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: 15-0115	Period: From 07/01/2016 To 06/30/2017	Worksheet S Parts I-III Date/Time Prepared: 11/28/2017 4:53 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 11/28/2017 Time: 4:53 pm
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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

PART II - CERTIFICATION

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

CERTIFICATION BY 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 MEMORIAL HOSP & HEALTH CARE CTR (15-0115) for the cost reporting period beginning 07/01/2016 and ending 06/30/2017 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.

(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	114,406	-7,327	7,275	0	1.00
2.00	Subprovider - IPF	0	7,473	-25		0	2.00
3.00	Subprovider - IRF	0	9,215	40		0	3.00
5.00	Swing bed - SNF	0	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
7.00	SKILLED NURSING FACILITY	0	4,555	-1,062		0	7.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
10.00	RURAL HEALTH CLINIC I	0		21,523		0	10.00
10.01	RURAL HEALTH CLINIC II	0		16,105		0	10.01
11.00	FEDERALLY QUALIFIED HEALTH CENTER I	0		0		0	11.00
200.00	Total	0	135,649	29,254	7,275	0	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0115 | Period: From 07/01/2016 To 06/30/2017 | Worksheet S-2 Part I | Date/Time Prepared: 11/28/2017 3:27 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 800 WEST 9TH STREET	PO Box:			1.00
2.00	City: JASPER	State: IN	Zip Code: 47546	County: DUBOIS	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	MEMORIAL HOSP & HEALTH CARE CTR	150115	99915	1	07/01/1966	N	P	O	3.00
4.00	Subprovider - IPF	MEMORIAL HOSP & HCC (PSYCH)	15S115	99915	4	07/01/1985	N	P	O	4.00
5.00	Subprovider - IRF	MEMORIAL HOSP & HCC (REHAB)	15T115	99915	5	07/01/2005	N	P	O	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	MEMORIAL HOSP & HEALTH CARE CTR	155305	99915		08/04/1987	N	P	O	9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA	MEMORIAL HOSP & HEALTH CARE CTR	157222	99915		08/28/1991	N	P	N	12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC	FRENCH LICK FAMILY MEDICINE	158507	99915		06/19/2009	N	O	N	15.00
15.01	Hospital-Based Health Clinic - RHC II	LOOGOOTEE FAMILY MEDICINE	158508	99915		12/14/2009	N	O	N	15.01
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	07/01/2016	06/30/2017	20.00
21.00	Type of Control (see instructions)	1		21.00
	Inpatient PPS Information			
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	Y	N	22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	Y	Y	22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N	22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.	N	N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	3	N	23.00

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	264	135	0	0	2,115	157	24.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0115 | Period: From 07/01/2016 To 06/30/2017 | Worksheet S-2 Part I Date/Time Prepared: 11/28/2017 3:27 pm

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	77	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)(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)(ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	Y	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)	Y	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 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.				58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59.00
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N			60.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0115 | Period: From 07/01/2016 To 06/30/2017 | Worksheet S-2 Part I Date/Time Prepared: 11/28/2017 3:27 pm

		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
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)		0.00	0.00			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)		0.00	0.00			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).		0.00	0.00			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)		0.00	0.00			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)		0.00	0.00			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 and enter in column 4, 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 and enter in column 4, 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 64-67. (see instructions)	N	63.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-0115	Period: From 07/01/2016 To 06/30/2017	Worksheet S-2 Part I Date/Time Prepared: 11/28/2017 3:27 pm

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

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

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

		1.00	2.00	3.00	
	Inpatient Psychiatric Facility PPS				
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	Y			70.00
71.00	If line 70 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)	N	N	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.	Y			75.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0115 | Period: From 07/01/2016 To 06/30/2017 | Worksheet S-2 Part I Date/Time Prepared: 11/28/2017 3:27 pm

		1.00	2.00	3.00	
76.00	If line 75 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)	N	N	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 a "subclause (II)" LTCH classified under section 1886(d)(1)(B)(iv)(II)? Enter "Y" for yes or "N" for no.	N	87.00

		V	XIX	
		1.00	2.00	
	Title V and XIX Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
	Rural Providers			
105.00	Does this hospital qualify as a critical access hospital (CAH)?	N		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)			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.			107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00

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

		1.00	
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (410A Demo)for the current cost reporting period? Enter "Y" for yes or "N" for no.	N	110.00

		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.	Y			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1			118.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0115 | Period: From 07/01/2016 To 06/30/2017 | Worksheet S-2 Part I Date/Time Prepared: 11/28/2017 3:27 pm

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	1,341,646	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 state health or similar taxes? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N		122.00
	Transplant Center Information			
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y		140.00

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

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

		1.00	2.00	
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.	N	N	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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0115 | Period: From 07/01/2016 To 06/30/2017 | Worksheet S-2 Part I | Date/Time Prepared: 11/28/2017 3:27 pm

		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)	0.25	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)	10/01/2016	12/29/2016	170.00

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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-0115 | Period: From 07/01/2016 To 06/30/2017 | Worksheet S-2 Part II | Date/Time Prepared: 11/28/2017 3:27 pm

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

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

		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	10/12/2017	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	10/24/2017	Y	10/24/2017	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: 15-0115	Period: From 07/01/2016 To 06/30/2017	Worksheet S-2 Part II Date/Time Prepared: 11/28/2017 3:27 pm

		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00

		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00

		1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)		
	Capital Related Cost		
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions		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.		23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions		24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.		25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.		26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.		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.		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		29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.		30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.		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.		32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.		33.00
	Provider-Based Physicians		
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.		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.		35.00

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

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	BOB	BRANDENBURG	41.00
42.00	Enter the employer/company name of the cost report preparer.	BKD,LLP		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	(317) 383-3787	BBRANDENBURG@BKD.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-0115	Period: From 07/01/2016 To 06/30/2017	Worksheet S-2 Part II Date/Time Prepared: 11/28/2017 3:27 pm

		3.00		
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	PARTNER		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: 15-0115 | Period: From 07/01/2016 To 06/30/2017 | Worksheet S-3 Part I Date/Time Prepared: 11/28/2017 3:27 pm

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	85	31,025	0.00	0	1.00
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		85	31,025	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	26	9,490	0.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		111	40,515	0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF	40.00	19	6,935		0	16.00
17.00	SUBPROVIDER - IRF	41.00	8	2,920		0	17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	44.00	20	7,300		0	19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	101.00				0	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	116.00	0	0			24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	88.00				0	26.00
26.01	RURAL HEALTH CLINIC II	88.01				0	26.01
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		158				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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-0115 | Period: From 07/01/2016 To 06/30/2017 | Worksheet S-3 Part I | Date/Time Prepared: 11/28/2017 3:27 pm

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	4,223	149	9,366			1.00
2.00	HMO and other (see instructions)	553	2,250				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	77				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)	4,223	149	9,366			7.00
8.00	INTENSIVE CARE UNIT	2,719	81	4,473			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		34	1,886			13.00
14.00	Total (see instructions)	6,942	264	15,725	0.00	1,221.64	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF	1,656	548	3,017	0.00	31.74	16.00
17.00	SUBPROVIDER - IRF	757	0	1,485	0.00	10.72	17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	4,149	96	5,026	0.00	24.10	19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	9,439	0	16,505	0.00	26.57	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	40			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	1,540	0	4,051	0.00	4.23	26.00
26.01	RURAL HEALTH CLINIC II	1,709	0	5,092	0.00	6.35	26.01
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	1,325.35	27.00
28.00	Observation Bed Days		585	2,492			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	157	346			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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-0115 | Period: From 07/01/2016 To 06/30/2017 | Worksheet S-3 Part I Date/Time Prepared: 11/28/2017 3:27 pm

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	2,255	236	3,764	1.00
2.00	HMO and other (see instructions)			0	0		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				0		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	2,255	236	3,764	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF	0.00	0	164	133	466	16.00
17.00	SUBPROVIDER - IRF	0.00	0	59	7	114	17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	0.00					19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0.00					22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	0.00					24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	0.00					26.00
26.01	RURAL HEALTH CLINIC II	0.00					26.01
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						33.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0115 | Period: From 07/01/2016 To 06/30/2017 | Worksheet S-3 Part II Date/Time Prepared: 11/28/2017 3:27 pm

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA							
	SALARIES							
1.00	Total salaries (see instructions)	200.00	97,768,273	0	97,768,273	2,756,738.00	35.47	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		3,319,471	0	3,319,471	32,423.00	102.38	3.00
4.00	Physician-Part A - Administrative		219,126	0	219,126	871.16	251.53	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician and Non Physician-Part B		9,331,643	0	9,331,643	48,631.25	191.89	5.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		223,495	0	223,495	15,645.00	14.29	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	1,260,319	0	1,260,319	50,135.00	25.14	9.00
10.00	Excluded area salaries (see instructions)		36,933,816	0	36,933,816	885,110.00	41.73	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		3,429,861	0	3,429,861	72,084.00	47.58	11.00
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00	12.00
13.00	Contract labor: Physician-Part A - Administrative		118,200	0	118,200	1,020.00	115.88	13.00
14.00	Home office and/or related orgainzation salaries and wage-related costs		0	0	0	0.00	0.00	14.00
14.01	Home office salaries		0	0	0	0.00	0.00	14.01
14.02	Related organization salaries		0	0	0	0.00	0.00	14.02
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
	WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		12,269,699	0	12,269,699			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		6,122,455	0	6,122,455			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		224,992	0	224,992			21.00
22.00	Physician Part A - Administrative		5,720	0	5,720			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		335,581	0	335,581			23.00
24.00	Wage-related costs (RHC/FQHC)		108,683	0	108,683			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
25.50	Home office wage-related		0	0	0			25.50
25.51	Related orgainzation wage-related		0	0	0			25.51
25.52	Home office: Physician Part A - Administrative - wage-related		0	0	0			25.52
25.53	Home office & Contract Physicians Part A - Teaching - wage-related		0	0	0			25.53

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0115 | Period: From 07/01/2016 To 06/30/2017 | Worksheet S-3 Part II Date/Time Prepared: 11/28/2017 3:27 pm

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	727,190	0	727,190	18,269.27	39.80	26.00
27.00	Administrative & General	5.00	8,368,595	0	8,368,595	327,320.81	25.57	27.00
28.00	Administrative & General under contract (see inst.)		391,600	0	391,600	2,724.00	143.76	28.00
29.00	Maintenance & Repairs	6.00	1,629,191	0	1,629,191	60,675.00	26.85	29.00
30.00	Operation of Plant	7.00	0	0	0	0.00	0.00	30.00
31.00	Laundry & Linen Service	8.00	235,488	0	235,488	18,688.00	12.60	31.00
32.00	Housekeeping	9.00	1,066,520	0	1,066,520	79,520.00	13.41	32.00
33.00	Housekeeping under contract (see instructions)		15,280	0	15,280	790.00	19.34	33.00
34.00	Dietary	10.00	972,577	-768,433	204,144	13,556.00	15.06	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	768,433	768,433	51,025.00	15.06	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	909,575	0	909,575	26,021.00	34.96	38.00
39.00	Central Services and Supply	14.00	260,154	0	260,154	16,127.00	16.13	39.00
40.00	Pharmacy	15.00	1,940,240	0	1,940,240	52,995.00	36.61	40.00
41.00	Medical Records & Medical Records Library	16.00	1,334,364	0	1,334,364	66,834.00	19.97	41.00
42.00	Social Service	17.00	0	0	0	0.00	0.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0115 | Period: From 07/01/2016 To 06/30/2017 | Worksheet S-3 Part III Date/Time Prepared: 11/28/2017 3:27 pm

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)		85,300,544	0	85,300,544	2,663,552.75	32.03	1.00
2.00	Excluded area salaries (see instructions)		38,194,135	0	38,194,135	935,245.00	40.84	2.00
3.00	Subtotal salaries (line 1 minus line 2)		47,106,409	0	47,106,409	1,728,307.75	27.26	3.00
4.00	Subtotal other wages & related costs (see inst.)		3,548,061	0	3,548,061	73,104.00	48.53	4.00
5.00	Subtotal wage-related costs (see inst.)		12,275,419	0	12,275,419	0.00	26.06	5.00
6.00	Total (sum of lines 3 thru 5)		62,929,889	0	62,929,889	1,801,411.75	34.93	6.00
7.00	Total overhead cost (see instructions)		17,850,774	0	17,850,774	734,545.08	24.30	7.00

HOSPITAL WAGE RELATED COSTS	Provider CCN: 15-0115	Period: From 07/01/2016 To 06/30/2017	Worksheet S-3 Part IV Date/Time Prepared: 11/28/2017 3:27 pm

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	1,528,374	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	964	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	0	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)	0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	0	8.02
8.03	Health Insurance (Purchased)	10,694,900	8.03
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	0	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	85,297	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	254,049	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	289,144	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	0	16.00
	TAXES		
17.00	FICA-Employers Portion Only	5,870,581	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	0	19.00
20.00	State or Federal Unemployment Taxes	34,157	20.00
	OTHER		
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	309,664	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	19,067,130	24.00
	Part B - Other than Core Related Cost		
25.00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST | Provider CCN: 15-0115 | Period: From 07/01/2016 To 06/30/2017 | Worksheet S-3 Part V Date/Time Prepared: 11/28/2017 3:27 pm

	Cost Center Description	Contract Labor	Benefit Cost	
		1.00	2.00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	0	0	1.00
2.00	Hospital	0	0	2.00
3.00	Subprovider - IPF	0	0	3.00
4.00	Subprovider - IRF	0	0	4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF	0	0	8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA	0	0	11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice	0	0	13.00
14.00	Hospital-Based Health Clinic RHC	0	0	14.00
14.01	Hospital-Based Health Clinic RHC 1	0	0	14.01
15.00	Hospital-Based Health Clinic FQHC	0	0	15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis	0	0	17.00
18.00	Other	0	0	18.00

HOME HEALTH AGENCY STATISTICAL DATA

Provider CCN: 15-0115 | Component CCN: 15-7222 | Period: From 07/01/2016 To 06/30/2017 | Worksheet S-4 | Date/Time Prepared: 11/28/2017 3:27 pm

Home Health Agency I | PPS

		1.00	
0.00	County	DEBOIS	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	4,070	519	1,136	5,725	1.00
2.00	Unduplicated Census Count (see instructions)	0.00	541.00	69.00	151.00	761.00	2.00

		Enter the number of hours in your normal work week	Number of Employees (Full Time Equivalent) Staff	Contract	Total	
		0	1.00	2.00	3.00	
	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES					
3.00	Administrator and Assistant Administrator(s)	40.00	0.00	0.00	0.00	3.00
4.00	Director(s) and Assistant Director(s)		1.10	0.00	1.10	4.00
5.00	Other Administrative Personnel		5.04	0.00	5.04	5.00
6.00	Direct Nursing Service		11.30	0.00	11.30	6.00
7.00	Nursing Supervisor		0.84	0.00	0.84	7.00
8.00	Physical Therapy Service		3.58	0.00	3.58	8.00
9.00	Physical Therapy Supervisor		0.00	0.00	0.00	9.00
10.00	Occupational Therapy Service		1.81	0.00	1.81	10.00
11.00	Occupational Therapy Supervisor		0.00	0.00	0.00	11.00
12.00	Speech Pathology Service		0.08	0.00	0.08	12.00
13.00	Speech Pathology Supervisor		0.00	0.00	0.00	13.00
14.00	Medical Social Service		0.13	0.00	0.13	14.00
15.00	Medical Social Service Supervisor		0.00	0.00	0.00	15.00
16.00	Home Health Aide		2.71	0.00	2.71	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.		1			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

		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	3,299	515	133	59	4,006	21.00
22.00	Skilled Nursing Visit Charges	687,282	104,109	29,428	12,163	832,982	22.00
23.00	Physical Therapy Visits	2,288	90	19	27	2,424	23.00
24.00	Physical Therapy Visit Charges	504,141	19,890	4,199	5,923	534,153	24.00
25.00	Occupational Therapy Visits	1,084	52	6	8	1,150	25.00
26.00	Occupational Therapy Visit Charges	238,827	11,492	1,326	1,768	253,413	26.00
27.00	Speech Pathology Visits	37	7	0	0	44	27.00
28.00	Speech Pathology Visit Charges	8,177	1,547	0	0	9,724	28.00
29.00	Medical Social Service Visits	0	0	0	0	0	29.00
30.00	Medical Social Service Visit Charges	0	0	0	0	0	30.00
31.00	Home Health Aide Visits	1,658	127	2	28	1,815	31.00
32.00	Home Health Aide Visit Charges	156,840	12,025	190	2,660	171,715	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	8,366	791	160	122	9,439	33.00
34.00	Other Charges	27,758	6,114	377	820	35,069	34.00
35.00	Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)	1,623,025	155,177	35,520	23,334	1,837,056	35.00
36.00	Total Number of Episodes (standard/non outlier)	466		61	5	532	36.00
37.00	Total Number of Outlier Episodes		20		2	22	37.00
38.00	Total Non-Routine Medical Supply Charges	20,042	7,537	2,086	648	30,313	38.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA | Provider CCN: 15-0115 | Period: From 07/01/2016 To 06/30/2017 | Worksheet S-7 Date/Time Prepared: 11/28/2017 3:27 pm

		1.00	2.00	
1.00	If this facility contains a hospital-based SNF, were all patients under managed care or was there no Medicare utilization? Enter "Y" for yes in column 1 and do not complete the rest of this worksheet.			1.00
2.00	Does this hospital have an agreement under either section 1883 or section 1913 for swing beds? Enter "Y" for yes or "N" for no in column 1. If yes, enter the agreement date (mm/dd/yyyy) in column 2.			2.00

		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
		1.00	2.00	3.00	4.00	
3.00		RUX	0	0	0	3.00
4.00		RUL	0	0	0	4.00
5.00		RVX	0	0	0	5.00
6.00		RVL	0	0	0	6.00
7.00		RHX	0	0	0	7.00
8.00		RHL	0	0	0	8.00
9.00		RMX	0	0	0	9.00
10.00		RML	0	0	0	10.00
11.00		RLX	0	0	0	11.00
12.00		RUC	25	0	25	12.00
13.00		RUB	42	0	42	13.00
14.00		RUA	0	0	0	14.00
15.00		RVC	243	0	243	15.00
16.00		RVB	526	0	526	16.00
17.00		RVA	32	0	32	17.00
18.00		RHC	917	0	917	18.00
19.00		RHB	1,532	0	1,532	19.00
20.00		RHA	373	0	373	20.00
21.00		RMC	73	0	73	21.00
22.00		RMB	216	0	216	22.00
23.00		RMA	50	0	50	23.00
24.00		RLB	0	0	0	24.00
25.00		RLA	0	0	0	25.00
26.00		ES3	0	0	0	26.00
27.00		ES2	0	0	0	27.00
28.00		ES1	0	0	0	28.00
29.00		HE2	0	0	0	29.00
30.00		HE1	0	0	0	30.00
31.00		HD2	0	0	0	31.00
32.00		HD1	2	0	2	32.00
33.00		HC2	0	0	0	33.00
34.00		HC1	14	0	14	34.00
35.00		HB2	0	0	0	35.00
36.00		HB1	18	0	18	36.00
37.00		LE2	0	0	0	37.00
38.00		LE1	0	0	0	38.00
39.00		LD2	0	0	0	39.00
40.00		LD1	0	0	0	40.00
41.00		LC2	0	0	0	41.00
42.00		LC1	7	0	7	42.00
43.00		LB2	0	0	0	43.00
44.00		LB1	0	0	0	44.00
45.00		CE2	0	0	0	45.00
46.00		CE1	0	0	0	46.00
47.00		CD2	0	0	0	47.00
48.00		CD1	40	0	40	48.00
49.00		CC2	0	0	0	49.00
50.00		CC1	19	0	19	50.00
51.00		CB2	0	0	0	51.00
52.00		CB1	8	0	8	52.00
53.00		CA2	0	0	0	53.00
54.00		CA1	3	0	3	54.00
55.00		SE3	0	0	0	55.00
56.00		SE2	0	0	0	56.00
57.00		SE1	0	0	0	57.00
58.00		SSC	0	0	0	58.00
59.00		SSB	0	0	0	59.00
60.00		SSA	0	0	0	60.00
61.00		IB2	0	0	0	61.00
62.00		IB1	0	0	0	62.00
63.00		IA2	0	0	0	63.00
64.00		IA1	0	0	0	64.00
65.00		BB2	0	0	0	65.00
66.00		BB1	0	0	0	66.00
67.00		BA2	0	0	0	67.00
68.00		BA1	0	0	0	68.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA	Provider CCN: 15-0115	Period: From 07/01/2016 To 06/30/2017	Worksheet S-7 Date/Time Prepared: 11/28/2017 3:27 pm

		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
		1.00	2.00	3.00	4.00	
69.00		PE2	0	0	0	69.00
70.00		PE1	0	0	0	70.00
71.00		PD2	0	0	0	71.00
72.00		PD1	0	0	0	72.00
73.00		PC2	0	0	0	73.00
74.00		PC1	8	0	8	74.00
75.00		PB2	0	0	0	75.00
76.00		PB1	1	0	1	76.00
77.00		PA2	0	0	0	77.00
78.00		PA1	0	0	0	78.00
199.00		AAA	0	0	0	199.00
200.00	TOTAL		4,149	0	4,149	200.00

		CBSA at Beginning of Cost Reporting Period	CBSA on/after October 1 of the Cost Reporting Period (if applicable)	
		1.00	2.00	
	SNF SERVICES			
201.00	Enter in column 1 the SNF CBSA code or 5 character non-CBSA code if a rural facility, in effect at the beginning of the cost reporting period. Enter in column 2, the code in effect on or after October 1 of the cost reporting period (if applicable).	99915	99915	201.00

		Expenses	Percentage	Associated with Direct Patient Care and Related Expenses?	
		1.00	2.00	3.00	
	A notice published in the Federal Register Volume 68, No. 149 August 4, 2003 provided for an increase in the RUG payments beginning 10/01/2003. Congress expected this increase to be used for direct patient care and related expenses. For lines 202 through 207: Enter in column 1 the amount of the expense for each category. Enter in column 2 the percentage of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 7, column 3. In column 3, enter "Y" for yes or "N" for no if the spending reflects increases associated with direct patient care and related expenses for each category. (see instructions)				
202.00	Staffing	0	0.00		202.00
203.00	Recruitment	0	0.00		203.00
204.00	Retention of employees	0	0.00		204.00
205.00	Training	0	0.00		205.00
206.00	OTHER (SPECIFY)	0	0.00		206.00
207.00	Total SNF revenue (Worksheet G-2, Part I, line 7, column 3)	1,457,168			207.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 15-0115 | Period: From 07/01/2016 To 06/30/2017 | Worksheet S-8

Component CCN: 15-8507 | Date/Time Prepared: 11/28/2017 3:27 pm

RHC I | Cost

		1.00	
	Clinic Address and Identification		
1.00	Street	522 SOUTH MAPLE STREET	1.00

		City	State	ZIP Code	
		1.00	2.00	3.00	
2.00	City, State, ZIP Code, County	FRENCH LICK	IN	47432	2.00

		1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban	0	3.00

		Grant Award	Date	
		1.00	2.00	
	Source of Federal Funds			
4.00	Community Health Center (Section 330(d), PHS Act)			4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)			5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)			6.00
7.00	Appalachian Regional Commission			7.00
8.00	Look-Alikes			8.00
9.00	OTHER (SPECIFY)			9.00

		1.00	2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)	N	0	10.00

		Sunday		Monday		Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
	Facility hours of operations (1)						
11.00	Clinic			08:00	17:00	07:00	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	ORANGE	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	16:00	08:00	12:00	07:00	16:00	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 15-0115 | Period: From 07/01/2016 To 06/30/2017 | Worksheet S-8

Component CCN: 15-8507 | Date/Time Prepared: 11/28/2017 3:27 pm

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	06:00	15:00				11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA	Provider CCN: 15-0115 Component CCN: 15-8508	Period: From 07/01/2016 To 06/30/2017	Worksheet S-8 Date/Time Prepared: 11/28/2017 3:27 pm
		RHC II	Cost

		1.00	
	Clinic Address and Identification		
1.00	Street	105 COOPER STREET	1.00

		City	State	ZIP Code	
		1.00	2.00	3.00	
2.00	City, State, ZIP Code, County	LOOGOOTEE	IN	47553	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	18:00	08:00	11.00

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

		Provider name	CCN number	
		1.00	2.00	
14.00	RHC/FQHC name, CCN number			14.00

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

		County	
		4.00	
2.00	City, State, ZIP Code, County	MARTIN	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	19:30	08:00	18:00	08:00	18:00	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 15-0115 | Period: From 07/01/2016 To 06/30/2017 | Worksheet S-8

Component CCN: 15-8508 | Date/Time Prepared: 11/28/2017 3:27 pm

RHC II | Cost

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

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 15-0115 | Period: From 07/01/2016 To 06/30/2017 | Worksheet S-10 | Date/Time Prepared: 11/28/2017 3:27 pm

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.309157	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	10,894,303	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?		3.00
4.00	If line 3 is yes, does line 2 include all DSH or supplemental payments from Medicaid?		4.00
5.00	If line 4 is no, then enter DSH or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	62,785,926	6.00
7.00	Medicaid cost (line 1 times line 6)	19,410,709	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)	8,516,406	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)	8,516,406	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)	2,466,978	0	2,466,978	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	762,684	0	762,684	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)	762,684	0	762,684	23.00

