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: 15-1310	Period: From 01/01/2017 To 12/31/2017	Worksheet S Parts I-III Date/Time Prepared: 5/30/2018 7:46 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 5/30/2018 Time: 7:46 am
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by PARKVIEW WABASH HOSPITAL, INC. (15-1310) for the cost reporting period beginning 01/01/2017 and ending 12/31/2017 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

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

_____
Title

_____
Date

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	97,043	-726,108	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	4,818	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
200.00	Total	0	101,861	-726,108	0	0	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1310 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-2 Part I | Date/Time Prepared: 5/29/2018 9:58 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 710 NORTH EAST STREET	PO Box: 548			1.00
2.00	City: WABASH	State: IN	Zip Code: 46992-0548	County: WABASH	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	PARKVIEW WABASH HOSPITAL, INC.	151310	99915	1	12/17/2001	N	O	P	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	PARKVIEW WABASH HOSPITAL SWING BEDS	15Z310	99915		12/17/2001	N	O	N	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA	WABASH-MIAMI HOME HEALTH	157061	99915		01/01/1979	N	P	N	12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice	WABASH-MIAMI HOSPICE	151545	99915		01/01/1996				14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1310 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-2 Part I Date/Time Prepared: 5/29/2018 9:58 am

		Urban/Rural S	Date of Geogr	
		1.00	2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	2		26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	2		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0		35.00
		Beginning:	Ending:	
		1.00	2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.			36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.	0		37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)	N		37.01
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.			38.00
		Y/N	Y/N	
		1.00	2.00	
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i) or (ii)? Enter in column 1 “Y” for yes or “N” for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i) or (ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	N	N	39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	N	N	40.00

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1310 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-2 Part I Date/Time Prepared: 5/29/2018 9:58 am

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1310 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-2 Part I Date/Time Prepared: 5/29/2018 9:58 am

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

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

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

		1.00	2.00	3.00	
	Inpatient Psychiatric Facility PPS				
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	N			70.00
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0	71.00
	Inpatient Rehabilitation Facility PPS				
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	N			75.00
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0	76.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-1310	Period: From 01/01/2017 To 12/31/2017	Worksheet S-2 Part I Date/Time Prepared: 5/29/2018 9:58 am

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1310 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-2 Part I | Date/Time Prepared: 5/29/2018 9:58 am

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

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

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	328,622	0	21,404	118.01

		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1310 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-2 Part I | Date/Time Prepared: 5/29/2018 9:58 am

	1.00	2.00	3.00	
	If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.			
141.00	Name: PARKVIEW HEALTH SYSTEM, INC.	Contractor's Name: WISCONSIN PHYSICIANS SERVICE	Contractor's Number: 08101	141.00
142.00	Street: 10501 CORPORATE DRIVE	PO Box: 5600		142.00
143.00	City: FORT WAYNE	State: IN	Zip Code: 46845	143.00

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

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

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

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

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

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

		1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act		
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.	Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)	199,434	168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)		168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	0.00	169.00

		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	10/01/2016	09/30/2017	170.00

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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-1310 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-2 Part II | Date/Time Prepared: 5/29/2018 9:58 am

			Y/N	Date	
			1.00	2.00	
	General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.				
	COMPLETED BY ALL HOSPITALS				
	Provider Organization and Operation				
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)		N		1.00
		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N			3.00
		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00
			Y/N	Legal Oper.	
			1.00	2.00	
	Approved Educational Activities				
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?		N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.		N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.		N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.		N		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.		N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.		N		11.00
				Y/N	
				1.00	
	Bad Debts				
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.			Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.			Y	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	05/01/2018	Y	05/01/2018
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	
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	
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	

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-1310 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-2 Part II Date/Time Prepared: 5/29/2018 9:58 am

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

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

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

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	ERIC	NICKESON	41.00
42.00	Enter the employer/company name of the cost report preparer.	PARKVIEW HEALTH SYSTEM, INC.		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	2603738406	ERIC.NICKESON@PARKVIEW.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-1310	Period: From 01/01/2017 To 12/31/2017	Worksheet S-2 Part II Date/Time Prepared: 5/29/2018 9:58 am

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-1310 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-3 Part I Date/Time Prepared: 5/29/2018 9:58 am

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	25	9,125	44,880.00	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)		25	9,125	44,880.00	0	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	43.00				0	13.00
14.00	Total (see instructions)		25	9,125	44,880.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	101.00				0	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	116.00	0	0			24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		25				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00
33.01	LTCH site neutral days and discharges						33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-1310 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-3 Part I | Date/Time Prepared: 5/29/2018 9:58 am

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	860	28	1,769			1.00
2.00	HMO and other (see instructions)	560	54				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	22	0	22			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	79			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	882	28	1,870			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		0	0			13.00
14.00	Total (see instructions)	882	28	1,870	0.00	168.60	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0	0	429	0.00	0.00	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	0	0	0	0.00	0.00	24.00
24.10	HOSPICE (non-distinct part)	0	0	0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	168.60	27.00
28.00	Observation Bed Days		8	719			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			9			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-1310 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-3 Part I Date/Time Prepared: 5/29/2018 9:58 am

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	315	9	688	1.00
2.00	HMO and other (see instructions)			191	18		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	315	9	688	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0.00					22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	0.00					24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01

HOME HEALTH AGENCY STATISTICAL DATA | Provider CCN: 15-1310 | Component CCN: 15-7061 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-4 | Date/Time Prepared: 5/29/2018 9:58 am

Home Health Agency I | PPS

					1.00		
0.00	County						0.00
		Title V	Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	5.00	
	HOME HEALTH AGENCY STATISTICAL DATA						
1.00	Home Health Aide Hours	0	0	0	0	0	1.00
2.00	Unduplicated Census Count (see instructions)	0.00	0.00	0.00	0.00	0.00	2.00
				Number of Employees (Full Time Equivalent)			
		Enter the number of hours in your normal work week		Staff	Contract	Total	
		0		1.00	2.00	3.00	
	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES						
3.00	Administrator and Assistant Administrator(s)		0.00	0.00	0.00	0.00	3.00
4.00	Director(s) and Assistant Director(s)			0.00	0.00	0.00	4.00
5.00	Other Administrative Personnel			0.00	0.00	0.00	5.00
6.00	Direct Nursing Service			0.00	0.00	0.00	6.00
7.00	Nursing Supervisor			0.00	0.00	0.00	7.00
8.00	Physical Therapy Service			0.00	0.00	0.00	8.00
9.00	Physical Therapy Supervisor			0.00	0.00	0.00	9.00
10.00	Occupational Therapy Service			0.00	0.00	0.00	10.00
11.00	Occupational Therapy Supervisor			0.00	0.00	0.00	11.00
12.00	Speech Pathology Service			0.00	0.00	0.00	12.00
13.00	Speech Pathology Supervisor			0.00	0.00	0.00	13.00
14.00	Medical Social Service			0.00	0.00	0.00	14.00
15.00	Medical Social Service Supervisor			0.00	0.00	0.00	15.00
16.00	Home Health Aide			0.00	0.00	0.00	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	96	1	15	9	121	21.00
22.00	Skilled Nursing Visit Charges	14,308	173	2,708	1,285	18,474	22.00
23.00	Physical Therapy Visits	157	18	0	0	175	23.00
24.00	Physical Therapy Visit Charges	27,870	3,113	0	0	30,983	24.00
25.00	Occupational Therapy Visits	30	17	1	0	48	25.00
26.00	Occupational Therapy Visit Charges	4,014	2,370	191	0	6,575	26.00
27.00	Speech Pathology Visits	0	0	0	0	0	27.00
28.00	Speech Pathology Visit Charges	0	0	0	0	0	28.00
29.00	Medical Social Service Visits	0	0	0	0	0	29.00
30.00	Medical Social Service Visit Charges	0	0	0	0	0	30.00
31.00	Home Health Aide Visits	0	0	0	0	0	31.00
32.00	Home Health Aide Visit Charges	0	0	0	0	0	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	283	36	16	9	344	33.00
34.00	Other Charges	0	0	0	0	0	34.00
35.00	Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)	46,192	5,656	2,899	1,285	56,032	35.00
36.00	Total Number of Episodes (standard/non outlier)	0		0	0	0	36.00
37.00	Total Number of Outlier Episodes		0		0	0	37.00
38.00	Total Non-Routine Medical Supply Charges	0	0	0	0	0	38.00

HOSPITAL-BASED HOSPICE IDENTIFICATION DATA

Provider CCN: 15-1310
Hospice CCN: 15-1545

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

Worksheet S-9
PARTS I THROUGH IV
Date/Time Prepared:
5/29/2018 9:58 am

Hospice I

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

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

		Title XVIII	Title XIX	Other	Total (sum of cols. 1 through 3)	
		1.00	2.00	3.00	4.00	
	PART III - ENROLLMENT DAYS FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2015					
10.00	Hospice Continuous Home Care	0	0	0	0	10.00
11.00	Hospice Routine Home Care	1,301	14	0	1,315	11.00
12.00	Hospice Inpatient Respite Care	5	0	0	5	12.00
13.00	Hospice General Inpatient Care	18	7	0	25	13.00
14.00	Total Hospice Days	1,324	21	0	1,345	14.00
	PART IV - CONTRACTED STATISTICAL DATA FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2015					
15.00	Hospice Inpatient Respite Care	0	0	0	0	15.00
16.00	Hospice General Inpatient Care	0	0	0	0	16.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 15-1310 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-10 | Date/Time Prepared: 5/29/2018 9:58 am

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.272134	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	809,127	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?	Y	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	6,637,437	6.00
7.00	Medicaid cost (line 1 times line 6)	1,806,272	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)	997,145	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)	1,933,958	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	9,387,451	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	2,554,645	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)	620,687	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)	1,617,832	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
	Uncompensated Care (see instructions for each line)				
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	1,032,205	628,272	1,660,477	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	280,898	628,272	909,170	21.00
22.00	Payments received from patients for amounts previously written off as charity care	1,943	3,068	5,011	22.00
23.00	Cost of charity care (line 21 minus line 22)	278,955	625,204	904,159	23.00

		1.00	
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?		24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	4,052,762	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	446,580	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	687,046	27.01
28.00	Non-Medicare bad debt expense (see instructions)	3,365,716	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	1,156,392	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	2,060,551	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	3,678,383	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1310 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A | Date/Time Prepared: 5/29/2018 9:58 am

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		8,751,889	8,751,889	221,123	8,973,012	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		0	0	558,002	558,002	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	76,112	3,701,831	3,777,943	-745	3,777,198	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	568,270	10,650,881	11,219,151	-77,736	11,141,415	5.00
7.00	00700	OPERATION OF PLANT	247,640	763,110	1,010,750	-285	1,010,465	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	205,380	227,121	432,501	0	432,501	9.00
10.00	01000	DIETARY	437,295	263,653	700,948	-474,970	225,978	10.00
11.00	01100	CAFETERIA	0	0	0	469,999	469,999	11.00
13.00	01300	NURSING ADMINISTRATION	378,111	17,976	396,087	-1,065	395,022	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	620,640	583,463	1,204,103	-85,231	1,118,872	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,073,563	621,206	1,694,769	-512	1,694,257	30.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	532,443	504,243	1,036,686	-95,215	941,471	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	44	44	0	44	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	800,100	857,393	1,657,493	-4,662	1,652,831	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
60.00	06000	LABORATORY	0	1,372,222	1,372,222	0	1,372,222	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
66.00	06600	PHYSICAL THERAPY	1,047,426	154,013	1,201,439	-254,598	946,841	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	89,202	89,202	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	72,866	72,866	68.00
69.00	06900	ELECTROCARDIOLOGY	542,456	28,606	571,062	-1,737	569,325	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	697,366	697,366	-327,089	370,277	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	326,892	326,892	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,707,571	1,707,571	79,807	1,787,378	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	117,752	117,752	4,971	122,723	90.00
90.01	09001	SENIOR CARE	147,941	91,785	239,726	0	239,726	90.01
91.00	09100	EMERGENCY	590,705	2,451,215	3,041,920	-1,006	3,040,914	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	169,783	42,140	211,923	0	211,923	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		498,011	498,011	-498,011	0	113.00
116.00	11600	HOSPICE	66,316	108,433	174,749	0	174,749	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	7,504,181	34,211,924	41,716,105	0	41,716,105	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	37,453	2,787	40,240	0	40,240	192.00
194.00	07950	FITNESS CENTER	0	0	0	0	0	194.00
194.01	07951	FOUNDATION	0	-185,645	-185,645	0	-185,645	194.01
194.02	07952	NEW DIRECTION	0	0	0	0	0	194.02
194.03	07953	COMMUNITY & VOLUNTEER SERVICES	0	63,388	63,388	0	63,388	194.03
194.04	07956	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.04
194.05	07955	OCCUPATIONAL HEALTH	0	0	0	0	0	194.05
200.00		TOTAL (SUM OF LINES 118 through 199)	7,541,634	34,092,454	41,634,088	0	41,634,088	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1310 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A | Date/Time Prepared: 5/29/2018 9:58 am

