy	0	0	0	0	0	176,617	8.00
9.00	Speech Pathology	0	0	0	0	0	3,588	9.00
10.00	Medical Social Services	0	0	0	0	0	13,236	10.00
11.00	Home Health Aide	0	0	0	0	0	38,944	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	0	12.00
13.00	Drugs	0	0	0		0	0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	191	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	-627,866	1,162,285	24.00
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0	0		627,866	25.00
26.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000		0.540200	26.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 15-1329 | HHA CCN: 15-7143 | Period: From 01/01/2017 To 12/31/2017 | Worksheet H-2 Part I | Date/Time Prepared: 5/17/2018 8:01 am

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	Cost Center Description	HHA Trial Balance (1)	CAPITAL RELATED COSTS				EMPLOYEE BENEFITS DEPARTMENT	
			NEW BLDG & FIXT	NEW OFFSITE BLDG	NEW MVBLE EQUIP	NEW MVBLE EQUIP OFFSIT		
		0	1.00	1.01	2.00	2.01	4.00	
1.00	Administrative and General	0	48,251	2,543	86,842	947	466,772	1.00
2.00	Skilled Nursing Care	774,771	0	0	0	0	0	2.00
3.00	Physical Therapy	657,166	0	0	0	0	0	3.00
4.00	Occupational Therapy	272,026	0	0	0	0	0	4.00
5.00	Speech Pathology	5,526	0	0	0	0	0	5.00
6.00	Medical Social Services	20,386	0	0	0	0	0	6.00
7.00	Home Health Aide	59,982	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	294	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	1,790,151	48,251	2,543	86,842	947	466,772	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

	Cost Center Description	Subtotal	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	OPERATION OF PLANT -OFFSITE	OPERATION OF PLANT - HOSPITAL & OFFS	LAUNDRY & LINEN SERVICE	
		4A	5.00	7.00	7.01	7.02	8.00	
1.00	Administrative and General	605,355	124,933	89,459	730	17,173	0	1.00
2.00	Skilled Nursing Care	774,771	159,897	0	0	0	0	2.00
3.00	Physical Therapy	657,166	135,625	0	0	0	0	3.00
4.00	Occupational Therapy	272,026	56,140	0	0	0	0	4.00
5.00	Speech Pathology	5,526	1,140	0	0	0	0	5.00
6.00	Medical Social Services	20,386	4,207	0	0	0	0	6.00
7.00	Home Health Aide	59,982	12,379	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	294	61	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	2,395,506	494,382	89,459	730	17,173	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: 15-1329 HHA CCN: 15-7143 | Period: From 01/01/2017 To 12/31/2017 | Worksheet H-2 Part I Date/Time Prepared: 5/17/2018 8:01 am

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	Cost Center Description	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
		9.00	10.00	11.00	13.00	14.00	15.00	
1.00	Administrative and General	67,642	0	0	0	18	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)	67,642	0	0	0	18	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	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	Allocated HHA A&G (see Part II)	Total HHA Costs	
		16.00	24.00	25.00	26.00	27.00	28.00	
1.00	Administrative and General	0	905,310	0	905,310			1.00
2.00	Skilled Nursing Care	0	934,668	0	934,668	391,816	1,326,484	2.00
3.00	Physical Therapy	0	792,791	0	792,791	332,340	1,125,131	3.00
4.00	Occupational Therapy	0	328,166	0	328,166	137,568	465,734	4.00
5.00	Speech Pathology	0	6,666	0	6,666	2,794	9,460	5.00
6.00	Medical Social Services	0	24,593	0	24,593	10,309	34,902	6.00
7.00	Home Health Aide	0	72,361	0	72,361	30,334	102,695	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	355	0	355	149	504	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	3,064,910	0	3,064,910	905,310	3,064,910	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.					0.419203		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: 15-1329 HHA CCN: 15-7143

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

Worksheet H-2 Part II Date/Time Prepared: 5/17/2018 8:01 am

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	Cost Center Description	CAPITAL RELATED COSTS						
		NEW BLDG & FIXT (SQUARE FEET)	NEW OFFSITE BLDG (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)	NEW MVBLE EQUIP OFFSIT (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	
		1.00	1.01	2.00	2.01	4.00	5A	
1.00	Administrative and General	3,415	219	3,415	219	1,592,122	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	3,415	219	3,415	219	1,592,122		20.00
21.00	Total cost to be allocated	48,251	2,543	86,842	947	466,772		21.00
22.00	Unit cost multiplier	14.129136	11.611872	25.429575	4.324201	0.293176		22.00

	Cost Center Description	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	OPERATION OF PLANT -OFFSITE (SQUARE FEET)	OPERATION OF PLANT - HOSPITAL & OFFS (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	
		5.00	7.00	7.01	7.02	8.00	9.00	
1.00	Administrative and General	605,355	3,415	219	3,634	0	3,634	1.00
2.00	Skilled Nursing Care	774,771	0	0	0	0	0	2.00
3.00	Physical Therapy	657,166	0	0	0	0	0	3.00
4.00	Occupational Therapy	272,026	0	0	0	0	0	4.00
5.00	Speech Pathology	5,526	0	0	0	0	0	5.00
6.00	Medical Social Services	20,386	0	0	0	0	0	6.00
7.00	Home Health Aide	59,982	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	294	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)	2,395,506	3,415	219	3,634	0	3,634	20.00
21.00	Total cost to be allocated	494,382	89,459	730	17,173	0	67,642	21.00
22.00	Unit cost multiplier	0.206379	26.195900	3.333333	4.725647	0.000000	18.613649	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 15-1329
HHA CCN: 15-7143

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

Worksheet H-2 Part II
Date/Time Prepared: 5/17/2018 8:01 am

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	Cost Center Description	DIETARY (MEALS SERVED)	CAFETERIA (HOURS OF SERVICE)	NURSING ADMINISTRATION (HOURS OF SERVICE)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (100% PHARMACY)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	
		10.00	11.00	13.00	14.00	15.00	16.00	
1.00	Administrative and General	0	0	0	30,504	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	30,504	0	0	20.00
21.00	Total cost to be allocated	0	0	0	18	0	0	21.00
22.00	Unit cost multiplier	0.000000	0.000000	0.000000	0.000590	0.000000	0.000000	22.00

APPORTIONMENT OF PATIENT SERVICE COSTS | Provider CCN: 15-1329 | HHA CCN: 15-7143 | Period: From 01/01/2017 To 12/31/2017 | Worksheet H-3 Part I | Date/Time Prepared: 5/17/2018 8:01 am