		1.00	
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?		24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	10,168,837	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	336,604	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	517,853	27.01
28.00	Non-Medicare bad debt expense (line 26 minus line 27.01)	9,650,984	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	3,164,918	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	3,927,602	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	12,444,008	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0115 | Period: From 07/01/2016 To 06/30/2017 | Worksheet A | Date/Time Prepared: 11/28/2017 3:27 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		7,640,220	7,640,220	0	7,640,220	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		9,150,727	9,150,727	0	9,150,727	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	727,190	19,944,372	20,671,562	0	20,671,562	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	8,368,595	16,893,173	25,261,768	-45,293	25,216,475	5.00
6.00	00600	MAINTENANCE & REPAIRS	1,629,191	5,914,950	7,544,141	0	7,544,141	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	235,488	80,060	315,548	0	315,548	8.00
9.00	00900	HOUSEKEEPING	1,066,520	347,436	1,413,956	0	1,413,956	9.00
10.00	01000	DIETARY	972,577	715,224	1,687,801	-1,333,531	354,270	10.00
11.00	01100	CAFETERIA	0	0	0	1,333,531	1,333,531	11.00
13.00	01300	NURSING ADMINISTRATION	909,575	118,938	1,028,513	-423	1,028,090	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	260,154	193,257	453,411	-11,409	442,002	14.00
15.00	01500	PHARMACY	1,940,240	13,324,106	15,264,346	-2,001	15,262,345	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,334,364	255,167	1,589,531	0	1,589,531	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,020,599	533,413	6,554,012	-2,259,988	4,294,024	30.00
31.00	03100	INTENSIVE CARE UNIT	2,583,397	181,588	2,764,985	-93,342	2,671,643	31.00
40.00	04000	SUBPROVIDER - IPF	2,059,323	349,301	2,408,624	-7,195	2,401,429	40.00
41.00	04100	SUBPROVIDER - IRF	622,970	173,416	796,386	-7,984	788,402	41.00
43.00	04300	NURSERY	0	0	0	504,015	504,015	43.00
44.00	04400	SKILLED NURSING FACILITY	1,260,319	56,099	1,316,418	-26,634	1,289,784	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,643,918	11,167,178	15,811,096	-72,914	15,738,182	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	1,638,047	1,638,047	52.00
53.00	05300	ANESTHESIOLOGY	3,758,716	527,257	4,285,973	-326	4,285,647	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,555,198	1,042,280	6,597,478	-55,283	6,542,195	54.00
56.00	05600	RADIOISOTOPE	202,812	534,527	737,339	-50	737,289	56.00
60.00	06000	LABORATORY	2,336,329	4,455,060	6,791,389	-690	6,790,699	60.00
65.00	06500	RESPIRATORY THERAPY	1,063,776	487,713	1,551,489	-5,394	1,546,095	65.00
66.00	06600	PHYSICAL THERAPY	2,393,507	257,023	2,650,530	-2,136	2,648,394	66.00
69.00	06900	ELECTROCARDIOLOGY	2,641,926	3,110,673	5,752,599	-41,923	5,710,676	69.00
69.01	06901	PULMONARY	0	0	0	0	0	69.01
69.02	06902	CARDIOPULMONARY	98,323	5,702	104,025	0	104,025	69.02
69.03	06903	SLEEP LAB	240,739	14,260	254,999	0	254,999	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	2,260,373	2,260,373	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	6,108,726	6,108,726	0	6,108,726	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	297,340	133,949	431,289	-1,092	430,197	88.00
88.01	08801	RURAL HEALTH CLINIC II	444,590	63,308	507,898	-337	507,561	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	451,079	1,419,072	1,870,151	-844,313	1,025,838	90.00
90.01	09001	IMED	365,174	111,403	476,577	-4,598	471,979	90.01
90.02	09002	ONCOLOGY	1,389,062	1,101,992	2,491,054	-69,654	2,421,400	90.02
90.03	09003	OUTPATIENT CENTER	212,183	194,152	406,335	-12,775	393,560	90.03
91.00	09100	EMERGENCY	7,431,576	1,589,696	9,021,272	-190,766	8,830,506	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1,861,347	141,346	2,002,693	-1,912	2,000,781	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
101.00	10100	HOME HEALTH AGENCY	1,526,970	280,399	1,807,369	-9,356	1,798,013	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	66,905,067	108,617,163	175,522,230	634,647	176,156,877	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	26,624,608	4,455,937	31,080,545	-634,025	30,446,520	192.00
192.01	19201	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	590,931	15,558	606,489	-453	606,036	192.01
194.00	07950	LODGE	315	3,489	3,804	0	3,804	194.00
194.02	07952	MEMORIAL HOSPITAL FOUNDATION	152,804	13,580	166,384	0	166,384	194.02
194.03	07953	MKT/PHY SERVICES	2,754,348	1,642,906	4,397,254	-7	4,397,247	194.03
194.04	07954	COMMUNITY EDUCATION	343,514	164,801	508,315	0	508,315	194.04
194.05	07955	VOLUNTEER	169,191	12,590	181,781	-162	181,619	194.05
194.06	07956	MAB	0	0	0	0	0	194.06
194.08	07958	PUBLIC RELATIONS	227,495	502,211	729,706	0	729,706	194.08
194.09	07959	UNUSED SPACE	0	0	0	0	0	194.09
200.00		TOTAL (SUM OF LINES 118-199)	97,768,273	115,428,235	213,196,508	0	213,196,508	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0115 | Period: From 07/01/2016 To 06/30/2017 | Worksheet A | Date/Time Prepared: 11/28/2017 3:27 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
	GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	-2,660,883	4,979,337	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	32,529	9,183,256	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-1,940,051	18,731,511	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-7,218,327	17,998,148	5.00
6.00	00600	MAINTENANCE & REPAIRS	-37,692	7,506,449	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	315,548	8.00
9.00	00900	HOUSEKEEPING	0	1,413,956	9.00
10.00	01000	DIETARY	-44,509	309,761	10.00
11.00	01100	CAFETERIA	-645,731	687,800	11.00
13.00	01300	NURSING ADMINISTRATION	-23,492	1,004,598	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	442,002	14.00
15.00	01500	PHARMACY	-231,080	15,031,265	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-50,289	1,539,242	16.00
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	4,294,024	30.00
31.00	03100	INTENSIVE CARE UNIT	0	2,671,643	31.00
40.00	04000	SUBPROVIDER - IPF	-284,205	2,117,224	40.00
41.00	04100	SUBPROVIDER - IRF	-67,540	720,862	41.00
43.00	04300	NURSERY	0	504,015	43.00
44.00	04400	SKILLED NURSING FACILITY	0	1,289,784	44.00
	ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-3,056,785	12,681,397	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,638,047	52.00
53.00	05300	ANESTHESIOLOGY	-3,745,708	539,939	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-3,191,211	3,350,984	54.00
56.00	05600	RADIOISOTOPE	0	737,289	56.00
60.00	06000	LABORATORY	-170,163	6,620,536	60.00
65.00	06500	RESPIRATORY THERAPY	-14,455	1,531,640	65.00
66.00	06600	PHYSICAL THERAPY	-8,157	2,640,237	66.00
69.00	06900	ELECTROCARDIOLOGY	-703,896	5,006,780	69.00
69.01	06901	PULMONARY	0	0	69.01
69.02	06902	CARDIOPULMONARY	-10,280	93,745	69.02
69.03	06903	SLEEP LAB	-2,019	252,980	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2,260,373	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	6,108,726	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	74.00
	OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	-12,149	418,048	88.00
88.01	08801	RURAL HEALTH CLINIC II	-15,674	491,887	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	89.00
90.00	09000	CLINIC	-418,131	607,707	90.00
90.01	09001	IMED	-185,860	286,119	90.01
90.02	09002	ONCOLOGY	-572	2,420,828	90.02
90.03	09003	OUTPATIENT CENTER	0	393,560	90.03
91.00	09100	EMERGENCY	-4,608,436	4,222,070	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
	OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	-664,084	1,336,697	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	96.00
101.00	10100	HOME HEALTH AGENCY	-42	1,797,971	101.00
	SPECIAL PURPOSE COST CENTERS				
116.00	11600	HOSPICE	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-29,978,892	146,177,985	118.00
	NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	30,446,520	192.00
192.01	19201	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	606,036	192.01
194.00	07950	LODGE	0	3,804	194.00
194.02	07952	MEMORIAL HOSPITAL FOUNDATION	0	166,384	194.02
194.03	07953	MKT/PHY SERVICES	0	4,397,247	194.03
194.04	07954	COMMUNITY EDUCATION	0	508,315	194.04
194.05	07955	VOLUNTEER	0	181,619	194.05
194.06	07956	MAB	0	0	194.06
194.08	07958	PUBLIC RELATIONS	0	729,706	194.08
194.09	07959	UNUSED SPACE	0	0	194.09
200.00		TOTAL (SUM OF LINES 118-199)	-29,978,892	183,217,616	200.00

RECLASSIFICATIONS | Provider CCN: 15-0115 | Period: From 07/01/2016 To 06/30/2017 | Worksheet A-6 | Date/Time Prepared: 11/28/2017 3:27 pm

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - LABOR AND DELIVERY				
1.00	DELIVERY ROOM & LABOR ROOM	52.00	250,515	1,387,532	1.00
2.00	NURSERY	43.00	77,082	426,933	2.00
	0		327,597	1,814,465	
	B - CAFETERIA				
1.00	CAFETERIA	11.00	768,433	565,098	1.00
	0		768,433	565,098	
	C - BILLABLE SUPPLES				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	2,260,373	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
23.00		0.00	0	0	23.00
24.00		0.00	0	0	24.00
25.00		0.00	0	0	25.00
26.00		0.00	0	0	26.00
27.00		0.00	0	0	27.00
28.00		0.00	0	0	28.00
29.00		0.00	0	0	29.00
30.00		0.00	0	0	30.00
	0		0	2,260,373	
500.00	Grand Total: Increases		1,096,030	4,639,936	500.00

RECLASSIFICATIONS | Provider CCN: 15-0115 | Period: From 07/01/2016 To 06/30/2017 | Worksheet A-6 | Date/Time Prepared: 11/28/2017 3:27 pm

	Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
	A - LABOR AND DELIVERY					
1.00	ADULTS & PEDIATRICS	30.00	327,597	1,814,465	0	1.00
2.00		0.00	0	0	0	2.00
	0		327,597	1,814,465		
	B - CAFETERIA					
1.00	DIETARY	10.00	768,433	565,098	0	1.00
	0		768,433	565,098		
	C - BILLABLE SUPPLES					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	45,293	0	1.00
2.00	NURSING ADMINISTRATION	13.00	0	423	0	2.00
3.00	CENTRAL SERVICES & SUPPLY	14.00	0	11,409	0	3.00
4.00	PHARMACY	15.00	0	2,001	0	4.00
5.00	ADULTS & PEDIATRICS	30.00	0	117,926	0	5.00
6.00	INTENSIVE CARE UNIT	31.00	0	93,342	0	6.00
7.00	SUBPROVIDER - IPF	40.00	0	7,195	0	7.00
8.00	SUBPROVIDER - IRF	41.00	0	7,984	0	8.00
9.00	SKILLED NURSING FACILITY	44.00	0	26,634	0	9.00
10.00	OPERATING ROOM	50.00	0	72,914	0	10.00
11.00	ANESTHESIOLOGY	53.00	0	326	0	11.00
12.00	RADIOLOGY-DIAGNOSTIC	54.00	0	55,283	0	12.00
13.00	RADIOISOTOPE	56.00	0	50	0	13.00
14.00	LABORATORY	60.00	0	690	0	14.00
15.00	RESPIRATORY THERAPY	65.00	0	5,394	0	15.00
16.00	PHYSICAL THERAPY	66.00	0	2,136	0	16.00
17.00	ELECTROCARDIOLOGY	69.00	0	41,923	0	17.00
18.00	RURAL HEALTH CLINIC	88.00	0	1,092	0	18.00
19.00	RURAL HEALTH CLINIC II	88.01	0	337	0	19.00
20.00	CLINIC	90.00	0	844,313	0	20.00
21.00	IMED	90.01	0	4,598	0	21.00
22.00	ONCOLOGY	90.02	0	69,654	0	22.00
23.00	OUTPATIENT CENTER	90.03	0	12,775	0	23.00
24.00	EMERGENCY	91.00	0	190,766	0	24.00
25.00	AMBULANCE SERVICES	95.00	0	1,912	0	25.00
26.00	HOME HEALTH AGENCY	101.00	0	9,356	0	26.00
27.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	634,025	0	27.00
28.00	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	192.01	0	453	0	28.00
29.00	MKT/PHY SERVICES	194.03	0	7	0	29.00
30.00	VOLUNTEER	194.05	0	162	0	30.00
	0		0	2,260,373		
500.00	Grand Total: Decreases		1,096,030	4,639,936		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0115 | Period: From 07/01/2016 To 06/30/2017 | Worksheet A-7 Part I Date/Time Prepared: 11/28/2017 3:27 pm

			Acquisitions				
		Beginning Balances	Purchases	Donation	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	9,165,761	819,716	0	819,716	0	1.00
2.00	Land Improvements	0	0	0	0	0	2.00
3.00	Buildings and Fixtures	113,373,872	131,942	0	131,942	0	3.00
4.00	Building Improvements	0	102,585	0	102,585	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	106,934,937	0	0	0	11,915,385	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	229,474,570	1,054,243	0	1,054,243	11,915,385	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	229,474,570	1,054,243	0	1,054,243	11,915,385	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	9,985,477	0	1.00
2.00	Land Improvements	0	0	2.00
3.00	Buildings and Fixtures	113,505,814	0	3.00
4.00	Building Improvements	102,585	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	95,019,552	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	218,613,428	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	218,613,428	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0115 | Period: From 07/01/2016 To 06/30/2017 | Worksheet A-7 Part II Date/Time Prepared: 11/28/2017 3:27 pm

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	4,104,594	768,557	2,611,773	155,296	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	9,150,727	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	13,255,321	768,557	2,611,773	155,296	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL		
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
		14.00	15.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	7,640,220	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	9,150,727	2.00
3.00	Total (sum of lines 1-2)	0	16,790,947	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0115 | Period: From 07/01/2016 To 06/30/2017 | Worksheet A-7 Part III Date/Time Prepared: 11/28/2017 3:27 pm

	Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	124,593,876	0	124,593,876	0.567333	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	95,019,552	0	95,019,552	0.432667	0	2.00
3.00	Total (sum of lines 1-2)	219,613,428	0	219,613,428	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	4,055,484	768,557	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	9,183,256	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	13,238,740	768,557	3.00

	Cost Center Description	SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	155,296	0	0	4,979,337	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	9,183,256	2.00
3.00	Total (sum of lines 1-2)	0	155,296	0	0	14,162,593	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0115 | Period: From 07/01/2016 To 06/30/2017 | Worksheet A-8 | Date/Time Prepared: 11/28/2017 3:27 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-2,611,773	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		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)	A	-10,586	ADMINISTRATIVE & GENERAL	5.00	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	-11,198,579			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)	B	-47,876	ADMINISTRATIVE & GENERAL	5.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	-1,994,158			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-645,731	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients	B	-231,080	PHARMACY	15.00	0	17.00
18.00	Sale of medical records and abstracts	B	-50,289	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines	B	-531	ADMINISTRATIVE & GENERAL	5.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	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	*** Cost Center Deleted ***	68.00		31.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0115 | Period: From 07/01/2016 To 06/30/2017 | Worksheet A-8 | Date/Time Prepared: 11/28/2017 3:27 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
		1.00	2.00	3.00	4.00	5.00	
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	TELEPHONE DEPRECIATION	A	-49,110	CAP REL COSTS-BLDG & FIXT	1.00	9	33.00
33.01	ADVERTISING - BENEFITS	A	-11,538	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.01
33.02	ADVERTISING - ADMIN	A	-1,877	ADMINISTRATIVE & GENERAL	5.00	0	33.02
33.03	ADVERTISING - NURSING ADMIN	A	-2,628	NURSING ADMINISTRATION	13.00	0	33.03
33.04	ADVERTISING - CARING HANDS	A	-963	SUBPROVIDER - IPF	40.00	0	33.04
33.05	PHYSICIAN EMPLOYEE BENEFIT OFFSET	A	-1,928,513	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.05
33.09	ADVERTISING - FRENCH LICK	A	-734	RURAL HEALTH CLINIC	88.00	0	33.09
33.10	ADVERTISING - LOOGOOTEE	A	-881	RURAL HEALTH CLINIC II	88.01	0	33.10
33.11	ADVERTISING - ONCOLOGY	A	-572	ONCOLOGY	90.02	0	33.11
33.12	ADVERTISING - AMBULANCE	A	-4,307	AMBULANCE SERVICES	95.00	0	33.12
33.13	ADVERTISING - HOME CARE	A	-42	HOME HEALTH AGENCY	101.00	0	33.13
33.15	MISC. PROC. CENTER	B	-2,080	ADMINISTRATIVE & GENERAL	5.00	0	33.15
33.16	MISCELLANEOUS REVENUE	B	-245,223	ADMINISTRATIVE & GENERAL	5.00	0	33.16
33.17	MISCELLANEOUS - FINANCE	B	-61,885	ADMINISTRATIVE & GENERAL	5.00	0	33.17
33.18	ACCOUNTS PAYABLE DISCOUNT	B	-29,859	ADMINISTRATIVE & GENERAL	5.00	0	33.18
33.19	MAINTENANCE	B	-31,773	ADMINISTRATIVE & GENERAL	5.00	0	33.19
33.20	CLINICAL ENGINEERING	B	-1,049	MAINTENANCE & REPAIRS	6.00	0	33.20
33.21	DIETARY SUPPLEMENTS	B	-43,470	DIETARY	10.00	0	33.21
33.22	MISCELLANEOUS - DIETARY	B	-1,039	DIETARY	10.00	0	33.22
33.23	MISCELLANEOUS - CLINICAL	B	-20,614	NURSING ADMINISTRATION	13.00	0	33.23
33.25	MISCELLANEOUS - REHAB	B	-720	SUBPROVIDER - IRF	41.00	0	33.25
33.26	MISCELLANEOUS - LABS	B	-20,163	LABORATORY	60.00	0	33.26
33.27	MISCELLANEOUS - AUDIOLOGY	B	-3,206	PHYSICAL THERAPY	66.00	0	33.27
33.28	MISCELLANEOUS - CARDIAC REHAB	B	-10,280	CARDIOPULMONARY	69.02	0	33.28
33.29	MISCELLANEOUS - SLEEP LAB	B	-2,019	SLEEP LAB	69.03	9	33.29
33.30	MISCELLANEOUS - FRENCH LICK	B	-11,415	RURAL HEALTH CLINIC	88.00	0	33.30
33.31	MISCELLANEOUS - LOOGOOTEE	B	-14,793	RURAL HEALTH CLINIC II	88.01	0	33.31
33.32	MISCELLANEOUS - AMBULANCE	B	-642,997	AMBULANCE SERVICES	95.00	0	33.32
33.33	AHA IHA LOBBYING DUES	A	-8,521	ADMINISTRATIVE & GENERAL	5.00	0	33.33
33.34	CRNA EXPENSE	A	-1,061,749	OPERATING ROOM	50.00	0	33.34
33.35	CRNA EXPENSE	A	-2,257,722	ANESTHESIOLOGY	53.00	0	33.35
33.38	CABLE TV EXPENSE	A	-36,643	MAINTENANCE & REPAIRS	6.00	0	33.38
33.39	START-UP COST OFFSET	A	32,529	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.39
33.40	START-UP COST OFFSET	A	51,698	SUBPROVIDER - IPF	40.00	0	33.40
33.41	BUSINESS EXPENSE OFFSET	A	-354,756	ADMINISTRATIVE & GENERAL	5.00	0	33.41
33.42	HOSPITAL ASSESSMENT FEE	A	-6,409,375	ADMINISTRATIVE & GENERAL	5.00	0	33.42
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-29,978,892				50.00

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	Provider CCN: 15-0115	Period: From 07/01/2016 To 06/30/2017	Worksheet A-8-1 Date/Time Prepared: 11/28/2017 3:27 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	50.00	OPERATING ROOM	AMBULATORY SURGERY CENTER	3,716,488	5,710,646	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	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			3,716,488	5,710,646	5.00

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

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

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

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

6.00	C	MHHCC	0.00	MEM HOS OP SURG	40.00	6.00
7.00			0.00		0.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	Provider CCN: 15-0115	Period: From 07/01/2016 To 06/30/2017	Worksheet A-8-1 Date/Time Prepared: 11/28/2017 3:27 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.	
	6.00	7.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:		
1.00	-1,994,158	0	1.00
2.00	0	0	2.00
3.00	0	0	3.00
4.00	0	0	4.00
5.00	-1,994,158		5.00

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

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

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

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

6.00	SURGERY CENTER		6.00
7.00			7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 15-0115 | Period: From 07/01/2016 To 06/30/2017 | Worksheet A-8-2 | Date/Time Prepared: 11/28/2017 3:27 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	43,575	0	43,575	211,500	291	1.00
2.00	13.00	NURSING ADMINISTRATION	250	250	0	179,000	0	2.00
3.00	40.00	SUBPROVIDER - IPF	334,940	334,940	0	181,300	0	3.00
4.00	41.00	SUBPROVIDER - IRF	151,070	41,070	110,000	179,000	979	4.00
5.00	50.00	OPERATING ROOM	878	878	0	246,400	0	5.00
6.00	53.00	ANESTHESIOLOGY	1,488,216	1,486,549	1,667	239,400	2	6.00
7.00	54.00	RADIOLOGY-DIAGNOSTIC	3,192,780	3,190,905	1,875	271,900	12	7.00
8.00	60.00	LABORATORY	150,000	150,000	0	260,300	0	8.00
9.00	65.00	RESPIRATORY THERAPY	14,455	14,455	0	211,500	0	9.00
10.00	66.00	PHYSICAL THERAPY	4,951	4,951	0	211,500	0	10.00
11.00	69.00	ELECTROCARDIOLOGY	785,242	579,658	205,584	211,500	800	11.00
12.00	90.00	CLINIC	418,131	418,131	0	211,500	0	12.00
13.00	90.01	IMED	185,860	185,860	0	211,500	0	13.00
14.00	91.00	EMERGENCY	4,617,181	4,602,981	14,200	211,500	86	14.00
15.00	95.00	AMBULANCE SERVICES	18,000	14,000	4,000	211,500	12	15.00
200.00			11,405,529	11,024,628	380,901		2,182	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	29,590	1,480	0	0	0	1.00
2.00	13.00	NURSING ADMINISTRATION	0	0	0	0	0	2.00
3.00	40.00	SUBPROVIDER - IPF	0	0	0	0	0	3.00
4.00	41.00	SUBPROVIDER - IRF	84,250	4,213	0	0	0	4.00
5.00	50.00	OPERATING ROOM	0	0	0	0	0	5.00
6.00	53.00	ANESTHESIOLOGY	230	12	0	0	0	6.00
7.00	54.00	RADIOLOGY-DIAGNOSTIC	1,569	78	0	0	0	7.00
8.00	60.00	LABORATORY	0	0	0	0	0	8.00
9.00	65.00	RESPIRATORY THERAPY	0	0	0	0	0	9.00
10.00	66.00	PHYSICAL THERAPY	0	0	0	0	0	10.00
11.00	69.00	ELECTROCARDIOLOGY	81,346	4,067	0	0	0	11.00
12.00	90.00	CLINIC	0	0	0	0	0	12.00
13.00	90.01	IMED	0	0	0	0	0	13.00
14.00	91.00	EMERGENCY	8,745	437	0	0	0	14.00
15.00	95.00	AMBULANCE SERVICES	1,220	61	0	0	0	15.00
200.00			206,950	10,348	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment	
	1.00	2.00	15.00	16.00	17.00	18.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	0	29,590	13,985	13,985	1.00
2.00	13.00	NURSING ADMINISTRATION	0	0	0	250	2.00
3.00	40.00	SUBPROVIDER - IPF	0	0	0	334,940	3.00
4.00	41.00	SUBPROVIDER - IRF	0	84,250	25,750	66,820	4.00
5.00	50.00	OPERATING ROOM	0	0	0	878	5.00
6.00	53.00	ANESTHESIOLOGY	0	230	1,437	1,487,986	6.00
7.00	54.00	RADIOLOGY-DIAGNOSTIC	0	1,569	306	3,191,211	7.00
8.00	60.00	LABORATORY	0	0	0	150,000	8.00
9.00	65.00	RESPIRATORY THERAPY	0	0	0	14,455	9.00
10.00	66.00	PHYSICAL THERAPY	0	0	0	4,951	10.00
11.00	69.00	ELECTROCARDIOLOGY	0	81,346	124,238	703,896	11.00
12.00	90.00	CLINIC	0	0	0	418,131	12.00
13.00	90.01	IMED	0	0	0	185,860	13.00
14.00	91.00	EMERGENCY	0	8,745	5,455	4,608,436	14.00
15.00	95.00	AMBULANCE SERVICES	0	1,220	2,780	16,780	15.00
200.00			0	206,950	173,951	11,198,579	200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0115 | Period: From 07/01/2016 To 06/30/2017 | Worksheet B Part I | Date/Time Prepared: 11/28/2017 3:27 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	4,979,337	4,979,337				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	9,183,256		9,183,256			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	18,731,511	0	0	18,731,511		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	17,998,148	1,514,736	2,793,585	1,615,365	23,921,834	5.00
6.00	00600	MAINTENANCE & REPAIRS	7,506,449	359,825	663,616	314,478	8,844,368	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	315,548	15,401	28,404	45,456	404,809	8.00
9.00	00900	HOUSEKEEPING	1,413,956	13,999	25,818	205,867	1,659,640	9.00
10.00	01000	DIETARY	309,761	13,090	24,142	39,405	386,398	10.00
11.00	01100	CAFETERIA	687,800	49,307	90,935	148,328	976,370	11.00
13.00	01300	NURSING ADMINISTRATION	1,004,598	10,710	19,753	175,573	1,210,634	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	442,002	8,931	16,470	50,217	517,620	14.00
15.00	01500	PHARMACY	15,031,265	28,083	51,792	374,519	15,485,659	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,539,242	24,236	44,698	257,568	1,865,744	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,294,024	271,859	501,381	1,098,903	6,166,167	30.00
31.00	03100	INTENSIVE CARE UNIT	2,671,643	110,476	203,749	498,665	3,484,533	31.00
40.00	04000	SUBPROVIDER - IPF	2,117,224	87,276	160,961	397,505	2,762,966	40.00
41.00	04100	SUBPROVIDER - IRF	720,862	45,535	83,978	120,250	970,625	41.00
43.00	04300	NURSERY	504,015	22,855	42,151	14,879	583,900	43.00
44.00	04400	SKILLED NURSING FACILITY	1,289,784	59,858	110,394	243,276	1,703,312	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	12,681,397	321,463	592,865	896,402	14,492,127	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,638,047	74,287	137,005	48,356	1,897,695	52.00
53.00	05300	ANESTHESIOLOGY	539,939	0	0	725,534	1,265,473	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,350,984	110,322	203,464	1,072,303	4,737,073	54.00
56.00	05600	RADIOISOTOPE	737,289	7,496	13,825	39,148	797,758	56.00
60.00	06000	LABORATORY	6,620,536	73,484	135,525	450,975	7,280,520	60.00
65.00	06500	RESPIRATORY THERAPY	1,531,640	21,022	38,771	205,337	1,796,770	65.00
66.00	06600	PHYSICAL THERAPY	2,640,237	38,198	70,447	462,011	3,210,893	66.00
69.00	06900	ELECTROCARDIOLOGY	5,006,780	103,952	191,717	509,963	5,812,412	69.00
69.01	06901	PULMONARY	0	0	0	0	0	69.01
69.02	06902	CARDIOPULMONARY	93,745	12,920	23,829	18,979	149,473	69.02
69.03	06903	SLEEP LAB	252,980	13,595	25,073	46,469	338,117	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,260,373	0	0	0	2,260,373	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	6,108,726	0	0	0	6,108,726	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	418,048	15,263	28,150	57,395	518,856	88.00
88.01	08801	RURAL HEALTH CLINIC II	491,887	35,212	64,941	85,818	677,858	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	607,707	45,221	83,400	87,070	823,398	90.00
90.01	09001	IMED	286,119	5,780	10,660	70,488	373,047	90.01
90.02	09002	ONCOLOGY	2,420,828	87,860	162,039	268,126	2,938,853	90.02
90.03	09003	OUTPATIENT CENTER	393,560	0	0	40,957	434,517	90.03
91.00	09100	EMERGENCY	4,222,070	86,261	159,089	1,434,495	5,901,915	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1,336,697	17,192	31,706	359,290	1,744,885	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
101.00	10100	HOME HEALTH AGENCY	1,797,971	19,965	36,821	294,746	2,149,503	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	146,177,985	3,725,670	6,871,154	12,774,116	136,654,821	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	7,911	14,589	0	22,500	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	30,446,520	833,447	1,537,104	5,139,231	37,956,302	192.00
192.01	19201	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	606,036	19,561	36,076	114,066	775,739	192.01
194.00	07950	LODGE	3,804	229,480	423,223	61	656,568	194.00
194.02	07952	MEMORIAL HOSPITAL FOUNDATION	166,384	2,433	4,487	29,495	202,799	194.02
194.03	07953	MKT/PHY SERVICES	4,397,247	48,324	89,122	531,664	5,066,357	194.03
194.04	07954	COMMUNITY EDUCATION	508,315	39,255	72,397	66,307	686,274	194.04
194.05	07955	VOLUNTEER	181,619	0	0	32,658	214,277	194.05
194.06	07956	MAB	0	0	0	0	0	194.06
194.08	07958	PUBLIC RELATIONS	729,706	10,370	19,126	43,913	803,115	194.08
194.09	07959	UNUSED SPACE	0	62,886	115,978	0	178,864	194.09
200.00		Cross Foot Adjustments					0	200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0115 | Period: From 07/01/2016 To 06/30/2017 | Worksheet B Part I Date/Time Prepared: 11/28/2017 3:27 pm

	Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			BLDG & FIXT	MVBLE EQUIP			
		0	1.00	2.00	4.00	4A	
201.00	Negative Cost Centers		0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	183,217,616	4,979,337	9,183,256	18,731,511	183,217,616	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0115 | Period: From 07/01/2016 To 06/30/2017 | Worksheet B Part I | Date/Time Prepared: 11/28/2017 3:27 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	6.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	23,921,834					5.00
6.00	00600	MAINTENANCE & REPAIRS	1,328,176	10,172,544				6.00
8.00	00800	LAUNDRY & LINEN SERVICE	60,791	50,461	516,061			8.00
9.00	00900	HOUSEKEEPING	249,231	45,866	0	1,954,737		9.00
10.00	01000	DIETARY	58,026	42,889	5,056	8,320	500,689	10.00
11.00	01100	CAFETERIA	146,623	161,549	0	31,340	0	11.00
13.00	01300	NURSING ADMINISTRATION	181,803	35,091	0	6,808	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	77,732	29,260	27,921	5,676	0	14.00
15.00	01500	PHARMACY	2,325,512	92,010	0	17,850	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	280,183	79,408	0	15,405	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	925,986	890,722	70,185	172,796	185,698	30.00
31.00	03100	INTENSIVE CARE UNIT	523,279	361,967	35,104	70,220	88,686	31.00
40.00	04000	SUBPROVIDER - IPF	414,920	285,953	17,715	55,473	59,818	40.00
41.00	04100	SUBPROVIDER - IRF	145,761	149,191	9,498	28,942	29,443	41.00
43.00	04300	NURSERY	87,685	74,882	3,144	14,527	37,394	43.00
44.00	04400	SKILLED NURSING FACILITY	255,790	196,118	24,780	38,046	99,650	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,176,312	1,053,246	104,832	204,325	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	284,981	243,394	45,165	47,217	0	52.00
53.00	05300	ANESTHESIOLOGY	190,039	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	711,376	361,462	51,187	70,122	0	54.00
56.00	05600	RADIOISOTOPE	119,801	24,560	0	4,765	0	56.00
60.00	06000	LABORATORY	1,093,330	240,766	1,674	46,707	0	60.00
65.00	06500	RESPIRATORY THERAPY	269,825	68,877	4,393	13,362	0	65.00
66.00	06600	PHYSICAL THERAPY	482,186	125,152	12,156	24,279	0	66.00
69.00	06900	ELECTROCARDIOLOGY	872,862	340,592	27,135	66,073	0	69.00
69.01	06901	PULMONARY	0	0	0	0	0	69.01
69.02	06902	CARDIOPULMONARY	22,447	42,332	0	8,212	0	69.02
69.03	06903	SLEEP LAB	50,776	44,543	0	8,641	0	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	339,445	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	917,360	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	77,918	50,009	0	9,701	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	101,795	115,370	0	22,381	0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	123,651	148,164	1,358	28,743	0	90.00
90.01	09001	IMED	56,021	18,938	11	3,674	0	90.01
90.02	09002	ONCOLOGY	441,333	287,868	8,145	55,845	0	90.02
90.03	09003	OUTPATIENT CENTER	65,252	0	0	0	0	90.03
91.00	09100	EMERGENCY	886,302	282,628	64,752	54,829	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	262,033	56,327	0	10,927	0	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
101.00	10100	HOME HEALTH AGENCY	322,795	65,413	0	12,690	0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	16,929,338	6,065,008	514,211	1,157,896	500,689	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	3,379	25,918	0	5,028	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	5,700,043	2,730,723	1,137	529,746	0	192.00
192.01	19201	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	116,494	64,090	0	12,433	0	192.01
194.00	07950	LODGE	98,598	751,871	0	145,859	0	194.00
194.02	07952	MEMORIAL HOSPITAL FOUNDATION	30,455	7,972	0	1,547	0	194.02
194.03	07953	MKT/PHY SERVICES	760,825	158,329	0	30,715	0	194.03
194.04	07954	COMMUNITY EDUCATION	103,059	128,616	0	24,951	0	194.04
194.05	07955	VOLUNTEER	32,178	0	0	0	0	194.05
194.06	07956	MAB	0	0	0	0	0	194.06
194.08	07958	PUBLIC RELATIONS	120,605	33,977	713	6,591	0	194.08
194.09	07959	UNUSED SPACE	26,860	206,040	0	39,971	0	194.09
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	23,921,834	10,172,544	516,061	1,954,737	500,689	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0115 | Period: From 07/01/2016 To 06/30/2017 | Worksheet B Part I Date/Time Prepared: 11/28/2017 3:27 pm

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	1,315,882					11.00
13.00	01300	NURSING ADMINISTRATION	15,652	1,449,988				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	9,700	0	667,909			14.00
15.00	01500	PHARMACY	31,876	0	1,563	17,954,470		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	40,200	0	393	0	2,281,333	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	106,861	570,079	11,224	0	53,749	30.00
31.00	03100	INTENSIVE CARE UNIT	54,487	290,677	2,799	0	38,486	31.00
40.00	04000	SUBPROVIDER - IPF	39,705	211,816	778	0	18,322	40.00
41.00	04100	SUBPROVIDER - IRF	13,413	71,554	302	0	7,994	41.00
43.00	04300	NURSERY	9,881	52,712	0	0	5,599	43.00
44.00	04400	SKILLED NURSING FACILITY	30,156	0	867	0	7,001	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	80,655	0	119,880	0	325,010	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	9,881	52,712	0	0	10,382	52.00
53.00	05300	ANESTHESIOLOGY	19,866	0	13,697	0	14,111	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	55,867	0	9,675	0	247,804	54.00
56.00	05600	RADIOISOTOPE	2,970	0	120	0	41,538	56.00
60.00	06000	LABORATORY	62,943	0	76,380	0	180,944	60.00
65.00	06500	RESPIRATORY THERAPY	25,852	0	12,502	0	28,885	65.00
66.00	06600	PHYSICAL THERAPY	47,241	0	2,854	0	43,711	66.00
69.00	06900	ELECTROCARDIOLOGY	34,831	0	94,984	0	150,529	69.00
69.01	06901	PULMONARY	0	0	0	0	0	69.01
69.02	06902	CARDIOPULMONARY	2,383	0	167	0	4,723	69.02
69.03	06903	SLEEP LAB	5,718	0	331	0	7,138	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	78,313	0	51,882	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	211,636	0	78,590	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	17,954,470	464,254	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	5,291	0	379	0	4,517	88.00
88.01	08801	RURAL HEALTH CLINIC II	7,949	0	332	0	0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	10,237	0	1,612	0	12,935	90.00
90.01	09001	IMED	6,992	37,303	1,893	0	2,151	90.01
90.02	09002	ONCOLOGY	30,579	163,135	2,221	0	41,636	90.02
90.03	09003	OUTPATIENT CENTER	4,133	0	155	0	3,638	90.03
91.00	09100	EMERGENCY	71,290	0	4,800	0	139,365	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	51,573	0	1,405	0	21,270	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
101.00	10100	HOME HEALTH AGENCY	33,247	0	1,919	0	11,714	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	921,429	1,449,988	653,181	17,954,470	2,017,878	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	289,345	0	12,535	0	258,748	192.00
192.01	19201	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	11,742	0	83	0	4,638	192.01
194.00	07950	LODGE	58	0	0	0	0	194.00
194.02	07952	MEMORIAL HOSPITAL FOUNDATION	3,697	0	188	0	0	194.02
194.03	07953	MKT/PHY SERVICES	68,864	0	574	0	69	194.03
194.04	07954	COMMUNITY EDUCATION	12,533	0	1,109	0	0	194.04
194.05	07955	VOLUNTEER	2,834	0	91	0	0	194.05
194.06	07956	MAB	0	0	0	0	0	194.06
194.08	07958	PUBLIC RELATIONS	5,380	0	148	0	0	194.08
194.09	07959	UNUSED SPACE	0	0	0	0	0	194.09
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	1,315,882	1,449,988	667,909	17,954,470	2,281,333	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0115 | Period: From 07/01/2016 To 06/30/2017 | Worksheet B Part I Date/Time Prepared: 11/28/2017 3:27 pm

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			24.00	25.00	26.00	
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
6.00	00600	MAINTENANCE & REPAIRS				6.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	9,153,467	0	9,153,467	30.00
31.00	03100	INTENSIVE CARE UNIT	4,950,238	0	4,950,238	31.00
40.00	04000	SUBPROVIDER - IPF	3,867,466	0	3,867,466	40.00
41.00	04100	SUBPROVIDER - IRF	1,426,723	0	1,426,723	41.00
43.00	04300	NURSERY	869,724	0	869,724	43.00
44.00	04400	SKILLED NURSING FACILITY	2,355,720	0	2,355,720	44.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	18,556,387	0	18,556,387	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,591,427	0	2,591,427	52.00
53.00	05300	ANESTHESIOLOGY	1,503,186	0	1,503,186	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,244,566	0	6,244,566	54.00
56.00	05600	RADIOISOTOPE	991,512	0	991,512	56.00
60.00	06000	LABORATORY	8,983,264	0	8,983,264	60.00
65.00	06500	RESPIRATORY THERAPY	2,220,466	0	2,220,466	65.00
66.00	06600	PHYSICAL THERAPY	3,948,472	0	3,948,472	66.00
69.00	06900	ELECTROCARDIOLOGY	7,399,418	0	7,399,418	69.00
69.01	06901	PULMONARY	0	0	0	69.01
69.02	06902	CARDIOPULMONARY	229,737	0	229,737	69.02
69.03	06903	SLEEP LAB	455,264	0	455,264	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,730,013	0	2,730,013	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	7,316,312	0	7,316,312	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	18,418,724	0	18,418,724	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	666,671	0	666,671	88.00
88.01	08801	RURAL HEALTH CLINIC II	925,685	0	925,685	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	89.00
90.00	09000	CLINIC	1,150,098	0	1,150,098	90.00
90.01	09001	IMED	500,030	0	500,030	90.01
90.02	09002	ONCOLOGY	3,969,615	0	3,969,615	90.02
90.03	09003	OUTPATIENT CENTER	507,695	0	507,695	90.03
91.00	09100	EMERGENCY	7,405,881	0	7,405,881	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0		92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	2,148,420	0	2,148,420	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	96.00
101.00	10100	HOME HEALTH AGENCY	2,597,281	0	2,597,281	101.00
		SPECIAL PURPOSE COST CENTERS				
116.00	11600	HOSPICE	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	124,083,462	0	124,083,462	118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	56,825	0	56,825	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	47,478,579	0	47,478,579	192.00
192.01	19201	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	985,219	0	985,219	192.01
194.00	07950	LODGE	1,652,954	0	1,652,954	194.00
194.02	07952	MEMORIAL HOSPITAL FOUNDATION	246,658	0	246,658	194.02
194.03	07953	MKT/PHY SERVICES	6,085,733	0	6,085,733	194.03
194.04	07954	COMMUNITY EDUCATION	956,542	0	956,542	194.04
194.05	07955	VOLUNTEER	249,380	0	249,380	194.05
194.06	07956	MAB	0	0	0	194.06
194.08	07958	PUBLIC RELATIONS	970,529	0	970,529	194.08
194.09	07959	UNUSED SPACE	451,735	0	451,735	194.09
200.00		Cross Foot Adjustments	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	183,217,616	0	183,217,616	202.00

11/28/2017 3:27 pm C:\MCRIF32\Memorial2017.mcrx

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0115 | Period: From 07/01/2016 To 06/30/2017 | Worksheet B Part II Date/Time Prepared: 11/28/2017 3:27 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	1,514,736	2,793,585	4,308,321	0	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	359,825	663,616	1,023,441	0	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	15,401	28,404	43,805	0	8.00
9.00	00900	HOUSEKEEPING	0	13,999	25,818	39,817	0	9.00
10.00	01000	DIETARY	0	13,090	24,142	37,232	0	10.00
11.00	01100	CAFETERIA	0	49,307	90,935	140,242	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	10,710	19,753	30,463	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	8,931	16,470	25,401	0	14.00
15.00	01500	PHARMACY	0	28,083	51,792	79,875	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	24,236	44,698	68,934	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	271,859	501,381	773,240	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	110,476	203,749	314,225	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	87,276	160,961	248,237	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	45,535	83,978	129,513	0	41.00
43.00	04300	NURSERY	0	22,855	42,151	65,006	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	59,858	110,394	170,252	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	321,463	592,865	914,328	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	74,287	137,005	211,292	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	110,322	203,464	313,786	0	54.00
56.00	05600	RADIOISOTOPE	0	7,496	13,825	21,321	0	56.00
60.00	06000	LABORATORY	0	73,484	135,525	209,009	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	21,022	38,771	59,793	0	65.00
66.00	06600	PHYSICAL THERAPY	0	38,198	70,447	108,645	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	103,952	191,717	295,669	0	69.00
69.01	06901	PULMONARY	0	0	0	0	0	69.01
69.02	06902	CARDIOPULMONARY	0	12,920	23,829	36,749	0	69.02
69.03	06903	SLEEP LAB	0	13,595	25,073	38,668	0	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	15,263	28,150	43,413	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	35,212	64,941	100,153	0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	45,221	83,400	128,621	0	90.00
90.01	09001	IMED	0	5,780	10,660	16,440	0	90.01
90.02	09002	ONCOLOGY	0	87,860	162,039	249,899	0	90.02
90.03	09003	OUTPATIENT CENTER	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	0	86,261	159,089	245,350	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	17,192	31,706	48,898	0	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
101.00	10100	HOME HEALTH AGENCY	0	19,965	36,821	56,786	0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	3,725,670	6,871,154	10,596,824	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	7,911	14,589	22,500	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	833,447	1,537,104	2,370,551	0	192.00
192.01	19201	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	19,561	36,076	55,637	0	192.01
194.00	07950	LODGE	0	229,480	423,223	652,703	0	194.00
194.02	07952	MEMORIAL HOSPITAL FOUNDATION	0	2,433	4,487	6,920	0	194.02
194.03	07953	MKT/PHY SERVICES	0	48,324	89,122	137,446	0	194.03
194.04	07954	COMMUNITY EDUCATION	0	39,255	72,397	111,652	0	194.04
194.05	07955	VOLUNTEER	0	0	0	0	0	194.05
194.06	07956	MAB	0	0	0	0	0	194.06
194.08	07958	PUBLIC RELATIONS	0	10,370	19,126	29,496	0	194.08
194.09	07959	UNUSED SPACE	0	62,886	115,978	178,864	0	194.09
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00

11/28/2017 3:27 pm C:\MCRIF32\Memorial2017.mcrx

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0115 | Period: From 07/01/2016 To 06/30/2017 | Worksheet B Part II Date/Time Prepared: 11/28/2017 3:27 pm

	Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			BLDG & FIXT	MVBLE EQUIP			
		0	1.00	2.00	2A	4.00	
202.00	TOTAL (sum lines 118-201)	0	4,979,337	9,183,256	14,162,593	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0115 | Period: From 07/01/2016 To 06/30/2017 | Worksheet B Part II Date/Time Prepared: 11/28/2017 3:27 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	6.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	4,308,321					5.00
6.00	00600	MAINTENANCE & REPAIRS	239,205	1,262,646				6.00
8.00	00800	LAUNDRY & LINEN SERVICE	10,948	6,263	61,016			8.00
9.00	00900	HOUSEKEEPING	44,887	5,693	0	90,397		9.00
10.00	01000	DIETARY	10,451	5,324	598	385	53,990	10.00
11.00	01100	CAFETERIA	26,407	20,052	0	1,449	0	11.00
13.00	01300	NURSING ADMINISTRATION	32,743	4,356	0	315	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	14,000	3,632	3,301	263	0	14.00
15.00	01500	PHARMACY	418,825	11,421	0	825	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	50,461	9,856	0	712	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	166,770	110,559	8,298	7,991	20,025	30.00
31.00	03100	INTENSIVE CARE UNIT	94,243	44,928	4,150	3,247	9,563	31.00
40.00	04000	SUBPROVIDER - IPF	74,727	35,493	2,095	2,565	6,450	40.00
41.00	04100	SUBPROVIDER - IRF	26,252	18,518	1,123	1,338	3,175	41.00
43.00	04300	NURSERY	15,792	9,295	372	672	4,032	43.00
44.00	04400	SKILLED NURSING FACILITY	46,068	24,343	2,930	1,759	10,745	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	391,954	130,732	12,396	9,449	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	51,325	30,211	5,340	2,184	0	52.00
53.00	05300	ANESTHESIOLOGY	34,226	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	128,119	44,866	6,052	3,243	0	54.00
56.00	05600	RADIOISOTOPE	21,576	3,049	0	220	0	56.00
60.00	06000	LABORATORY	196,909	29,885	198	2,160	0	60.00
65.00	06500	RESPIRATORY THERAPY	48,595	8,549	519	618	0	65.00
66.00	06600	PHYSICAL THERAPY	86,842	15,534	1,437	1,123	0	66.00
69.00	06900	ELECTROCARDIOLOGY	157,202	42,275	3,208	3,056	0	69.00
69.01	06901	PULMONARY	0	0	0	0	0	69.01
69.02	06902	CARDIOPULMONARY	4,043	5,254	0	380	0	69.02
69.03	06903	SLEEP LAB	9,145	5,529	0	400	0	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	61,134	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	165,217	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	14,033	6,207	0	449	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	18,333	14,320	0	1,035	0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	22,270	18,390	161	1,329	0	90.00
90.01	09001	IMED	10,089	2,351	1	170	0	90.01
90.02	09002	ONCOLOGY	79,484	35,731	963	2,583	0	90.02
90.03	09003	OUTPATIENT CENTER	11,752	0	0	0	0	90.03
91.00	09100	EMERGENCY	159,623	35,081	7,656	2,536	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	47,192	6,991	0	505	0	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
101.00	10100	HOME HEALTH AGENCY	58,135	8,119	0	587	0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	3,048,977	752,807	60,798	53,548	53,990	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	609	3,217	0	233	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,026,571	338,946	134	24,497	0	192.00
192.01	19201	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	20,981	7,955	0	575	0	192.01
194.00	07950	LODGE	17,758	93,324	0	6,745	0	194.00
194.02	07952	MEMORIAL HOSPITAL FOUNDATION	5,485	990	0	72	0	194.02
194.03	07953	MKT/PHY SERVICES	137,025	19,652	0	1,420	0	194.03
194.04	07954	COMMUNITY EDUCATION	18,561	15,964	0	1,154	0	194.04
194.05	07955	VOLUNTEER	5,795	0	0	0	0	194.05
194.06	07956	MAB	0	0	0	0	0	194.06
194.08	07958	PUBLIC RELATIONS	21,721	4,217	84	305	0	194.08
194.09	07959	UNUSED SPACE	4,838	25,574	0	1,848	0	194.09
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	4,308,321	1,262,646	61,016	90,397	53,990	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0115 | Period: From 07/01/2016 To 06/30/2017 | Worksheet B Part II | Date/Time Prepared: 11/28/2017 3:27 pm

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	188,150					11.00
13.00	01300	NURSING ADMINISTRATION	2,238	70,115				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,387	0	47,984			14.00
15.00	01500	PHARMACY	4,558	0	112	515,616		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	5,748	0	28	0	135,739	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	15,279	27,566	806	0	3,194	30.00
31.00	03100	INTENSIVE CARE UNIT	7,791	14,056	201	0	2,287	31.00
40.00	04000	SUBPROVIDER - IPF	5,677	10,243	56	0	1,089	40.00
41.00	04100	SUBPROVIDER - IRF	1,918	3,460	22	0	475	41.00
43.00	04300	NURSERY	1,413	2,549	0	0	333	43.00
44.00	04400	SKILLED NURSING FACILITY	4,312	0	62	0	416	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	11,532	0	8,612	0	19,314	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,413	2,549	0	0	617	52.00
53.00	05300	ANESTHESIOLOGY	2,840	0	984	0	839	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,988	0	695	0	14,726	54.00
56.00	05600	RADIOISOTOPE	425	0	9	0	2,468	56.00
60.00	06000	LABORATORY	9,000	0	5,487	0	10,753	60.00
65.00	06500	RESPIRATORY THERAPY	3,696	0	898	0	1,717	65.00
66.00	06600	PHYSICAL THERAPY	6,755	0	205	0	2,598	66.00
69.00	06900	ELECTROCARDIOLOGY	4,980	0	6,824	0	8,946	69.00
69.01	06901	PULMONARY	0	0	0	0	0	69.01
69.02	06902	CARDIOPULMONARY	341	0	12	0	281	69.02
69.03	06903	SLEEP LAB	818	0	24	0	424	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	5,626	0	3,083	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	15,204	0	4,670	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	515,616	27,755	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	757	0	27	0	268	88.00
88.01	08801	RURAL HEALTH CLINIC II	1,137	0	24	0	0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	1,464	0	116	0	769	90.00
90.01	09001	IMED	1,000	1,804	136	0	128	90.01
90.02	09002	ONCOLOGY	4,372	7,888	160	0	2,474	90.02
90.03	09003	OUTPATIENT CENTER	591	0	11	0	216	90.03
91.00	09100	EMERGENCY	10,193	0	345	0	8,282	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	7,374	0	101	0	1,264	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
101.00	10100	HOME HEALTH AGENCY	4,754	0	138	0	696	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	131,751	70,115	46,925	515,616	120,082	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	41,371	0	900	0	15,377	192.00
192.01	19201	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	1,679	0	6	0	276	192.01
194.00	07950	LODGE	8	0	0	0	0	194.00
194.02	07952	MEMORIAL HOSPITAL FOUNDATION	529	0	14	0	0	194.02
194.03	07953	MKT/PHY SERVICES	9,846	0	41	0	4	194.03
194.04	07954	COMMUNITY EDUCATION	1,792	0	80	0	0	194.04
194.05	07955	VOLUNTEER	405	0	7	0	0	194.05
194.06	07956	MAB	0	0	0	0	0	194.06
194.08	07958	PUBLIC RELATIONS	769	0	11	0	0	194.08
194.09	07959	UNUSED SPACE	0	0	0	0	0	194.09
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	188,150	70,115	47,984	515,616	135,739	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0115 | Period: From 07/01/2016 To 06/30/2017 | Worksheet B Part II Date/Time Prepared: 11/28/2017 3:27 pm