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	-8,668,236	304,776		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-44,188	513,814		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-1,126,740	2,650,458		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-3,749,476	7,391,939		5.00
7.00	00700	OPERATION OF PLANT	-117,993	892,472		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0		8.00
9.00	00900	HOUSEKEEPING	0	432,501		9.00
10.00	01000	DIETARY	0	225,978		10.00
11.00	01100	CAFETERIA	-167,917	302,082		11.00
13.00	01300	NURSING ADMINISTRATION	0	395,022		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0		14.00
15.00	01500	PHARMACY	-356,003	762,869		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	17,434	1,711,691		30.00
43.00	04300	NURSERY	0	0		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	941,471		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	44		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-679,607	973,224		54.00
56.00	05600	RADIOISOTOPE	0	0		56.00
60.00	06000	LABORATORY	-85,479	1,286,743		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0		63.00
66.00	06600	PHYSICAL THERAPY	0	946,841		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	89,202		67.00
68.00	06800	SPEECH PATHOLOGY	0	72,866		68.00
69.00	06900	ELECTROCARDIOLOGY	0	569,325		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	370,277		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	326,892		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,787,378		73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	122,723		90.00
90.01	09001	SENIOR CARE	0	239,726		90.01
91.00	09100	EMERGENCY	-648,620	2,392,294		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
		OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY	0	211,923		101.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
116.00	11600	HOSPICE	0	174,749		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-15,626,825	26,089,280		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	40,240		192.00
194.00	07950	FITNESS CENTER	0	0		194.00
194.01	07951	FOUNDATION	0	-185,645		194.01
194.02	07952	NEW DIRECTION	0	0		194.02
194.03	07953	COMMUNITY & VOLUNTEER SERVICES	0	63,388		194.03
194.04	07956	OTHER NONREIMBURSABLE COST CENTERS	0	0		194.04
194.05	07955	OCCUPATIONAL HEALTH	0	0		194.05
200.00		TOTAL (SUM OF LINES 118 through 199)	-15,626,825	26,007,263		200.00

RECLASSIFICATIONS | Provider CCN: 15-1310 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-6 | Date/Time Prepared: 5/29/2018 9:58 am

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - REHAB THERAPY RECLASS					
1.00	OCCUPATIONAL THERAPY	67.00	77,767	11,435		1.00
2.00	SPEECH PATHOLOGY	68.00	63,525	9,341		2.00
	0		141,292	20,776		
	B - CLINIC DIETICIAN					
1.00	CLINIC	90.00	4,971	0		1.00
	0		4,971	0		
	C - CAFETERIA RECLASS					
1.00	CAFETERIA	11.00	291,952	178,047		1.00
	0		291,952	178,047		
	D - DRUGS CHARGED TO PATIENTS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	79,807		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
	0		0	79,807		
	E - SALARY RECLASS					
1.00	ADMINISTRATIVE & GENERAL	5.00	2,662,524	0		1.00
	0		2,662,524	0		
	G - DEPRECIATION					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	405,436		1.00
	0		0	405,436		
	H - EQUIP & BLDG LEASE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	85,800		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	124,298		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
	0		0	210,098		
	I - IMPLANTABLE MEDICAL SUP.					
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	326,892		1.00
	0		0	326,892		
	J - RECLASS TAXES					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	7,569		1.00
	0		0	7,569		
	K - INTEREST EXPENSE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	498,011		1.00
	0		0	498,011		
	L - INSURANCE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	35,179		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	28,268		2.00
	0		0	63,447		
500.00	Grand Total: Increases		3,100,739	1,790,083		500.00

RECLASSIFICATIONS | Provider CCN: 15-1310 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-6 | Date/Time Prepared: 5/29/2018 9:58 am

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - REHAB THERAPY RECLASS						
1.00	PHYSICAL THERAPY	66.00	141,292	20,776	0		1.00
2.00		0.00	0	0	0		2.00
	0		141,292	20,776			
	B - CLINIC DIETICIAN						
1.00	DIETARY	10.00	4,971	0	0		1.00
	0		4,971	0			
	C - CAFETERIA RECLASS						
1.00	DIETARY	10.00	291,952	178,047	0		1.00
	0		291,952	178,047			
	D - DRUGS CHARGED TO PATIENTS						
1.00	PHARMACY	15.00	0	75,352	0		1.00
2.00	RADIOLOGY-DIAGNOSTIC	54.00	0	4,217	0		2.00
3.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	197	0		3.00
4.00	EMERGENCY	91.00	0	41	0		4.00
	0		0	79,807			
	E - SALARY RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	2,662,524	0		1.00
	0		0	2,662,524			
	G - DEPRECIATION						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	405,436	9		1.00
	0		0	405,436			
	H - EQUIP & BLDG LEASE						
1.00	PHYSICAL THERAPY	66.00	0	85,800	10		1.00
2.00	RADIOLOGY-DIAGNOSTIC	54.00	0	445	10		2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	745	10		3.00
4.00	ADMINISTRATIVE & GENERAL	5.00	0	6,720	10		4.00
5.00	OPERATION OF PLANT	7.00	0	285	10		5.00
6.00	NURSING ADMINISTRATION	13.00	0	1,065	10		6.00
7.00	PHARMACY	15.00	0	9,879	10		7.00
8.00	ADULTS & PEDIATRICS	30.00	0	512	10		8.00
9.00	OPERATING ROOM	50.00	0	95,215	10		9.00
10.00	ELECTROCARDIOLOGY	69.00	0	1,737	10		10.00
11.00	PHYSICAL THERAPY	66.00	0	6,730	10		11.00
12.00	EMERGENCY	91.00	0	965	10		12.00
	0		0	210,098			
	I - IMPLANTABLE MEDICAL SUP.						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	326,892	0		1.00
	0		0	326,892			
	J - RECLASS TAXES						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	7,569	10		1.00
	0		0	7,569			
	K - INTEREST EXPENSE						
1.00	INTEREST EXPENSE	113.00	0	498,011	11		1.00
	0		0	498,011			
	L - INSURANCE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	63,447	12		1.00
2.00		0.00	0	0	12		2.00
	0		0	63,447			
500.00	Grand Total: Decreases		438,215	4,452,607			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1310 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-7 Part I | Date/Time Prepared: 5/29/2018 9:58 am

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	1,295,014	0	0	0	0	1.00
2.00	Land Improvements	314,699	0	0	0	0	2.00
3.00	Buildings and Fixtures	12,586,529	0	0	0	0	3.00
4.00	Building Improvements	4,150,859	0	0	0	0	4.00
5.00	Fixed Equipment	921,093	0	0	0	0	5.00
6.00	Movable Equipment	14,181,638	321,735	0	321,735	4,931	6.00
7.00	HIT designated Assets	2,108,409	199,434	0	199,434	6,475	7.00
8.00	Subtotal (sum of lines 1-7)	35,558,241	521,169	0	521,169	11,406	8.00
9.00	Reconciling Items	10,046	299,271	0	299,271	0	9.00
10.00	Total (line 8 minus line 9)	35,548,195	221,898	0	221,898	11,406	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	1,295,014	0	1.00
2.00	Land Improvements	314,699	211,729	2.00
3.00	Buildings and Fixtures	12,586,529	12,521,286	3.00
4.00	Building Improvements	4,150,859	2,749,486	4.00
5.00	Fixed Equipment	921,093	644,215	5.00
6.00	Movable Equipment	14,498,442	11,828,723	6.00
7.00	HIT designated Assets	2,301,368	1,476,650	7.00
8.00	Subtotal (sum of lines 1-7)	36,068,004	29,432,089	8.00
9.00	Reconciling Items	309,317	0	9.00
10.00	Total (line 8 minus line 9)	35,758,687	29,432,089	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1310 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-7 Part II | Date/Time Prepared: 5/29/2018 9:58 am

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	8,744,320	0	0	0	7,569	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	8,744,320	0	0	0	7,569	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	8,751,889	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	2.00
3.00	Total (sum of lines 1-2)	0	8,751,889	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1310 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-7 Part III Date/Time Prepared: 5/29/2018 9:58 am

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	COMPUTATION OF RATIOS: Capitalized Leases	COMPUTATION OF RATIOS: Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	ALLOCATION OF OTHER CAPITAL: Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	19,268,194	0	19,268,194	0.570628	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	14,498,443	0	14,498,443	0.429372	0	2.00
3.00	Total (sum of lines 1-2)	33,766,637	0	33,766,637	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	ALLOCATION OF OTHER CAPITAL: Other Capital-Related Costs	ALLOCATION OF OTHER CAPITAL: Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	SUMMARY OF CAPITAL: Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	168,659	93,369	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	361,248	124,298	2.00
3.00	Total (sum of lines 1-2)	0	0	0	529,907	217,667	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	SUMMARY OF CAPITAL: Insurance (see instructions)	SUMMARY OF CAPITAL: Taxes (see instructions)	SUMMARY OF CAPITAL: Other Capital-Related Costs (see instructions)	SUMMARY OF CAPITAL: Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	35,179	7,569	0	304,776	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	28,268	0	0	513,814	2.00
3.00	Total (sum of lines 1-2)	0	63,447	7,569	0	818,590	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1310 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-8 | Date/Time Prepared: 5/29/2018 9:58 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	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)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)	A	-4,351	OPERATION OF PLANT	7.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-651,399			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	-3,680,068			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-167,917	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	-356,003	PHARMACY	15.00	0	17.00
18.00	Sale of medical records and abstracts		0		0.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines	B	0	OPERATION OF PLANT	7.00	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	*** Cost Center Deleted ***	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	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1310 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-8 | Date/Time Prepared: 5/29/2018 9:58 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.00	DEPRECIATION - - HIT ASSETS 2016	A	-54,759	ADMINISTRATIVE & GENERAL	5.00	0	33.00
33.01	DEPRECIATION - - HIT ASSETS PRIOR	A	-44,188	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.01
34.00	RECRUITMENT	A	-2,377	ADMINISTRATIVE & GENERAL	5.00	0	34.00
38.00	SELF INSURANCE ADJUSTMENT	A	-1,125,864	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	38.00
39.00	LOBBYING	A	-3,422	ADMINISTRATIVE & GENERAL	5.00	0	39.00
40.00	MARKETING	A	-453	ADMINISTRATIVE & GENERAL	5.00	0	40.00
42.00	LIQUOR ADJUSTMENT	A	-347	ADMINISTRATIVE & GENERAL	5.00	0	42.00
44.00	DEPRECIATION REDUCTION FOR ACCELERAT	A	-8,170,225	CAP REL COSTS-BLDG & FIXT	1.00	9	44.00
45.00	TELEMETRY MONITORING	A	17,434	ADULTS & PEDIATRICS	30.00	0	45.00
45.01	FITNESS CENTER	B	-876	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	45.01
45.02	PURCHASING DISCOUNTS	A	-3,162	ADMINISTRATIVE & GENERAL	5.00	0	45.02
46.01	CAPITALIZED INTEREST EXPENSE	A	-498,011	CAP REL COSTS-BLDG & FIXT	1.00	11	46.01
48.00	OTHER OPERATING REV	A	-679,607	RADIOLOGY-DIAGNOSTIC	54.00	0	48.00
49.00	OTHER OPERATING REV	A	-85,479	LABORATORY	60.00	0	49.00
49.01	REMOVE EMS INTERSUBISDY	A	-2,109	ADMINISTRATIVE & GENERAL	5.00	0	49.01
49.05	PHYSICIAN CLINIC RENT OFFSET	B	-113,642	OPERATION OF PLANT	7.00	0	49.05
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-15,626,825				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: 15-1310 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-8-1 | Date/Time Prepared: 5/29/2018 9:58 am