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	Cost Center Description	From, Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Visits	Average Cost Per Visit (col. 3 ÷ col. 4)	
		0	1.00	2.00	3.00	4.00	5.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	2.00	1,326,484		1,326,484	5,033	263.56	1.00
2.00	Physical Therapy	3.00	1,125,131	0	1,125,131	3,008	374.05	2.00
3.00	Occupational Therapy	4.00	465,734	0	465,734	1,306	356.61	3.00
4.00	Speech Pathology	5.00	9,460	0	9,460	54	175.19	4.00
5.00	Medical Social Services	6.00	34,902		34,902	8	4,362.75	5.00
6.00	Home Health Aide	7.00	102,695		102,695	897	114.49	6.00
7.00	Total (sum of lines 1-6)		3,064,406	0	3,064,406	10,306		7.00

	Cost Center Description	Cost Limits	CBSA No. (1)	Program Visits: Part A	Program Visits: Part B Not Subject to Deductibles & Coinsurance	Program Visits: Part B Subject to Deductibles		
		0	1.00	2.00	3.00	4.00	5.00	
	Limitation Cost Computation							
8.00	Skilled Nursing Care		99915	0	2,536			8.00
8.01	Skilled Nursing Care		17140	0	291			8.01
9.00	Physical Therapy		99915	0	1,560			9.00
9.01	Physical Therapy		17140	0	210			9.01
10.00	Occupational Therapy		99915	0	657			10.00
10.01	Occupational Therapy		17140	0	71			10.01
11.00	Speech Pathology		99915	0	31			11.00
11.01	Speech Pathology		17140	0	5			11.01
12.00	Medical Social Services		99915	0	7			12.00
12.01	Medical Social Services		17140	0	0			12.01
13.00	Home Health Aide		99915	0	456			13.00
13.01	Home Health Aide		17140	0	123			13.01
14.00	Total (sum of lines 8-13)			0	5,947			14.00

	Cost Center Description	From Wkst. H-2 Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Charges (from HHA Records)	Ratio (col. 3 ÷ col. 4)	
		0	1.00	2.00	3.00	4.00	5.00	
	Supplies and Drugs Cost Computations							
15.00	Cost of Medical Supplies	8.00	0	0	0	0	0.000000	15.00
16.00	Cost of Drugs	9.00	0	0	0	0	0.000000	16.00

	Cost Center Description	Program Visits: Part A	Program Visits: Part B Not Subject to Deductibles & Coinsurance	Program Visits: Part B Subject to Deductibles & Coinsurance	Cost of Services: Part A	Cost of Services: Part B Not Subject to Deductibles & Coinsurance	Cost of Services: Part B Subject to Deductibles & Coinsurance	
		6.00	7.00	8.00	9.00	10.00	11.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	0	2,827		0	745,084		1.00
2.00	Physical Therapy	0	1,770		0	662,069		2.00
3.00	Occupational Therapy	0	728		0	259,612		3.00
4.00	Speech Pathology	0	36		0	6,307		4.00
5.00	Medical Social Services	0	7		0	30,539		5.00
6.00	Home Health Aide	0	579		0	66,290		6.00
7.00	Total (sum of lines 1-6)	0	5,947		0	1,769,901		7.00

APPORTIONMENT OF PATIENT SERVICE COSTS | Provider CCN: 15-1329 HHA CCN: 15-7143 | Period: From 01/01/2017 To 12/31/2017 | Worksheet H-3 Part I Date/Time Prepared: 5/17/2018 8:01 am

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	Cost Center Description							
		6.00	7.00	8.00	9.00	10.00	11.00	
	Limitation Cost Computation							
8.00	Skilled Nursing Care							8.00
8.01	Skilled Nursing Care							8.01
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 A	Part B		Part A	Part B		
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance		Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
		6.00	7.00	8.00	9.00	10.00	11.00	
	Supplies and Drugs Cost Computations							
15.00	Cost of Medical Supplies	0	0	0	0	0	0	15.00
16.00	Cost of Drugs	0	0	0		0	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	745,084						1.00
2.00	Physical Therapy	662,069						2.00
3.00	Occupational Therapy	259,612						3.00
4.00	Speech Pathology	6,307						4.00
5.00	Medical Social Services	30,539						5.00
6.00	Home Health Aide	66,290						6.00
7.00	Total (sum of lines 1-6)	1,769,901						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: 15-1329 | HHA CCN: 15-7143 | Period: From 01/01/2017 To 12/31/2017 | Worksheet H-3 Part II | Date/Time Prepared: 5/17/2018 8:01 am

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	Cost Center Description	From Wkst. C, Part I, col. 9, line	Cost to Charge Ratio	Total HHA Charge (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)	Transfer to Part I as Indicated		
		0	1.00	2.00	3.00	4.00		
	PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS							
1.00	Physical Therapy	66.00	0.541771	0	0	col. 2, line 2.00		1.00
2.00	Occupational Therapy	67.00	0.515679	0	0	col. 2, line 3.00		2.00
3.00	Speech Pathology	68.00	0.533905	0	0	col. 2, line 4.00		3.00
4.00	Cost of Medical Supplies	71.00	0.377170	0	0	col. 2, line 15.00		4.00
5.00	Cost of Drugs	73.00	0.330068	0	0	col. 2, line 16.00		5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1329 HHA CCN: 15-7143	Period: From 01/01/2017 To 12/31/2017	Worksheet H-4 Part I-II Date/Time Prepared: 5/17/2018 8:01 am
	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	784,068	11.00
12.00	Total PPS Reimbursement - Full Episodes with Outliers	0	147,395	12.00
13.00	Total PPS Reimbursement - LUPA Episodes	0	11,740	13.00
14.00	Total PPS Reimbursement - PEP Episodes	0	5,429	14.00
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers	0	36,945	15.00
16.00	Total PPS Outlier Reimbursement - PEP Episodes	0	1,960	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	987,537	22.00
23.00	Excess reasonable cost (from line 8)	0	0	23.00
24.00	Subtotal (line 22 minus line 23)	0	987,537	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	987,537	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	987,537	29.00
30.00	OTHER ADJUSTMENT	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	987,537	31.00
31.01	Sequestration adjustment (see instructions)	0	19,748	31.01
31.02	Demonstration payment adjustment amount after sequestration	0	150	31.02
32.00	Interim payments (see instructions)	0	967,638	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	1	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: 15-1329 | HHA CCN: 15-7143 | Period: From 01/01/2017 To 12/31/2017 | Worksheet H-5 | Date/Time Prepared: 5/17/2018 8:01 am

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		967,638	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		967,638	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		151	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		0		967,789	7.00

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

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS

Provider CCN: 15-1329 | Hospice CCN: 15-1551 | Period: From 01/01/2017 To 12/31/2017 | Worksheet O | Date/Time Prepared: 5/17/2018 8:01 am