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			24.00	25.00	26.00	
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
6.00	00600	MAINTENANCE & REPAIRS				6.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	1,133,728	0	1,133,728	30.00
31.00	03100	INTENSIVE CARE UNIT	494,691	0	494,691	31.00
40.00	04000	SUBPROVIDER - IPF	386,632	0	386,632	40.00
41.00	04100	SUBPROVIDER - IRF	185,794	0	185,794	41.00
43.00	04300	NURSERY	99,464	0	99,464	43.00
44.00	04400	SKILLED NURSING FACILITY	260,887	0	260,887	44.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	1,498,317	0	1,498,317	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	304,931	0	304,931	52.00
53.00	05300	ANESTHESIOLOGY	38,889	0	38,889	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	519,475	0	519,475	54.00
56.00	05600	RADIOISOTOPE	49,068	0	49,068	56.00
60.00	06000	LABORATORY	463,401	0	463,401	60.00
65.00	06500	RESPIRATORY THERAPY	124,385	0	124,385	65.00
66.00	06600	PHYSICAL THERAPY	223,139	0	223,139	66.00
69.00	06900	ELECTROCARDIOLOGY	522,160	0	522,160	69.00
69.01	06901	PULMONARY	0	0	0	69.01
69.02	06902	CARDIOPULMONARY	47,060	0	47,060	69.02
69.03	06903	SLEEP LAB	55,008	0	55,008	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	69,843	0	69,843	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	185,091	0	185,091	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	543,371	0	543,371	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	65,154	0	65,154	88.00
88.01	08801	RURAL HEALTH CLINIC II	135,002	0	135,002	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	89.00
90.00	09000	CLINIC	173,120	0	173,120	90.00
90.01	09001	IMED	32,119	0	32,119	90.01
90.02	09002	ONCOLOGY	383,554	0	383,554	90.02
90.03	09003	OUTPATIENT CENTER	12,570	0	12,570	90.03
91.00	09100	EMERGENCY	469,066	0	469,066	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0		92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	112,325	0	112,325	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	96.00
101.00	10100	HOME HEALTH AGENCY	129,215	0	129,215	101.00
		SPECIAL PURPOSE COST CENTERS				
116.00	11600	HOSPICE	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	8,717,459	0	8,717,459	118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	26,559	0	26,559	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	3,818,347	0	3,818,347	192.00
192.01	19201	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	87,109	0	87,109	192.01
194.00	07950	LODGE	770,538	0	770,538	194.00
194.02	07952	MEMORIAL HOSPITAL FOUNDATION	14,010	0	14,010	194.02
194.03	07953	MKT/PHY SERVICES	305,434	0	305,434	194.03
194.04	07954	COMMUNITY EDUCATION	149,203	0	149,203	194.04
194.05	07955	VOLUNTEER	6,207	0	6,207	194.05
194.06	07956	MAB	0	0	0	194.06
194.08	07958	PUBLIC RELATIONS	56,603	0	56,603	194.08
194.09	07959	UNUSED SPACE	211,124	0	211,124	194.09
200.00		Cross Foot Adjustments	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	14,162,593	0	14,162,593	202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0115 | Period: From 07/01/2016 To 06/30/2017 | Worksheet B-1 | Date/Time Prepared: 11/28/2017 3:27 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	937,262					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		937,262				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	97,041,083			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	285,119	285,119	8,368,595	-23,921,834	159,295,782	5.00
6.00	00600	MAINTENANCE & REPAIRS	67,730	67,730	1,629,191	0	8,844,368	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,899	2,899	235,488	0	404,809	8.00
9.00	00900	HOUSEKEEPING	2,635	2,635	1,066,520	0	1,659,640	9.00
10.00	01000	DIETARY	2,464	2,464	204,144	0	386,398	10.00
11.00	01100	CAFETERIA	9,281	9,281	768,433	0	976,370	11.00
13.00	01300	NURSING ADMINISTRATION	2,016	2,016	909,575	0	1,210,634	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,681	1,681	260,154	0	517,620	14.00
15.00	01500	PHARMACY	5,286	5,286	1,940,240	0	15,485,659	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,562	4,562	1,334,364	0	1,865,744	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	51,172	51,172	5,693,002	0	6,166,167	30.00
31.00	03100	INTENSIVE CARE UNIT	20,795	20,795	2,583,397	0	3,484,533	31.00
40.00	04000	SUBPROVIDER - IPF	16,428	16,428	2,059,323	0	2,762,966	40.00
41.00	04100	SUBPROVIDER - IRF	8,571	8,571	622,970	0	970,625	41.00
43.00	04300	NURSERY	4,302	4,302	77,082	0	583,900	43.00
44.00	04400	SKILLED NURSING FACILITY	11,267	11,267	1,260,319	0	1,703,312	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	60,509	60,509	4,643,918	0	14,492,127	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	13,983	13,983	250,515	0	1,897,695	52.00
53.00	05300	ANESTHESIOLOGY	0	0	3,758,716	0	1,265,473	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	20,766	20,766	5,555,198	0	4,737,073	54.00
56.00	05600	RADIOISOTOPE	1,411	1,411	202,812	0	797,758	56.00
60.00	06000	LABORATORY	13,832	13,832	2,336,329	0	7,280,520	60.00
65.00	06500	RESPIRATORY THERAPY	3,957	3,957	1,063,776	0	1,796,770	65.00
66.00	06600	PHYSICAL THERAPY	7,190	7,190	2,393,507	0	3,210,893	66.00
69.00	06900	ELECTROCARDIOLOGY	19,567	19,567	2,641,926	0	5,812,412	69.00
69.01	06901	PULMONARY	0	0	0	0	0	69.01
69.02	06902	CARDIOPULMONARY	2,432	2,432	98,323	0	149,473	69.02
69.03	06903	SLEEP LAB	2,559	2,559	240,739	0	338,117	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	2,260,373	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	6,108,726	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	2,873	2,873	297,340	0	518,856	88.00
88.01	08801	RURAL HEALTH CLINIC II	6,628	6,628	444,590	0	677,858	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	8,512	8,512	451,079	0	823,398	90.00
90.01	09001	IMED	1,088	1,088	365,174	0	373,047	90.01
90.02	09002	ONCOLOGY	16,538	16,538	1,389,062	0	2,938,853	90.02
90.03	09003	OUTPATIENT CENTER	0	0	212,183	0	434,517	90.03
91.00	09100	EMERGENCY	16,237	16,237	7,431,576	0	5,901,915	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	3,236	3,236	1,861,347	0	1,744,885	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
101.00	10100	HOME HEALTH AGENCY	3,758	3,758	1,526,970	0	2,149,503	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	701,284	701,284	66,177,877	-23,921,834	112,732,987	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,489	1,489	0	0	22,500	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	156,880	156,880	26,624,608	0	37,956,302	192.00
192.01	19201	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	3,682	3,682	590,931	0	775,739	192.01
194.00	07950	LODGE	43,195	43,195	315	0	656,568	194.00
194.02	07952	MEMORIAL HOSPITAL FOUNDATION	458	458	152,804	0	202,799	194.02
194.03	07953	MKT/PHY SERVICES	9,096	9,096	2,754,348	0	5,066,357	194.03
194.04	07954	COMMUNITY EDUCATION	7,389	7,389	343,514	0	686,274	194.04
194.05	07955	VOLUNTEER	0	0	169,191	0	214,277	194.05
194.06	07956	MAB	0	0	0	0	0	194.06
194.08	07958	PUBLIC RELATIONS	1,952	1,952	227,495	0	803,115	194.08
194.09	07959	UNUSED SPACE	11,837	11,837	0	0	178,864	194.09
200.00		Cross Foot Adjustments						200.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0115 | Period: From 07/01/2016 To 06/30/2017 | Worksheet B-1 | Date/Time Prepared: 11/28/2017 3:27 pm

	Cost Center Description	CAPITAL RELATED COSTS					
		BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
		1.00	2.00	4.00	5A	5.00	
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	4,979,337	9,183,256	18,731,511		23,921,834	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	5.312642	9.797960	0.193027		0.150172	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)			0		4,308,321	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)			0.000000		0.027046	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0115 | Period: From 07/01/2016 To 06/30/2017 | Worksheet B-1 | Date/Time Prepared: 11/28/2017 3:27 pm

		Cost Center Description	MAINTENANCE & REPAIRS (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (PATIENT DAYS)	CAFETERIA (HOURS)	
			6.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS	584,413					6.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,899	874,801				8.00
9.00	00900	HOUSEKEEPING	2,635	0	578,879			9.00
10.00	01000	DIETARY	2,464	8,570	2,464	25,253		10.00
11.00	01100	CAFETERIA	9,281	0	9,281	0	2,187,684	11.00
13.00	01300	NURSING ADMINISTRATION	2,016	0	2,016	0	26,021	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,681	47,331	1,681	0	16,127	14.00
15.00	01500	PHARMACY	5,286	0	5,286	0	52,995	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,562	0	4,562	0	66,834	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	51,172	118,975	51,172	9,366	177,659	30.00
31.00	03100	INTENSIVE CARE UNIT	20,795	59,506	20,795	4,473	90,586	31.00
40.00	04000	SUBPROVIDER - IPF	16,428	30,030	16,428	3,017	66,010	40.00
41.00	04100	SUBPROVIDER - IRF	8,571	16,100	8,571	1,485	22,299	41.00
43.00	04300	NURSERY	4,302	5,329	4,302	1,886	16,427	43.00
44.00	04400	SKILLED NURSING FACILITY	11,267	42,006	11,267	5,026	50,135	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	60,509	177,707	60,509	0	134,091	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	13,983	76,562	13,983	0	16,427	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	33,027	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	20,766	86,770	20,766	0	92,881	54.00
56.00	05600	RADIOISOTOPE	1,411	0	1,411	0	4,937	56.00
60.00	06000	LABORATORY	13,832	2,837	13,832	0	104,644	60.00
65.00	06500	RESPIRATORY THERAPY	3,957	7,446	3,957	0	42,980	65.00
66.00	06600	PHYSICAL THERAPY	7,190	20,606	7,190	0	78,540	66.00
69.00	06900	ELECTROCARDIOLOGY	19,567	45,998	19,567	0	57,907	69.00
69.01	06901	PULMONARY	0	0	0	0	0	69.01
69.02	06902	CARDIOPULMONARY	2,432	0	2,432	0	3,962	69.02
69.03	06903	SLEEP LAB	2,559	0	2,559	0	9,506	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	2,873	0	2,873	0	8,797	88.00
88.01	08801	RURAL HEALTH CLINIC II	6,628	0	6,628	0	13,215	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	8,512	2,302	8,512	0	17,020	90.00
90.01	09001	IMED	1,088	19	1,088	0	11,625	90.01
90.02	09002	ONCOLOGY	16,538	13,807	16,538	0	50,839	90.02
90.03	09003	OUTPATIENT CENTER	0	0	0	0	6,871	90.03
91.00	09100	EMERGENCY	16,237	109,765	16,237	0	118,522	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	3,236	0	3,236	0	85,741	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
101.00	10100	HOME HEALTH AGENCY	3,758	0	3,758	0	55,274	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	348,435	871,666	342,901	25,253	1,531,899	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,489	0	1,489	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	156,880	1,927	156,880	0	481,040	192.00
192.01	19201	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	3,682	0	3,682	0	19,522	192.01
194.00	07950	LODGE	43,195	0	43,195	0	96	194.00
194.02	07952	MEMORIAL HOSPITAL FOUNDATION	458	0	458	0	6,146	194.02
194.03	07953	MKT/PHY SERVICES	9,096	0	9,096	0	114,488	194.03
194.04	07954	COMMUNITY EDUCATION	7,389	0	7,389	0	20,837	194.04
194.05	07955	VOLUNTEER	0	0	0	0	4,712	194.05
194.06	07956	MAB	0	0	0	0	0	194.06
194.08	07958	PUBLIC RELATIONS	1,952	1,208	1,952	0	8,944	194.08
194.09	07959	UNUSED SPACE	11,837	0	11,837	0	0	194.09
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)	10,172,544	516,061	1,954,737	500,689	1,315,882	202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0115 | Period: From 07/01/2016 To 06/30/2017 | Worksheet B-1 | Date/Time Prepared: 11/28/2017 3:27 pm

	Cost Center Description	MAINTENANCE & REPAIRS (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (PATIENT DAYS)	CAFETERIA (HOURS)	
		6.00	8.00	9.00	10.00	11.00	
203.00	Unit cost multiplier (Wkst. B, Part I)	17.406430	0.589918	3.376763	19.826912	0.601495	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	1,262,646	61,016	90,397	53,990	188,150	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	2.160537	0.069748	0.156159	2.137964	0.086004	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0115 | Period: From 07/01/2016 To 06/30/2017 | Worksheet B-1 | Date/Time Prepared: 11/28/2017 3:27 pm

		Cost Center Description	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (REVENUE)		
			13.00	14.00	15.00	16.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	451,872					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	19,278,232				14.00
15.00	01500	PHARMACY	0	45,110	100			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	11,332	0	450,433,442		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	177,659	323,956	0	10,611,787		30.00
31.00	03100	INTENSIVE CARE UNIT	90,586	80,779	0	7,598,485		31.00
40.00	04000	SUBPROVIDER - IPF	66,010	22,456	0	3,617,401		40.00
41.00	04100	SUBPROVIDER - IRF	22,299	8,723	0	1,578,307		41.00
43.00	04300	NURSERY	16,427	0	0	1,105,382		43.00
44.00	04400	SKILLED NURSING FACILITY	0	25,013	0	1,382,151		44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	3,460,153	0	64,167,738		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	16,427	0	0	2,049,755		52.00
53.00	05300	ANESTHESIOLOGY	0	395,340	0	2,785,910		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	279,241	0	48,924,810		54.00
56.00	05600	RADIOISOTOPE	0	3,469	0	8,200,920		56.00
60.00	06000	LABORATORY	0	2,204,577	0	35,724,463		60.00
65.00	06500	RESPIRATORY THERAPY	0	360,854	0	5,702,775		65.00
66.00	06600	PHYSICAL THERAPY	0	82,371	0	8,630,090		66.00
69.00	06900	ELECTROCARDIOLOGY	0	2,741,544	0	29,719,515		69.00
69.01	06901	PULMONARY	0	0	0	0		69.01
69.02	06902	CARDIOPULMONARY	0	4,822	0	932,403		69.02
69.03	06903	SLEEP LAB	0	9,541	0	1,409,326		69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2,260,373	0	10,243,236		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	6,108,726	0	15,516,258		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	100	91,681,783		73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0		74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	10,926	0	891,886		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	9,589	0	0		88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0		89.00
90.00	09000	CLINIC	0	46,533	0	2,553,727		90.00
90.01	09001	IMED	11,625	54,634	0	424,622		90.01
90.02	09002	ONCOLOGY	50,839	64,100	0	8,220,260		90.02
90.03	09003	OUTPATIENT CENTER	0	4,487	0	718,262		90.03
91.00	09100	EMERGENCY	0	138,541	0	27,515,277		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	40,548	0	4,199,445		95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0		96.00
101.00	10100	HOME HEALTH AGENCY	0	55,386	0	2,312,697		101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	0		116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	451,872	18,853,124	100	398,418,671		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	361,789	0	51,085,465		192.00
192.01	19201	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	2,398	0	915,751		192.01
194.00	07950	LODGE	0	0	0	0		194.00
194.02	07952	MEMORIAL HOSPITAL FOUNDATION	0	5,436	0	0		194.02
194.03	07953	MKT/PHY SERVICES	0	16,572	0	13,555		194.03
194.04	07954	COMMUNITY EDUCATION	0	32,012	0	0		194.04
194.05	07955	VOLUNTEER	0	2,633	0	0		194.05
194.06	07956	MAB	0	0	0	0		194.06
194.08	07958	PUBLIC RELATIONS	0	4,268	0	0		194.08
194.09	07959	UNUSED SPACE	0	0	0	0		194.09
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0115

Period: From 07/01/2016 To 06/30/2017

Worksheet B-1

Date/Time Prepared: 11/28/2017 3:27 pm

		Cost Center Description	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (REVENUE)		
			13.00	14.00	15.00	16.00		
202.00		Cost to be allocated (per Wkst. B, Part I)	1,449,988	667,909	17,954,470	2,281,333		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	3.208847	0.034646	179,544.700000	0.005065		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	70,115	47,984	515,616	135,739		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.155166	0.002489	5,156.160000	0.000301		205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0115 | Period: From 07/01/2016 To 06/30/2017 | Worksheet C Part I | Date/Time Prepared: 11/28/2017 3:27 pm

Title XVIII | Hospital | PPS

		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	9,153,467		9,153,467	0	9,153,467	30.00
31.00	03100	INTENSIVE CARE UNIT	4,950,238		4,950,238	0	4,950,238	31.00
40.00	04000	SUBPROVIDER - IPF	3,867,466		3,867,466	0	3,867,466	40.00
41.00	04100	SUBPROVIDER - IRF	1,426,723		1,426,723	25,750	1,452,473	41.00
43.00	04300	NURSERY	869,724		869,724	0	869,724	43.00
44.00	04400	SKILLED NURSING FACILITY	2,355,720		2,355,720	0	2,355,720	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	18,556,387		18,556,387	0	18,556,387	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,591,427		2,591,427	0	2,591,427	52.00
53.00	05300	ANESTHESIOLOGY	1,503,186		1,503,186	1,437	1,504,623	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,244,566		6,244,566	306	6,244,872	54.00
56.00	05600	RADIOISOTOPE	991,512		991,512	0	991,512	56.00
60.00	06000	LABORATORY	8,983,264		8,983,264	0	8,983,264	60.00
65.00	06500	RESPIRATORY THERAPY	2,220,466	0	2,220,466	0	2,220,466	65.00
66.00	06600	PHYSICAL THERAPY	3,948,472	0	3,948,472	0	3,948,472	66.00
69.00	06900	ELECTROCARDIOLOGY	7,399,418		7,399,418	124,238	7,523,656	69.00
69.01	06901	PULMONARY	0		0	0	0	69.01
69.02	06902	CARDIOPULMONARY	229,737		229,737	0	229,737	69.02
69.03	06903	SLEEP LAB	455,264		455,264	0	455,264	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0		0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,730,013		2,730,013	0	2,730,013	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	7,316,312		7,316,312	0	7,316,312	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	18,418,724		18,418,724	0	18,418,724	73.00
74.00	07400	RENAL DIALYSIS	0		0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	666,671		666,671	0	666,671	88.00
88.01	08801	RURAL HEALTH CLINIC II	925,685		925,685	0	925,685	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0	89.00
90.00	09000	CLINIC	1,150,098		1,150,098	0	1,150,098	90.00
90.01	09001	IMED	500,030		500,030	0	500,030	90.01
90.02	09002	ONCOLOGY	3,969,615		3,969,615	0	3,969,615	90.02
90.03	09003	OUTPATIENT CENTER	507,695		507,695	0	507,695	90.03
91.00	09100	EMERGENCY	7,405,881		7,405,881	5,455	7,411,336	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,923,625		1,923,625		1,923,625	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	2,148,420		2,148,420	2,780	2,151,200	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0		0	0	0	96.00
101.00	10100	HOME HEALTH AGENCY	2,597,281		2,597,281		2,597,281	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0		0		0	116.00
200.00		Subtotal (see instructions)	126,007,087	0	126,007,087	159,966	126,167,053	200.00
201.00		Less Observation Beds	1,923,625		1,923,625		1,923,625	201.00
202.00		Total (see instructions)	124,083,462	0	124,083,462	159,966	124,243,428	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0115 | Period: From 07/01/2016 To 06/30/2017 | Worksheet C Part I | Date/Time Prepared: 11/28/2017 3:27 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Charges Inpatient	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	10,611,787		10,611,787			30.00
31.00	03100	INTENSIVE CARE UNIT	7,598,485		7,598,485			31.00
40.00	04000	SUBPROVIDER - IPF	3,617,401		3,617,401			40.00
41.00	04100	SUBPROVIDER - IRF	1,578,307		1,578,307			41.00
43.00	04300	NURSERY	1,105,382		1,105,382			43.00
44.00	04400	SKILLED NURSING FACILITY	1,382,151		1,382,151			44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	9,659,714	54,508,024	64,167,738	0.289186	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,021,780	27,975	2,049,755	1.264262	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	798,295	1,987,615	2,785,910	0.539567	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,058,834	42,865,976	48,924,810	0.127636	0.000000	54.00
56.00	05600	RADIOISOTOPE	355,343	7,845,577	8,200,920	0.120903	0.000000	56.00
60.00	06000	LABORATORY	7,380,470	28,343,993	35,724,463	0.251460	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	2,370,498	3,332,277	5,702,775	0.389366	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	4,670,040	3,960,050	8,630,090	0.457524	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	9,790,863	19,928,652	29,719,515	0.248975	0.000000	69.00
69.01	06901	PULMONARY	0	0	0	0.000000	0.000000	69.01
69.02	06902	CARDIOPULMONARY	1,269	931,134	932,403	0.246392	0.000000	69.02
69.03	06903	SLEEP LAB	782	1,408,544	1,409,326	0.323037	0.000000	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,847,342	6,395,894	10,243,236	0.266519	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	9,272,281	6,243,977	15,516,258	0.471526	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	27,356,342	64,325,441	91,681,783	0.200898	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0.000000	0.000000	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	891,886	891,886			88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0			88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0			89.00
90.00	09000	CLINIC	69,002	2,484,725	2,553,727	0.450361	0.000000	90.00
90.01	09001	IMED	0	424,622	424,622	1.177589	0.000000	90.01
90.02	09002	ONCOLOGY	94,334	8,125,926	8,220,260	0.482906	0.000000	90.02
90.03	09003	OUTPATIENT CENTER	284,566	433,696	718,262	0.706838	0.000000	90.03
91.00	09100	EMERGENCY	4,412,426	23,102,851	27,515,277	0.269155	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	315,839	2,626,439	2,942,278	0.653788	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1,123,811	3,075,634	4,199,445	0.511596	0.000000	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0.000000	0.000000	96.00
101.00	10100	HOME HEALTH AGENCY	0	2,312,697	2,312,697			101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0			116.00
200.00		Subtotal (see instructions)	115,777,344	285,583,605	401,360,949			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	115,777,344	285,583,605	401,360,949			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0115 | Period: From 07/01/2016 To 06/30/2017 | Worksheet C Part I Date/Time Prepared: 11/28/2017 3:27 pm

Title XVIII | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
40.00	04000	SUBPROVIDER - IPF		40.00
41.00	04100	SUBPROVIDER - IRF		41.00
43.00	04300	NURSERY		43.00
44.00	04400	SKILLED NURSING FACILITY		44.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.289186	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.264262	52.00
53.00	05300	ANESTHESIOLOGY	0.540083	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.127642	54.00
56.00	05600	RADIOISOTOPE	0.120903	56.00
60.00	06000	LABORATORY	0.251460	60.00
65.00	06500	RESPIRATORY THERAPY	0.389366	65.00
66.00	06600	PHYSICAL THERAPY	0.457524	66.00
69.00	06900	ELECTROCARDIOLOGY	0.253155	69.00
69.01	06901	PULMONARY	0.000000	69.01
69.02	06902	CARDIOPULMONARY	0.246392	69.02
69.03	06903	SLEEP LAB	0.323037	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.266519	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.471526	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.200898	73.00
74.00	07400	RENAL DIALYSIS	0.000000	74.00
		OUTPATIENT SERVICE COST CENTERS		
88.00	08800	RURAL HEALTH CLINIC		88.00
88.01	08801	RURAL HEALTH CLINIC II		88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER		89.00
90.00	09000	CLINIC	0.450361	90.00
90.01	09001	IMED	1.177589	90.01
90.02	09002	ONCOLOGY	0.482906	90.02
90.03	09003	OUTPATIENT CENTER	0.706838	90.03
91.00	09100	EMERGENCY	0.269353	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.653788	92.00
		OTHER REIMBURSABLE COST CENTERS		
95.00	09500	AMBULANCE SERVICES	0.512258	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000	96.00
101.00	10100	HOME HEALTH AGENCY		101.00
		SPECIAL PURPOSE COST CENTERS		
116.00	11600	HOSPICE		116.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0115 | Period: From 07/01/2016 To 06/30/2017 | Worksheet C Part I | Date/Time Prepared: 11/28/2017 3:27 pm

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs: Total Costs	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	9,153,467		9,153,467	0	9,153,467	30.00
31.00	03100	INTENSIVE CARE UNIT	4,950,238		4,950,238	0	4,950,238	31.00
40.00	04000	SUBPROVIDER - IPF	3,867,466		3,867,466	0	3,867,466	40.00
41.00	04100	SUBPROVIDER - IRF	1,426,723		1,426,723	25,750	1,452,473	41.00
43.00	04300	NURSERY	869,724		869,724	0	869,724	43.00
44.00	04400	SKILLED NURSING FACILITY	2,355,720		2,355,720	0	2,355,720	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	18,556,387		18,556,387	0	18,556,387	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,591,427		2,591,427	0	2,591,427	52.00
53.00	05300	ANESTHESIOLOGY	1,503,186		1,503,186	1,437	1,504,623	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,244,566		6,244,566	306	6,244,872	54.00
56.00	05600	RADIOISOTOPE	991,512		991,512	0	991,512	56.00
60.00	06000	LABORATORY	8,983,264		8,983,264	0	8,983,264	60.00
65.00	06500	RESPIRATORY THERAPY	2,220,466	0	2,220,466	0	2,220,466	65.00
66.00	06600	PHYSICAL THERAPY	3,948,472	0	3,948,472	0	3,948,472	66.00
69.00	06900	ELECTROCARDIOLOGY	7,399,418		7,399,418	124,238	7,523,656	69.00
69.01	06901	PULMONARY	0		0	0	0	69.01
69.02	06902	CARDIOPULMONARY	229,737		229,737	0	229,737	69.02
69.03	06903	SLEEP LAB	455,264		455,264	0	455,264	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0		0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,730,013		2,730,013	0	2,730,013	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	7,316,312		7,316,312	0	7,316,312	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	18,418,724		18,418,724	0	18,418,724	73.00
74.00	07400	RENAL DIALYSIS	0		0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	666,671		666,671	0	666,671	88.00
88.01	08801	RURAL HEALTH CLINIC II	925,685		925,685	0	925,685	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0	89.00
90.00	09000	CLINIC	1,150,098		1,150,098	0	1,150,098	90.00
90.01	09001	IMED	500,030		500,030	0	500,030	90.01
90.02	09002	ONCOLOGY	3,969,615		3,969,615	0	3,969,615	90.02
90.03	09003	OUTPATIENT CENTER	507,695		507,695	0	507,695	90.03
91.00	09100	EMERGENCY	7,405,881		7,405,881	5,455	7,411,336	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,923,625		1,923,625		1,923,625	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	2,148,420		2,148,420	2,780	2,151,200	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0		0	0	0	96.00
101.00	10100	HOME HEALTH AGENCY	2,597,281		2,597,281		2,597,281	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0		0		0	116.00
200.00		Subtotal (see instructions)	126,007,087	0	126,007,087	159,966	126,167,053	200.00
201.00		Less Observation Beds	1,923,625		1,923,625		1,923,625	201.00
202.00		Total (see instructions)	124,083,462	0	124,083,462	159,966	124,243,428	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0115 | Period: From 07/01/2016 To 06/30/2017 | Worksheet C Part I Date/Time Prepared: 11/28/2017 3:27 pm

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	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	10,611,787		10,611,787			30.00
31.00	03100	INTENSIVE CARE UNIT	7,598,485		7,598,485			31.00
40.00	04000	SUBPROVIDER - IPF	3,617,401		3,617,401			40.00
41.00	04100	SUBPROVIDER - IRF	1,578,307		1,578,307			41.00
43.00	04300	NURSERY	1,105,382		1,105,382			43.00
44.00	04400	SKILLED NURSING FACILITY	1,382,151		1,382,151			44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	9,659,714	54,508,024	64,167,738	0.289186	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,021,780	27,975	2,049,755	1.264262	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	798,295	1,987,615	2,785,910	0.539567	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,058,834	42,865,976	48,924,810	0.127636	0.000000	54.00
56.00	05600	RADIOISOTOPE	355,343	7,845,577	8,200,920	0.120903	0.000000	56.00
60.00	06000	LABORATORY	7,380,470	28,343,993	35,724,463	0.251460	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	2,370,498	3,332,277	5,702,775	0.389366	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	4,670,040	3,960,050	8,630,090	0.457524	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	9,790,863	19,928,652	29,719,515	0.248975	0.000000	69.00
69.01	06901	PULMONARY	0	0	0	0.000000	0.000000	69.01
69.02	06902	CARDIOPULMONARY	1,269	931,134	932,403	0.246392	0.000000	69.02
69.03	06903	SLEEP LAB	782	1,408,544	1,409,326	0.323037	0.000000	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,847,342	6,395,894	10,243,236	0.266519	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	9,272,281	6,243,977	15,516,258	0.471526	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	27,356,342	64,325,441	91,681,783	0.200898	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0.000000	0.000000	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	891,886	891,886	0.747485	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0.000000	0.000000	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.000000	0.000000	89.00
90.00	09000	CLINIC	69,002	2,484,725	2,553,727	0.450361	0.000000	90.00
90.01	09001	IMED	0	424,622	424,622	1.177589	0.000000	90.01
90.02	09002	ONCOLOGY	94,334	8,125,926	8,220,260	0.482906	0.000000	90.02
90.03	09003	OUTPATIENT CENTER	284,566	433,696	718,262	0.706838	0.000000	90.03
91.00	09100	EMERGENCY	4,412,426	23,102,851	27,515,277	0.269155	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	315,839	2,626,439	2,942,278	0.653788	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1,123,811	3,075,634	4,199,445	0.511596	0.000000	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0.000000	0.000000	96.00
101.00	10100	HOME HEALTH AGENCY	0	2,312,697	2,312,697			101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0			116.00
200.00		Subtotal (see instructions)	115,777,344	285,583,605	401,360,949			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	115,777,344	285,583,605	401,360,949			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0115 | Period: From 07/01/2016 To 06/30/2017 | Worksheet C Part I Date/Time Prepared: 11/28/2017 3:27 pm