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE ALLOCATION	6,236,867	5,256,000	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	RELATED PARTY SUBSIDY ADJ.	0	4,660,935	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.			6,236,867	9,916,935	5.00

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

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

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

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

6.00	B		0.00	PARKVIEW HEALTH	100.00	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: 15-1310	Period: From 01/01/2017 To 12/31/2017	Worksheet A-8-1 Date/Time Prepared: 5/29/2018 9:58 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	980,867	0		1.00
2.00	-4,660,935	0		2.00
3.00	0	0		3.00
4.00	0	0		4.00
5.00	-3,680,068			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	HEALTH SYSTEM		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: 15-1310 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-8-2 | Date/Time Prepared: 5/29/2018 9:58 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	91.00	DR. A	40,000	0	40,000	0	0	1.00
2.00	91.00	DR. B	1,678,241	648,620	1,029,621	0	0	2.00
3.00	30.00	DR. C	9,900	0	9,900	0	0	3.00
4.00	90.01	DR. D	20,851	0	20,851	0	0	4.00
5.00	5.00	DR. E	2,779	2,779	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			1,751,771	651,399	1,100,372		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	91.00	DR. A	0	0	0	0	0	1.00
2.00	91.00	DR. B	0	0	0	0	0	2.00
3.00	30.00	DR. C	0	0	0	0	0	3.00
4.00	90.01	DR. D	0	0	0	0	0	4.00
5.00	5.00	DR. E	0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	91.00	DR. A	0	0	0	0		1.00
2.00	91.00	DR. B	0	0	0	648,620		2.00
3.00	30.00	DR. C	0	0	0	0		3.00
4.00	90.01	DR. D	0	0	0	0		4.00
5.00	5.00	DR. E	0	0	0	2,779		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	651,399		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1310 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part I Date/Time Prepared: 5/29/2018 9:58 am

		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	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	304,776	304,776				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	513,814		513,814			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,650,458	2,047	3,451	2,655,956		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	7,391,939	85,125	143,513	847,232	8,467,809	5.00
7.00	00700	OPERATION OF PLANT	892,472	6,970	11,750	64,941	976,133	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	432,501	6,016	10,143	53,858	502,518	9.00
10.00	01000	DIETARY	225,978	12,188	20,547	36,811	295,524	10.00
11.00	01100	CAFETERIA	302,082	3,780	6,372	76,561	388,795	11.00
13.00	01300	NURSING ADMINISTRATION	395,022	5,178	8,730	99,155	508,085	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	9,813	16,544	0	26,357	14.00
15.00	01500	PHARMACY	762,869	15,611	26,318	162,755	967,553	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,711,691	30,490	51,402	281,529	2,075,112	30.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	941,471	25,137	42,378	139,627	1,148,613	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	44	420	709	0	1,173	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	973,224	17,445	29,409	209,817	1,229,895	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
60.00	06000	LABORATORY	1,286,743	7,425	12,517	0	1,306,685	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
66.00	06600	PHYSICAL THERAPY	946,841	1,416	2,387	237,623	1,188,267	66.00
67.00	06700	OCCUPATIONAL THERAPY	89,202	0	0	20,393	109,595	67.00
68.00	06800	SPEECH PATHOLOGY	72,866	0	0	16,659	89,525	68.00
69.00	06900	ELECTROCARDIOLOGY	569,325	9,074	15,297	142,253	735,949	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	370,277	0	0	0	370,277	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	326,892	0	0	0	326,892	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,787,378	0	0	0	1,787,378	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	122,723	0	0	1,304	124,027	90.00
90.01	09001	SENIOR CARE	239,726	3,645	6,145	38,796	288,312	90.01
91.00	09100	EMERGENCY	2,392,294	6,449	10,872	154,905	2,564,520	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	211,923	2,227	3,754	44,524	262,428	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	174,749	0	0	17,391	192,140	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	26,089,280	250,456	422,238	2,646,134	25,933,562	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	1,966	3,315	0	5,281	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	40,240	38,141	64,300	9,822	152,503	192.00
194.00	07950	FITNESS CENTER	0	9,492	16,002	0	25,494	194.00
194.01	07951	FOUNDATION	-185,645	1,344	2,266	0	-182,035	194.01
194.02	07952	NEW DIRECTION	0	0	0	0	0	194.02
194.03	07953	COMMUNITY & VOLUNTEER SERVICES	63,388	258	435	0	64,081	194.03
194.04	07956	OTHER NONREIMBURSABLE COST CENTERS	0	3,119	5,258	0	8,377	194.04
194.05	07955	OCCUPATIONAL HEALTH	0	0	0	0	0	194.05
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	26,007,263	304,776	513,814	2,655,956	26,007,263	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1310 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part I Date/Time Prepared: 5/29/2018 9:58 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	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	8,467,809					5.00
7.00	00700	OPERATION OF PLANT	468,489	1,444,622				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0			8.00
9.00	00900	HOUSEKEEPING	241,180	51,315	0	795,013		9.00
10.00	01000	DIETARY	141,835	103,951	0	59,314	600,624	10.00
11.00	01100	CAFETERIA	186,600	32,240	0	18,396	0	11.00
13.00	01300	NURSING ADMINISTRATION	243,852	44,167	0	25,201	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	12,650	83,702	0	47,760	0	14.00
15.00	01500	PHARMACY	464,371	133,151	0	75,975	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	995,938	260,054	0	148,386	600,624	30.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	551,270	214,400	0	122,335	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	563	3,585	0	2,045	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	590,281	148,789	0	84,898	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
60.00	06000	LABORATORY	627,136	63,326	0	36,134	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
66.00	06600	PHYSICAL THERAPY	570,302	12,074	0	6,889	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	52,599	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	42,967	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	353,214	77,392	0	44,159	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	177,712	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	156,890	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	857,841	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	59,526	0	0	0	0	90.00
90.01	09001	SENIOR CARE	138,374	31,087	0	17,738	0	90.01
91.00	09100	EMERGENCY	1,230,833	55,004	0	31,385	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	125,951	18,992	0	10,837	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	92,216	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	8,382,590	1,333,229	0	731,452	600,624	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,535	16,770	0	9,569	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	35,673	0	0	0	0	192.00
194.00	07950	FITNESS CENTER	12,236	80,956	0	46,193	0	194.00
194.01	07951	FOUNDATION	0	11,466	0	6,543	0	194.01
194.02	07952	NEW DIRECTION	0	0	0	0	0	194.02
194.03	07953	COMMUNITY & VOLUNTEER SERVICES	30,755	2,201	0	1,256	0	194.03
194.04	07956	OTHER NONREIMBURSABLE COST CENTERS	4,020	0	0	0	0	194.04
194.05	07955	OCCUPATIONAL HEALTH	0	0	0	0	0	194.05
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	8,467,809	1,444,622	0	795,013	600,624	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1310 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part I | Date/Time Prepared: 5/29/2018 9:58 am

		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
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	626,031					11.00
13.00	01300	NURSING ADMINISTRATION	30,306	851,611				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	170,469			14.00
15.00	01500	PHARMACY	53,722	0	11,655	1,706,427		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	126,074	425,976	9,076	271	0	30.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	57,040	192,753	28,688	115,407	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	2,514	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	92,897	0	4,178	4,624	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
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
66.00	06600	PHYSICAL THERAPY	0	0	3,573	14,999	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	5,104	0	260	1,131	0	67.00
68.00	06800	SPEECH PATHOLOGY	5,551	0	0	242	0	68.00
69.00	06900	ELECTROCARDIOLOGY	169,267	0	1,421	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	53,090	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	41,788	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,567,096	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	574	0	12	0	0	90.00
90.01	09001	SENIOR CARE	16,589	0	67	0	0	90.01
91.00	09100	EMERGENCY	68,907	232,882	15,005	143	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	1,157	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	383	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	626,031	851,611	170,353	1,706,427	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	111	0	0	192.00
194.00	07950	FITNESS CENTER	0	0	0	0	0	194.00
194.01	07951	FOUNDATION	0	0	0	0	0	194.01
194.02	07952	NEW DIRECTION	0	0	0	0	0	194.02
194.03	07953	COMMUNITY & VOLUNTEER SERVICES	0	0	5	0	0	194.03
194.04	07956	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.04
194.05	07955	OCCUPATIONAL HEALTH	0	0	0	0	0	194.05
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	626,031	851,611	170,469	1,706,427	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1310 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part I Date/Time Prepared: 5/29/2018 9:58 am

		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
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	4,641,511	0	4,641,511		30.00
43.00	04300	NURSERY	0	0	0		43.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	2,430,506	0	2,430,506		50.00
51.00	05100	RECOVERY ROOM	0	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
53.00	05300	ANESTHESIOLOGY	9,880	0	9,880		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,155,562	0	2,155,562		54.00
56.00	05600	RADIOISOTOPE	0	0	0		56.00
60.00	06000	LABORATORY	2,033,281	0	2,033,281		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0		63.00
66.00	06600	PHYSICAL THERAPY	1,796,104	0	1,796,104		66.00
67.00	06700	OCCUPATIONAL THERAPY	168,689	0	168,689		67.00
68.00	06800	SPEECH PATHOLOGY	138,285	0	138,285		68.00
69.00	06900	ELECTROCARDIOLOGY	1,381,402	0	1,381,402		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	601,079	0	601,079		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	525,570	0	525,570		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,212,315	0	4,212,315		73.00
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	184,139	0	184,139		90.00
90.01	09001	SENIOR CARE	492,167	0	492,167		90.01
91.00	09100	EMERGENCY	4,198,679	0	4,198,679		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0			92.00
		OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY	419,365	0	419,365		101.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
116.00	11600	HOSPICE	284,739	0	284,739		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	25,673,273	0	25,673,273		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	34,155	0	34,155		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	188,287	0	188,287		192.00
194.00	07950	FITNESS CENTER	164,879	0	164,879		194.00
194.01	07951	FOUNDATION	-164,026	0	-164,026		194.01
194.02	07952	NEW DIRECTION	0	0	0		194.02
194.03	07953	COMMUNITY & VOLUNTEER SERVICES	98,298	0	98,298		194.03
194.04	07956	OTHER NONREIMBURSABLE COST CENTERS	12,397	0	12,397		194.04
194.05	07955	OCCUPATIONAL HEALTH	0	0	0		194.05
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 through 201)	26,007,263	0	26,007,263		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1310 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part II Date/Time Prepared: 5/29/2018 9:58 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS 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	2,047	3,451	5,498	5,498	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	633,683	85,125	143,513	862,321	1,754	5.00
7.00	00700	OPERATION OF PLANT	0	6,970	11,750	18,720	134	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	0	6,016	10,143	16,159	112	9.00
10.00	01000	DIETARY	0	12,188	20,547	32,735	76	10.00
11.00	01100	CAFETERIA	0	3,780	6,372	10,152	159	11.00
13.00	01300	NURSING ADMINISTRATION	0	5,178	8,730	13,908	205	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	9,813	16,544	26,357	0	14.00
15.00	01500	PHARMACY	0	15,611	26,318	41,929	337	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	30,490	51,402	81,892	583	30.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	25,137	42,378	67,515	289	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	420	709	1,129	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	17,445	29,409	46,854	434	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
60.00	06000	LABORATORY	0	7,425	12,517	19,942	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
66.00	06600	PHYSICAL THERAPY	0	1,416	2,387	3,803	492	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	42	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	34	68.00
69.00	06900	ELECTROCARDIOLOGY	0	9,074	15,297	24,371	295	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	3	90.00
90.01	09001	SENIOR CARE	0	3,645	6,145	9,790	80	90.01
91.00	09100	EMERGENCY	0	6,449	10,872	17,321	321	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	2,227	3,754	5,981	92	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0	36	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	633,683	250,456	422,238	1,306,377	5,478	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	1,966	3,315	5,281	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	38,141	64,300	102,441	20	192.00
194.00	07950	FITNESS CENTER	0	9,492	16,002	25,494	0	194.00
194.01	07951	FOUNDATION	0	1,344	2,266	3,610	0	194.01
194.02	07952	NEW DIRECTION	0	0	0	0	0	194.02
194.03	07953	COMMUNITY & VOLUNTEER SERVICES	0	258	435	693	0	194.03
194.04	07956	OTHER NONREIMBURSABLE COST CENTERS	0	3,119	5,258	8,377	0	194.04
194.05	07955	OCCUPATIONAL HEALTH	0	0	0	0	0	194.05
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	633,683	304,776	513,814	1,452,273	5,498	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1310 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part II Date/Time Prepared: 5/29/2018 9:58 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	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	864,075					5.00
7.00	00700	OPERATION OF PLANT	47,806	66,660				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0			8.00
9.00	00900	HOUSEKEEPING	24,611	2,368	0	43,250		9.00
10.00	01000	DIETARY	14,473	4,797	0	3,227	55,308	10.00
11.00	01100	CAFETERIA	19,041	1,488	0	1,001	0	11.00
13.00	01300	NURSING ADMINISTRATION	24,883	2,038	0	1,371	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,291	3,862	0	2,598	0	14.00
15.00	01500	PHARMACY	47,386	6,144	0	4,133	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	101,629	12,000	0	8,072	55,308	30.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	56,253	9,893	0	6,655	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	57	165	0	111	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	60,234	6,866	0	4,619	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
60.00	06000	LABORATORY	63,995	2,922	0	1,966	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
66.00	06600	PHYSICAL THERAPY	58,195	557	0	375	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	5,367	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	4,384	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	36,043	3,571	0	2,402	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	18,134	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	16,010	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	87,537	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	6,074	0	0	0	0	90.00
90.01	09001	SENIOR CARE	14,120	1,434	0	965	0	90.01
91.00	09100	EMERGENCY	125,594	2,538	0	1,707	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	12,852	876	0	590	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	9,410	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	855,379	61,519	0	39,792	55,308	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	259	774	0	521	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	3,640	0	0	0	0	192.00
194.00	07950	FITNESS CENTER	1,249	3,736	0	2,513	0	194.00
194.01	07951	FOUNDATION	0	529	0	356	0	194.01
194.02	07952	NEW DIRECTION	0	0	0	0	0	194.02
194.03	07953	COMMUNITY & VOLUNTEER SERVICES	3,138	102	0	68	0	194.03
194.04	07956	OTHER NONREIMBURSABLE COST CENTERS	410	0	0	0	0	194.04
194.05	07955	OCCUPATIONAL HEALTH	0	0	0	0	0	194.05
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	864,075	66,660	0	43,250	55,308	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1310 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part II Date/Time Prepared: 5/29/2018 9:58 am