Hospice I

		SALARIES	OTHER	SUBTOTAL (col. 1 plus col. 2)	RECLASSIFI-CATIONS	SUBTOTAL	
		1.00	2.00	3.00	4.00	5.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT*		0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP*		0	0	0	0	2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT*	0	0	0	0	0	3.00
4.00	ADMINISTRATIVE & GENERAL*	180,675	157,854	338,529	0	338,529	4.00
5.00	PLANT OPERATION & MAINTENANCE*	0	11,815	11,815	0	11,815	5.00
6.00	LAUNDRY & LINEN SERVICE*	0	0	0	0	0	6.00
7.00	HOUSEKEEPING*	0	0	0	0	0	7.00
8.00	DIETARY*	0	0	0	0	0	8.00
9.00	NURSING ADMINISTRATION*	0	0	0	0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES*	0	0	0	0	0	10.00
11.00	MEDICAL RECORDS*	0	0	0	0	0	11.00
12.00	STAFF TRANSPORTATION*	0	58,878	58,878	0	58,878	12.00
13.00	VOLUNTEER SERVICE COORDINATION*	0	0	0	0	0	13.00
14.00	PHARMACY*	0	144,030	144,030	0	144,030	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES*	0	0	0	0	0	15.00
16.00	OTHER GENERAL SERVICE*	0	0	0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES						17.00
	DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED**		0	0	0	0	25.00
26.00	PHYSICIAN SERVICES**	0	14,400	14,400	0	14,400	26.00
27.00	NURSE PRACTITIONER**	194	0	194	0	194	27.00
28.00	REGISTERED NURSE**	281,720	0	281,720	0	281,720	28.00
29.00	LPN/LVN**	36,214	0	36,214	0	36,214	29.00
30.00	PHYSICAL THERAPY**	0	0	0	0	0	30.00
31.00	OCCUPATIONAL THERAPY**	0	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY**	0	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES**	60,040	0	60,040	0	60,040	33.00
34.00	SPIRITUAL COUNSELING**	27,139	0	27,139	0	27,139	34.00
35.00	DIETARY COUNSELING**	0	0	0	0	0	35.00
36.00	COUNSELING - OTHER**	0	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES**	93,780	0	93,780	0	93,780	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN**	0	0	0	0	0	38.00
39.00	PATIENT TRANSPORTATION**	0	0	0	0	0	39.00
40.00	IMAGING SERVICES**	0	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS**	0	0	0	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE**	0	0	0	0	0	42.00
42.50	DRUGS CHARGED TO PATIENTS**	0	0	0	0	0	42.50
43.00	OUTPATIENT SERVICES**	0	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY**	0	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY**	0	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)**	0	0	0	0	0	46.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM *	0	0	0	0	0	60.00
61.00	VOLUNTEER PROGRAM *	0	0	0	0	0	61.00
62.00	FUNDRAISING*	0	0	0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS*	0	0	0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM*	0	0	0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES*	0	0	0	0	0	65.00
66.00	RESIDENTIAL CARE*	0	0	0	0	0	66.00
67.00	ADVERTISING*	0	0	0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING*	0	0	0	0	0	68.00
69.00	THRIFT STORE*	0	0	0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD*	0	0	0	0	0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)*	0	0	0	0	0	71.00
100.00	TOTAL	679,762	386,977	1,066,739	0	1,066,739	100.00

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

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS

Provider CCN: 15-1329 | Hospice CCN: 15-1551 | Period: From 01/01/2017 To 12/31/2017 | Worksheet O | Date/Time Prepared: 5/17/2018 8:01 am

Hospice I

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)		
		6.00	7.00		
	GENERAL SERVICE COST CENTERS				
1.00	CAP REL COSTS-BLDG & FIXT*	0	0		1.00
2.00	CAP REL COSTS-MVBLE EQUIP*	0	0		2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT*	0	0		3.00
4.00	ADMINISTRATIVE & GENERAL*	0	338,529		4.00
5.00	PLANT OPERATION & MAINTENANCE*	0	11,815		5.00
6.00	LAUNDRY & LINEN SERVICE*	0	0		6.00
7.00	HOUSEKEEPING*	0	0		7.00
8.00	DIETARY*	0	0		8.00
9.00	NURSING ADMINISTRATION*	0	0		9.00
10.00	ROUTINE MEDICAL SUPPLIES*	0	0		10.00
11.00	MEDICAL RECORDS*	0	0		11.00
12.00	STAFF TRANSPORTATION*	0	58,878		12.00
13.00	VOLUNTEER SERVICE COORDINATION*	0	0		13.00
14.00	PHARMACY*	0	144,030		14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES*	0	0		15.00
16.00	OTHER GENERAL SERVICE*	0	0		16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES				17.00
	DIRECT PATIENT CARE SERVICE COST CENTERS				
25.00	INPATIENT CARE-CONTRACTED**	0	0		25.00
26.00	PHYSICIAN SERVICES**	0	14,400		26.00
27.00	NURSE PRACTITIONER**	0	194		27.00
28.00	REGISTERED NURSE**	0	281,720		28.00
29.00	LPN/LVN**	0	36,214		29.00
30.00	PHYSICAL THERAPY**	0	0		30.00
31.00	OCCUPATIONAL THERAPY**	0	0		31.00
32.00	SPEECH/LANGUAGE PATHOLOGY**	0	0		32.00
33.00	MEDICAL SOCIAL SERVICES**	0	60,040		33.00
34.00	SPIRITUAL COUNSELING**	0	27,139		34.00
35.00	DIETARY COUNSELING**	0	0		35.00
36.00	COUNSELING - OTHER**	0	0		36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES**	0	93,780		37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN**	0	0		38.00
39.00	PATIENT TRANSPORTATION**	0	0		39.00
40.00	IMAGING SERVICES**	0	0		40.00
41.00	LABS & DIAGNOSTICS**	0	0		41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE**	0	0		42.00
42.50	DRUGS CHARGED TO PATIENTS**	0	0		42.50
43.00	OUTPATIENT SERVICES**	0	0		43.00
44.00	PALLIATIVE RADIATION THERAPY**	0	0		44.00
45.00	PALLIATIVE CHEMOTHERAPY**	0	0		45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)**	0	0		46.00
	NONREIMBURSABLE COST CENTERS				
60.00	BEREAVEMENT PROGRAM *	0	0		60.00
61.00	VOLUNTEER PROGRAM *	0	0		61.00
62.00	FUNDRAISING*	0	0		62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS*	0	0		63.00
64.00	PALLIATIVE CARE PROGRAM*	0	0		64.00
65.00	OTHER PHYSICIAN SERVICES*	0	0		65.00
66.00	RESIDENTIAL CARE*	0	0		66.00
67.00	ADVERTISING*	0	0		67.00
68.00	TELEHEALTH/TELEMONITORING*	0	0		68.00
69.00	THRIFT STORE*	0	0		69.00
70.00	NURSING FACILITY ROOM & BOARD*	0	0		70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)*	0	0		71.00
100.00	TOTAL	0	1,066,739		100.00

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

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

Provider CCN: 15-1329 Hospice CCN: 15-1551 | Period: From 01/01/2017 To 12/31/2017 | Worksheet O-2 | Date/Time Prepared: 5/17/2018 8:01 am