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
40.00	04000	SUBPROVIDER - IPF		40.00
41.00	04100	SUBPROVIDER - IRF		41.00
43.00	04300	NURSERY		43.00
44.00	04400	SKILLED NURSING FACILITY		44.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	54.00
56.00	05600	RADIOISOTOPE	0.000000	56.00
60.00	06000	LABORATORY	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	69.00
69.01	06901	PULMONARY	0.000000	69.01
69.02	06902	CARDIOPULMONARY	0.000000	69.02
69.03	06903	SLEEP LAB	0.000000	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0.000000	74.00
		OUTPATIENT SERVICE COST CENTERS		
88.00	08800	RURAL HEALTH CLINIC	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	89.00
90.00	09000	CLINIC	0.000000	90.00
90.01	09001	IMED	0.000000	90.01
90.02	09002	ONCOLOGY	0.000000	90.02
90.03	09003	OUTPATIENT CENTER	0.000000	90.03
91.00	09100	EMERGENCY	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS		
95.00	09500	AMBULANCE SERVICES	0.000000	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000	96.00
101.00	10100	HOME HEALTH AGENCY		101.00
		SPECIAL PURPOSE COST CENTERS		
116.00	11600	HOSPICE		116.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 15-0115 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D Part I | Date/Time Prepared: 11/28/2017 3:27 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	1,133,728	0	1,133,728	11,858	95.61	30.00
31.00	INTENSIVE CARE UNIT	494,691		494,691	4,473	110.59	31.00
40.00	SUBPROVIDER - IPF	386,632	0	386,632	3,017	128.15	40.00
41.00	SUBPROVIDER - IRF	185,794	0	185,794	1,485	125.11	41.00
43.00	NURSERY	99,464		99,464	1,886	52.74	43.00
44.00	SKILLED NURSING FACILITY	260,887		260,887	5,026	51.91	44.00
200.00	Total (lines 30-199)	2,561,196		2,561,196	27,745		200.00

	Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)	
		6.00	7.00	
	INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	ADULTS & PEDIATRICS	4,223	403,761	30.00
31.00	INTENSIVE CARE UNIT	2,719	300,694	31.00
40.00	SUBPROVIDER - IPF	1,656	212,216	40.00
41.00	SUBPROVIDER - IRF	757	94,708	41.00
43.00	NURSERY	0	0	43.00
44.00	SKILLED NURSING FACILITY	4,149	215,375	44.00
200.00	Total (lines 30-199)	13,504	1,226,754	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-0115 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D Part II Date/Time Prepared: 11/28/2017 3:27 pm

Title XVIII | Hospital | PPS

		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	1,498,317	64,167,738	0.023350	4,773,929	111,471	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	304,931	2,049,755	0.148765	5,925	881	52.00
53.00	05300	ANESTHESIOLOGY	38,889	2,785,910	0.013959	290,338	4,053	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	519,475	48,924,810	0.010618	3,859,796	40,983	54.00
56.00	05600	RADIOISOTOPE	49,068	8,200,920	0.005983	282,192	1,688	56.00
60.00	06000	LABORATORY	463,401	35,724,463	0.012972	3,662,140	47,505	60.00
65.00	06500	RESPIRATORY THERAPY	124,385	5,702,775	0.021811	1,410,934	30,774	65.00
66.00	06600	PHYSICAL THERAPY	223,139	8,630,090	0.025856	1,294,120	33,461	66.00
69.00	06900	ELECTROCARDIOLOGY	522,160	29,719,515	0.017570	5,889,622	103,481	69.00
69.01	06901	PULMONARY	0	0	0.000000	0	0	69.01
69.02	06902	CARDIOPULMONARY	47,060	932,403	0.050472	386	19	69.02
69.03	06903	SLEEP LAB	55,008	1,409,326	0.039031	0	0	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	69,843	10,243,236	0.006818	2,107,433	14,368	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	185,091	15,516,258	0.011929	5,841,732	69,686	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	543,371	91,681,783	0.005927	12,995,601	77,025	73.00
74.00	07400	RENAL DIALYSIS	0	0	0.000000	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	65,154	891,886	0.073052	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	135,002	0	0.000000	0	0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00
90.00	09000	CLINIC	173,120	2,553,727	0.067791	38,650	2,620	90.00
90.01	09001	IMED	32,119	424,622	0.075641	0	0	90.01
90.02	09002	ONCOLOGY	383,554	8,220,260	0.046660	82,141	3,833	90.02
90.03	09003	OUTPATIENT CENTER	12,570	718,262	0.017501	4,453	78	90.03
91.00	09100	EMERGENCY	469,066	27,515,277	0.017047	2,797,059	47,681	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	238,256	2,942,278	0.080977	316,592	25,637	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0.000000	0	0	96.00
200.00		Total (lines 50-199)	6,152,979	368,955,294		45,653,043	615,244	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0115	Period: From 07/01/2016 To 06/30/2017	Worksheet D Part III Date/Time Prepared: 11/28/2017 3:27 pm
	Title XVIII	Hospital	PPS

		Cost Center Description	Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0		0	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
43.00	04300	NURSERY	0	0	0		0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0			0	44.00
200.00		Total (lines 30-199)	0	0	0		0	200.00

		Cost Center Description	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
			6.00	7.00	8.00	9.00	
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	11,858	0.00	4,223	0	30.00
31.00	03100	INTENSIVE CARE UNIT	4,473	0.00	2,719	0	31.00
40.00	04000	SUBPROVIDER - IPF	3,017	0.00	1,656	0	40.00
41.00	04100	SUBPROVIDER - IRF	1,485	0.00	757	0	41.00
43.00	04300	NURSERY	1,886	0.00	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	5,026	0.00	4,149	0	44.00
200.00		Total (lines 30-199)	27,745		13,504	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0115 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D Part IV | Date/Time Prepared: 11/28/2017 3:27 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901	PULMONARY	0	0	0	0	0	69.01
69.02	06902	CARDIOPULMONARY	0	0	0	0	0	69.02
69.03	06903	SLEEP LAB	0	0	0	0	0	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	IMED	0	0	0	0	0	90.01
90.02	09002	ONCOLOGY	0	0	0	0	0	90.02
90.03	09003	OUTPATIENT CENTER	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0115 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D Part IV | Date/Time Prepared: 11/28/2017 3:27 pm

Title XVIII | Hospital | PPS

		Cost Center Description	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)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	64,167,738	0.000000	0.000000	4,773,929	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	2,049,755	0.000000	0.000000	5,925	52.00
53.00	05300	ANESTHESIOLOGY	0	2,785,910	0.000000	0.000000	290,338	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	48,924,810	0.000000	0.000000	3,859,796	54.00
56.00	05600	RADIOISOTOPE	0	8,200,920	0.000000	0.000000	282,192	56.00
60.00	06000	LABORATORY	0	35,724,463	0.000000	0.000000	3,662,140	60.00
65.00	06500	RESPIRATORY THERAPY	0	5,702,775	0.000000	0.000000	1,410,934	65.00
66.00	06600	PHYSICAL THERAPY	0	8,630,090	0.000000	0.000000	1,294,120	66.00
69.00	06900	ELECTROCARDIOLOGY	0	29,719,515	0.000000	0.000000	5,889,622	69.00
69.01	06901	PULMONARY	0	0	0.000000	0.000000	0	69.01
69.02	06902	CARDIOPULMONARY	0	932,403	0.000000	0.000000	386	69.02
69.03	06903	SLEEP LAB	0	1,409,326	0.000000	0.000000	0	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0.000000	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	10,243,236	0.000000	0.000000	2,107,433	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	15,516,258	0.000000	0.000000	5,841,732	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	91,681,783	0.000000	0.000000	12,995,601	73.00
74.00	07400	RENAL DIALYSIS	0	0	0.000000	0.000000	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	891,886	0.000000	0.000000	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0.000000	0.000000	0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0.000000	0	89.00
90.00	09000	CLINIC	0	2,553,727	0.000000	0.000000	38,650	90.00
90.01	09001	IMED	0	424,622	0.000000	0.000000	0	90.01
90.02	09002	ONCOLOGY	0	8,220,260	0.000000	0.000000	82,141	90.02
90.03	09003	OUTPATIENT CENTER	0	718,262	0.000000	0.000000	4,453	90.03
91.00	09100	EMERGENCY	0	27,515,277	0.000000	0.000000	2,797,059	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	2,942,278	0.000000	0.000000	316,592	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0.000000	0.000000	0	96.00
200.00		Total (lines 50-199)	0	368,955,294			45,653,043	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0115 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D Part IV | Date/Time Prepared: 11/28/2017 3:27 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	14,415,386	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	700,029	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	14,039,270	0	54.00
56.00	05600	RADIOISOTOPE	0	4,101,974	0	56.00
60.00	06000	LABORATORY	0	4,151,830	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	549,763	0	65.00
66.00	06600	PHYSICAL THERAPY	0	108,369	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	9,320,143	0	69.00
69.01	06901	PULMONARY	0	0	0	69.01
69.02	06902	CARDIOPULMONARY	0	533,934	0	69.02
69.03	06903	SLEEP LAB	0	478,132	0	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2,184,758	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	2,991,752	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	26,706,669	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	89.00
90.00	09000	CLINIC	0	1,316,478	0	90.00
90.01	09001	IMED	0	0	0	90.01
90.02	09002	ONCOLOGY	0	4,423,463	0	90.02
90.03	09003	OUTPATIENT CENTER	0	185,732	0	90.03
91.00	09100	EMERGENCY	0	6,440,200	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	629,188	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	96.00
200.00		Total (lines 50-199)	0	93,277,070	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0115 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D Part V Date/Time Prepared: 11/28/2017 3:27 pm

Title XVIII | Hospital | PPS

		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	0.289186	14,415,386	0	0	4,168,728	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.264262	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.539567	700,029	0	0	377,713	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.127636	14,039,270	0	0	1,791,916	54.00
56.00	05600	RADIOISOTOPE	0.120903	4,101,974	0	0	495,941	56.00
60.00	06000	LABORATORY	0.251460	4,151,830	390	0	1,044,019	60.00
65.00	06500	RESPIRATORY THERAPY	0.389366	549,763	0	0	214,059	65.00
66.00	06600	PHYSICAL THERAPY	0.457524	108,369	0	0	49,581	66.00
69.00	06900	ELECTROCARDIOLOGY	0.248975	9,320,143	0	0	2,320,483	69.00
69.01	06901	PULMONARY	0.000000	0	0	0	0	69.01
69.02	06902	CARDIOPULMONARY	0.246392	533,934	0	0	131,557	69.02
69.03	06903	SLEEP LAB	0.323037	478,132	0	0	154,454	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.266519	2,184,758	0	0	582,280	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.471526	2,991,752	0	0	1,410,689	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.200898	26,706,669	211,133	0	5,365,316	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000				0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000				0	89.00
90.00	09000	CLINIC	0.450361	1,316,478	0	0	592,890	90.00
90.01	09001	IMED	1.177589	0	0	0	0	90.01
90.02	09002	ONCOLOGY	0.482906	4,423,463	0	0	2,136,117	90.02
90.03	09003	OUTPATIENT CENTER	0.706838	185,732	0	0	131,282	90.03
91.00	09100	EMERGENCY	0.269155	6,440,200	79	0	1,733,412	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.653788	629,188	0	0	411,356	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.511596		0			95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0	0	0	96.00
200.00		Subtotal (see instructions)		93,277,070	211,602	0	23,111,793	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		93,277,070	211,602	0	23,111,793	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0115 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D Part V Date/Time Prepared: 11/28/2017 3:27 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Costs		
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
			6.00	7.00	
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	56.00
60.00	06000	LABORATORY	98	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
69.01	06901	PULMONARY	0	0	69.01
69.02	06902	CARDIOPULMONARY	0	0	69.02
69.03	06903	SLEEP LAB	0	0	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	42,416	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	89.00
90.00	09000	CLINIC	0	0	90.00
90.01	09001	IMED	0	0	90.01
90.02	09002	ONCOLOGY	0	0	90.02
90.03	09003	OUTPATIENT CENTER	0	0	90.03
91.00	09100	EMERGENCY	21	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0		95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	96.00
200.00		Subtotal (see instructions)	42,535	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 +/- line 201)	42,535	0	202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-0115 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D Part II

Component CCN: 15-S115 | Date/Time Prepared: 11/28/2017 3:27 pm

Title XVIII | Subprovider - IPF | PPS

		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	1,498,317	64,167,738	0.023350	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	304,931	2,049,755	0.148765	0	0	52.00
53.00	05300	ANESTHESIOLOGY	38,889	2,785,910	0.013959	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	519,475	48,924,810	0.010618	101,989	1,083	54.00
56.00	05600	RADIOISOTOPE	49,068	8,200,920	0.005983	0	0	56.00
60.00	06000	LABORATORY	463,401	35,724,463	0.012972	230,408	2,989	60.00
65.00	06500	RESPIRATORY THERAPY	124,385	5,702,775	0.021811	14,111	308	65.00
66.00	06600	PHYSICAL THERAPY	223,139	8,630,090	0.025856	25,719	665	66.00
69.00	06900	ELECTROCARDIOLOGY	522,160	29,719,515	0.017570	22,117	389	69.00
69.01	06901	PULMONARY	0	0	0.000000	0	0	69.01
69.02	06902	CARDIOPULMONARY	47,060	932,403	0.050472	0	0	69.02
69.03	06903	SLEEP LAB	55,008	1,409,326	0.039031	0	0	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	69,843	10,243,236	0.006818	7,108	48	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	185,091	15,516,258	0.011929	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	543,371	91,681,783	0.005927	368,186	2,182	73.00
74.00	07400	RENAL DIALYSIS	0	0	0.000000	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	65,154	891,886	0.073052	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	135,002	0	0.000000	0	0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00
90.00	09000	CLINIC	173,120	2,553,727	0.067791	0	0	90.00
90.01	09001	IMED	32,119	424,622	0.075641	0	0	90.01
90.02	09002	ONCOLOGY	383,554	8,220,260	0.046660	0	0	90.02
90.03	09003	OUTPATIENT CENTER	12,570	718,262	0.017501	0	0	90.03
91.00	09100	EMERGENCY	469,066	27,515,277	0.017047	165,589	2,823	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	2,942,278	0.000000	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0.000000	0	0	96.00
200.00		Total (lines 50-199)	5,914,723	368,955,294		935,227	10,487	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0115 | Component CCN: 15-S115 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D Part IV | Date/Time Prepared: 11/28/2017 3:27 pm

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901	PULMONARY	0	0	0	0	0	69.01
69.02	06902	CARDIOPULMONARY	0	0	0	0	0	69.02
69.03	06903	SLEEP LAB	0	0	0	0	0	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	IMED	0	0	0	0	0	90.01
90.02	09002	ONCOLOGY	0	0	0	0	0	90.02
90.03	09003	OUTPATIENT CENTER	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0115 | Component CCN: 15-S115 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D Part IV | Date/Time Prepared: 11/28/2017 3:27 pm

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	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)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	64,167,738	0.000000	0.000000	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	2,049,755	0.000000	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0	2,785,910	0.000000	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	48,924,810	0.000000	0.000000	101,989	54.00
56.00	05600	RADIOISOTOPE	0	8,200,920	0.000000	0.000000	0	56.00
60.00	06000	LABORATORY	0	35,724,463	0.000000	0.000000	230,408	60.00
65.00	06500	RESPIRATORY THERAPY	0	5,702,775	0.000000	0.000000	14,111	65.00
66.00	06600	PHYSICAL THERAPY	0	8,630,090	0.000000	0.000000	25,719	66.00
69.00	06900	ELECTROCARDIOLOGY	0	29,719,515	0.000000	0.000000	22,117	69.00
69.01	06901	PULMONARY	0	0	0.000000	0.000000	0	69.01
69.02	06902	CARDIOPULMONARY	0	932,403	0.000000	0.000000	0	69.02
69.03	06903	SLEEP LAB	0	1,409,326	0.000000	0.000000	0	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0.000000	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	10,243,236	0.000000	0.000000	7,108	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	15,516,258	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	91,681,783	0.000000	0.000000	368,186	73.00
74.00	07400	RENAL DIALYSIS	0	0	0.000000	0.000000	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	891,886	0.000000	0.000000	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0.000000	0.000000	0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0.000000	0	89.00
90.00	09000	CLINIC	0	2,553,727	0.000000	0.000000	0	90.00
90.01	09001	IMED	0	424,622	0.000000	0.000000	0	90.01
90.02	09002	ONCOLOGY	0	8,220,260	0.000000	0.000000	0	90.02
90.03	09003	OUTPATIENT CENTER	0	718,262	0.000000	0.000000	0	90.03
91.00	09100	EMERGENCY	0	27,515,277	0.000000	0.000000	165,589	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	2,942,278	0.000000	0.000000	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0.000000	0.000000	0	96.00
200.00		Total (lines 50-199)	0	368,955,294			935,227	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0115 Component CCN: 15-S115	Period: From 07/01/2016 To 06/30/2017	Worksheet D Part IV Date/Time Prepared: 11/28/2017 3:27 pm
	Title XVIII	Subprovider - IPF	PPS

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,139	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	56.00
60.00	06000	LABORATORY	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	374	0	69.00
69.01	06901	PULMONARY	0	0	0	69.01
69.02	06902	CARDIOPULMONARY	0	0	0	69.02
69.03	06903	SLEEP LAB	0	0	0	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	753	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	90.00
90.01	09001	IMED	0	0	0	90.01
90.02	09002	ONCOLOGY	0	0	0	90.02
90.03	09003	OUTPATIENT CENTER	0	0	0	90.03
91.00	09100	EMERGENCY	0	286	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	96.00
200.00		Total (lines 50-199)	0	2,552	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0115 | Component CCN: 15-S115 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D Part V | Date/Time Prepared: 11/28/2017 3:27 pm

Title XVIII | Subprovider - IPF | PPS

		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	0.289186	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.264262	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.539567	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.127636	1,139	0	0	145	54.00
56.00	05600	RADIOISOTOPE	0.120903	0	0	0	0	56.00
60.00	06000	LABORATORY	0.251460	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.389366	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.457524	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.248975	374	0	0	93	69.00
69.01	06901	PULMONARY	0.000000	0	0	0	0	69.01
69.02	06902	CARDIOPULMONARY	0.246392	0	0	0	0	69.02
69.03	06903	SLEEP LAB	0.323037	0	0	0	0	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.266519	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.471526	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.200898	753	1,028	0	151	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000				0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000				0	89.00
90.00	09000	CLINIC	0.450361	0	0	0	0	90.00
90.01	09001	IMED	1.177589	0	0	0	0	90.01
90.02	09002	ONCOLOGY	0.482906	0	0	0	0	90.02
90.03	09003	OUTPATIENT CENTER	0.706838	0	0	0	0	90.03
91.00	09100	EMERGENCY	0.269155	286	0	0	77	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.653788	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.511596		0			95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0	0	0	96.00
200.00		Subtotal (see instructions)		2,552	1,028	0	466	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		2,552	1,028	0	466	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0115 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D Part V Date/Time Prepared: 11/28/2017 3:27 pm

Component CCN: 15-S115

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Costs		
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
			6.00	7.00	
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	56.00
60.00	06000	LABORATORY	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
69.01	06901	PULMONARY	0	0	69.01
69.02	06902	CARDIOPULMONARY	0	0	69.02
69.03	06903	SLEEP LAB	0	0	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	207	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	89.00
90.00	09000	CLINIC	0	0	90.00
90.01	09001	IMED	0	0	90.01
90.02	09002	ONCOLOGY	0	0	90.02
90.03	09003	OUTPATIENT CENTER	0	0	90.03
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0		95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	96.00
200.00		Subtotal (see instructions)	207	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 +/- line 201)	207	0	202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 15-0115 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D Part II | Date/Time Prepared: 11/28/2017 3:27 pm

Component CCN: 15-T115

Title XVIII | Subprovider - IRF | PPS

		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	1,498,317	64,167,738	0.023350	2,475	58	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	304,931	2,049,755	0.148765	0	0	52.00
53.00	05300	ANESTHESIOLOGY	38,889	2,785,910	0.013959	16	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	519,475	48,924,810	0.010618	16,231	172	54.00
56.00	05600	RADIOISOTOPE	49,068	8,200,920	0.005983	0	0	56.00
60.00	06000	LABORATORY	463,401	35,724,463	0.012972	45,106	585	60.00
65.00	06500	RESPIRATORY THERAPY	124,385	5,702,775	0.021811	6,367	139	65.00
66.00	06600	PHYSICAL THERAPY	223,139	8,630,090	0.025856	588,005	15,203	66.00
69.00	06900	ELECTROCARDIOLOGY	522,160	29,719,515	0.017570	16,376	288	69.00
69.01	06901	PULMONARY	0	0	0.000000	0	0	69.01
69.02	06902	CARDIOPULMONARY	47,060	932,403	0.050472	0	0	69.02
69.03	06903	SLEEP LAB	55,008	1,409,326	0.039031	0	0	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	69,843	10,243,236	0.006818	11,329	77	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	185,091	15,516,258	0.011929	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	543,371	91,681,783	0.005927	251,991	1,494	73.00
74.00	07400	RENAL DIALYSIS	0	0	0.000000	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	65,154	891,886	0.073052	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	135,002	0	0.000000	0	0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00
90.00	09000	CLINIC	173,120	2,553,727	0.067791	0	0	90.00
90.01	09001	IMED	32,119	424,622	0.075641	0	0	90.01
90.02	09002	ONCOLOGY	383,554	8,220,260	0.046660	0	0	90.02
90.03	09003	OUTPATIENT CENTER	12,570	718,262	0.017501	630	11	90.03
91.00	09100	EMERGENCY	469,066	27,515,277	0.017047	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	2,942,278	0.000000	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0.000000	0	0	96.00
200.00		Total (lines 50-199)	5,914,723	368,955,294		938,526	18,027	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0115 Component CCN: 15-T115	Period: From 07/01/2016 To 06/30/2017	Worksheet D Part IV Date/Time Prepared: 11/28/2017 3:27 pm
	Title XVIII	Subprovider - IRF	PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901	PULMONARY	0	0	0	0	0	69.01
69.02	06902	CARDIOPULMONARY	0	0	0	0	0	69.02
69.03	06903	SLEEP LAB	0	0	0	0	0	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	IMED	0	0	0	0	0	90.01
90.02	09002	ONCOLOGY	0	0	0	0	0	90.02
90.03	09003	OUTPATIENT CENTER	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

	Provider CCN: 15-0115	Period:	Worksheet D
	Component CCN: 15-T115	From 07/01/2016 To 06/30/2017	Part IV Date/Time Prepared: 11/28/2017 3:27 pm
	Title XVIII	Subprovider - IRF	PPS

		Cost Center Description	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)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	64,167,738	0.000000	0.000000	2,475	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	2,049,755	0.000000	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0	2,785,910	0.000000	0.000000	16	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	48,924,810	0.000000	0.000000	16,231	54.00
56.00	05600	RADIOISOTOPE	0	8,200,920	0.000000	0.000000	0	56.00
60.00	06000	LABORATORY	0	35,724,463	0.000000	0.000000	45,106	60.00
65.00	06500	RESPIRATORY THERAPY	0	5,702,775	0.000000	0.000000	6,367	65.00
66.00	06600	PHYSICAL THERAPY	0	8,630,090	0.000000	0.000000	588,005	66.00
69.00	06900	ELECTROCARDIOLOGY	0	29,719,515	0.000000	0.000000	16,376	69.00
69.01	06901	PULMONARY	0	0	0.000000	0.000000	0	69.01
69.02	06902	CARDIOPULMONARY	0	932,403	0.000000	0.000000	0	69.02
69.03	06903	SLEEP LAB	0	1,409,326	0.000000	0.000000	0	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0.000000	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	10,243,236	0.000000	0.000000	11,329	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	15,516,258	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	91,681,783	0.000000	0.000000	251,991	73.00
74.00	07400	RENAL DIALYSIS	0	0	0.000000	0.000000	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	891,886	0.000000	0.000000	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0.000000	0.000000	0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0.000000	0	89.00
90.00	09000	CLINIC	0	2,553,727	0.000000	0.000000	0	90.00
90.01	09001	IMED	0	424,622	0.000000	0.000000	0	90.01
90.02	09002	ONCOLOGY	0	8,220,260	0.000000	0.000000	0	90.02
90.03	09003	OUTPATIENT CENTER	0	718,262	0.000000	0.000000	630	90.03
91.00	09100	EMERGENCY	0	27,515,277	0.000000	0.000000	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	2,942,278	0.000000	0.000000	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0.000000	0.000000	0	96.00
200.00		Total (lines 50-199)	0	368,955,294			938,526	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0115 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D Part IV | Date/Time Prepared: 11/28/2017 3:27 pm

Component CCN: 15-T115

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	56.00
60.00	06000	LABORATORY	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	69.00
69.01	06901	PULMONARY	0	0	0	69.01
69.02	06902	CARDIOPULMONARY	0	0	0	69.02
69.03	06903	SLEEP LAB	0	0	0	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	90.00
90.01	09001	IMED	0	0	0	90.01
90.02	09002	ONCOLOGY	0	0	0	90.02
90.03	09003	OUTPATIENT CENTER	0	0	0	90.03
91.00	09100	EMERGENCY	0	687	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	96.00
200.00		Total (lines 50-199)	0	687	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-0115 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D Part V
Component CCN: 15-T115 | Date/Time Prepared: 11/28/2017 3:27 pm