		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
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	31,841					11.00
13.00	01300	NURSING ADMINISTRATION	1,541	43,946				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	34,108			14.00
15.00	01500	PHARMACY	2,732	0	2,332	104,993		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,412	21,981	1,816	17	0	30.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,901	9,947	5,740	7,101	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	155	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,725	0	836	285	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
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
66.00	06600	PHYSICAL THERAPY	0	0	715	923	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	260	0	52	70	0	67.00
68.00	06800	SPEECH PATHOLOGY	282	0	0	15	0	68.00
69.00	06900	ELECTROCARDIOLOGY	8,610	0	284	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	10,624	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	8,361	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	96,418	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	29	0	2	0	0	90.00
90.01	09001	SENIOR CARE	844	0	13	0	0	90.01
91.00	09100	EMERGENCY	3,505	12,018	3,002	9	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	231	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	77	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	31,841	43,946	34,085	104,993	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	22	0	0	192.00
194.00	07950	FITNESS CENTER	0	0	0	0	0	194.00
194.01	07951	FOUNDATION	0	0	0	0	0	194.01
194.02	07952	NEW DIRECTION	0	0	0	0	0	194.02
194.03	07953	COMMUNITY & VOLUNTEER SERVICES	0	0	1	0	0	194.03
194.04	07956	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.04
194.05	07955	OCCUPATIONAL HEALTH	0	0	0	0	0	194.05
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	31,841	43,946	34,108	104,993	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1310 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part II | Date/Time Prepared: 5/29/2018 9:58 am

		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
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	289,710	0	289,710		30.00
43.00	04300	NURSERY	0	0	0		43.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	166,294	0	166,294		50.00
51.00	05100	RECOVERY ROOM	0	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
53.00	05300	ANESTHESIOLOGY	1,617	0	1,617		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	124,853	0	124,853		54.00
56.00	05600	RADIOISOTOPE	0	0	0		56.00
60.00	06000	LABORATORY	88,825	0	88,825		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0		63.00
66.00	06600	PHYSICAL THERAPY	65,060	0	65,060		66.00
67.00	06700	OCCUPATIONAL THERAPY	5,791	0	5,791		67.00
68.00	06800	SPEECH PATHOLOGY	4,715	0	4,715		68.00
69.00	06900	ELECTROCARDIOLOGY	75,576	0	75,576		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	28,758	0	28,758		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	24,371	0	24,371		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	183,955	0	183,955		73.00
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	6,108	0	6,108		90.00
90.01	09001	SENIOR CARE	27,246	0	27,246		90.01
91.00	09100	EMERGENCY	166,015	0	166,015		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0			92.00
		OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY	20,622	0	20,622		101.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
116.00	11600	HOSPICE	9,523	0	9,523		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,289,039	0	1,289,039		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	6,835	0	6,835		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	106,123	0	106,123		192.00
194.00	07950	FITNESS CENTER	32,992	0	32,992		194.00
194.01	07951	FOUNDATION	4,495	0	4,495		194.01
194.02	07952	NEW DIRECTION	0	0	0		194.02
194.03	07953	COMMUNITY & VOLUNTEER SERVICES	4,002	0	4,002		194.03
194.04	07956	OTHER NONREIMBURSABLE COST CENTERS	8,787	0	8,787		194.04
194.05	07955	OCCUPATIONAL HEALTH	0	0	0		194.05
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 through 201)	1,452,273	0	1,452,273		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1310 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B-1 | Date/Time Prepared: 5/29/2018 9:58 am

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS 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	124,010					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		124,010				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	833	833	10,128,046			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	34,637	34,637	3,230,794	-8,467,809	17,643,313	5.00
7.00	00700	OPERATION OF PLANT	2,836	2,836	247,640	0	976,133	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	2,448	2,448	205,380	0	502,518	9.00
10.00	01000	DIETARY	4,959	4,959	140,372	0	295,524	10.00
11.00	01100	CAFETERIA	1,538	1,538	291,952	0	388,795	11.00
13.00	01300	NURSING ADMINISTRATION	2,107	2,107	378,111	0	508,085	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3,993	3,993	0	0	26,357	14.00
15.00	01500	PHARMACY	6,352	6,352	620,640	0	967,553	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	12,406	12,406	1,073,563	0	2,075,112	30.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	10,228	10,228	532,443	0	1,148,613	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	171	171	0	0	1,173	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,098	7,098	800,100	0	1,229,895	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
60.00	06000	LABORATORY	3,021	3,021	0	0	1,306,685	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
66.00	06600	PHYSICAL THERAPY	576	576	906,134	0	1,188,267	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	77,767	0	109,595	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	63,525	0	89,525	68.00
69.00	06900	ELECTROCARDIOLOGY	3,692	3,692	542,456	0	735,949	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	370,277	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	326,892	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	1,787,378	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	4,971	0	124,027	90.00
90.01	09001	SENIOR CARE	1,483	1,483	147,941	0	288,312	90.01
91.00	09100	EMERGENCY	2,624	2,624	590,705	0	2,564,520	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	906	906	169,783	0	262,428	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	66,316	0	192,140	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	101,908	101,908	10,090,593	-8,467,809	17,465,753	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	800	800	0	0	5,281	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	15,519	15,519	37,453	-78,176	74,327	192.00
194.00	07950	FITNESS CENTER	3,862	3,862	0	0	25,494	194.00
194.01	07951	FOUNDATION	547	547	0	182,035	0	194.01
194.02	07952	NEW DIRECTION	0	0	0	0	0	194.02
194.03	07953	COMMUNITY & VOLUNTEER SERVICES	105	105	0	0	64,081	194.03
194.04	07956	OTHER NONREIMBURSABLE COST CENTERS	1,269	1,269	0	0	8,377	194.04
194.05	07955	OCCUPATIONAL HEALTH	0	0	0	0	0	194.05
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)	304,776	513,814	2,655,956		8,467,809	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	2.457673	4.143327	0.262238		0.479944	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			5,498		864,075	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000543		0.048975	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1310 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B-1 | Date/Time Prepared: 5/29/2018 9:58 am

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDR)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (HOURS)	
			7.00	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
7.00	00700	OPERATION OF PLANT	68,916					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	10,000				8.00
9.00	00900	HOUSEKEEPING	2,448	0	66,468			9.00
10.00	01000	DIETARY	4,959	62	4,959	20,693		10.00
11.00	01100	CAFETERIA	1,538	0	1,538	0	9,812	11.00
13.00	01300	NURSING ADMINISTRATION	2,107	0	2,107	0	475	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3,993	0	3,993	0	0	14.00
15.00	01500	PHARMACY	6,352	0	6,352	0	842	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	12,406	3,883	12,406	20,693	1,976	30.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	10,228	783	10,228	0	894	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	171	0	171	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,098	1,956	7,098	0	1,456	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
60.00	06000	LABORATORY	3,021	0	3,021	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
66.00	06600	PHYSICAL THERAPY	576	0	576	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	80	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	87	68.00
69.00	06900	ELECTROCARDIOLOGY	3,692	27	3,692	0	2,653	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	9	90.00
90.01	09001	SENIOR CARE	1,483	0	1,483	0	260	90.01
91.00	09100	EMERGENCY	2,624	3,126	2,624	0	1,080	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	906	0	906	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	63,602	9,837	61,154	20,693	9,812	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	800	0	800	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	163	0	0	0	192.00
194.00	07950	FITNESS CENTER	3,862	0	3,862	0	0	194.00
194.01	07951	FOUNDATION	547	0	547	0	0	194.01
194.02	07952	NEW DIRECTION	0	0	0	0	0	194.02
194.03	07953	COMMUNITY & VOLUNTEER SERVICES	105	0	105	0	0	194.03
194.04	07956	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.04
194.05	07955	OCCUPATIONAL HEALTH	0	0	0	0	0	194.05
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)	1,444,622	0	795,013	600,624	626,031	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	20.962070	0.000000	11.960838	29.025468	63.802589	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	66,660	0	43,250	55,308	31,841	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.967264	0.000000	0.650689	2.672788	3.245108	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1310 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B-1 | Date/Time Prepared: 5/29/2018 9:58 am

		Cost Center Description	NURSING ADMINISTRATION (DIRECT NRS ING HR)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS REV)		
			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
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	82,403					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,333,503				14.00
15.00	01500	PHARMACY	0	91,175	359,052			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	41,218	70,999	57	0		30.00
43.00	04300	NURSERY	0	0	0	0		43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	18,651	224,415	24,283	0		50.00
51.00	05100	RECOVERY ROOM	0	0	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0	529	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	32,681	973	0		54.00
56.00	05600	RADIOISOTOPE	0	0	0	0		56.00
60.00	06000	LABORATORY	0	0	0	0		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0		63.00
66.00	06600	PHYSICAL THERAPY	0	27,947	3,156	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	2,030	238	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	51	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	11,112	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	415,305	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	326,892	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	329,735	0		73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	92	0	0		90.00
90.01	09001	SENIOR CARE	0	526	0	0		90.01
91.00	09100	EMERGENCY	22,534	117,381	30	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	9,048	0	0		101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	2,994	0	0		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	82,403	1,332,597	359,052	0		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	868	0	0		192.00
194.00	07950	FITNESS CENTER	0	0	0	0		194.00
194.01	07951	FOUNDATION	0	0	0	0		194.01
194.02	07952	NEW DIRECTION	0	0	0	0		194.02
194.03	07953	COMMUNITY & VOLUNTEER SERVICES	0	38	0	0		194.03
194.04	07956	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0		194.04
194.05	07955	OCCUPATIONAL HEALTH	0	0	0	0		194.05
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)	851,611	170,469	1,706,427	0		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	10.334709	0.127835	4.752590	0.000000		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	43,946	34,108	104,993	0		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.533306	0.025578	0.292417	0.000000		205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1310 | Period: From 01/01/2017 To 12/31/2017 | Worksheet C Part I Date/Time Prepared: 5/29/2018 9:58 am