Hospice I

		SALARIES	OTHER	SUBTOTAL (col. 1 + col. 2)	RECLASSIFI-CATIONS	SUBTOTAL	
		1.00	2.00	3.00	4.00	5.00	
	DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED						25.00
26.00	PHYSICIAN SERVICES	0	14,400	14,400	0	14,400	26.00
27.00	NURSE PRACTITIONER	194	0	194	0	194	27.00
28.00	REGISTERED NURSE	281,103	0	281,103	0	281,103	28.00
29.00	LPN/LVN	36,135	0	36,135	0	36,135	29.00
30.00	PHYSICAL THERAPY	0	0	0	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	59,908	0	59,908	0	59,908	33.00
34.00	SPIRITUAL COUNSELING	27,080	0	27,080	0	27,080	34.00
35.00	DIETARY COUNSELING	0	0	0	0	0	35.00
36.00	COUNSELING - OTHER	0	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	93,574	0	93,574	0	93,574	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	0	0	0	38.00
39.00	PATIENT TRANSPORTATION	0	0	0	0	0	39.00
40.00	IMAGING SERVICES	0	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	0	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	0	0	0	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	42.50
43.00	OUTPATIENT SERVICES	0	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	0	0	0	46.00
100.00	TOTAL *	497,994	14,400	512,394	0	512,394	100.00

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

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)		
		6.00	7.00		
	DIRECT PATIENT CARE SERVICE COST CENTERS				
25.00	INPATIENT CARE-CONTRACTED				25.00
26.00	PHYSICIAN SERVICES	0	14,400		26.00
27.00	NURSE PRACTITIONER	0	194		27.00
28.00	REGISTERED NURSE	0	281,103		28.00
29.00	LPN/LVN	0	36,135		29.00
30.00	PHYSICAL THERAPY	0	0		30.00
31.00	OCCUPATIONAL THERAPY	0	0		31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0		32.00
33.00	MEDICAL SOCIAL SERVICES	0	59,908		33.00
34.00	SPIRITUAL COUNSELING	0	27,080		34.00
35.00	DIETARY COUNSELING	0	0		35.00
36.00	COUNSELING - OTHER	0	0		36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	93,574		37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0		38.00
39.00	PATIENT TRANSPORTATION	0	0		39.00
40.00	IMAGING SERVICES	0	0		40.00
41.00	LABS & DIAGNOSTICS	0	0		41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0		42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0		42.50
43.00	OUTPATIENT SERVICES	0	0		43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0		44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0		45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0		46.00
100.00	TOTAL *	0	512,394		100.00

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

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

Provider CCN: 15-1329 Hospice CCN: 15-1551 | Period: From 01/01/2017 To 12/31/2017 | Worksheet O-3 | Date/Time Prepared: 5/17/2018 8:01 am

Hospice I

		SALARIES	OTHER	SUBTOTAL (col. 1 + col. 2)	RECLASSIFI-CATIONS	SUBTOTAL	
		1.00	2.00	3.00	4.00	5.00	
	DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED		0	0	0	0	25.00
26.00	PHYSICIAN SERVICES	0	0	0	0	0	26.00
27.00	NURSE PRACTITIONER	0	0	0	0	0	27.00
28.00	REGISTERED NURSE	477	0	477	0	477	28.00
29.00	LPN/LVN	61	0	61	0	61	29.00
30.00	PHYSICAL THERAPY	0	0	0	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	102	0	102	0	102	33.00
34.00	SPIRITUAL COUNSELING	46	0	46	0	46	34.00
35.00	DIETARY COUNSELING	0	0	0	0	0	35.00
36.00	COUNSELING - OTHER	0	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	160	0	160	0	160	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	0	0	0	38.00
39.00	PATIENT TRANSPORTATION	0	0	0	0	0	39.00
40.00	IMAGING SERVICES	0	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	0	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	0	0	0	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	42.50
43.00	OUTPATIENT SERVICES	0	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	0	0	0	46.00
100.00	TOTAL *	846	0	846	0	846	100.00

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

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)		
		6.00	7.00		
	DIRECT PATIENT CARE SERVICE COST CENTERS				
25.00	INPATIENT CARE-CONTRACTED	0	0		25.00
26.00	PHYSICIAN SERVICES	0	0		26.00
27.00	NURSE PRACTITIONER	0	0		27.00
28.00	REGISTERED NURSE	0	477		28.00
29.00	LPN/LVN	0	61		29.00
30.00	PHYSICAL THERAPY	0	0		30.00
31.00	OCCUPATIONAL THERAPY	0	0		31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0		32.00
33.00	MEDICAL SOCIAL SERVICES	0	102		33.00
34.00	SPIRITUAL COUNSELING	0	46		34.00
35.00	DIETARY COUNSELING	0	0		35.00
36.00	COUNSELING - OTHER	0	0		36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	160		37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0		38.00
39.00	PATIENT TRANSPORTATION	0	0		39.00
40.00	IMAGING SERVICES	0	0		40.00
41.00	LABS & DIAGNOSTICS	0	0		41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0		42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0		42.50
43.00	OUTPATIENT SERVICES	0	0		43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0		44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0		45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0		46.00
100.00	TOTAL *	0	846		100.00

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

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

Provider CCN: 15-1329 | Hospice CCN: 15-1551 | Period: From 01/01/2017 To 12/31/2017 | Worksheet O-4 | Date/Time Prepared: 5/17/2018 8:01 am

Hospice I

		SALARIES	OTHER	SUBTOTAL (col. 1 + col. 2)	RECLASSIFI-CATIONS	SUBTOTAL	
		1.00	2.00	3.00	4.00	5.00	
	DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED		0	0	0	0	25.00
26.00	PHYSICIAN SERVICES	0	0	0	0	0	26.00
27.00	NURSE PRACTITIONER	0	0	0	0	0	27.00
28.00	REGISTERED NURSE	140	0	140	0	140	28.00
29.00	LPN/LVN	18	0	18	0	18	29.00
30.00	PHYSICAL THERAPY	0	0	0	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	30	0	30	0	30	33.00
34.00	SPIRITUAL COUNSELING	13	0	13	0	13	34.00
35.00	DIETARY COUNSELING	0	0	0	0	0	35.00
36.00	COUNSELING - OTHER	0	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	46	0	46	0	46	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	0	0	0	38.00
39.00	PATIENT TRANSPORTATION	0	0	0	0	0	39.00
40.00	IMAGING SERVICES	0	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	0	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	0	0	0	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	42.50
43.00	OUTPATIENT SERVICES	0	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	0	0	0	46.00
100.00	TOTAL *	247	0	247	0	247	100.00