Title XVIII | Subprovider - IRF | PPS

		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	0.289186	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.264262	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.539567	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.127636	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0.120903	0	0	0	0	56.00
60.00	06000	LABORATORY	0.251460	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.389366	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.457524	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.248975	0	0	0	0	69.00
69.01	06901	PULMONARY	0.000000	0	0	0	0	69.01
69.02	06902	CARDIOPULMONARY	0.246392	0	0	0	0	69.02
69.03	06903	SLEEP LAB	0.323037	0	0	0	0	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.266519	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.471526	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.200898	0	2,022	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000				0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000				0	89.00
90.00	09000	CLINIC	0.450361	0	0	0	0	90.00
90.01	09001	IMED	1.177589	0	0	0	0	90.01
90.02	09002	ONCOLOGY	0.482906	0	0	0	0	90.02
90.03	09003	OUTPATIENT CENTER	0.706838	0	0	0	0	90.03
91.00	09100	EMERGENCY	0.269155	687	0	0	185	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.653788	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.511596		0			95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0	0	0	96.00
200.00		Subtotal (see instructions)		687	2,022	0	185	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		687	2,022	0	185	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0115 | Component CCN: 15-T115 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D Part V | Date/Time Prepared: 11/28/2017 3:27 pm

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Costs		
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
			6.00	7.00	
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	56.00
60.00	06000	LABORATORY	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
69.01	06901	PULMONARY	0	0	69.01
69.02	06902	CARDIOPULMONARY	0	0	69.02
69.03	06903	SLEEP LAB	0	0	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	406	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	89.00
90.00	09000	CLINIC	0	0	90.00
90.01	09001	IMED	0	0	90.01
90.02	09002	ONCOLOGY	0	0	90.02
90.03	09003	OUTPATIENT CENTER	0	0	90.03
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0		95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	96.00
200.00		Subtotal (see instructions)	406	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 +/- line 201)	406	0	202.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0115 | Component CCN: 15-5305 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D Part IV | Date/Time Prepared: 11/28/2017 3:27 pm

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901	PULMONARY	0	0	0	0	0	69.01
69.02	06902	CARDIOPULMONARY	0	0	0	0	0	69.02
69.03	06903	SLEEP LAB	0	0	0	0	0	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	IMED	0	0	0	0	0	90.01
90.02	09002	ONCOLOGY	0	0	0	0	0	90.02
90.03	09003	OUTPATIENT CENTER	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0115 | Component CCN: 15-5305 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D Part IV | Date/Time Prepared: 11/28/2017 3:27 pm

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	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)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	64,167,738	0.000000	0.000000	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	2,049,755	0.000000	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0	2,785,910	0.000000	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	48,924,810	0.000000	0.000000	16,318	54.00
56.00	05600	RADIOISOTOPE	0	8,200,920	0.000000	0.000000	0	56.00
60.00	06000	LABORATORY	0	35,724,463	0.000000	0.000000	280,767	60.00
65.00	06500	RESPIRATORY THERAPY	0	5,702,775	0.000000	0.000000	142,062	65.00
66.00	06600	PHYSICAL THERAPY	0	8,630,090	0.000000	0.000000	1,244,288	66.00
69.00	06900	ELECTROCARDIOLOGY	0	29,719,515	0.000000	0.000000	52,792	69.00
69.01	06901	PULMONARY	0	0	0.000000	0.000000	0	69.01
69.02	06902	CARDIOPULMONARY	0	932,403	0.000000	0.000000	0	69.02
69.03	06903	SLEEP LAB	0	1,409,326	0.000000	0.000000	0	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0.000000	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	10,243,236	0.000000	0.000000	88,357	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	15,516,258	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	91,681,783	0.000000	0.000000	1,648,321	73.00
74.00	07400	RENAL DIALYSIS	0	0	0.000000	0.000000	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	891,886	0.000000	0.000000	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0.000000	0.000000	0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0.000000	0	89.00
90.00	09000	CLINIC	0	2,553,727	0.000000	0.000000	0	90.00
90.01	09001	IMED	0	424,622	0.000000	0.000000	0	90.01
90.02	09002	ONCOLOGY	0	8,220,260	0.000000	0.000000	0	90.02
90.03	09003	OUTPATIENT CENTER	0	718,262	0.000000	0.000000	5,775	90.03
91.00	09100	EMERGENCY	0	27,515,277	0.000000	0.000000	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	2,942,278	0.000000	0.000000	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0.000000	0.000000	0	96.00
200.00		Total (lines 50-199)	0	368,955,294			3,478,680	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0115 | Component CCN: 15-5305 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D Part IV | Date/Time Prepared: 11/28/2017 3:27 pm

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	56.00
60.00	06000	LABORATORY	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	69.00
69.01	06901	PULMONARY	0	0	0	69.01
69.02	06902	CARDIOPULMONARY	0	0	0	69.02
69.03	06903	SLEEP LAB	0	0	0	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,252	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	90.00
90.01	09001	IMED	0	0	0	90.01
90.02	09002	ONCOLOGY	0	0	0	90.02
90.03	09003	OUTPATIENT CENTER	0	0	0	90.03
91.00	09100	EMERGENCY	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	96.00
200.00		Total (lines 50-199)	0	1,252	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-0115 | Component CCN: 15-5305 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D Part V | Date/Time Prepared: 11/28/2017 3:27 pm

Title XVIII | Skilled Nursing Facility | PPS

		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	0.289186	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.264262	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.539567	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.127636	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0.120903	0	0	0	0	56.00
60.00	06000	LABORATORY	0.251460	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.389366	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.457524	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.248975	0	0	0	0	69.00
69.01	06901	PULMONARY	0.000000	0	0	0	0	69.01
69.02	06902	CARDIOPULMONARY	0.246392	0	0	0	0	69.02
69.03	06903	SLEEP LAB	0.323037	0	0	0	0	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.266519	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.471526	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.200898	1,252	0	0	252	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000				0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000				0	89.00
90.00	09000	CLINIC	0.450361	0	0	0	0	90.00
90.01	09001	IMED	1.177589	0	0	0	0	90.01
90.02	09002	ONCOLOGY	0.482906	0	0	0	0	90.02
90.03	09003	OUTPATIENT CENTER	0.706838	0	0	0	0	90.03
91.00	09100	EMERGENCY	0.269155	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.653788	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.511596		0			95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0	0	0	96.00
200.00		Subtotal (see instructions)		1,252	0	0	252	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		1,252	0	0	252	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0115 | Component CCN: 15-5305 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D Part V | Date/Time Prepared: 11/28/2017 3:27 pm

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Costs		
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
			6.00	7.00	
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	56.00
60.00	06000	LABORATORY	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
69.01	06901	PULMONARY	0	0	69.01
69.02	06902	CARDIOPULMONARY	0	0	69.02
69.03	06903	SLEEP LAB	0	0	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	89.00
90.00	09000	CLINIC	0	0	90.00
90.01	09001	IMED	0	0	90.01
90.02	09002	ONCOLOGY	0	0	90.02
90.03	09003	OUTPATIENT CENTER	0	0	90.03
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0		95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	96.00
200.00		Subtotal (see instructions)	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 +/- line 201)	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0115 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D Part V Date/Time Prepared: 11/28/2017 3:27 pm

Title XIX | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.289186	0	747,397	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.264262	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.539567	0	126,577	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.127636	0	517,991	0	0	54.00
56.00	05600	RADIOISOTOPE	0.120903	0	29,639	0	0	56.00
60.00	06000	LABORATORY	0.251460	0	474,299	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.389366	0	18,082	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.457524	0	61,641	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.248975	0	116,389	0	0	69.00
69.01	06901	PULMONARY	0.000000	0	0	0	0	69.01
69.02	06902	CARDIOPULMONARY	0.246392	0	1,573	0	0	69.02
69.03	06903	SLEEP LAB	0.323037	0	9,553	0	0	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.266519	0	63,126	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.471526	0	8,934	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.200898	0	1,534,261	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.747485				0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000				0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000				0	89.00
90.00	09000	CLINIC	0.450361	0	38,840	0	0	90.00
90.01	09001	IMED	1.177589	0	0	0	0	90.01
90.02	09002	ONCOLOGY	0.482906	0	70,036	0	0	90.02
90.03	09003	OUTPATIENT CENTER	0.706838	0	3,214	0	0	90.03
91.00	09100	EMERGENCY	0.269155	0	1,005,328	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.653788	0	65,149	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.511596	0	101,152			95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0	0	0	96.00
200.00		Subtotal (see instructions)		0	4,993,181	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		0	4,993,181	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0115 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D Part V Date/Time Prepared: 11/28/2017 3:27 pm

Title XIX | Hospital | Cost

		Cost Center Description	Costs		
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
			6.00	7.00	
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	216,137	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300	ANESTHESIOLOGY	68,297	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	66,114	0	54.00
56.00	05600	RADIOISOTOPE	3,583	0	56.00
60.00	06000	LABORATORY	119,267	0	60.00
65.00	06500	RESPIRATORY THERAPY	7,041	0	65.00
66.00	06600	PHYSICAL THERAPY	28,202	0	66.00
69.00	06900	ELECTROCARDIOLOGY	28,978	0	69.00
69.01	06901	PULMONARY	0	0	69.01
69.02	06902	CARDIOPULMONARY	388	0	69.02
69.03	06903	SLEEP LAB	3,086	0	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	16,824	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	4,213	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	308,230	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	89.00
90.00	09000	CLINIC	17,492	0	90.00
90.01	09001	IMED	0	0	90.01
90.02	09002	ONCOLOGY	33,821	0	90.02
90.03	09003	OUTPATIENT CENTER	2,272	0	90.03
91.00	09100	EMERGENCY	270,589	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	42,594	0	92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	51,749		95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	96.00
200.00		Subtotal (see instructions)	1,288,877	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 +/- line 201)	1,288,877	0	202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0115 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D-1 | Date/Time Prepared: 11/28/2017 3:27 pm

Title XVIII | Hospital | PPS

	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)	11,858	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	11,858	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)	9,366	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)	4,223	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	9,153,467	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)	9,153,467	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)	9,153,467	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)	771.92	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	3,259,818	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)	3,259,818	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0115 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D-1 | Date/Time Prepared: 11/28/2017 3:27 pm

Title XVIII | Hospital | PPS

	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	4,950,238	4,473	1,106.69	2,719	3,009,090	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)	12,572,656	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	18,841,564	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)	704,455	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	615,244	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	1,319,699	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	17,521,865	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)	2,492	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	771.92	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,923,625	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0115 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D-1 | Date/Time Prepared: 11/28/2017 3:27 pm

Title XVIII | Hospital | PPS

	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	1,133,728	9,153,467	0.123858	1,923,625	238,256	90.00
91.00	Nursing School cost	0	9,153,467	0.000000	1,923,625	0	91.00
92.00	Allied health cost	0	9,153,467	0.000000	1,923,625	0	92.00
93.00	All other Medical Education	0	9,153,467	0.000000	1,923,625	0	93.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0115 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D-1

Component CCN: 15-S115 | Date/Time Prepared: 11/28/2017 3:27 pm

Title XVIII | Subprovider - IPF | PPS

	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)	3,017	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	3,017	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)	3,017	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)	1,656	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	3,867,466	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)	3,867,466	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	3,867,466	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)	1,281.89	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	2,122,810	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)	2,122,810	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0115 | Component CCN: 15-S115 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D-1 | Date/Time Prepared: 11/28/2017 3:27 pm

Title XVIII | Subprovider - IPF | PPS

	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	0	0	0.00	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description	1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	214,280	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	2,337,090	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)	212,216	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	10,487	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	222,703	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	2,114,387	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)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0115 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D-1

Component CCN: 15-S115 | Date/Time Prepared: 11/28/2017 3:27 pm

Title XVIII | Subprovider - IPF | PPS

	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	386,632	3,867,466	0.099970	0	0	90.00
91.00	Nursing School cost	0	3,867,466	0.000000	0	0	91.00
92.00	Allied health cost	0	3,867,466	0.000000	0	0	92.00
93.00	All other Medical Education	0	3,867,466	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0115 | Component CCN: 15-T115 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D-1 | Date/Time Prepared: 11/28/2017 3:27 pm

Title XVIII | Subprovider - IRF | PPS

	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)	1,485	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,485	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	1,485	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)	757	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	1,452,473	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)	1,452,473	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)	1,452,473	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)	978.10	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	740,422	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)	740,422	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0115 | Component CCN: 15-T115 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D-1 | Date/Time Prepared: 11/28/2017 3:27 pm

Title XVIII | Subprovider - IRF | PPS

	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	0	0	0.00	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	343,878	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	1,084,300	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)	94,708	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	18,027	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	112,735	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	971,565	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)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0115 | Component CCN: 15-T115 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D-1 | Date/Time Prepared: 11/28/2017 3:27 pm

Title XVIII | Subprovider - IRF | PPS

	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	185,794	1,452,473	0.127916	0	0	90.00
91.00	Nursing School cost	0	1,452,473	0.000000	0	0	91.00
92.00	Allied health cost	0	1,452,473	0.000000	0	0	92.00
93.00	All other Medical Education	0	1,452,473	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0115 | Component CCN: 15-5305 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D-1 | Date/Time Prepared: 11/28/2017 3:27 pm

Title XVIII | Skilled Nursing Facility | PPS

	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)	5,026	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	5,026	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)	5,026	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)	4,149	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	2,355,720	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)	2,355,720	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	2,355,720	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)		38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0115 | Component CCN: 15-5305 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D-1 | Date/Time Prepared: 11/28/2017 3:27 pm

Title XVIII | Skilled Nursing Facility | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT						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)		48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)		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)		50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)		51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)		52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)		53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges		54.00
55.00	Target amount per discharge		55.00
56.00	Target amount (line 54 x line 55)		56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)		57.00
58.00	Bonus payment (see instructions)		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		59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket		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)		61.00
62.00	Relief payment (see instructions)		62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)		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)		64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)		65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)		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)		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)		68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)		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)	2,355,720	70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)	468.71	71.00
72.00	Program routine service cost (line 9 x line 71)	1,944,678	72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)	0	73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)	1,944,678	74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)	0	75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)	0.00	76.00
77.00	Program capital-related costs (line 9 x line 76)	0	77.00
78.00	Inpatient routine service cost (line 74 minus line 77)	0	78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)	0	79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)	0	80.00
81.00	Inpatient routine service cost per diem limitation	0.00	81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)	0	82.00
83.00	Reasonable inpatient routine service costs (see instructions)	1,944,678	83.00
84.00	Program inpatient ancillary services (see instructions)	1,069,210	84.00
85.00	Utilization review - physician compensation (see instructions)	0	85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)	3,013,888	86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0115 | Component CCN: 15-5305 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D-1 | Date/Time Prepared: 11/28/2017 3:27 pm

Title XVIII | Skilled Nursing Facility | PPS

	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	0	0	0.000000	0	0	90.00
91.00	Nursing School cost	0	0	0.000000	0	0	91.00
92.00	Allied health cost	0	0	0.000000	0	0	92.00
93.00	All other Medical Education	0	0	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0115 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D-3 | Date/Time Prepared: 11/28/2017 3:27 pm

Title XVIII | Hospital | PPS

		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		5,131,605		30.00
31.00	03100	INTENSIVE CARE UNIT		4,800,936		31.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
41.00	04100	SUBPROVIDER - IRF		605		41.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.289186	4,773,929	1,380,553	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.264262	5,925	7,491	52.00
53.00	05300	ANESTHESIOLOGY	0.540083	290,338	156,807	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.127642	3,859,796	492,672	54.00
56.00	05600	RADIOISOTOPE	0.120903	282,192	34,118	56.00
60.00	06000	LABORATORY	0.251460	3,662,140	920,882	60.00
65.00	06500	RESPIRATORY THERAPY	0.389366	1,410,934	549,370	65.00
66.00	06600	PHYSICAL THERAPY	0.457524	1,294,120	592,091	66.00
69.00	06900	ELECTROCARDIOLOGY	0.253155	5,889,622	1,490,987	69.00
69.01	06901	PULMONARY	0.000000	0	0	69.01
69.02	06902	CARDIOPULMONARY	0.246392	386	95	69.02
69.03	06903	SLEEP LAB	0.323037	0	0	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.266519	2,107,433	561,671	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.471526	5,841,732	2,754,529	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.200898	12,995,601	2,610,790	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000		0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0	89.00
90.00	09000	CLINIC	0.450361	38,650	17,406	90.00
90.01	09001	IMED	1.177589	0	0	90.01
90.02	09002	ONCOLOGY	0.482906	82,141	39,666	90.02
90.03	09003	OUTPATIENT CENTER	0.706838	4,453	3,148	90.03
91.00	09100	EMERGENCY	0.269353	2,797,059	753,396	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.653788	316,592	206,984	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0	96.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		45,653,043	12,572,656	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)		45,653,043		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CCN: 15-0115 Component CCN: 15-S115	Period: From 07/01/2016 To 06/30/2017	Worksheet D-3 Date/Time Prepared: 11/28/2017 3:27 pm
	Title XVIII	Subprovider - IPF	PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
40.00	04000	SUBPROVIDER - IPF		1,985,050		40.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.289186	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.264262	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.540083	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.127642	101,989	13,018	54.00
56.00	05600	RADIOISOTOPE	0.120903	0	0	56.00
60.00	06000	LABORATORY	0.251460	230,408	57,938	60.00
65.00	06500	RESPIRATORY THERAPY	0.389366	14,111	5,494	65.00
66.00	06600	PHYSICAL THERAPY	0.457524	25,719	11,767	66.00
69.00	06900	ELECTROCARDIOLOGY	0.253155	22,117	5,599	69.00
69.01	06901	PULMONARY	0.000000	0	0	69.01
69.02	06902	CARDIOPULMONARY	0.246392	0	0	69.02
69.03	06903	SLEEP LAB	0.323037	0	0	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.266519	7,108	1,894	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.471526	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.200898	368,186	73,968	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000		0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0	89.00
90.00	09000	CLINIC	0.450361	0	0	90.00
90.01	09001	IMED	1.177589	0	0	90.01
90.02	09002	ONCOLOGY	0.482906	0	0	90.02
90.03	09003	OUTPATIENT CENTER	0.706838	0	0	90.03
91.00	09100	EMERGENCY	0.269353	165,589	44,602	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.653788	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0	96.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		935,227	214,280	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)		935,227		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0115 | Component CCN: 15-T115 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D-3 | Date/Time Prepared: 11/28/2017 3:27 pm

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
41.00	04100	SUBPROVIDER - IRF		794,850		41.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.289186	2,475	716	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.264262	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.540083	16	9	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.127642	16,231	2,072	54.00
56.00	05600	RADIOISOTOPE	0.120903	0	0	56.00
60.00	06000	LABORATORY	0.251460	45,106	11,342	60.00
65.00	06500	RESPIRATORY THERAPY	0.389366	6,367	2,479	65.00
66.00	06600	PHYSICAL THERAPY	0.457524	588,005	269,026	66.00
69.00	06900	ELECTROCARDIOLOGY	0.253155	16,376	4,146	69.00
69.01	06901	PULMONARY	0.000000	0	0	69.01
69.02	06902	CARDIOPULMONARY	0.246392	0	0	69.02
69.03	06903	SLEEP LAB	0.323037	0	0	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.266519	11,329	3,019	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.471526	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.200898	251,991	50,624	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000		0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0	89.00
90.00	09000	CLINIC	0.450361	0	0	90.00
90.01	09001	IMED	1.177589	0	0	90.01
90.02	09002	ONCOLOGY	0.482906	0	0	90.02
90.03	09003	OUTPATIENT CENTER	0.706838	630	445	90.03
91.00	09100	EMERGENCY	0.269353	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.653788	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0	96.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		938,526	343,878	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)		938,526		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0115 | Component CCN: 15-5305 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D-3 | Date/Time Prepared: 11/28/2017 3:27 pm

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.289186	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.264262	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.539567	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.127636	16,318	2,083	54.00
56.00	05600	RADIOISOTOPE	0.120903	0	0	56.00
60.00	06000	LABORATORY	0.251460	280,767	70,602	60.00
65.00	06500	RESPIRATORY THERAPY	0.389366	142,062	55,314	65.00
66.00	06600	PHYSICAL THERAPY	0.457524	1,244,288	569,292	66.00
69.00	06900	ELECTROCARDIOLOGY	0.248975	52,792	13,144	69.00
69.01	06901	PULMONARY	0.000000	0	0	69.01
69.02	06902	CARDIOPULMONARY	0.246392	0	0	69.02
69.03	06903	SLEEP LAB	0.323037	0	0	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.266519	88,357	23,549	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.471526	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.200898	1,648,321	331,144	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000		0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0	89.00
90.00	09000	CLINIC	0.450361	0	0	90.00
90.01	09001	IMED	1.177589	0	0	90.01
90.02	09002	ONCOLOGY	0.482906	0	0	90.02
90.03	09003	OUTPATIENT CENTER	0.706838	5,775	4,082	90.03
91.00	09100	EMERGENCY	0.269155	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.653788	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0	96.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		3,478,680	1,069,210	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		3,478,680		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0115 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D-3 | Date/Time Prepared: 11/28/2017 3:27 pm

Title XIX | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		402,191		30.00
31.00	03100	INTENSIVE CARE UNIT		78,976		31.00
40.00	04000	SUBPROVIDER - IPF		71,896		40.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
43.00	04300	NURSERY		0		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.289186	15,769	4,560	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.264262	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.539567	90,029	48,577	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.127636	58,023	7,406	54.00
56.00	05600	RADIOISOTOPE	0.120903	10,445	1,263	56.00
60.00	06000	LABORATORY	0.251460	108,516	27,287	60.00
65.00	06500	RESPIRATORY THERAPY	0.389366	22,998	8,955	65.00
66.00	06600	PHYSICAL THERAPY	0.457524	9,527	4,359	66.00
69.00	06900	ELECTROCARDIOLOGY	0.248975	40,267	10,025	69.00
69.01	06901	PULMONARY	0.000000	0	0	69.01
69.02	06902	CARDIOPULMONARY	0.246392	0	0	69.02
69.03	06903	SLEEP LAB	0.323037	0	0	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.266519	32,198	8,581	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.471526	6,584	3,105	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.200898	382,234	76,790	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.747485	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000	0	0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	0	89.00
90.00	09000	CLINIC	0.450361	628	283	90.00
90.01	09001	IMED	1.177589	0	0	90.01
90.02	09002	ONCOLOGY	0.482906	1,071	517	90.02
90.03	09003	OUTPATIENT CENTER	0.706838	169	119	90.03
91.00	09100	EMERGENCY	0.269155	72,799	19,594	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.653788	-753	-492	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0	96.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		850,504	220,929	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)		850,504		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CCN: 15-0115 Component CCN: 15-S115	Period: From 07/01/2016 To 06/30/2017	Worksheet D-3 Date/Time Prepared: 11/28/2017 3:27 pm
	Title XIX	Subprovider - IPF	Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
40.00	04000	SUBPROVIDER - IPF		72,259		40.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
43.00	04300	NURSERY		0		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.289186	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.264262	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.539567	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.127636	0	0	54.00
56.00	05600	RADIOISOTOPE	0.120903	0	0	56.00
60.00	06000	LABORATORY	0.251460	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.389366	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.457524	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.248975	0	0	69.00
69.01	06901	PULMONARY	0.000000	0	0	69.01
69.02	06902	CARDIOPULMONARY	0.246392	0	0	69.02
69.03	06903	SLEEP LAB	0.323037	0	0	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.266519	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.471526	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.200898	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.747485	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000	0	0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	0	89.00
90.00	09000	CLINIC	0.450361	0	0	90.00
90.01	09001	IMED	1.177589	0	0	90.01
90.02	09002	ONCOLOGY	0.482906	0	0	90.02
90.03	09003	OUTPATIENT CENTER	0.706838	0	0	90.03
91.00	09100	EMERGENCY	0.269155	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.653788	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0	96.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		0	0	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		0		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0115	Period: From 07/01/2016 To 06/30/2017	Worksheet E Part A Date/Time Prepared: 11/28/2017 3:27 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS		
1.00	DRG Amounts Other than Outlier Payments	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)	4,280,428	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	13,821,685	1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)	0	1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)	0	1.04
2.00	Outlier payments for discharges. (see instructions)	115,828	2.00
2.01	Outlier reconciliation amount	0	2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)	0	2.02
3.00	Managed Care Simulated Payments	1,319,349	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)	104.06	4.00
	Indirect Medical Education Adjustment		
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)	0.00	5.00
6.00	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)	0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)	0.00	7.00
7.01	ACA Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.	0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).	0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.	0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions)	0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see instructions)	0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records	0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.	0.00	11.00
12.00	Current year allowable FTE (see instructions)	0.00	12.00
13.00	Total allowable FTE count for the prior year.	0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.	0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.	0.00	15.00
16.00	Adjustment for residents in initial years of the program	0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure	0.00	17.00
18.00	Adjusted rolling average FTE count	0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).	0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)	0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)	0.000000	21.00
22.00	IME payment adjustment (see instructions)	0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)	0	22.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA		
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 (f)(1)(iv)(C).	0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)	0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)	0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)	0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)	0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)	0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)	0	28.01
29.00	Total IME payment (sum of lines 22 and 28)	0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)	0	29.01
	Disproportionate Share Adjustment		
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	2.09	30.00
31.00	Percentage of Medicaid patient days (see instructions)	16.62	31.00
32.00	Sum of lines 30 and 31	18.71	32.00
33.00	Allowable disproportionate share percentage (see instructions)	4.91	33.00
34.00	Disproportionate share adjustment (see instructions)	222,203	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0115	Period: From 07/01/2016 To 06/30/2017	Worksheet E Part A Date/Time Prepared: 11/28/2017 3:27 pm
	Title XVIII	Hospital	PPS

		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	Uncompensated Care Adjustment			
35.00	Total uncompensated care amount (see instructions)	6,406,145,534	5,977,483,147	35.00
35.01	Factor 3 (see instructions)	0.000083687	0.000083484	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	536,114	499,025	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	134,761	373,243	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	508,004		36.00
	Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)			
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)	0		40.00
		Before 1/1	On/After 1/1	
		1.00	1.01	
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0	0	41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0	0	41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)	0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)	0.00	0.00	45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)	0		46.00
47.00	Subtotal (see instructions)	18,948,148		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)	0		48.00