Title XVIII | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,641,511		4,641,511	0	0	30.00
43.00	04300	NURSERY	0		0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,430,506		2,430,506	0	0	50.00
51.00	05100	RECOVERY ROOM	0		0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0		0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	9,880		9,880	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,155,562		2,155,562	0	0	54.00
56.00	05600	RADIOISOTOPE	0		0	0	0	56.00
60.00	06000	LABORATORY	2,033,281		2,033,281	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0		0	0	0	63.00
66.00	06600	PHYSICAL THERAPY	1,796,104	0	1,796,104	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	168,689	0	168,689	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	138,285	0	138,285	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	1,381,402		1,381,402	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	601,079		601,079	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	525,570		525,570	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,212,315		4,212,315	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	184,139		184,139	0	0	90.00
90.01	09001	SENIOR CARE	492,167		492,167	0	0	90.01
91.00	09100	EMERGENCY	4,198,679		4,198,679	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,326,476		1,326,476		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	419,365		419,365		0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	284,739		284,739		0	116.00
200.00		Subtotal (see instructions)	26,999,749	0	26,999,749	0	0	200.00
201.00		Less Observation Beds	1,326,476		1,326,476		0	201.00
202.00		Total (see instructions)	25,673,273	0	25,673,273	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1310 | Period: From 01/01/2017 To 12/31/2017 | Worksheet C Part I Date/Time Prepared: 5/29/2018 9:58 am

Title XVIII | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,532,591		3,532,591			30.00
43.00	04300	NURSERY	0		0			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	201,640	8,716,513	8,918,153	0.272535	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0.000000	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0.000000	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	34,575	1,242,237	1,276,812	0.007738	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,092,863	25,325,207	26,418,070	0.081594	0.000000	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0.000000	0.000000	56.00
60.00	06000	LABORATORY	911,061	10,642,325	11,553,386	0.175990	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0.000000	0.000000	63.00
66.00	06600	PHYSICAL THERAPY	177,305	3,603,052	3,780,357	0.475115	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	110,516	166,882	277,398	0.608112	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	18,924	62,783	81,707	1.692450	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	994,401	2,237,111	3,231,512	0.427479	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	80,053	1,822,163	1,902,216	0.315989	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	352	1,771,148	1,771,500	0.296681	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,629,542	13,497,939	15,127,481	0.278454	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	751,050	751,050	0.245175	0.000000	90.00
90.01	09001	SENIOR CARE	0	461,516	461,516	1.066414	0.000000	90.01
91.00	09100	EMERGENCY	397,850	13,434,399	13,832,249	0.303543	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	1,058,992	1,058,992	1.252584	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	165,297	165,297			101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	200,368	200,368			116.00
200.00		Subtotal (see instructions)	9,181,673	85,158,982	94,340,655			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	9,181,673	85,158,982	94,340,655			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1310 | Period: From 01/01/2017 To 12/31/2017 | Worksheet C Part I Date/Time Prepared: 5/29/2018 9:58 am

Title XVIII | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
43.00	04300	NURSERY			43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
51.00	05100	RECOVERY ROOM	0.000000		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
56.00	05600	RADIOISOTOPE	0.000000		56.00
60.00	06000	LABORATORY	0.000000		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000		63.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0.000000		90.00
90.01	09001	SENIOR CARE	0.000000		90.01
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
		OTHER REIMBURSABLE COST CENTERS			
101.00	10100	HOME HEALTH AGENCY			101.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
116.00	11600	HOSPICE			116.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1310 | Period: From 01/01/2017 To 12/31/2017 | Worksheet C Part I Date/Time Prepared: 5/29/2018 9:58 am

Title XIX | 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	4,641,511		4,641,511	0	4,641,511	30.00
43.00	04300	NURSERY	0		0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,430,506		2,430,506	0	2,430,506	50.00
51.00	05100	RECOVERY ROOM	0		0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0		0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	9,880		9,880	0	9,880	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,155,562		2,155,562	0	2,155,562	54.00
56.00	05600	RADIOISOTOPE	0		0	0	0	56.00
60.00	06000	LABORATORY	2,033,281		2,033,281	0	2,033,281	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0		0	0	0	63.00
66.00	06600	PHYSICAL THERAPY	1,796,104	0	1,796,104	0	1,796,104	66.00
67.00	06700	OCCUPATIONAL THERAPY	168,689	0	168,689	0	168,689	67.00
68.00	06800	SPEECH PATHOLOGY	138,285	0	138,285	0	138,285	68.00
69.00	06900	ELECTROCARDIOLOGY	1,381,402		1,381,402	0	1,381,402	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	601,079		601,079	0	601,079	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	525,570		525,570	0	525,570	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,212,315		4,212,315	0	4,212,315	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	184,139		184,139	0	184,139	90.00
90.01	09001	SENIOR CARE	492,167		492,167	0	492,167	90.01
91.00	09100	EMERGENCY	4,198,679		4,198,679	0	4,198,679	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,326,476		1,326,476		1,326,476	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	419,365		419,365		419,365	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	284,739		284,739		284,739	116.00
200.00		Subtotal (see instructions)	26,999,749	0	26,999,749	0	26,999,749	200.00
201.00		Less Observation Beds	1,326,476		1,326,476		1,326,476	201.00
202.00		Total (see instructions)	25,673,273	0	25,673,273	0	25,673,273	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1310 | Period: From 01/01/2017 To 12/31/2017 | Worksheet C Part I Date/Time Prepared: 5/29/2018 9:58 am

Title XIX | Hospital | PPS

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,532,591		3,532,591			30.00
43.00	04300	NURSERY	0		0			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	201,640	8,716,513	8,918,153	0.272535	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0.000000	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0.000000	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	34,575	1,242,237	1,276,812	0.007738	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,092,863	25,325,207	26,418,070	0.081594	0.000000	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0.000000	0.000000	56.00
60.00	06000	LABORATORY	911,061	10,642,325	11,553,386	0.175990	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0.000000	0.000000	63.00
66.00	06600	PHYSICAL THERAPY	177,305	3,603,052	3,780,357	0.475115	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	110,516	166,882	277,398	0.608112	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	18,924	62,783	81,707	1.692450	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	994,401	2,237,111	3,231,512	0.427479	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	80,053	1,822,163	1,902,216	0.315989	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	352	1,771,148	1,771,500	0.296681	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,629,542	13,497,939	15,127,481	0.278454	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	751,050	751,050	0.245175	0.000000	90.00
90.01	09001	SENIOR CARE	0	461,516	461,516	1.066414	0.000000	90.01
91.00	09100	EMERGENCY	397,850	13,434,399	13,832,249	0.303543	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	1,058,992	1,058,992	1.252584	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	165,297	165,297			101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	200,368	200,368			116.00
200.00		Subtotal (see instructions)	9,181,673	85,158,982	94,340,655			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	9,181,673	85,158,982	94,340,655			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1310 | Period: From 01/01/2017 To 12/31/2017 | Worksheet C Part I Date/Time Prepared: 5/29/2018 9:58 am

Title XIX | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
43.00	04300	NURSERY		43.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.272535	50.00
51.00	05100	RECOVERY ROOM	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0.007738	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.081594	54.00
56.00	05600	RADIOISOTOPE	0.000000	56.00
60.00	06000	LABORATORY	0.175990	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	63.00
66.00	06600	PHYSICAL THERAPY	0.475115	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.608112	67.00
68.00	06800	SPEECH PATHOLOGY	1.692450	68.00
69.00	06900	ELECTROCARDIOLOGY	0.427479	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.315989	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.296681	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.278454	73.00
		OUTPATIENT SERVICE COST CENTERS		
90.00	09000	CLINIC	0.245175	90.00
90.01	09001	SENIOR CARE	1.066414	90.01
91.00	09100	EMERGENCY	0.303543	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.252584	92.00
		OTHER REIMBURSABLE COST CENTERS		
101.00	10100	HOME HEALTH AGENCY		101.00
		SPECIAL PURPOSE COST CENTERS		
113.00	11300	INTEREST EXPENSE		113.00
116.00	11600	HOSPICE		116.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY

Provider CCN: 15-1310 | Period: From 01/01/2017 To 12/31/2017 | Worksheet C Part II Date/Time Prepared: 5/29/2018 9:58 am

Title XIX | Hospital | PPS

		Cost Center Description	Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,430,506	166,294	2,264,212	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	9,880	1,617	8,263	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,155,562	124,853	2,030,709	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
60.00	06000	LABORATORY	2,033,281	88,825	1,944,456	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
66.00	06600	PHYSICAL THERAPY	1,796,104	65,060	1,731,044	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	168,689	5,791	162,898	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	138,285	4,715	133,570	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	1,381,402	75,576	1,305,826	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	601,079	28,758	572,321	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	525,570	24,371	501,199	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,212,315	183,955	4,028,360	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	184,139	6,108	178,031	0	0	90.00
90.01	09001	SENIOR CARE	492,167	27,246	464,921	0	0	90.01
91.00	09100	EMERGENCY	4,198,679	166,015	4,032,664	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,326,476	82,795	1,243,681	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	419,365	20,622	398,743	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	284,739	9,523	275,216	0	0	116.00
200.00		Subtotal (sum of lines 50 thru 199)	22,358,238	1,082,124	21,276,114	0	0	200.00
201.00		Less Observation Beds	1,326,476	82,795	1,243,681	0	0	201.00
202.00		Total (line 200 minus line 201)	21,031,762	999,329	20,032,433	0	0	202.00

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY

Provider CCN: 15-1310 | Period: From 01/01/2017 To 12/31/2017 | Worksheet C Part II | Date/Time Prepared: 5/29/2018 9:58 am

Title XIX | Hospital | PPS

		Cost Center Description	Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)		
			6.00	7.00	8.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	2,430,506	8,918,153	0.272535		50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0.000000		52.00
53.00	05300	ANESTHESIOLOGY	9,880	1,276,812	0.007738		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,155,562	26,418,070	0.081594		54.00
56.00	05600	RADIOISOTOPE	0	0	0.000000		56.00
60.00	06000	LABORATORY	2,033,281	11,553,386	0.175990		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0.000000		63.00
66.00	06600	PHYSICAL THERAPY	1,796,104	3,780,357	0.475115		66.00
67.00	06700	OCCUPATIONAL THERAPY	168,689	277,398	0.608112		67.00
68.00	06800	SPEECH PATHOLOGY	138,285	81,707	1.692450		68.00
69.00	06900	ELECTROCARDIOLOGY	1,381,402	3,231,512	0.427479		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	601,079	1,902,216	0.315989		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	525,570	1,771,500	0.296681		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,212,315	15,127,481	0.278454		73.00
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	184,139	751,050	0.245175		90.00
90.01	09001	SENIOR CARE	492,167	461,516	1.066414		90.01
91.00	09100	EMERGENCY	4,198,679	13,832,249	0.303543		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,326,476	1,058,992	1.252584		92.00
		OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY	419,365	165,297	2.537039		101.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
116.00	11600	HOSPICE	284,739	200,368	1.421080		116.00
200.00		Subtotal (sum of lines 50 thru 199)	22,358,238	90,808,064			200.00
201.00		Less Observation Beds	1,326,476	0			201.00
202.00		Total (line 200 minus line 201)	21,031,762	90,808,064			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-1310 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part II Date/Time Prepared: 5/29/2018 9:58 am