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

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)		
		6.00	7.00		
	DIRECT PATIENT CARE SERVICE COST CENTERS				
25.00	INPATIENT CARE-CONTRACTED	0	0		25.00
26.00	PHYSICIAN SERVICES	0	0		26.00
27.00	NURSE PRACTITIONER	0	0		27.00
28.00	REGISTERED NURSE	0	140		28.00
29.00	LPN/LVN	0	18		29.00
30.00	PHYSICAL THERAPY	0	0		30.00
31.00	OCCUPATIONAL THERAPY	0	0		31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0		32.00
33.00	MEDICAL SOCIAL SERVICES	0	30		33.00
34.00	SPIRITUAL COUNSELING	0	13		34.00
35.00	DIETARY COUNSELING	0	0		35.00
36.00	COUNSELING - OTHER	0	0		36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	46		37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0		38.00
39.00	PATIENT TRANSPORTATION	0	0		39.00
40.00	IMAGING SERVICES	0	0		40.00
41.00	LABS & DIAGNOSTICS	0	0		41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0		42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0		42.50
43.00	OUTPATIENT SERVICES	0	0		43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0		44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0		45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0		46.00
100.00	TOTAL *	0	247		100.00

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

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

Provider CCN: 15-1329 Hospice CCN: 15-1551

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

Worksheet O-5

Date/Time Prepared: 5/17/2018 8:01 am

Hospice I

	Descriptions	HOSPICE DIRECT EXPENSES (see instructions)	GENERAL SERVICE EXPENSES FROM WKST B PART I (see instructions)	TOTAL EXPENSES (sum of cols. 1 + 2)	
		1.00	2.00	3.00	
	GENERAL SERVICE COST CENTERS				
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	0	199,290	199,290	3.00
4.00	ADMINISTRATIVE & GENERAL	338,529	261,282	599,811	4.00
5.00	PLANT OPERATION & MAINTENANCE	11,815	0	11,815	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0	6.00
7.00	HOUSEKEEPING	0	0	0	7.00
8.00	DIETARY	0	0	0	8.00
9.00	NURSING ADMINISTRATION	0	0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	13	13	10.00
11.00	MEDICAL RECORDS	0	0	0	11.00
12.00	STAFF TRANSPORTATION	58,878		58,878	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0		0	13.00
14.00	PHARMACY	144,030	0	144,030	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0		0	15.00
16.00	OTHER GENERAL SERVICE	0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES		0	0	17.00
	LEVEL OF CARE				
50.00	HOSPICE CONTINUOUS HOME CARE	0		0	50.00
51.00	HOSPICE ROUTINE HOME CARE	512,394		512,394	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	846		846	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	247		247	53.00
	NONREIMBURSABLE COST CENTERS				
60.00	BEREAVEMENT PROGRAM	0		0	60.00
61.00	VOLUNTEER PROGRAM	0		0	61.00
62.00	FUNDRAISING	0		0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0		0	63.00
64.00	PALLIATIVE CARE PROGRAM	0		0	64.00
65.00	OTHER PHYSICIAN SERVICES	0		0	65.00
66.00	RESIDENTIAL CARE	0		0	66.00
67.00	ADVERTISING	0		0	67.00
68.00	TELEHEALTH/TELEMONITORING	0		0	68.00
69.00	THRIFT STORE	0		0	69.00
70.00	NURSING FACILITY ROOM & BOARD	0		0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0		0	71.00
99.00	NEGATIVE COST CENTER	0		0	99.00
100.00	TOTAL	1,066,739	460,585	1,527,324	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS | Provider CCN: 15-1329 | Hospice CCN: 15-1551 | Period: From 01/01/2017 To 12/31/2017 | Worksheet O-6 Part I Date/Time Prepared: 5/17/2018 8:01 am

Hospice I

	Descriptions	TOTAL EXPENSES	CAP REL BLDG & FIX	CAP REL MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	SUBTOTAL	
		0	1.00	2.00	3.00	3A	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0		0			2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	199,290	0	0	199,290		3.00
4.00	ADMINISTRATIVE & GENERAL	599,811	0	0	0	599,811	4.00
5.00	PLANT OPERATION & MAINTENANCE	11,815	0	0	0	11,815	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0	0	0	6.00
7.00	HOUSEKEEPING	0	0	0	0	0	7.00
8.00	DIETARY	0	0	0	0	0	8.00
9.00	NURSING ADMINISTRATION	0	0	0	0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES	13	0	0	0	13	10.00
11.00	MEDICAL RECORDS	0	0	0	0	0	11.00
12.00	STAFF TRANSPORTATION	58,878	0	0	0	58,878	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0	0	0	0	0	13.00
14.00	PHARMACY	144,030	0	0	0	144,030	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0	0	0	0	15.00
16.00	OTHER GENERAL SERVICE	0	0	0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES		0	0		0	17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0			0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	512,394			198,853	711,247	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	846	0	0	338	1,184	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	247	0	0	99	346	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0	0	0	0	0	60.00
61.00	VOLUNTEER PROGRAM	0	0	0	0	0	61.00
62.00	FUNDRAISING	0	0	0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0	0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0	0	0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES	0	0	0	0	0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0	0	0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING	0	0	0	0	0	68.00
69.00	THRIFT STORE	0	0	0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD	0				0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER	0	0	0	0		99.00
100.00	TOTAL	1,527,324	0	0	199,290	1,527,324	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS | Provider CCN: 15-1329 Hospice CCN: 15-1551 | Period: From 01/01/2017 To 12/31/2017 | Worksheet O-6 Part I Date/Time Prepared: 5/17/2018 8:01 am

Hospice I

	Descriptions	ADMINISTRATIVE & GENERAL	PLANT OPERATION & MAINTENANCE	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		4.00	5.00	6.00	7.00	8.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL	599,811					4.00
5.00	PLANT OPERATION & MAINTENANCE	7,641	19,456				5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0			6.00
7.00	HOUSEKEEPING	0	0		0		7.00
8.00	DIETARY	0	0		0	0	8.00
9.00	NURSING ADMINISTRATION	0	0		0		9.00
10.00	ROUTINE MEDICAL SUPPLIES	8	0		0		10.00
11.00	MEDICAL RECORDS	0	0		0		11.00
12.00	STAFF TRANSPORTATION	38,076	0		0		12.00
13.00	VOLUNTEER SERVICE COORDINATION	0	0		0		13.00
14.00	PHARMACY	93,142	0		0		14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0		0		15.00
16.00	OTHER GENERAL SERVICE	0	0		0		16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0	0		0		17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0					50.00
51.00	HOSPICE ROUTINE HOME CARE	459,954					51.00
52.00	HOSPICE INPATIENT RESPITE CARE	766	15,063	0	0	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	224	4,393	0	0	0	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0	0		0		60.00
61.00	VOLUNTEER PROGRAM	0	0		0		61.00
62.00	FUNDRAISING	0	0		0		62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0		0		63.00
64.00	PALLIATIVE CARE PROGRAM	0	0		0		64.00
65.00	OTHER PHYSICIAN SERVICES	0	0		0		65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0	0		0		67.00
68.00	TELEHEALTH/TELEMONITORING	0	0		0		68.00
69.00	THRIFT STORE	0	0		0		69.00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER	0	0	0	0	0	99.00
100.00	TOTAL	599,811	19,456	0	0	0	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS | Provider CCN: 15-1329 | Hospice CCN: 15-1551 | Period: From 01/01/2017 To 12/31/2017 | Worksheet O-6 Part I | Date/Time Prepared: 5/17/2018 8:01 am