		Amount	
		1.00	
49.00	Total payment for inpatient operating costs (see instructions)	18,948,148	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)	1,455,588	50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)	0	51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).	0	52.00
53.00	Nursing and Allied Health Managed Care payment	0	53.00
54.00	Special add-on payments for new technologies	2,623	54.00
54.01	Islet isolation add-on payment	0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)	0	55.00
56.00	Cost of physicians' services in a teaching hospital (see intructions)	0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).	0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)	0	58.00
59.00	Total (sum of amounts on lines 49 through 58)	20,406,359	59.00
60.00	Primary payer payments	0	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)	20,406,359	61.00
62.00	Deductibles billed to program beneficiaries	2,332,652	62.00
63.00	Coinsurance billed to program beneficiaries	7,147	63.00
64.00	Allowable bad debts (see instructions)	74,442	64.00
65.00	Adjusted reimbursable bad debts (see instructions)	48,387	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	37,286	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	18,114,947	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)	0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96).(For SCH see instructions)	0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	70.00
70.50	RURAL DEMONSTRATION PROJECT	0	70.50
70.88	SCH or MDH volume decrease adjustment	0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)	0	70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)	0	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)	0	70.91
70.92	Bundled Model 1 discount amount (see instructions)	0	70.92
70.93	HVBP payment adjustment amount (see instructions)	191,006	70.93
70.94	HRR adjustment amount (see instructions)	0	70.94
70.95	Recovery of accelerated depreciation	0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-0115 | Period: From 07/01/2016 To 06/30/2017 | Worksheet E Part A Date/Time Prepared: 11/28/2017 3:27 pm

Title XVIII | Hospital | PPS

		FFY (yyyy)	Amount	
		0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0	70.97
70.98	Low Volume Payment-3		0	70.98
70.99	HAC adjustment amount (see instructions)		48,833	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		18,257,120	71.00
71.01	Sequestration adjustment (see instructions)		365,142	71.01
72.00	Interim payments		17,777,572	72.00
73.00	Tentative settlement (for contractor use only)		0	73.00
74.00	Balance due provider (Program) (line 71 minus lines 71.01, 72, and 73)		114,406	74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		136,061	75.00
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)			
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2 (see instructions)		0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00
95.00	Time value of money for operating expenses (see instructions)		0	95.00
96.00	Time value of money for capital related expenses (see instructions)		0	96.00

		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	HSP Bonus Payment Amount			
100.00	HSP bonus amount (see instructions)	0	0	100.00
	HVBP Adjustment for HSP Bonus Payment			
101.00	HVBP adjustment factor (see instructions)	0.0000000000	0.0000000000	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)	0	0	102.00
	HRR Adjustment for HSP Bonus Payment			
103.00	HRR adjustment factor (see instructions)	0.0000	0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)	0	0	104.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 15-0115 | Period: From 07/01/2016 To 06/30/2017 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 11/28/2017 3:27 pm

Title XVIII | Hospital | PPS

		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	4,280,428	0	4,280,428		4,280,428	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	13,821,685	0		13,821,685	13,821,685	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00	115,828	0	45,618	70,210	115,828	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0	2.01
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	1,319,349	0	354,375	964,974	1,319,349	4.00
	Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	0	6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	0	9.01
	Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0491	0.0491	0.0491	0.0491		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	222,203	0	52,542	169,661	222,203	11.00
11.01	Uncompensated care payments	36.00	508,004	0	134,761	373,243	508,004	11.01
	Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	18,948,148	0	4,513,349	14,434,799	18,948,148	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	18,948,148	0	4,513,349	14,434,799	18,948,148	15.00
16.00	Payment for inpatient program capital	50.00	1,455,588	0	343,896	1,111,692	1,455,588	16.00
17.00	Special add-on payments for new technologies	54.00	2,623	0	0	0	0	17.00
17.01	Net organ aquisition cost							17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0	17.02

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 15-0115 | Period: From 07/01/2016 To 06/30/2017 | Worksheet E Part A Exhibit 4 | Date/Time Prepared: 11/28/2017 3:27 pm

Title XVIII | Hospital | PPS

		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0	18.00
19.00	SUBTOTAL			0	4,857,245	15,546,491	20,403,736	19.00
		W/S L, line	(Amounts from L)					
		0	1.00	2.00	3.00	4.00	5.00	
20.00	Capital DRG other than outlier	1.00	1,445,939	0	339,961	1,105,978	1,445,939	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	9,649	0	3,935	5,714	9,649	20.01
21.00	Capital DRG outlier payments	2.00	0	0	0	0	0	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	1,455,588	0	343,896	1,111,692	1,455,588	26.00
		W/S E, Part A line	(Amounts to E, Part A)					
		0	1.00	2.00	3.00	4.00	5.00	
27.00	Low volume adjustment factor				0.000000	0.000000		27.00
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			0		0	28.00
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				0	0	29.00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 | Provider CCN: 15-0115 | Period: From 07/01/2016 To 06/30/2017 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 11/28/2017 3:27 pm

Title XVIII | Hospital | PPS

		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	1.00	2.00	3.00	4.00	
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	4,280,428	4,280,428		4,280,428	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	13,821,685		13,821,685	13,821,685	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00	115,828	45,618	70,210	115,828	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	2.01
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	1,319,349	354,375	964,974	1,319,349	4.00
	Indirect Medical Education Adjustment						
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA						
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	9.01
	Disproportionate Share Adjustment						
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0491	0.0491	0.0491		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	222,203	52,542	169,661	222,203	11.00
11.01	Uncompensated care payments	36.00	508,004	134,761	373,243	508,004	11.01
	Additional payment for high percentage of ESRD beneficiary discharges						
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	18,948,148	4,513,349	14,434,799	18,948,148	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	18,948,148	4,513,349	14,434,799	18,948,148	15.00
16.00	Payment for inpatient program capital	50.00	1,455,588	343,896	1,111,692	1,455,588	16.00
17.00	Special add-on payments for new technologies	54.00	2,623	1,587	1,036	2,623	17.00
17.01	Net organ acquisition cost						17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	18.00
19.00	SUBTOTAL			4,858,832	15,547,527	20,406,359	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5	Provider CCN: 15-0115	Period: From 07/01/2016 To 06/30/2017	Worksheet E Part A Exhibit 5 Date/Time Prepared: 11/28/2017 3:27 pm
	Title XVIII	Hospital	PPS

		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	1,445,939	339,961	1,105,978	1,445,939	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	9,649	3,935	5,714	9,649	20.01
21.00	Capital DRG outlier payments	2.00	0	0	0	0	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	1,455,588	343,896	1,111,692	1,455,588	26.00
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
		0	1.00	2.00	3.00	4.00	
27.00							27.00
28.00	Low volume adjustment prior to October 1	70.96	0	0		0	28.00
29.00	Low volume adjustment on or after October 1	70.97	0		0	0	29.00
30.00	HVBP payment adjustment (see instructions)	70.93	191,006	24,500	166,506	191,006	30.00
30.01	HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	0	0	0	0	30.01
31.00	HRR adjustment (see instructions)	70.94	0	0	0	0	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	0	0	0	0	31.01
						(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3.00	4.00	
32.00	HAC Reduction Program adjustment (see instructions)	70.99		48,833	0	48,833	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		Y				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-0115 | Period: From 07/01/2016 To 06/30/2017 | Worksheet E Part B Date/Time Prepared: 11/28/2017 3:27 pm

Title XVIII | Hospital | PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	42,535	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	23,111,793	2.00
3.00	PPS payments	23,675,947	3.00
4.00	Outlier payment (see instructions)	19,071	4.00
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 line 3 plus line 4 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)	42,535	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	211,602	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)	211,602	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)	211,602	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	169,067	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 (line 11 minus line 20) (for CAH see instructions)	42,535	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, 8 and 9)	23,695,018	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	4,600,820	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)	19,136,733	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)	19,136,733	30.00
31.00	Primary payer payments	4,778	31.00
32.00	Subtotal (line 30 minus line 31)	19,131,955	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)	424,558	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	275,963	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	383,515	36.00
37.00	Subtotal (see instructions)	19,407,918	37.00
38.00	MSP-LCC reconciliation amount from PS&R	-38	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	39.50
39.98	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)	19,407,956	40.00
40.01	Sequestration adjustment (see instructions)	388,159	40.01
41.00	Interim payments	19,027,124	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	-7,327	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

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0115 Component CCN: 15-S115	Period: From 07/01/2016 To 06/30/2017	Worksheet E Part B Date/Time Prepared: 11/28/2017 3:27 pm
	Title XVIII	Subprovider - IPF	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	207	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	466	2.00
3.00	PPS payments	656	3.00
4.00	Outlier payment (see instructions)	0	4.00
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 line 3 plus line 4 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)	207	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	1,028	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)	1,028	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)	1,028	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	821	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 (line 11 minus line 20) (for CAH see instructions)	207	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, 8 and 9)	656	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	101	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)	762	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)	762	30.00
31.00	Primary payer payments	0	31.00
32.00	Subtotal (line 30 minus line 31)	762	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)	0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	36.00
37.00	Subtotal (see instructions)	762	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	39.50
39.98	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)	762	40.00
40.01	Sequestration adjustment (see instructions)	15	40.01
41.00	Interim payments	772	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	-25	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

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 15-0115 | Period: From 07/01/2016 To 06/30/2017 | Worksheet E Part B
Component CCN: 15-T115 | Date/Time Prepared: 11/28/2017 3:27 pm

Title XVIII | Subprovider - IRF | PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	406	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	185	2.00
3.00	PPS payments	337	3.00
4.00	Outlier payment (see instructions)	0	4.00
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 line 3 plus line 4 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)	406	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	2,022	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	2,022	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)	2,022	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	1,616	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 (line 11 minus line 20) (for CAH see instructions)	406	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, 8 and 9)	337	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	0	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)	743	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)	743	30.00
31.00	Primary payer payments	0	31.00
32.00	Subtotal (line 30 minus line 31)	743	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)	0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	36.00
37.00	Subtotal (see instructions)	743	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	39.50
39.98	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)	743	40.00
40.01	Sequestration adjustment (see instructions)	15	40.01
41.00	Interim payments	688	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	40	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

CALCULATION OF REIMBURSEMENT SETTLEMENT

	Provider CCN: 15-0115 Component CCN: 15-5305	Period: From 07/01/2016 To 06/30/2017	Worksheet E Part B Date/Time Prepared: 11/28/2017 3:27 pm
	Title XVIII	Skilled Nursing Facility	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	0	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	252	2.00
3.00	PPS payments		3.00
4.00	Outlier payment (see instructions)		4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)		5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of line 3 plus line 4 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)	0	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 (line 11 minus line 20) (for CAH see instructions)	0	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, 8 and 9)	0	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		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)	0	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)	0	30.00
31.00	Primary payer payments	0	31.00
32.00	Subtotal (line 30 minus line 31)	0	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)	0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	36.00
37.00	Subtotal (see instructions)	0	37.00
38.00	MSP-LCC reconciliation amount from PS&R		38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	39.50
39.98	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)	0	40.00
40.01	Sequestration adjustment (see instructions)	0	40.01
41.00	Interim payments	1,062	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	-1,062	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)		90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		91.00
92.00	The rate used to calculate the Time Value of Money		92.00
93.00	Time Value of Money (see instructions)		93.00
94.00	Total (sum of lines 91 and 93)		94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED | Provider CCN: 15-0115 | Period: From 07/01/2016 To 06/30/2017 | Worksheet E-1 Part I Date/Time Prepared: 11/28/2017 3:27 pm

Title XVIII | Hospital | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		17,777,572		18,995,724	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0	12/21/2016	31,400	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		31,400	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)		17,777,572		19,027,124	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		114,406		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		7,327	6.02
7.00	Total Medicare program liability (see instructions)		17,891,978		19,019,797	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 15-0115 | Component CCN: 15-S115 | Period: From 07/01/2016 To 06/30/2017 | Worksheet E-1 Part I | Date/Time Prepared: 11/28/2017 3:27 pm

Title XVIII | Subprovider - IPF | 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		1,423,657		772	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,423,657		772	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		7,473		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		25	6.02
7.00	Total Medicare program liability (see instructions)		1,431,130		747	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 15-0115 | Component CCN: 15-T115 | Period: From 07/01/2016 To 06/30/2017 | Worksheet E-1 Part I | Date/Time Prepared: 11/28/2017 3:27 pm

Title XVIII | Subprovider - IRF | 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		1,142,587		688	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,142,587		688	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		9,215		40	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,151,802		728	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 15-0115 | Component CCN: 15-5305 | Period: From 07/01/2016 To 06/30/2017 | Worksheet E-1 Part I | Date/Time Prepared: 11/28/2017 3:27 pm

Title XVIII | Skilled Nursing Facility | 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		1,365,984		1,062	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,365,984		1,062	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		4,555		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		1,062	6.02
7.00	Total Medicare program liability (see instructions)		1,370,539		0	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-0115	Period: From 07/01/2016 To 06/30/2017	Worksheet E-1 Part II Date/Time Prepared: 11/28/2017 3:27 pm
	Title XVIII	Hospital	PPS

		1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS		
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION		
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14	3,764	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12	6,942	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2	553	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12	13,839	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200	401,360,949	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20	2,466,978	6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168	0	7.00
8.00	Calculation of the HIT incentive payment (see instructions)	343,696	8.00
9.00	Sequestration adjustment amount (see instructions)	6,874	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)	336,822	10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH		
30.00	Initial/interim HIT payment adjustment (see instructions)	329,547	30.00
31.00	Other Adjustment (specify)	0	31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)	7,275	32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0115 Component CCN: 15-S115	Period: From 07/01/2016 To 06/30/2017	Worksheet E-3 Part II Date/Time Prepared: 11/28/2017 3:27 pm
	Title XVIII	Subprovider - IPF	PPS

		1.00	
	PART II - MEDICARE PART A SERVICES - IPF PPS		
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)	1,578,088	1.00
2.00	Net IPF PPS Outlier Payments	31,548	2.00
3.00	Net IPF PPS ECT Payments	0	3.00
4.00	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004. (see instructions)	0.00	4.00
4.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)	0.00	4.01
5.00	New Teaching program adjustment. (see instructions)	0.00	5.00
6.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instuctions)	0.00	6.00
7.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instuctions)	0.00	7.00
8.00	Intern and resident count for IPF PPS medical education adjustment (see instructions)	0.00	8.00
9.00	Average Daily Census (see instructions)	8.265753	9.00
10.00	Teaching Adjustment Factor {((1 + (line 8/line 9)) raised to the power of .5150 -1}.	0.000000	10.00
11.00	Teaching Adjustment (line 1 multiplied by line 10).	0	11.00
12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)	1,609,636	12.00
13.00	Nursing and Allied Health Managed Care payment (see instruction)	0	13.00
14.00	Organ acquisition (DO NOT USE THIS LINE)		14.00
15.00	Cost of physicians' services in a teaching hospital (see instructions)	0	15.00
16.00	Subtotal (see instructions)	1,609,636	16.00
17.00	Primary payer payments	0	17.00
18.00	Subtotal (line 16 less line 17).	1,609,636	18.00
19.00	Deductibles	135,240	19.00
20.00	Subtotal (line 18 minus line 19)	1,474,396	20.00
21.00	Coinsurance	21,665	21.00
22.00	Subtotal (line 20 minus line 21)	1,452,731	22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	11,702	23.00
24.00	Adjusted reimbursable bad debts (see instructions)	7,606	24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	9,126	25.00
26.00	Subtotal (sum of lines 22 and 24)	1,460,337	26.00
27.00	Direct graduate medical education payments (from Wkst. E-4, line 49)	0	27.00
28.00	Other pass through costs (see instructions)	0	28.00
29.00	Outlier payments reconciliation	0	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	30.50
30.99	Recovery of Accelerated Depreciation	0	30.99
31.00	Total amount payable to the provider (see instructions)	1,460,337	31.00
31.01	Sequestration adjustment (see instructions)	29,207	31.01
32.00	Interim payments	1,423,657	32.00
33.00	Tentative settlement (for contractor use only)	0	33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 32 and 33)	7,473	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	35.00
	TO BE COMPLETED BY CONTRACTOR		
50.00	Original outlier amount from Worksheet E-3, Part II, line 2	31,548	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)	0	51.00
52.00	The rate used to calculate the Time Value of Money	0.00	52.00
53.00	Time Value of Money (see instructions)	0	53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT

	Provider CCN: 15-0115 Component CCN: 15-T115	Period: From 07/01/2016 To 06/30/2017	Worksheet E-3 Part III Date/Time Prepared: 11/28/2017 3:27 pm
	Title XVIII	Subprovider - IRF	PPS

		1.00	
	PART III - MEDICARE PART A SERVICES - IRF PPS		
1.00	Net Federal PPS Payment (see instructions)	1,136,575	1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)	0.0061	2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)	20,572	3.00
4.00	Outlier Payments	28,549	4.00
5.00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)	0.00	5.00
5.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)	0.00	5.01
6.00	New Teaching program adjustment. (see instructions)	0.00	6.00
7.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)	0.00	7.00
8.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)	0.00	8.00
9.00	Intern and resident count for IRF PPS medical education adjustment (see instructions)	0.00	9.00
10.00	Average Daily Census (see instructions)	4.068493	10.00
11.00	Teaching Adjustment Factor (see instructions)	0.000000	11.00
12.00	Teaching Adjustment (see instructions)	0	12.00
13.00	Total PPS Payment (see instructions)	1,185,696	13.00
14.00	Nursing and Allied Health Managed Care payments (see instruction)	0	14.00
15.00	Organ acquisition (DO NOT USE THIS LINE)		15.00
16.00	Cost of physicians' services in a teaching hospital (see instructions)	0	16.00
17.00	Subtotal (see instructions)	1,185,696	17.00
18.00	Primary payer payments	0	18.00
19.00	Subtotal (line 17 less line 18).	1,185,696	19.00
20.00	Deductibles	10,388	20.00
21.00	Subtotal (line 19 minus line 20)	1,175,308	21.00
22.00	Coinsurance	0	22.00
23.00	Subtotal (line 21 minus line 22)	1,175,308	23.00
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	0	24.00
25.00	Adjusted reimbursable bad debts (see instructions)	0	25.00
26.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	26.00
27.00	Subtotal (sum of lines 23 and 25)	1,175,308	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 49)	0	28.00
29.00	Other pass through costs (see instructions)	0	29.00
30.00	Outlier payments reconciliation	0	30.00
31.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	31.00
31.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	31.50
31.99	Recovery of Accelerated Depreciation	0	31.99
32.00	Total amount payable to the provider (see instructions)	1,175,308	32.00
32.01	Sequestration adjustment (see instructions)	23,506	32.01
33.00	Interim payments	1,142,587	33.00
34.00	Tentative settlement (for contractor use only)	0	34.00
35.00	Balance due provider/program (line 32 minus lines 32.01, 33, and 34)	9,215	35.00
36.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	36.00
	TO BE COMPLETED BY CONTRACTOR		
50.00	Original outlier amount from Wkst. E-3, Pt. III, line 4	28,549	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)	0	51.00
52.00	The rate used to calculate the Time Value of Money	0.00	52.00
53.00	Time Value of Money (see instructions)	0	53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0115 Component CCN: 15-5305	Period: From 07/01/2016 To 06/30/2017	Worksheet E-3 Part VI Date/Time Prepared: 11/28/2017 3:27 pm
	Title XVIII	Skilled Nursing Facility	PPS

		1.00	
	PART VI - CALCULATION OF REIMBURSEMENT SETTLEMEMENT - ALL OTHER HEALTH SERVICES FOR TITLE XVIII PART A PPS SNF SERVICES		
	PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCTIONS)		
1.00	Resource Utilization Group Payment (RUGS)	1,576,120	1.00
2.00	Routine service other pass through costs	0	2.00
3.00	Ancillary service other pass through costs	0	3.00
4.00	Subtotal (sum of lines 1 through 3)	1,576,120	4.00
	COMPUTATION OF NET COST OF COVERED SERVICES		
5.00	Medical and other services (Do not use this line as vaccine costs are included in line 1 of W/S E, Part B. This line is now shaded.)		5.00
6.00	Deductible	0	6.00
7.00	Coinsurance	182,259	7.00
8.00	Allowable bad debts (see instructions)	7,151	8.00
9.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)	1,103	9.00
10.00	Adjusted reimbursable bad debts (see instructions)	4,648	10.00
11.00	Utilization review	0	11.00
12.00	Subtotal (sum of lines 4, 5 minus lines 6 and 7, plus lines 10 and 11)(see instructions)	1,398,509	12.00
13.00	Inpatient primary payer payments	0	13.00
14.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	14.00
14.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	14.50
14.99	Recovery of Accelerated Depreciation	0	14.99
15.00	Subtotal (see instructions	1,398,509	15.00
15.01	Sequestration adjustment (see instructions)	27,970	15.01
16.00	Interim payments	1,365,984	16.00
17.00	Tentative settlement (for contractor use only)	0	17.00
18.00	Balance due provider/program (line 15 minus lines 15.01, 16, and 17)	4,555	18.00
19.00	Protested amounts (nonallowable cost report items) in accordance with CMS 19 Pub. 15-2, chapter 1, §115.2	0	19.00

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

Provider CCN: 15-0115 | Period: From 07/01/2016 To 06/30/2017 | Worksheet G | Date/Time Prepared: 11/28/2017 3:27 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	31,186,170	0	0	0	1.00
2.00	Temporary investments	50,667,498	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	27,055,672	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	0	0	0	0	7.00
8.00	Prepaid expenses	0	0	0	0	8.00
9.00	Other current assets	9,742,325	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)	118,651,665	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	9,985,477	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	114,505,814	0	0	0	15.00
16.00	Accumulated depreciation	-65,415,017	0	0	0	16.00
17.00	Leasehold improvements	102,585	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	95,019,552	0	0	0	19.00
20.00	Accumulated depreciation	-61,496,871	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	0	0	0	0	23.00
24.00	Accumulated depreciation	0	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)	92,701,540	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	27,846,247	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	8,868,599	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	36,714,846	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	248,068,051	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	4,181,694	0	0	0	37.00
38.00	Salaries, wages, and fees payable	12,993,064	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	1,847,965	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	1,628,953				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	0	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	20,651,676	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	51,092,906	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	299,649	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	51,392,555	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	72,044,231	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	176,023,820				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)	176,023,820	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	248,068,051	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-0115 | Period: From 07/01/2016 To 06/30/2017 | Worksheet G-1 | Date/Time Prepared: 11/28/2017 3:27 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		164,305,778		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		11,422,721				2.00
3.00	Total (sum of line 1 and line 2)		175,728,499		0		3.00
4.00	NET ASSETS RELEASED FROM RESTRICTION	295,321		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)		295,321		0		10.00
11.00	Subtotal (line 3 plus line 10)		176,023,820		0		11.00
12.00		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)		176,023,820		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	NET ASSETS RELEASED FROM RESTRICTION		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			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: 15-0115 | Period: From 07/01/2016 To 06/30/2017 | Worksheet G-2 Parts I & II | Date/Time Prepared: 11/28/2017 3:27 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	19,676,915		19,676,915	1.00
2.00	SUBPROVIDER - IPF	4,298,269		4,298,269	2.00
3.00	SUBPROVIDER - IRF	1,621,681		1,621,681	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	1,457,168		1,457,168	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)	27,054,033		27,054,033	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	9,403,588		9,403,588	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)	9,403,588		9,403,588	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	36,457,621		36,457,621	17.00
18.00	Ancillary services	91,591,253	309,367,682	400,958,935	18.00
19.00	Outpatient services	0	0	0	19.00
20.00	RURAL HEALTH CLINIC	0	891,886	891,886	20.00
20.01	RURAL HEALTH CLINIC II	0	0	0	20.01
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		2,312,697	2,312,697	22.00
23.00	AMBULANCE SERVICES	1,117,645	3,075,634	4,193,279	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE	0	0	0	26.00
27.00	OTHER (PHYSICIANS	0	54,798,014	54,798,014	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	129,166,519	370,445,913	499,612,432	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		213,196,508		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)		213,196,508		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 15-0115 | Period: From 07/01/2016 To 06/30/2017 | Worksheet G-3 Date/Time Prepared: 11/28/2017 3:27 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	499,612,432	1.00
2.00	Less contractual allowances and discounts on patients' accounts	289,928,031	2.00
3.00	Net patient revenues (line 1 minus line 2)	209,684,401	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	213,196,508	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-3,512,107	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	3,275,260	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	690,024	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	231,080	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	531	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER (MISCELLANEOUS)	10,737,933	24.00
25.00	Total other income (sum of lines 6-24)	14,934,828	25.00
26.00	Total (line 5 plus line 25)	11,422,721	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)	11,422,721	29.00

ANALYSIS OF HOSPITAL-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 15-0115 | HHA CCN: 15-7222

Period: From 07/01/2016 To 06/30/2017

Worksheet H

Date/Time Prepared: 11/28/2017 3:27 pm

Home Health Agency I | PPS

		Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased Services	Other Costs	Total (sum of cols. 1 thru 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures			0		0	0	1.00
2.00	Capital Related - Movable Equipment			0		0	0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0	0	0	3.00
4.00	Transportation	0	0	0	0	0	0	4.00
5.00	Administrative and General	1,526,970	0	139,583	42,947	87,306	1,796,806	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	0	0	6.00
7.00	Physical Therapy	0	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	0	8.00
9.00	Speech Pathology	0	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	0	10.00
11.00	Home Health Aide	0	0	0	0	0	0	11.00
12.00	Supplies (see instructions)	0	0	0	0	9,356	9,356	12.00
13.00	Drugs	0	0	0	0	1,207	1,207	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	1,526,970	0	139,583	42,947	97,869	1,807,369	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	-1,294,516	502,290	-42	502,248	5.00
	HHA REIMBURSABLE SERVICES					
6.00	Skilled Nursing Care	767,005	767,005	0	767,005	6.00
7.00	Physical Therapy	259,338	259,338	0	259,338	7.00
8.00	Occupational Therapy	146,782	146,782	0	146,782	8.00
9.00	Speech Pathology	7,180	7,180	0	7,180	9.00
10.00	Medical Social Services	5,379	5,379	0	5,379	10.00
11.00	Home Health Aide	108,832	108,832	0	108,832	11.00
12.00	Supplies (see instructions)	0	9,356	-9,356	0	12.00
13.00	Drugs	0	1,207	0	1,207	13.00
14.00	DME	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES					
15.00	Home Dialysis Aide Services	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	0	1,807,369	-9,398	1,797,971	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: 15-0115 | HHA CCN: 15-7222