Title XVIII | Hospital | Cost

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	166,294	8,918,153	0.018647	62,072	1,157	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0	0	52.00
53.00	05300	ANESTHESIOLOGY	1,617	1,276,812	0.001266	7,190	9	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	124,853	26,418,070	0.004726	387,363	1,831	54.00
56.00	05600	RADIOISOTOPE	0	0	0.000000	0	0	56.00
60.00	06000	LABORATORY	88,825	11,553,386	0.007688	367,445	2,825	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0.000000	0	0	63.00
66.00	06600	PHYSICAL THERAPY	65,060	3,780,357	0.017210	93,148	1,603	66.00
67.00	06700	OCCUPATIONAL THERAPY	5,791	277,398	0.020876	57,192	1,194	67.00
68.00	06800	SPEECH PATHOLOGY	4,715	81,707	0.057706	8,308	479	68.00
69.00	06900	ELECTROCARDIOLOGY	75,576	3,231,512	0.023387	452,394	10,580	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	28,758	1,902,216	0.015118	49,338	746	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	24,371	1,771,500	0.013757	122	2	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	183,955	15,127,481	0.012160	739,905	8,997	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	6,108	751,050	0.008133	0	0	90.00
90.01	09001	SENIOR CARE	27,246	461,516	0.059036	0	0	90.01
91.00	09100	EMERGENCY	166,015	13,832,249	0.012002	2,846	34	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	82,795	1,058,992	0.078183	0	0	92.00
200.00		Total (lines 50 through 199)	1,051,979	90,442,399		2,227,323	29,457	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1310 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part IV | Date/Time Prepared: 5/29/2018 9:58 am

Title XVIII | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	SENIOR CARE	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1310 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part IV | Date/Time Prepared: 5/29/2018 9:58 am

Title XVIII | Hospital | Cost

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	8,918,153	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	1,276,812	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	26,418,070	0.000000	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0.000000	56.00
60.00	06000	LABORATORY	0	0	0	11,553,386	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0.000000	63.00
66.00	06600	PHYSICAL THERAPY	0	0	0	3,780,357	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	277,398	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	81,707	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	3,231,512	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	1,902,216	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1,771,500	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	15,127,481	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	751,050	0.000000	90.00
90.01	09001	SENIOR CARE	0	0	0	461,516	0.000000	90.01
91.00	09100	EMERGENCY	0	0	0	13,832,249	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	1,058,992	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	90,442,399		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-1310 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part IV | Date/Time Prepared: 5/29/2018 9:58 am

Title XVIII | Hospital | Cost

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	62,072	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	7,190	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	387,363	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
60.00	06000	LABORATORY	0.000000	367,445	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	0	0	63.00
66.00	06600	PHYSICAL THERAPY	0.000000	93,148	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	57,192	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	8,308	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	452,394	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	49,338	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	122	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	739,905	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	SENIOR CARE	0.000000	0	0	0	0	90.01
91.00	09100	EMERGENCY	0.000000	2,846	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		2,227,323	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1310 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part V Date/Time Prepared: 5/29/2018 9:58 am

Title XVIII | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.272535	0	2,089,103	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.007738	0	295,017	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.081594	0	7,813,248	0	0	54.00
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
60.00	06000	LABORATORY	0.175990	0	3,825,416	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	0	0	63.00
66.00	06600	PHYSICAL THERAPY	0.475115	0	1,225,737	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.608112	0	66,982	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	1.692450	0	22,082	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.427479	0	556,942	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.315989	0	323,993	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.296681	0	507,942	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.278454	0	5,099,525	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.245175	0	0	0	0	90.00
90.01	09001	SENIOR CARE	1.066414	0	327,345	0	0	90.01
91.00	09100	EMERGENCY	0.303543	0	3,449,747	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.252584	0	493,099	0	0	92.00
200.00		Subtotal (see instructions)		0	26,096,178	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	26,096,178	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1310 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part V Date/Time Prepared: 5/29/2018 9:58 am

Title XVIII | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	569,354	0		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	2,283	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	637,514	0		54.00
56.00	05600	RADIOISOTOPE	0	0		56.00
60.00	06000	LABORATORY	673,235	0		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0		63.00
66.00	06600	PHYSICAL THERAPY	582,366	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	40,733	0		67.00
68.00	06800	SPEECH PATHOLOGY	37,373	0		68.00
69.00	06900	ELECTROCARDIOLOGY	238,081	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	102,378	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	150,697	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,419,983	0		73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
90.01	09001	SENIOR CARE	349,085	0		90.01
91.00	09100	EMERGENCY	1,047,147	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	617,648	0		92.00
200.00		Subtotal (see instructions)	6,467,877	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	6,467,877	0		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-1310 | Component CCN: 15-Z310 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part V Date/Time Prepared: 5/29/2018 9:58 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.272535	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.007738	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.081594	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
60.00	06000	LABORATORY	0.175990	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	0	0	63.00
66.00	06600	PHYSICAL THERAPY	0.475115	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.608112	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	1.692450	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.427479	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.315989	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.296681	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.278454	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.245175	0	0	0	0	90.00
90.01	09001	SENIOR CARE	1.066414	0	0	0	0	90.01
91.00	09100	EMERGENCY	0.303543	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.252584	0	0	0	0	92.00
200.00		Subtotal (see instructions)		0	0	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-1310 | Component CCN: 15-Z310 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part V | Date/Time Prepared: 5/29/2018 9:58 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
56.00	05600	RADIOISOTOPE	0	0		56.00
60.00	06000	LABORATORY	0	0		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0		63.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
90.01	09001	SENIOR CARE	0	0		90.01
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
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 INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 15-1310 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part I Date/Time Prepared: 5/29/2018 9:58 am

Title XIX | 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	289,710	2,539	287,171	2,488	115.42	30.00
43.00	NURSERY	0		0	0	0.00	43.00
200.00	Total (lines 30 through 199)	289,710		287,171	2,488		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	28	3,232				30.00
43.00	NURSERY	0	0				43.00
200.00	Total (lines 30 through 199)	28	3,232				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-1310 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part II Date/Time Prepared: 5/29/2018 9:58 am

Title XIX | 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	166,294	8,918,153	0.018647	2,775	52	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0	0	52.00
53.00	05300	ANESTHESIOLOGY	1,617	1,276,812	0.001266	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	124,853	26,418,070	0.004726	24,270	115	54.00
56.00	05600	RADIOISOTOPE	0	0	0.000000	0	0	56.00
60.00	06000	LABORATORY	88,825	11,553,386	0.007688	22,602	174	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0.000000	0	0	63.00
66.00	06600	PHYSICAL THERAPY	65,060	3,780,357	0.017210	1,335	23	66.00
67.00	06700	OCCUPATIONAL THERAPY	5,791	277,398	0.020876	502	10	67.00
68.00	06800	SPEECH PATHOLOGY	4,715	81,707	0.057706	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	75,576	3,231,512	0.023387	14,052	329	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	28,758	1,902,216	0.015118	1,792	27	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	24,371	1,771,500	0.013757	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	183,955	15,127,481	0.012160	29,310	356	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	6,108	751,050	0.008133	0	0	90.00
90.01	09001	SENIOR CARE	27,246	461,516	0.059036	0	0	90.01
91.00	09100	EMERGENCY	166,015	13,832,249	0.012002	14,162	170	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	82,989	1,058,992	0.078366	0	0	92.00
200.00		Total (lines 50 through 199)	1,052,173	90,442,399		110,800	1,256	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-1310 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part III Date/Time Prepared: 5/29/2018 9:58 am

Title XIX | Hospital | PPS

		Cost Center Description	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
			1A	1.00	2A	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
200.00		Total (lines 30 through 199)	0	0	0	0	0	200.00

		Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
			4.00	5.00	6.00	7.00	8.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	2,488	0.00	28	30.00
43.00	04300	NURSERY		0	0	0.00	0	43.00
200.00		Total (lines 30 through 199)		0	2,488		28	200.00

		Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
			9.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS	0	30.00
43.00	04300	NURSERY	0	43.00
200.00		Total (lines 30 through 199)	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1310 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part IV | Date/Time Prepared: 5/29/2018 9:58 am

Title XIX | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	SENIOR CARE	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1310 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part IV Date/Time Prepared: 5/29/2018 9:58 am

Title XIX | Hospital | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	8,918,153	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	1,276,812	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	26,418,070	0.000000	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0.000000	56.00
60.00	06000	LABORATORY	0	0	0	11,553,386	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0.000000	63.00
66.00	06600	PHYSICAL THERAPY	0	0	0	3,780,357	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	277,398	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	81,707	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	3,231,512	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	1,902,216	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1,771,500	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	15,127,481	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	751,050	0.000000	90.00
90.01	09001	SENIOR CARE	0	0	0	461,516	0.000000	90.01
91.00	09100	EMERGENCY	0	0	0	13,832,249	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	1,058,992	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	90,442,399		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1310 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part IV | Date/Time Prepared: 5/29/2018 9:58 am

Title XIX | Hospital | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	2,775	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	24,270	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
60.00	06000	LABORATORY	0.000000	22,602	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	0	0	63.00
66.00	06600	PHYSICAL THERAPY	0.000000	1,335	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	502	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	14,052	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	1,792	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	29,310	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	SENIOR CARE	0.000000	0	0	0	0	90.01
91.00	09100	EMERGENCY	0.000000	14,162	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		110,800	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1310 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part V Date/Time Prepared: 5/29/2018 9:58 am

Title XIX | 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	0.272535	0	0	27,845	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.007738	0	0	2,416	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.081594	0	0	285,014	0	54.00
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
60.00	06000	LABORATORY	0.175990	0	0	210,856	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	0	0	63.00
66.00	06600	PHYSICAL THERAPY	0.475115	0	0	31,837	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.608112	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	1.692450	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.427479	0	0	6,555	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.315989	0	0	33,134	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.296681	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.278454	0	0	216,894	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.245175	0	0	0	0	90.00
90.01	09001	SENIOR CARE	1.066414	0	0	0	0	90.01
91.00	09100	EMERGENCY	0.303543	0	0	240,463	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.252584	0	0	32,476	0	92.00
200.00		Subtotal (see instructions)		0	0	1,087,490	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	0	1,087,490	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1310 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part V Date/Time Prepared: 5/29/2018 9:58 am

Title XIX | Hospital | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	7,589		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	19		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	23,255		54.00
56.00	05600	RADIOISOTOPE	0	0		56.00
60.00	06000	LABORATORY	0	37,109		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0		63.00
66.00	06600	PHYSICAL THERAPY	0	15,126		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	2,802		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	10,470		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	60,395		73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
90.01	09001	SENIOR CARE	0	0		90.01
91.00	09100	EMERGENCY	0	72,991		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	40,679		92.00
200.00		Subtotal (see instructions)	0	270,435		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	270,435		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1310 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-1 | Date/Time Prepared: 5/29/2018 9:58 am

Title XVIII | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	2,589	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,488	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)	1,769	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	22	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	79	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)	860	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)	22	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	137.32	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	137.32	20.00
21.00	Total general inpatient routine service cost (see instructions)	4,641,511	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)	10,848	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)	51,436	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	4,590,075	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)	4,590,075	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)	1,844.89	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,586,605	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	1,586,605	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1310 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-1 | Date/Time Prepared: 5/29/2018 9:58 am

Title XVIII | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT						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)	622,251	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	2,208,856	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	40,588	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)	40,588	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)	719	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,844.89	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,326,476	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1310 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-1 | Date/Time Prepared: 5/29/2018 9:58 am

Title XVIII | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	289,710	4,641,511	0.062417	1,326,476	82,795	90.00
91.00	Nursing School cost	0	4,641,511	0.000000	1,326,476	0	91.00
92.00	Allied health cost	0	4,641,511	0.000000	1,326,476	0	92.00
93.00	All other Medical Education	0	4,641,511	0.000000	1,326,476	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1310 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-1 | Date/Time Prepared: 5/29/2018 9:58 am

Title XIX | 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)	2,589	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,488	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)	1,769	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	22	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	79	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)	28	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	4,641,511	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)	40,683	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	4,600,828	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)	4,600,828	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)	1,849.21	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	51,778	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)	51,778	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1310 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-1 | Date/Time Prepared: 5/29/2018 9:58 am

Title XIX | 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						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)	26,686	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	78,464	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)	3,232	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	1,256	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	4,488	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	73,976	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)	719	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,849.21	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,329,582	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1310 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-1 | Date/Time Prepared: 5/29/2018 9:58 am

Title XIX | 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	289,710	4,641,511	0.062417	1,329,582	82,989	90.00
91.00	Nursing School cost	0	4,641,511	0.000000	1,329,582	0	91.00
92.00	Allied health cost	0	4,641,511	0.000000	1,329,582	0	92.00
93.00	All other Medical Education	0	4,641,511	0.000000	1,329,582	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1310 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-3 | Date/Time Prepared: 5/29/2018 9:58 am