Hospice I

	Descriptions	NURSING ADMINISTRATION	ROUTINE MEDICAL SUPPLIES	MEDICAL RECORDS	STAFF TRANSPORTATION	VOLUNTEER SERVICE COORDINATION	
		9.00	10.00	11.00	12.00	13.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5.00
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPING						7.00
8.00	DIETARY						8.00
9.00	NURSING ADMINISTRATION	0					9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	21				10.00
11.00	MEDICAL RECORDS	0		0			11.00
12.00	STAFF TRANSPORTATION	0			96,954		12.00
13.00	VOLUNTEER SERVICE COORDINATION	0			0	0	13.00
14.00	PHARMACY	0			0	0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0			0	0	15.00
16.00	OTHER GENERAL SERVICE	0			0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES						17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0	0	0	0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	0	21	0	96,741	0	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0	0	165	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	0	48	0	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0			0	0	60.00
61.00	VOLUNTEER PROGRAM	0			0	0	61.00
62.00	FUNDRAISING	0			0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0			0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0			0	0	64.00
65.00	OTHER PHYSICIAN SERVICES	0			0	0	65.00
66.00	RESIDENTIAL CARE	0			0	0	66.00
67.00	ADVERTISING	0			0	0	67.00
68.00	TELEHEALTH/TELEMONITORING	0			0	0	68.00
69.00	THRIFT STORE	0			0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0			0	0	71.00
99.00	NEGATIVE COST CENTER	0	0	0	0	0	99.00
100.00	TOTAL	0	21	0	96,954	0	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS | Provider CCN: 15-1329 Hospice CCN: 15-1551 | Period: From 01/01/2017 To 12/31/2017 | Worksheet O-6 Part I Date/Time Prepared: 5/17/2018 8:01 am

Hospice I

	Descriptions	PHARMACY	PHYSICIAN ADMINISTRATIVE SERVICES	OTHER GENERAL SERVICE	PATIENT/ RESIDENTIAL CARE SERVICES	TOTAL	
		14.00	15.00	16.00	17.00	18.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5.00
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPING						7.00
8.00	DIETARY						8.00
9.00	NURSING ADMINISTRATION						9.00
10.00	ROUTINE MEDICAL SUPPLIES						10.00
11.00	MEDICAL RECORDS						11.00
12.00	STAFF TRANSPORTATION						12.00
13.00	VOLUNTEER SERVICE COORDINATION						13.00
14.00	PHARMACY	237,172					14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0				15.00
16.00	OTHER GENERAL SERVICE	0		0			16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES				0		17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0	0	0		0	50.00
51.00	HOSPICE ROUTINE HOME CARE	236,653	0	0		1,504,616	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	402	0	0	0	17,580	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	117	0	0	0	5,128	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0		0		0	60.00
61.00	VOLUNTEER PROGRAM	0		0		0	61.00
62.00	FUNDRAISING	0		0		0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0		0		0	63.00
64.00	PALLIATIVE CARE PROGRAM	0		0		0	64.00
65.00	OTHER PHYSICIAN SERVICES	0		0		0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0		0		0	67.00
68.00	TELEHEALTH/TELEMONITORING	0		0		0	68.00
69.00	THRIFT STORE	0		0		0	69.00
70.00	NURSING FACILITY ROOM & BOARD					0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER	0	0	0	0	0	99.00
100.00	TOTAL	237,172	0	0	0	1,527,324	100.00

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

Provider CCN: 15-1329
Hospice CCN: 15-1551

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

Worksheet O-6
Part II
Date/Time Prepared:
5/17/2018 8:01 am

Hospice I

	Cost Center Descriptions	CAP REL BLDG & FIX (SQUARE FEET)	CAP REL MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	RECONCILIATION	ADMINISTRATIVE & GENERAL (ACCUMULATED COSTS)	
		1.00	2.00	3.00	4A	4.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0					1.00
2.00	CAP REL COSTS-MVBLE EQUIP		0				2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	0	0	199,476			3.00
4.00	ADMINISTRATIVE & GENERAL	0	0	0	-599,811	927,513	4.00
5.00	PLANT OPERATION & MAINTENANCE	0	0	0	0	11,815	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0	0	0	6.00
7.00	HOUSEKEEPING	0	0	0	0	0	7.00
8.00	DIETARY	0	0	0	0	0	8.00
9.00	NURSING ADMINISTRATION	0	0	0	0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	0	0	0	13	10.00
11.00	MEDICAL RECORDS	0	0	0	0	0	11.00
12.00	STAFF TRANSPORTATION	0	0	0	0	58,878	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0	0	0	0	0	13.00
14.00	PHARMACY	0	0	0	0	144,030	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0	0	0	0	15.00
16.00	OTHER GENERAL SERVICE	0	0	0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0	0		0	0	17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE			0	0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE			199,039	0	711,247	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0	338	0	1,184	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	99	0	346	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0	0	0	0	0	60.00
61.00	VOLUNTEER PROGRAM	0	0	0	0	0	61.00
62.00	FUNDRAISING	0	0	0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0	0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0	0	0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES	0	0	0	0	0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0	0	0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING	0	0	0	0	0	68.00
69.00	THRIFT STORE	0	0	0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD				0		70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER						99.00
100.00	COST TO BE ALLOCATED (per Wkst. O-6, Part I)	0	0	199,290		599,811	100.00
101.00	UNIT COST MULTIPLIER	0.000000	0.000000	0.999068		0.646687	101.00

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

Provider CCN: 15-1329
Hospice CCN: 15-1551

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

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

	Cost Center Descriptions	PLANT OPERATION & MAINTENANCE (SQUARE FEET)	LAUNDRY & LINEN SERVICE (IN-FACILITY DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (IN-FACILITY DAYS)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	
		5.00	6.00	7.00	8.00	9.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE	20,783					5.00
6.00	LAUNDRY & LINEN SERVICE	0	0				6.00
7.00	HOUSEKEEPING	0		0			7.00
8.00	DIETARY	0		0	0		8.00
9.00	NURSING ADMINISTRATION	0		0		0	9.00
10.00	ROUTINE MEDICAL SUPPLIES	0		0		0	10.00
11.00	MEDICAL RECORDS	0		0		0	11.00
12.00	STAFF TRANSPORTATION	0		0		0	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0		0		0	13.00
14.00	PHARMACY	0		0		0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0		0		0	15.00
16.00	OTHER GENERAL SERVICE	0		0		0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0		0			17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE					0	50.00
51.00	HOSPICE ROUTINE HOME CARE					0	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	16,090	0	0	0	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	4,693	0	0	0	0	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0		0		0	60.00
61.00	VOLUNTEER PROGRAM	0		0		0	61.00
62.00	FUNDRAISING	0		0		0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0		0		0	63.00
64.00	PALLIATIVE CARE PROGRAM	0		0		0	64.00
65.00	OTHER PHYSICIAN SERVICES	0		0		0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0		0		0	67.00
68.00	TELEHEALTH/TELEMONITORING	0		0		0	68.00
69.00	THRIFT STORE	0		0		0	69.00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER						99.00
100.00	COST TO BE ALLOCATED (per Wkst. O-6, Part I)	19,456	0	0	0	0	100.00
101.00	UNIT COST MULTIPLIER	0.936150	0.000000	0.000000	0.000000	0.000000	101.00