Period: From 07/01/2016 To 06/30/2017

Worksheet H-1 Part I | Date/Time Prepared: 11/28/2017 3:27 pm

Home Health Agency I | PPS

		Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Capital Related Costs		Plant Operation & Maintenance	Transportation	Subtotal (cols. 0-4)	
			Bldgs & Fixtures	Movable Equipment				
		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	502,248	0	0	0	0	502,248	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	767,005	0	0	0	0	767,005	6.00
7.00	Physical Therapy	259,338	0	0	0	0	259,338	7.00
8.00	Occupational Therapy	146,782	0	0	0	0	146,782	8.00
9.00	Speech Pathology	7,180	0	0	0	0	7,180	9.00
10.00	Medical Social Services	5,379	0	0	0	0	5,379	10.00
11.00	Home Health Aide	108,832	0	0	0	0	108,832	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	0	12.00
13.00	Drugs	1,207	0	0	0		1,207	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	1,797,971	0	0	0	0	1,797,971	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	502,248		5.00
	HHA REIMBURSABLE SERVICES			
6.00	Skilled Nursing Care	297,306	1,064,311	6.00
7.00	Physical Therapy	100,525	359,863	7.00
8.00	Occupational Therapy	56,896	203,678	8.00
9.00	Speech Pathology	2,783	9,963	9.00
10.00	Medical Social Services	2,085	7,464	10.00
11.00	Home Health Aide	42,185	151,017	11.00
12.00	Supplies (see instructions)	0	0	12.00
13.00	Drugs	468	1,675	13.00
14.00	DME	0	0	14.00
	HHA NONREIMBURSABLE SERVICES			
15.00	Home Dialysis Aide Services	0	0	15.00
16.00	Respiratory Therapy	0	0	16.00
17.00	Private Duty Nursing	0	0	17.00
18.00	Clinic	0	0	18.00
19.00	Health Promotion Activities	0	0	19.00
20.00	Day Care Program	0	0	20.00
21.00	Home Delivered Meals Program	0	0	21.00
22.00	Homemaker Service	0	0	22.00
23.00	All Others (specify)	0	0	23.00
23.50	Telemedicine	0	0	23.50
24.00	Total (sum of lines 1-23)		1,797,971	24.00

COST ALLOCATION - HHA STATISTICAL BASIS

Provider CCN: 15-0115 | HHA CCN: 15-7222 | Period: From 07/01/2016 To 06/30/2017 | Worksheet H-1 Part II | Date/Time Prepared: 11/28/2017 3:27 pm

Home Health Agency I | PPS

		Capital Related Costs						
		Bldgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)	Plant Operation & Maintenance (SQUARE FEET)	Transportation (MILEAGE)	Reconciliation	Administrative & General (ACCUM. COST)	
		1.00	2.00	3.00	4.00	5A.00	5.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0				0		1.00
2.00	Capital Related - Movable Equipment		0			0		2.00
3.00	Plant Operation & Maintenance	0	0	0		0		3.00
4.00	Transportation (see instructions)	0	0	0	0			4.00
5.00	Administrative and General	0	0	0	0	-502,248	1,295,723	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	0	767,005	6.00
7.00	Physical Therapy	0	0	0	0	0	259,338	7.00
8.00	Occupational Therapy	0	0	0	0	0	146,782	8.00
9.00	Speech Pathology	0	0	0	0	0	7,180	9.00
10.00	Medical Social Services	0	0	0	0	0	5,379	10.00
11.00	Home Health Aide	0	0	0	0	0	108,832	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	0	12.00
13.00	Drugs	0	0	0		0	1,207	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	0	0	0	0	-502,248	1,295,723	24.00
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0	0		502,248	25.00
26.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000		0.387620	26.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS | Provider CCN: 15-0115 | HHA CCN: 15-7222 | Period: From 07/01/2016 To 06/30/2017 | Worksheet H-2 Part I | Date/Time Prepared: 11/28/2017 3:27 pm

Home Health Agency I | PPS

	Cost Center Description	HHA Trial Balance (1)	CAPITAL RELATED COSTS BLDG & FIXT	MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	
		0	1.00	2.00	4.00	4A	5.00	
1.00	Administrative and General	0	19,965	36,821	71,813	128,599	19,312	1.00
2.00	Skilled Nursing Care	1,064,311	0	0	135,537	1,199,848	180,183	2.00
3.00	Physical Therapy	359,863	0	0	43,887	403,750	60,632	3.00
4.00	Occupational Therapy	203,678	0	0	25,607	229,285	34,432	4.00
5.00	Speech Pathology	9,963	0	0	1,249	11,212	1,684	5.00
6.00	Medical Social Services	7,464	0	0	1,028	8,492	1,275	6.00
7.00	Home Health Aide	151,017	0	0	15,625	166,642	25,025	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	1,675	0	0	0	1,675	252	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	1,797,971	19,965	36,821	294,746	2,149,503	322,795	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.					0.000000		21.00

	Cost Center Description	MAINTENANCE & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
		6.00	8.00	9.00	10.00	11.00	13.00	
1.00	Administrative and General	65,413	0	12,690	0	7,674	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	15,181	0	2.00
3.00	Physical Therapy	0	0	0	0	4,475	0	3.00
4.00	Occupational Therapy	0	0	0	0	2,269	0	4.00
5.00	Speech Pathology	0	0	0	0	103	0	5.00
6.00	Medical Social Services	0	0	0	0	157	0	6.00
7.00	Home Health Aide	0	0	0	0	3,388	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)	65,413	0	12,690	0	33,247	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 15-0115 | HHA CCN: 15-7222 | Period: From 07/01/2016 To 06/30/2017 | Worksheet H-2 Part I | Date/Time Prepared: 11/28/2017 3:27 pm

Home Health Agency I | PPS

	Cost Center Description	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	
		14.00	15.00	16.00	24.00	25.00	26.00	
1.00	Administrative and General	1,919	0	0	235,607	0	235,607	1.00
2.00	Skilled Nursing Care	0	0	5,442	1,400,654	0	1,400,654	2.00
3.00	Physical Therapy	0	0	2,683	471,540	0	471,540	3.00
4.00	Occupational Therapy	0	0	1,185	267,171	0	267,171	4.00
5.00	Speech Pathology	0	0	60	13,059	0	13,059	5.00
6.00	Medical Social Services	0	0	4	9,928	0	9,928	6.00
7.00	Home Health Aide	0	0	2,340	197,395	0	197,395	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	1,927	0	1,927	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	1,919	0	11,714	2,597,281	0	2,597,281	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	Allocated HHA A&G (see Part II)	Total HHA Costs	
		27.00	28.00	
1.00	Administrative and General			1.00
2.00	Skilled Nursing Care	139,733	1,540,387	2.00
3.00	Physical Therapy	47,042	518,582	3.00
4.00	Occupational Therapy	26,654	293,825	4.00
5.00	Speech Pathology	1,303	14,362	5.00
6.00	Medical Social Services	990	10,918	6.00
7.00	Home Health Aide	19,693	217,088	7.00
8.00	Supplies (see instructions)	0	0	8.00
9.00	Drugs	192	2,119	9.00
10.00	DME	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	11.00
12.00	Respiratory Therapy	0	0	12.00
13.00	Private Duty Nursing	0	0	13.00
14.00	Clinic	0	0	14.00
15.00	Health Promotion Activities	0	0	15.00
16.00	Day Care Program	0	0	16.00
17.00	Home Delivered Meals Program	0	0	17.00
18.00	Homemaker Service	0	0	18.00
19.00	All Others (specify)	0	0	19.00
19.50	Telemedicine	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	235,607	2,597,281	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.	0.099763		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: 15-0115 | HHA CCN: 15-7222 | Period: From 07/01/2016 To 06/30/2017 | Worksheet H-2 Part II | Date/Time Prepared: 11/28/2017 3:27 pm

Home Health Agency I | PPS

	Cost Center Description	CAPITAL RELATED COSTS						
		BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	
		1.00	2.00	4.00	5A	5.00	6.00	
1.00	Administrative and General	3,758	3,758	372,036	0	128,599	3,758	1.00
2.00	Skilled Nursing Care	0	0	702,169	0	1,199,848	0	2.00
3.00	Physical Therapy	0	0	227,360	0	403,750	0	3.00
4.00	Occupational Therapy	0	0	132,659	0	229,285	0	4.00
5.00	Speech Pathology	0	0	6,469	0	11,212	0	5.00
6.00	Medical Social Services	0	0	5,328	0	8,492	0	6.00
7.00	Home Health Aide	0	0	80,949	0	166,642	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	1,675	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)	3,758	3,758	1,526,970		2,149,503	3,758	20.00
21.00	Total cost to be allocated	19,965	36,821	294,746		322,795	65,413	21.00
22.00	Unit cost multiplier	5.312666	9.798031	0.193027		0.150172	17.406333	22.00

	Cost Center Description	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (PATIENT DAYS)	CAFETERIA (HOURS)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	
		8.00	9.00	10.00	11.00	13.00	14.00	
1.00	Administrative and General	0	3,758	0	12,758	0	55,386	1.00
2.00	Skilled Nursing Care	0	0	0	25,238	0	0	2.00
3.00	Physical Therapy	0	0	0	7,440	0	0	3.00
4.00	Occupational Therapy	0	0	0	3,772	0	0	4.00
5.00	Speech Pathology	0	0	0	172	0	0	5.00
6.00	Medical Social Services	0	0	0	261	0	0	6.00
7.00	Home Health Aide	0	0	0	5,633	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	3,758	0	55,274	0	55,386	20.00
21.00	Total cost to be allocated	0	12,690	0	33,247	0	1,919	21.00
22.00	Unit cost multiplier	0.000000	3.376796	0.000000	0.601494	0.000000	0.034648	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 15-0115 | HHA CCN: 15-7222 | Period: From 07/01/2016 To 06/30/2017 | Worksheet H-2 Part II | Date/Time Prepared: 11/28/2017 3:27 pm

Home Health Agency I | PPS

	Cost Center Description	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (REVENUE)	
		15.00	16.00	
1.00	Administrative and General	0	0	1.00
2.00	Skilled Nursing Care	0	1,074,332	2.00
3.00	Physical Therapy	0	529,806	3.00
4.00	Occupational Therapy	0	233,990	4.00
5.00	Speech Pathology	0	11,777	5.00
6.00	Medical Social Services	0	841	6.00
7.00	Home Health Aide	0	461,951	7.00
8.00	Supplies (see instructions)	0	0	8.00
9.00	Drugs	0	0	9.00
10.00	DME	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	11.00
12.00	Respiratory Therapy	0	0	12.00
13.00	Private Duty Nursing	0	0	13.00
14.00	Clinic	0	0	14.00
15.00	Health Promotion Activities	0	0	15.00
16.00	Day Care Program	0	0	16.00
17.00	Home Delivered Meals Program	0	0	17.00
18.00	Homemaker Service	0	0	18.00
19.00	All Others (specify)	0	0	19.00
19.50	Telemedicine	0	0	19.50
20.00	Total (sum of lines 1-19)	0	2,312,697	20.00
21.00	Total cost to be allocated	0	11,714	21.00
22.00	Unit cost multiplier	0.000000	0.005065	22.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 15-0115 | HHA CCN: 15-7222 | Period: From 07/01/2016 To 06/30/2017 | Worksheet H-3 Part I | Date/Time Prepared: 11/28/2017 3:27 pm

Title XVIII | Home Health Agency I | PPS

	Cost Center Description	From, Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Visits	Average Cost Per Visit (col. 3 ÷ col. 4)	
		0	1.00	2.00	3.00	4.00	5.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	2.00	1,540,387		1,540,387	7,662	201.04	1.00
2.00	Physical Therapy	3.00	518,582	0	518,582	3,779	137.23	2.00
3.00	Occupational Therapy	4.00	293,825	0	293,825	1,669	176.05	3.00
4.00	Speech Pathology	5.00	14,362	0	14,362	84	170.98	4.00
5.00	Medical Social Services	6.00	10,918		10,918	16	682.38	5.00
6.00	Home Health Aide	7.00	217,088		217,088	3,295	65.88	6.00
7.00	Total (sum of lines 1-6)		2,595,162	0	2,595,162	16,505		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	4,006			8.00
9.00	Physical Therapy		99915	0	2,424			9.00
10.00	Occupational Therapy		99915	0	1,150			10.00
11.00	Speech Pathology		99915	0	44			11.00
12.00	Medical Social Services		99915	0	0			12.00
13.00	Home Health Aide		99915	0	1,815			13.00
14.00	Total (sum of lines 8-13)			0	9,439			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	50,890	0.000000	15.00
16.00	Cost of Drugs	9.00	2,119	0	2,119	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	4,006		0	805,366		1.00
2.00	Physical Therapy	0	2,424		0	332,646		2.00
3.00	Occupational Therapy	0	1,150		0	202,458		3.00
4.00	Speech Pathology	0	44		0	7,523		4.00
5.00	Medical Social Services	0	0		0	0		5.00
6.00	Home Health Aide	0	1,815		0	119,572		6.00
7.00	Total (sum of lines 1-6)	0	9,439		0	1,467,565		7.00

APPORTIONMENT OF PATIENT SERVICE COSTS | Provider CCN: 15-0115 | HHA CCN: 15-7222 | Period: From 07/01/2016 To 06/30/2017 | Worksheet H-3 Part I | Date/Time Prepared: 11/28/2017 3:27 pm

Title XVIII | Home Health Agency I | PPS

	Cost Center Description							
		6.00	7.00	8.00	9.00	10.00	11.00	
	Limitation Cost Computation							
8.00	Skilled Nursing Care							8.00
9.00	Physical Therapy							9.00
10.00	Occupational Therapy							10.00
11.00	Speech Pathology							11.00
12.00	Medical Social Services							12.00
13.00	Home Health Aide							13.00
14.00	Total (sum of lines 8-13)							14.00

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

	Cost Center Description	Total Program Cost (sum of cols. 9-10)	
		12.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION		
	Cost Per Visit Computation		
1.00	Skilled Nursing Care	805,366	1.00
2.00	Physical Therapy	332,646	2.00
3.00	Occupational Therapy	202,458	3.00
4.00	Speech Pathology	7,523	4.00
5.00	Medical Social Services	0	5.00
6.00	Home Health Aide	119,572	6.00
7.00	Total (sum of lines 1-6)	1,467,565	7.00

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

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 15-0115 | HHA CCN: 15-7222 | Period: From 07/01/2016 To 06/30/2017 | Worksheet H-3 Part II | Date/Time Prepared: 11/28/2017 3:27 pm

Title XVIII | Home Health Agency I | PPS

	Cost Center Description	From Wkst. C, Part I, col. 9, line	Cost to Charge Ratio	Total HHA Charge (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)	Transfer to Part I as Indicated	
		0	1.00	2.00	3.00	4.00	
	PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS						
1.00	Physical Therapy	66.00	0.457524	0	0	col. 2, line 2.00	1.00
2.00	Occupational Therapy						2.00
3.00	Speech Pathology						3.00
4.00	Cost of Medical Supplies	71.00	0.266519	0	0	col. 2, line 15.00	4.00
5.00	Cost of Drugs	73.00	0.200898	0	0	col. 2, line 16.00	5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT

Provider CCN: 15-0115 | HHA CCN: 15-7222 | Period: From 07/01/2016 To 06/30/2017 | Worksheet H-4 Part I-II | Date/Time Prepared: 11/28/2017 3:27 pm

Title XVIII | Home Health Agency I | PPS

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

		Part A Services	Part B Services	
		1.00	2.00	
	PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT			
10.00	Total reasonable cost (see instructions)	0	0	10.00
11.00	Total PPS Reimbursement - Full Episodes without Outliers	0	1,264,878	11.00
12.00	Total PPS Reimbursement - Full Episodes with Outliers	0	56,227	12.00
13.00	Total PPS Reimbursement - LUPA Episodes	0	23,312	13.00
14.00	Total PPS Reimbursement - PEP Episodes	0	4,569	14.00
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers	0	17,662	15.00
16.00	Total PPS Outlier Reimbursement - PEP Episodes	0	5,008	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)		1,322	21.00
22.00	Subtotal (sum of lines 10 thru 20 minus line 21)	0	1,370,334	22.00
23.00	Excess reasonable cost (from line 8)	0	0	23.00
24.00	Subtotal (line 22 minus line 23)	0	1,370,334	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	1,370,334	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	1,370,334	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	0	30.50
31.00	Subtotal (see instructions)	0	1,370,334	31.00
31.01	Sequestration adjustment (see instructions)	0	27,407	31.01
32.00	Interim payments (see instructions)	0	1,342,927	32.00
33.00	Tentative settlement (for contractor use only)	0	0	33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 32, and 33)	0	0	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	35.00

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

Provider CCN: 15-0115 | HHA CCN: 15-7222 | Period: From 07/01/2016 To 06/30/2017 | Worksheet H-5 | Date/Time Prepared: 11/28/2017 3:27 pm

Home Health Agency I | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		0		1,342,927	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		1,342,927	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01			0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50			0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		0		1,342,927	7.00

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

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 15-0115	Period: From 07/01/2016 To 06/30/2017	Worksheet L Parts I-III Date/Time Prepared: 11/28/2017 3:27 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	1,445,939	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	9,649	1.01
2.00	Capital DRG outlier payments	0	2.00
2.01	Model 4 BPCI Capital DRG outlier payments	0	2.01
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)	38.86	3.00
4.00	Number of interns & residents (see instructions)	0.00	4.00
5.00	Indirect medical education percentage (see instructions)	0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)	0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)	0.00	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)	0.00	8.00
9.00	Sum of lines 7 and 8	0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)	0.00	10.00
11.00	Disproportionate share adjustment (see instructions)	0	11.00
12.00	Total prospective capital payments (see instructions)	1,455,588	12.00

		1.00	
	PART II - PAYMENT UNDER REASONABLE COST		
1.00	Program inpatient routine capital cost (see instructions)	0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)	0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)	0	3.00
4.00	Capital cost payment factor (see instructions)	0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)	0	5.00

		1.00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS		
1.00	Program inpatient capital costs (see instructions)	0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)	0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)	0	3.00
4.00	Applicable exception percentage (see instructions)	0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)	0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)	0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)	0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)	0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)	0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)	0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)	0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)	0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)	0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)	0	14.00
15.00	Current year allowable operating and capital payment (see instructions)	0	15.00
16.00	Current year operating and capital costs (see instructions)	0	16.00
17.00	Current year exception offset amount (see instructions)	0	17.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-0115 | Period: From 07/01/2016 To 06/30/2017 | Worksheet M-1

Component CCN: 15-8507 | Date/Time Prepared: 11/28/2017 3:27 pm

RHC I | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	297,340	0	297,340	-230,577	66,763	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	0	0	0	158,450	158,450	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	0	0	0	0	0	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	50,105	50,105	9.00
10.00	Subtotal (sum of lines 1 through 9)	297,340	0	297,340	-22,022	275,318	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	1,092	1,092	0	1,092	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	22,022	22,022	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	1,092	1,092	22,022	23,114	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	297,340	1,092	298,432	0	298,432	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	21,058	21,058	0	21,058	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	21,058	21,058	0	21,058	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	59,253	59,253	0	59,253	29.00
30.00	Administrative Costs	0	52,546	52,546	0	52,546	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	111,799	111,799	0	111,799	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	297,340	133,949	431,289	0	431,289	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-0115 | Period: From 07/01/2016 To 06/30/2017 | Worksheet M-1

Component CCN: 15-8507 | Date/Time Prepared: 11/28/2017 3:27 pm

RHC I | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
		6.00	7.00	
	FACILITY HEALTH CARE STAFF COSTS			
1.00	Physician	0	66,763	1.00
2.00	Physician Assistant	0	0	2.00
3.00	Nurse Practitioner	0	158,450	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	0	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	50,105	9.00
10.00	Subtotal (sum of lines 1 through 9)	0	275,318	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	-1,092	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	-11,415	10,607	19.00
20.00	Allowable GME Costs			20.00
21.00	Subtotal (sum of lines 15 through 20)	-12,507	10,607	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-12,507	285,925	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES			
23.00	Pharmacy	0	21,058	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	21,058	28.00
	FACILITY OVERHEAD			
29.00	Facility Costs	0	59,253	29.00
30.00	Administrative Costs	-734	51,812	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-734	111,065	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-13,241	418,048	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-0115 | Period: From 07/01/2016 To 06/30/2017 | Worksheet M-1

Component CCN: 15-8508 | Date/Time Prepared: 11/28/2017 3:27 pm

RHC II | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	444,590	0	444,590	-273,089	171,501	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	0	0	0	121,721	121,721	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	0	0	0	0	0	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	86,972	86,972	9.00
10.00	Subtotal (sum of lines 1 through 9)	444,590	0	444,590	-64,396	380,194	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	337	337	0	337	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	64,396	64,396	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	337	337	64,396	64,733	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	444,590	337	444,927	0	444,927	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	17,811	17,811	0	17,811	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	17,811	17,811	0	17,811	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	3,388	3,388	0	3,388	29.00
30.00	Administrative Costs	0	41,772	41,772	0	41,772	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	45,160	45,160	0	45,160	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	444,590	63,308	507,898	0	507,898	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS | Provider CCN: 15-0115 | Period: From 07/01/2016 To 06/30/2017 | Worksheet M-1

Component CCN: 15-8508 | Date/Time Prepared: 11/28/2017 3:27 pm

RHC II | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
		6.00	7.00	
	FACILITY HEALTH CARE STAFF COSTS			
1.00	Physician	0	171,501	1.00
2.00	Physician Assistant	0	0	2.00
3.00	Nurse Practitioner	0	121,721	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	0	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	86,972	9.00
10.00	Subtotal (sum of lines 1 through 9)	0	380,194	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	-337	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	-14,793	49,603	19.00
20.00	Allowable GME Costs			20.00
21.00	Subtotal (sum of lines 15 through 20)	-15,130	49,603	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-15,130	429,797	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES			
23.00	Pharmacy	0	17,811	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	17,811	28.00
	FACILITY OVERHEAD			
29.00	Facility Costs	-881	2,507	29.00
30.00	Administrative Costs	0	41,772	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-881	44,279	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-16,011	491,887	32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES | Provider CCN: 15-0115 | Component CCN: 15-8507 | Period: From 07/01/2016 To 06/30/2017 | Worksheet M-2 | Date/Time Prepared: 11/28/2017 3:27 pm

RHC I | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	0.08	516	4,200	336		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	0.96	3,535	2,100	2,016		3.00
4.00	Subtotal (sum of lines 1 through 3)	1.04	4,051		2,352	4,051	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	1.04	4,051			4,051	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)	285,925	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)	21,058	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)	306,983	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)	0.931403	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)	111,065	14.00
15.00	Parent provider overhead allocated to facility (see instructions)	248,623	15.00
16.00	Total overhead (sum of lines 14 and 15)	359,688	16.00
17.00	Allowable GME overhead (see instructions)	0	17.00
18.00	Enter the amount from line 16	359,688	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)	335,014	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)	620,939	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 15-0115 | Component CCN: 15-8508 | Period: From 07/01/2016 To 06/30/2017 | Worksheet M-2 | Date/Time Prepared: 11/28/2017 3:27 pm

RHC II | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	0.88	2,598	4,200	3,696		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	0.75	2,494	2,100	1,575		3.00
4.00	Subtotal (sum of lines 1 through 3)	1.63	5,092		5,271	5,271	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	1.63	5,092			5,271	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)	429,797	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)	17,811	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)	447,608	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)	0.960208	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)	44,279	14.00
15.00	Parent provider overhead allocated to facility (see instructions)	433,798	15.00
16.00	Total overhead (sum of lines 14 and 15)	478,077	16.00
17.00	Allowable GME overhead (see instructions)	0	17.00
18.00	Enter the amount from line 16	478,077	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)	459,053	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)	888,850	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 15-0115 Component CCN: 15-8507	Period: From 07/01/2016 To 06/30/2017	Worksheet M-3 Date/Time Prepared: 11/28/2017 3:27 pm
	Title XVIII	RHC I	Cost

			1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES			
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)		620,939	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)		31,274	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		589,665	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		4,051	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)		0	5.00
6.00	Total adjusted visits (line 4 plus line 5)		4,051	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		145.56	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)	81.32	82.30	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	745	795	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	60,583	65,429	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	126,012	16.00
16.01	Total program charges (see instructions)(from contractor's records)		309,939	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		5,582	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		2,269	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.)		73,381	16.04
16.05	Total program cost (see instructions)	0	75,650	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		32,017	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		55,584	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		75,650	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		19,159	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		94,809	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
26.00	Net reimbursable amount (see instructions)		94,809	26.00
26.01	Sequestration adjustment (see instructions)		1,896	26.01
27.00	Interim payments		71,390	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, 27, and 28)		21,523	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0	30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 15-0115 Component CCN: 15-8508	Period: From 07/01/2016 To 06/30/2017	Worksheet M-3 Date/Time Prepared: 11/28/2017 3:27 pm
	Title XVIII	RHC II	Cost

			1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES			
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)		888,850	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)		25,246	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		863,604	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		5,271	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)		5,271	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		163.84	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)	81.32	82.30	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	833	876	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	67,740	72,095	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	139,835	16.00
16.01	Total program charges (see instructions)(from contractor's records)		305,663	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		2,206	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		1,009	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.)		80,420	16.04
16.05	Total program cost (see instructions)	0	81,429	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		38,301	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		53,472	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		81,429	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		12,643	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		94,072	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
26.00	Net reimbursable amount (see instructions)		94,072	26.00
26.01	Sequestration adjustment (see instructions)		1,881	26.01
27.00	Interim payments		76,086	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, 27, and 28)		16,105	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: 15-0115 | Component CCN: 15-8507 | Period: From 07/01/2016 To 06/30/2017 | Worksheet M-4 | Date/Time Prepared: 11/28/2017 3:27 pm

Title XVIII | RHC I | Cost

		Pneumococcal	Influenza	
		1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	275,318	275,318	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000035	0.013308	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	10	3,664	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	5,641	5,086	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	5,651	8,750	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	285,925	285,925	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	335,014	335,014	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.019764	0.030602	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	6,621	10,252	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	12,272	19,002	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	49	181	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	250.45	104.98	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	35	99	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	8,766	10,393	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)		31,274	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)		19,159	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA VACCINE COST	Provider CCN: 15-0115 Component CCN: 15-8508	Period: From 07/01/2016 To 06/30/2017	Worksheet M-4 Date/Time Prepared: 11/28/2017 3:27 pm
	Title XVIII	RHC II	Cost

		Pneumococcal	Influenza	
		1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	380,194	380,194	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000805	0.009181	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	306	3,491	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	2,392	6,019	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	2,698	9,510	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	429,797	429,797	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	459,053	459,053	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.006277	0.022127	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	2,881	10,157	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	5,579	19,667	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	20	228	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	278.95	86.26	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	11	111	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	3,068	9,575	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)		25,246	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)		12,643	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 15-0115 Component CCN: 15-8507	Period: From 07/01/2016 To 06/30/2017	Worksheet M-5 Date/Time Prepared: 11/28/2017 3:27 pm
		RHC I	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		71,390	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)		71,390	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		21,523	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		92,913	7.00

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

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 15-0115 Component CCN: 15-8508	Period: From 07/01/2016 To 06/30/2017	Worksheet M-5 Date/Time Prepared: 11/28/2017 3:27 pm
		RHC II	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		76,086	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)		76,086	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		16,105	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		92,191	7.00

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