Title XVIII | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		1,553,538		30.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.272535	62,072	16,917	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.007738	7,190	56	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.081594	387,363	31,606	54.00
56.00	05600	RADIOISOTOPE	0.000000	0	0	56.00
60.00	06000	LABORATORY	0.175990	367,445	64,667	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	63.00
66.00	06600	PHYSICAL THERAPY	0.475115	93,148	44,256	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.608112	57,192	34,779	67.00
68.00	06800	SPEECH PATHOLOGY	1.692450	8,308	14,061	68.00
69.00	06900	ELECTROCARDIOLOGY	0.427479	452,394	193,389	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.315989	49,338	15,590	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.296681	122	36	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.278454	739,905	206,030	73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.245175	0	0	90.00
90.01	09001	SENIOR CARE	1.066414	0	0	90.01
91.00	09100	EMERGENCY	0.303543	2,846	864	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.252584	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		2,227,323	622,251	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)		2,227,323		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-1310 | Component CCN: 15-Z310 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-3 | Date/Time Prepared: 5/29/2018 9:58 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		15,286		30.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.272535	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.007738	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.081594	0	0	54.00
56.00	05600	RADIOISOTOPE	0.000000	0	0	56.00
60.00	06000	LABORATORY	0.175990	866	152	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	63.00
66.00	06600	PHYSICAL THERAPY	0.475115	3,148	1,496	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.608112	4,115	2,502	67.00
68.00	06800	SPEECH PATHOLOGY	1.692450	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.427479	15,851	6,776	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.315989	132	42	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.296681	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.278454	4,345	1,210	73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.245175	0	0	90.00
90.01	09001	SENIOR CARE	1.066414	0	0	90.01
91.00	09100	EMERGENCY	0.303543	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.252584	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		28,457	12,178	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		28,457		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1310 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-3 | Date/Time Prepared: 5/29/2018 9:58 am

Title XIX | 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		49,198		30.00
43.00	04300	NURSERY		0		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.272535	2,775	756	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.007738	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.081594	24,270	1,980	54.00
56.00	05600	RADIOISOTOPE	0.000000	0	0	56.00
60.00	06000	LABORATORY	0.175990	22,602	3,978	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	63.00
66.00	06600	PHYSICAL THERAPY	0.475115	1,335	634	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.608112	502	305	67.00
68.00	06800	SPEECH PATHOLOGY	1.692450	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.427479	14,052	6,007	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.315989	1,792	566	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.296681	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.278454	29,310	8,161	73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.245175	0	0	90.00
90.01	09001	SENIOR CARE	1.066414	0	0	90.01
91.00	09100	EMERGENCY	0.303543	14,162	4,299	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.252584	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		110,800	26,686	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)		110,800		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1310	Period: From 01/01/2017 To 12/31/2017	Worksheet E Part B Date/Time Prepared: 5/29/2018 9:58 am
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	6,467,877	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	OPPS payments	0	3.00
4.00	Outlier payment (see instructions)	0	4.00
4.01	Outlier reconciliation amount (see instructions)	0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	6,467,877	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	0	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (see instructions)	6,532,556	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	0	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	53,700	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	4,398,782	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)	2,080,074	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)	2,080,074	30.00
31.00	Primary payer payments	842	31.00
32.00	Subtotal (line 30 minus line 31)	2,079,232	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)	517,160	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	336,154	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	517,160	36.00
37.00	Subtotal (see instructions)	2,415,386	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		39.50
39.97	Demonstration payment adjustment amount before sequestration	0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	2,415,386	40.00
40.01	Sequestration adjustment (see instructions)	48,308	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
41.00	Interim payments	3,093,186	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	-726,108	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 15-1310 | Period: From 01/01/2017 To 12/31/2017 | Worksheet E-1 Part I | Date/Time Prepared: 5/29/2018 9:58 am

Title XVIII | Hospital | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,920,357		3,093,186	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)		1,920,357		3,093,186	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		97,043		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		726,108	6.02
7.00	Total Medicare program liability (see instructions)		2,017,400		2,367,078	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: 15-1310 | Component CCN: 15-Z310 | Period: From 01/01/2017 To 12/31/2017 | Worksheet E-1 Part I | Date/Time Prepared: 5/29/2018 9:58 am

Title XVIII | Swing Beds - SNF | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		47,410		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		47,410		0	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		4,818		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		52,228		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: 15-1310	Period: From 01/01/2017 To 12/31/2017	Worksheet E-1 Part II Date/Time Prepared: 5/29/2018 9:58 am
	Title XVIII	Hospital	Cost

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

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS | Provider CCN: 15-1310 | Component CCN: 15-Z310 | Period: From 01/01/2017 To 12/31/2017 | Worksheet E-2 | Date/Time Prepared: 5/29/2018 9:58 am

Title XVIII | Swing Beds - SNF | Cost

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	40,994	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)			2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202, for Part B) (For CAH, see instructions)	12,300	0	3.00
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)		0.00	4.00
5.00	Program days	22	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)		0	6.00
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	53,294	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	53,294	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0	0	11.00
12.00	Subtotal (line 10 minus line 11)	53,294	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	0	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)	53,294	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)			16.50
16.55	Rural community hospital demonstration project (§410A Demonstration) payment adjustment (see instructions)	0		16.55
16.99	Demonstration payment adjustment amount before sequestration	0	0	16.99
17.00	Allowable bad debts (see instructions)	0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (see instructions)	53,294	0	19.00
19.01	Sequestration adjustment (see instructions)	1,066	0	19.01
19.02	Demonstration payment adjustment amount after sequestration)	0	0	19.02
20.00	Interim payments	47,410	0	20.00
21.00	Tentative settlement (for contractor use only)	0	0	21.00
22.00	Balance due provider/program (line 19 minus lines 19.01, 20, and 21)	4,818	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	23.00
	Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment			
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
	Cost Reimbursement			
201.00	Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital))			201.00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))			202.00
203.00	Total (sum of lines 201 and 202)			203.00
204.00	Medicare swing-bed SNF discharges (see instructions)			204.00
	Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)			
205.00	Medicare swing-bed SNF target amount			205.00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)			206.00
	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement			
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)			208.00
209.00	Adjustment to Medicare swing-bed SNF PPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
	Comparision of PPS versus Cost Reimbursement			
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see instructions)			215.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1310	Period: From 01/01/2017 To 12/31/2017	Worksheet E-3 Part V Date/Time Prepared: 5/29/2018 9:58 am
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	2,208,856	1.00
2.00	Nursing and Allied Health Managed Care payment (see instructions)	0	2.00
3.00	Organ acquisition	0	3.00
4.00	Subtotal (sum of lines 1 through 3)	2,208,856	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	2,230,945	6.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
7.00	Routine service charges	0	7.00
8.00	Ancillary service charges	0	8.00
9.00	Organ acquisition charges, net of revenue	0	9.00
10.00	Total reasonable charges	0	10.00
	Customary charges		
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)	0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)	0.000000	13.00
14.00	Total customary charges (see instructions)	0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)	0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)	0	16.00
17.00	Cost of physicians' services in a teaching hospital (see instructions)	0	17.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)	0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)	2,230,945	19.00
20.00	Deductibles (exclude professional component)	282,800	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	1,948,145	22.00
23.00	Coinsurance	0	23.00
24.00	Subtotal (line 22 minus line 23)	1,948,145	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	169,886	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	110,426	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	169,886	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	2,058,571	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	29.50
29.99	Demonstration payment adjustment amount before sequestration	0	29.99
30.00	Subtotal (see instructions)	2,058,571	30.00
30.01	Sequestration adjustment (see instructions)	41,171	30.01
30.02	Demonstration payment adjustment amount after sequestration	0	30.02
31.00	Interim payments	1,920,357	31.00
32.00	Tentative settlement (for contractor use only)	0	32.00
33.00	Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32)	97,043	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	34.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 15-1310 | Period: From 01/01/2017 To 12/31/2017 | Worksheet G | Date/Time Prepared: 5/29/2018 9:58 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	896,683	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	5,963,432	0	0	0	4.00
5.00	Other receivable	-270,370	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	284,051	0	0	0	7.00
8.00	Prepaid expenses	5,687,765	0	0	0	8.00
9.00	Other current assets	25,745,029	0	0	0	9.00
10.00	Due from other funds	-22,261,249	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	16,045,341	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	985,290	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	20,662,927	0	0	0	15.00
16.00	Accumulated depreciation	-16,436,316	0	0	0	16.00
17.00	Leasehold improvements	-2,058	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	117,827	0	0	0	19.00
20.00	Accumulated depreciation	-96,051	0	0	0	20.00
21.00	Automobiles and trucks	23,432	0	0	0	21.00
22.00	Accumulated depreciation	-23,431	0	0	0	22.00
23.00	Major movable equipment	3,264,478	0	0	0	23.00
24.00	Accumulated depreciation	-2,164,233	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)	6,331,865	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	206,748	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	0	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	206,748	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	22,583,954	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	3,451,717	0	0	0	37.00
38.00	Salaries, wages, and fees payable	461,059	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	2,042,797	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	5,955,573	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	24,531,826	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	24,531,826	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	30,487,399	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	-7,903,445				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)	-7,903,445	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	22,583,954	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-1310 | Period: From 01/01/2017 To 12/31/2017 | Worksheet G-1 | Date/Time Prepared: 5/29/2018 9:58 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		-743,891		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-7,159,553				2.00
3.00	Total (sum of line 1 and line 2)		-7,903,444		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		-7,903,444		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		-7,903,444		0		19.00

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

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 15-1310 | Period: From 01/01/2017 To 12/31/2017 | Worksheet G-2 Parts I & II Date/Time Prepared: 5/29/2018 9:58 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	3,171,514		3,171,514	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	58,580		58,580	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	3,230,094		3,230,094	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT				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)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	3,230,094		3,230,094	17.00
18.00	Ancillary services	6,105,759	0	6,105,759	18.00
19.00	Outpatient services	0	90,863,146	90,863,146	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		165,297	165,297	22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE	0	200,368	200,368	26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	9,335,853	91,228,811	100,564,664	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		41,634,088		29.00
30.00	BAD DEBT	4,068,850			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)		4,068,850		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)		45,702,938		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 15-1310 | Period: From 01/01/2017 To 12/31/2017 | Worksheet G-3 | Date/Time Prepared: 5/29/2018 9:58 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	100,564,664	1.00
2.00	Less contractual allowances and discounts on patients' accounts	63,576,853	2.00
3.00	Net patient revenues (line 1 minus line 2)	36,987,811	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	45,702,938	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-8,715,127	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	6,789	6.00
7.00	Income from investments	679,087	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	82,693	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	167,385	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	356,003	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	159,918	22.00
23.00	Governmental appropriations	0	23.00
24.00	GAIN ON DISPOSAL OF ASSETS	600	24.00
24.01	OTHER OPERATING REVENUE	103,099	24.01
25.00	Total other income (sum of lines 6-24)	1,555,574	25.00
26.00	Total (line 5 plus line 25)	-7,159,553	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-7,159,553	29.00

ANALYSIS OF HOSPITAL-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 15-1310 | HHA CCN: 15-7061 | Period: From 01/01/2017 To 12/31/2017 | Worksheet H | Date/Time Prepared: 5/29/2018 9:58 am

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		Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased Services	Other Costs	Total (sum of cols. 1 thru 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures			0		0	0	1.00
2.00	Capital Related - Movable Equipment			0		0	0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0	0	0	3.00
4.00	Transportation	0	0	0	0	0	0	4.00
5.00	Administrative and General	70,679	0	13,776	0	10,593	95,048	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	39,698	0	0	0	0	39,698	6.00
7.00	Physical Therapy	40,312	0	0	0	0	40,312	7.00
8.00	Occupational Therapy	7,306	0	0	0	0	7,306	8.00
9.00	Speech Pathology	1,780	0	0	0	0	1,780	9.00
10.00	Medical Social Services	0	0	0	0	0	0	10.00
11.00	Home Health Aide	10,008	0	0	0	0	10,008	11.00
12.00	Supplies (see instructions)	0	0	0	0	17,771	17,771	12.00
13.00	Drugs	0	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	169,783	0	13,776	0	28,364	211,923	24.00