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

Provider CCN: 15-1329
Hospice CCN: 15-1551

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

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

	Cost Center Descriptions	ROUTINE MEDICAL SUPPLIES (PATIENT DAYS)	MEDICAL RECORDS (PATIENT DAYS)	STAFF TRANSPORTATION (MILEAGE)	VOLUNTEER SERVICE COORDINATION (HOURS OF SERVICE)	PHARMACY (CHARGES)	
		10.00	11.00	12.00	13.00	14.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5.00
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPING						7.00
8.00	DIETARY						8.00
9.00	NURSING ADMINISTRATION						9.00
10.00	ROUTINE MEDICAL SUPPLIES	14,162					10.00
11.00	MEDICAL RECORDS		0				11.00
12.00	STAFF TRANSPORTATION			103,570			12.00
13.00	VOLUNTEER SERVICE COORDINATION			0	0		13.00
14.00	PHARMACY			0	0	253,356	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES			0	0	0	15.00
16.00	OTHER GENERAL SERVICE			0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES						17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0	0	0	0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	14,131	0	103,343	0	252,802	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	24	0	176	0	429	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	7	0	51	0	125	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM			0	0	0	60.00
61.00	VOLUNTEER PROGRAM			0	0	0	61.00
62.00	FUNDRAISING			0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS			0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM			0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES			0	0	0	65.00
66.00	RESIDENTIAL CARE			0	0	0	66.00
67.00	ADVERTISING			0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING			0	0	0	68.00
69.00	THRIFT STORE			0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)			0	0	0	71.00
99.00	NEGATIVE COST CENTER						99.00
100.00	COST TO BE ALLOCATED (per Wkst. O-6, Part I)	21	0	96,954	0	237,172	100.00
101.00	UNIT COST MULTIPLIER	0.001483	0.000000	0.936120	0.000000	0.936122	101.00

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

Provider CCN: 15-1329
Hospice CCN: 15-1551

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

Worksheet O-6 Part II
Date/Time Prepared: 5/17/2018 8:01 am

Hospice I

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

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

Provider CCN: 15-1329 Hospice CCN: 15-1551

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

Worksheet O-7

Date/Time Prepared: 5/17/2018 8:01 am

Hospice I

	Cost Center Descriptions	From Wkst. C, Part I, Col. 9 line	Cost to Charge Ratio	Charges by LOC (from Provider Records) HCHC	HRHC	HIRC	
		0	1.00	2.00	3.00	4.00	
	ANCILLARY SERVICE COST CENTERS						
1.00	PHYSICAL THERAPY	66.00	0.541771	0	0	0	1.00
2.00	OCCUPATIONAL THERAPY	67.00	0.515679	0	0	0	2.00
3.00	SPEECH PATHOLOGY	68.00	0.533905	0	0	0	3.00
4.00	DRUGS CHARGED TO PATIENTS	73.00	0.330068	0	0	0	4.00
5.00	DURABLE MEDICAL EQUIP-RENTED	96.00					5.00
6.00	LABORATORY	60.00	0.200348	0	0	0	6.00
6.01	BLOOD LABORATORY	60.01	0.000000	0	0	0	6.01
7.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0.377170	0	0	0	7.00
8.00	OTHER OUTPATIENT SERVICE COST CENTER	93.00					8.00
9.00	RADIOLOGY-THERAPEUTIC	55.00					9.00
10.00	OTHER ANCILLARY SERVICE COST CENTERS	76.00					10.00
11.00	Totals (sum of lines 1-11)						11.00

	Cost Center Descriptions	Charges by LOC (from Provider Records) HGIP	Shared Service Costs by LOC HCHC (col. 1 x col. 2)	HRHC (col. 1 x col. 3)	HIRC (col. 1 x col. 4)	HGIP (col. 1 x col. 5)	
		5.00	6.00	7.00	8.00	9.00	
	ANCILLARY SERVICE COST CENTERS						
1.00	PHYSICAL THERAPY	0	0	0	0	0	1.00
2.00	OCCUPATIONAL THERAPY	0	0	0	0	0	2.00
3.00	SPEECH PATHOLOGY	0	0	0	0	0	3.00
4.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	4.00
5.00	DURABLE MEDICAL EQUIP-RENTED						5.00
6.00	LABORATORY	0	0	0	0	0	6.00
6.01	BLOOD LABORATORY	0	0	0	0	0	6.01
7.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	7.00
8.00	OTHER OUTPATIENT SERVICE COST CENTER						8.00
9.00	RADIOLOGY-THERAPEUTIC						9.00
10.00	OTHER ANCILLARY SERVICE COST CENTERS						10.00
11.00	Totals (sum of lines 1-11)		0	0	0	0	11.00

CALCULATION OF HOSPITAL-BASED HOSPICE PER DIEM COST

Provider CCN: 15-1329 | Hospice CCN: 15-1551 | Period: From 01/01/2017 To 12/31/2017 | Worksheet O-8 | Date/Time Prepared: 5/17/2018 8:01 am

Hospice I

		TITLE XVIII MEDICARE	TITLE XIX MEDICAID	TOTAL	
		1.00	2.00	3.00	
	HOSPICE CONTINUOUS HOME CARE				
1.00	Total cost (Wkst. O-6, Part I, col. 18, line 50 plus Wkst. O-7, col. 6, line 11)			0	1.00
2.00	Total unduplicated days (Wkst. S-9, col. 4, line 10)			0	2.00
3.00	Total average cost per diem (line 1 divided by line 2)			0.00	3.00
4.00	Unduplicated program days (Wkst. S-9 col. as appropriate, line 10)	0	0		4.00
5.00	Program cost (line 3 times line 4)	0	0		5.00
	HOSPICE ROUTINE HOME CARE				
6.00	Total cost (Wkst. O-6, Part I, col. 18, line 51 plus Wkst. O-7, col. 7, line 11)			1,504,616	6.00
7.00	Total unduplicated days (Wkst. S-9, col. 4, line 11)			14,131	7.00
8.00	Total average cost per diem (line 6 divided by line 7)			106.48	8.00
9.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 11)	12,385	265		9.00
10.00	Program cost (line 8 times line 9)	1,318,755	28,217		10.00
	HOSPICE INPATIENT RESPITE CARE				
11.00	Total cost (Wkst. O-6, Part I, col. 18, line 52 plus Wkst. O-7, col. 8, line 11)			17,580	11.00
12.00	Total unduplicated days (Wkst. S-9, col. 4, line 12)			24	12.00
13.00	Total average cost per diem (line 11 divided by line 12)			732.50	13.00
14.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 12)	16	0		14.00
15.00	Program cost (line 13 times line 14)	11,720	0		15.00
	HOSPICE GENERAL INPATIENT CARE				
16.00	Total cost (Wkst. O-6, Part I, col. 18, line 53 plus Wkst. O-7, col. 9, line 11)			5,128	16.00
17.00	Total unduplicated days (Wkst. S-9, col. 4, line 13)			7	17.00
18.00	Total average cost per diem (line 16 divided by line 17)			732.57	18.00
19.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 13)	6	0		19.00
20.00	Program cost (line 18 times line 19)	4,395	0		20.00
	TOTAL HOSPICE CARE				
21.00	Total cost (sum of line 1 + line 6 + line 11 + line 16)			1,527,324	21.00
22.00	Total unduplicated days (Wkst. S-9, col. 4, line 14)			14,162	22.00
23.00	Average cost per diem (line 21 divided by line 22)			107.85	23.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1329 | Component CCN: 15-8511 | Period: From 01/01/2017 To 12/31/2017 | Worksheet M-1 | Date/Time Prepared: 5/17/2018 8:01 am

RHC I | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	291,018	0	291,018	0	291,018	1.00
2.00	Physician Assistant	118,798	0	118,798	0	118,798	2.00
3.00	Nurse Practitioner	63,354	0	63,354	0	63,354	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	56,479	0	56,479	0	56,479	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	116,942	0	116,942	0	116,942	9.00
10.00	Subtotal (sum of lines 1 through 9)	646,591	0	646,591	0	646,591	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	0	0	0	0	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	0	0	0	0	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	646,591	0	646,591	0	646,591	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
25.01	Telehealth	0	0	0	0	0	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	103,581	103,581	0	103,581	29.00
30.00	Administrative Costs	154,455	0	154,455	0	154,455	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	154,455	103,581	258,036	0	258,036	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	801,046	103,581	904,627	0	904,627	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1329 | Component CCN: 15-8511 | Period: From 01/01/2017 To 12/31/2017 | Worksheet M-1 | Date/Time Prepared: 5/17/2018 8:01 am

RHC I | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	291,018		1.00
2.00	Physician Assistant	0	118,798		2.00
3.00	Nurse Practitioner	0	63,354		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	56,479		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	116,942		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	646,591		10.00
11.00	Physician Services Under Agreement	0	0		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	0		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0		14.00
15.00	Medical Supplies	0	0		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	0		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	646,591		22.00
	COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
25.01	Telehealth	0	0		25.01
25.02	Chronic Care Management	0	0		25.02
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs				27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	103,581		29.00
30.00	Administrative Costs	0	154,455		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	258,036		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	904,627		32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 15-1329 | Component CCN: 15-8511 | Period: From 01/01/2017 To 12/31/2017 | Worksheet M-2 | Date/Time Prepared: 5/17/2018 8:01 am

RHC I | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	1.13	2,142	4,200	4,746		1.00
2.00	Physician Assistant	0.87	1,216	2,100	1,827		2.00
3.00	Nurse Practitioner	0.47	755	2,100	987		3.00
4.00	Subtotal (sum of lines 1 through 3)	2.47	4,113		7,560	7,560	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	2.47	4,113			7,560	8.00
9.00	Physician Services Under Agreements		0			0	9.00
						1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)					646,591	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					646,591	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					1.000000	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					258,036	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					587,674	15.00
16.00	Total overhead (sum of lines 14 and 15)					845,710	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					845,710	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					845,710	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					1,492,301	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 15-1329 Component CCN: 15-8511	Period: From 01/01/2017 To 12/31/2017	Worksheet M-3 Date/Time Prepared: 5/17/2018 8:01 am
	Title XVIII	RHC I	Cost

				1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES				
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			1,492,301	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			76,864	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			1,415,437	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			7,560	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)			0	5.00
6.00	Total adjusted visits (line 4 plus line 5)			7,560	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			187.23	7.00
		Calculation of Limit (1)			
		Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)		
		1.00	2.00		
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	81.32	82.30		8.00
9.00	Rate for Program covered visits (see instructions)	187.23	187.23		9.00
	CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	0	1,261		10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	236,097		11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0		12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0		13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0		14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)				15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *	0	236,097		16.00
16.01	Total program charges (see instructions)(from contractor's records)		171,044		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		12,414		16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		17,135		16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)		160,594		16.04
16.05	Total program cost (see instructions)	0	177,729		16.05
17.00	Primary payer amounts		0		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		18,219		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		28,082		19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		177,729		20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		51,756		21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		229,485		22.00
23.00	Allowable bad debts (see instructions)		0		23.00
23.01	Adjusted reimbursable bad debts (see instructions)		0		23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0		24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0		25.50
25.99	Demonstration payment adjustment amount before sequestration		0		25.99
26.00	Net reimbursable amount (see instructions)		229,485		26.00
26.01	Sequestration adjustment (see instructions)		4,590		26.01
26.02	Demonstration payment adjustment amount after sequestration		0		26.02
27.00	Interim payments		194,105		27.00
28.00	Tentative settlement (for contractor use only)		0		28.00
29.00	Balance due component/program (line 26 minus lines 26.01, 26.02, 27, and 28)		30,790		29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0		30.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA VACCINE COST	Provider CCN: 15-1329 Component CCN: 15-8511	Period: From 01/01/2017 To 12/31/2017	Worksheet M-4 Date/Time Prepared: 5/17/2018 8:01 am
	Title XVIII	RHC I	Cost

		Pneumococcal	Influenza	
		1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	646,591	646,591	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.001717	0.006562	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	1,110	4,243	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	14,452	13,499	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	15,562	17,742	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	646,591	646,591	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	845,710	845,710	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.024068	0.027439	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	20,355	23,205	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	35,917	40,947	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	56	214	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	641.38	191.34	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	44	123	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	28,221	23,535	14.00
15.00	Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2)		76,864	15.00
16.00	Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3, line 21)		51,756	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 15-1329 Component CCN: 15-8511	Period: From 01/01/2017 To 12/31/2017	Worksheet M-5 Date/Time Prepared: 5/17/2018 8:01 am
		RHC I	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		194,105	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00
	Program to Provider			
3.01			0	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
	Provider to Program			
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		194,105	4.00
	TO BE COMPLETED BY CONTRACTOR			
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			5.00
	Program to Provider			
5.01			0	5.01
5.02			0	5.02
5.03			0	5.03
	Provider to Program			
5.50			0	5.50
5.51			0	5.51
5.52			0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00
6.01	SETTLEMENT TO PROVIDER		30,790	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		224,895	7.00

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