		Reclassification	Reclassified Trial Balance (col. 6 + col.7)	Adjustments	Net Expenses for Allocation (col. 8 + col. 9)			
		7.00	8.00	9.00	10.00			
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0	0	0			1.00
2.00	Capital Related - Movable Equipment	0	0	0	0			2.00
3.00	Plant Operation & Maintenance	0	0	0	0			3.00
4.00	Transportation	0	0	0	0			4.00
5.00	Administrative and General	0	95,048	0	95,048			5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	39,698	0	39,698			6.00
7.00	Physical Therapy	0	40,312	0	40,312			7.00
8.00	Occupational Therapy	0	7,306	0	7,306			8.00
9.00	Speech Pathology	0	1,780	0	1,780			9.00
10.00	Medical Social Services	0	0	0	0			10.00
11.00	Home Health Aide	0	10,008	0	10,008			11.00
12.00	Supplies (see instructions)	0	17,771	0	17,771			12.00
13.00	Drugs	0	0	0	0			13.00
14.00	DME	0	0	0	0			14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0			15.00
16.00	Respiratory Therapy	0	0	0	0			16.00
17.00	Private Duty Nursing	0	0	0	0			17.00
18.00	Clinic	0	0	0	0			18.00
19.00	Health Promotion Activities	0	0	0	0			19.00
20.00	Day Care Program	0	0	0	0			20.00
21.00	Home Delivered Meals Program	0	0	0	0			21.00
22.00	Homemaker Service	0	0	0	0			22.00
23.00	All Others (specify)	0	0	0	0			23.00
23.50	Telemedicine	0	0	0	0			23.50
24.00	Total (sum of lines 1-23)	0	211,923	0	211,923			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: 15-1310 HHA CCN: 15-7061 | Period: From 01/01/2017 To 12/31/2017 | Worksheet H-1 Part I Date/Time Prepared: 5/29/2018 9:58 am

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		Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Capital Related Costs: Bldgs & Fixtures	Capital Related Costs: Movable Equipment	Plant Operation & Maintenance	Transportation	Subtotal (cols. 0-4)	
		0	1.00	2.00	3.00	4.00	4A.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0				0	1.00
2.00	Capital Related - Movable Equipment	0		0			0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0		0	3.00
4.00	Transportation	0	0	0	0	0		4.00
5.00	Administrative and General	95,048	0	0	0	0	95,048	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	39,698	0	0	0	0	39,698	6.00
7.00	Physical Therapy	40,312	0	0	0	0	40,312	7.00
8.00	Occupational Therapy	7,306	0	0	0	0	7,306	8.00
9.00	Speech Pathology	1,780	0	0	0	0	1,780	9.00
10.00	Medical Social Services	0	0	0	0	0	0	10.00
11.00	Home Health Aide	10,008	0	0	0	0	10,008	11.00
12.00	Supplies (see instructions)	17,771	0	0	0	0	17,771	12.00
13.00	Drugs	0	0	0	0		0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	211,923	0	0	0	0	211,923	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	95,048		5.00
	HHA REIMBURSABLE SERVICES			
6.00	Skilled Nursing Care	32,284	71,982	6.00
7.00	Physical Therapy	32,783	73,095	7.00
8.00	Occupational Therapy	5,942	13,248	8.00
9.00	Speech Pathology	1,448	3,228	9.00
10.00	Medical Social Services	0	0	10.00
11.00	Home Health Aide	8,139	18,147	11.00
12.00	Supplies (see instructions)	14,452	32,223	12.00
13.00	Drugs	0	0	13.00
14.00	DME	0	0	14.00
	HHA NONREIMBURSABLE SERVICES			
15.00	Home Dialysis Aide Services	0	0	15.00
16.00	Respiratory Therapy	0	0	16.00
17.00	Private Duty Nursing	0	0	17.00
18.00	Clinic	0	0	18.00
19.00	Health Promotion Activities	0	0	19.00
20.00	Day Care Program	0	0	20.00
21.00	Home Delivered Meals Program	0	0	21.00
22.00	Homemaker Service	0	0	22.00
23.00	All Others (specify)	0	0	23.00
23.50	Telemedicine	0	0	23.50
24.00	Total (sum of lines 1-23)		211,923	24.00

COST ALLOCATION - HHA STATISTICAL BASIS | Provider CCN: 15-1310 HHA CCN: 15-7061 | Period: From 01/01/2017 To 12/31/2017 | Worksheet H-1 Part II Date/Time Prepared: 5/29/2018 9:58 am

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		Capital Related Costs						
		Bldgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)	Plant Operation & Maintenance (SQUARE FEET)	Transportation (MILEAGE)	Reconciliation	Administrative & General (ACCUM. COST)	
		1.00	2.00	3.00	4.00	5A.00	5.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0				0		1.00
2.00	Capital Related - Movable Equipment		0			0		2.00
3.00	Plant Operation & Maintenance	0	0	0		0		3.00
4.00	Transportation (see instructions)	0	0	0	0			4.00
5.00	Administrative and General	0	0	0	0	-95,048	116,875	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	0	39,698	6.00
7.00	Physical Therapy	0	0	0	0	0	40,312	7.00
8.00	Occupational Therapy	0	0	0	0	0	7,306	8.00
9.00	Speech Pathology	0	0	0	0	0	1,780	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	10,008	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	17,771	12.00
13.00	Drugs	0	0	0		0	0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	0	0	0	0	-95,048	116,875	24.00
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0	0		95,048	25.00
26.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000		0.813245	26.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 15-1310 HHA CCN: 15-7061

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

Worksheet H-2 Part I Date/Time Prepared: 5/29/2018 9:58 am

Home Health Agency I

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	Cost Center Description	HHA Trial Balance (1)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	
		0	1.00	2.00	4.00	4A	5.00	
1.00	Administrative and General	0	2,227	3,754	44,524	50,505	24,240	1.00
2.00	Skilled Nursing Care	71,982	0	0	0	71,982	34,547	2.00
3.00	Physical Therapy	73,095	0	0	0	73,095	35,082	3.00
4.00	Occupational Therapy	13,248	0	0	0	13,248	6,358	4.00
5.00	Speech Pathology	3,228	0	0	0	3,228	1,549	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	18,147	0	0	0	18,147	8,710	7.00
8.00	Supplies (see instructions)	32,223	0	0	0	32,223	15,465	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)	211,923	2,227	3,754	44,524	262,428	125,951	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	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
		7.00	8.00	9.00	10.00	11.00	13.00	
1.00	Administrative and General	18,992	0	10,837	0	0	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	18,992	0	10,837	0	0	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

(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: 15-1310 HHA CCN: 15-7061 | Period: From 01/01/2017 To 12/31/2017 | Worksheet H-2 Part I Date/Time Prepared: 5/29/2018 9:58 am

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	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	1,157	0	0	105,731	0	105,731	1.00
2.00	Skilled Nursing Care	0	0	0	106,529	0	106,529	2.00
3.00	Physical Therapy	0	0	0	108,177	0	108,177	3.00
4.00	Occupational Therapy	0	0	0	19,606	0	19,606	4.00
5.00	Speech Pathology	0	0	0	4,777	0	4,777	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	26,857	0	26,857	7.00
8.00	Supplies (see instructions)	0	0	0	47,688	0	47,688	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	1,157	0	0	419,365	0	419,365	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	35,913	142,442					2.00
3.00	Physical Therapy	36,469	144,646					3.00
4.00	Occupational Therapy	6,609	26,215					4.00
5.00	Speech Pathology	1,610	6,387					5.00
6.00	Medical Social Services	0	0					6.00
7.00	Home Health Aide	9,054	35,911					7.00
8.00	Supplies (see instructions)	16,076	63,764					8.00
9.00	Drugs	0	0					9.00
10.00	DME	0	0					10.00
11.00	Home Dialysis Aide Services	0	0					11.00
12.00	Respiratory Therapy	0	0					12.00
13.00	Private Duty Nursing	0	0					13.00
14.00	Clinic	0	0					14.00
15.00	Health Promotion Activities	0	0					15.00
16.00	Day Care Program	0	0					16.00
17.00	Home Delivered Meals Program	0	0					17.00
18.00	Homemaker Service	0	0					18.00
19.00	All Others (specify)	0	0					19.00
19.50	Telemedicine	0	0					19.50
20.00	Total (sum of lines 1-19) (2)	105,731	419,365					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.	0.337116						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: 15-1310 HHA CCN: 15-7061

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

Worksheet H-2 Part II Date/Time Prepared: 5/29/2018 9:58 am

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	Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
		1.00	2.00	4.00	5A	5.00	7.00	
1.00	Administrative and General	906	906	169,783	0	50,505	906	1.00
2.00	Skilled Nursing Care	0	0	0	0	71,982	0	2.00
3.00	Physical Therapy	0	0	0	0	73,095	0	3.00
4.00	Occupational Therapy	0	0	0	0	13,248	0	4.00
5.00	Speech Pathology	0	0	0	0	3,228	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	18,147	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	32,223	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)	906	906	169,783		262,428	906	20.00
21.00	Total cost to be allocated	2,227	3,754	44,524		125,951	18,992	21.00
22.00	Unit cost multiplier	2.458057	4.143488	0.262241		0.479945	20.962472	22.00

	Cost Center Description	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDR)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (HOURS)	NURSING ADMINISTRATION (DIRECT NRS ING HR)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	
		8.00	9.00	10.00	11.00	13.00	14.00	
1.00	Administrative and General	0	906	0	0	0	9,048	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	0	906	0	0	0	9,048	20.00
21.00	Total cost to be allocated	0	10,837	0	0	0	1,157	21.00
22.00	Unit cost multiplier	0.000000	11.961369	0.000000	0.000000	0.000000	0.127874	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 15-1310 | HHA CCN: 15-7061 | Period: From 01/01/2017 To 12/31/2017 | Worksheet H-2 Part II | Date/Time Prepared: 5/29/2018 9:58 am

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

APPORTIONMENT OF PATIENT SERVICE COSTS | Provider CCN: 15-1310 HHA CCN: 15-7061 | Period: From 01/01/2017 To 12/31/2017 | Worksheet H-3 Part I Date/Time Prepared: 5/29/2018 9:58 am

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	Cost Center Description	From, Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Visits	Average Cost Per Visit (col. 3 ÷ col. 4)	
		0	1.00	2.00	3.00	4.00	5.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	2.00	142,442		142,442	186	765.82	1.00
2.00	Physical Therapy	3.00	144,646	0	144,646	175	826.55	2.00
3.00	Occupational Therapy	4.00	26,215	0	26,215	48	546.15	3.00
4.00	Speech Pathology	5.00	6,387	0	6,387	0	0.00	4.00
5.00	Medical Social Services	6.00	0		0	0	0.00	5.00
6.00	Home Health Aide	7.00	35,911		35,911	20	1,795.55	6.00
7.00	Total (sum of lines 1-6)		355,601	0	355,601	429		7.00

	Cost Center Description	Cost Limits	CBSA No. (1)	Part A	Program Visits Part B Not Subject to Deductibles & Coinsurance	Part B Subject to Deductibles		
		0	1.00	2.00	3.00	4.00	5.00	
	Limitation Cost Computation							
8.00	Skilled Nursing Care		99915	0	121			8.00
9.00	Physical Therapy		99915	0	175			9.00
10.00	Occupational Therapy		99915	0	48			10.00
11.00	Speech Pathology		99915	0	0			11.00
12.00	Medical Social Services		99915	0	0			12.00
13.00	Home Health Aide		99915	0	0			13.00
14.00	Total (sum of lines 8-13)			0	344			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	63,764	0	63,764	0	0.000000	15.00
16.00	Cost of Drugs	9.00	0	0	0	0	0.000000	16.00

	Cost Center Description	Program Visits Part A	Program Visits Part B Not Subject to Deductibles & Coinsurance	Program Visits Part B Subject to Deductibles & Coinsurance	Cost of Services Part A	Part B Not Subject to Deductibles & Coinsurance	Part B Subject to Deductibles & Coinsurance	
		6.00	7.00	8.00	9.00	10.00	11.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	0	121		0	92,664		1.00
2.00	Physical Therapy	0	175		0	144,646		2.00
3.00	Occupational Therapy	0	48		0	26,215		3.00
4.00	Speech Pathology	0	0		0	0		4.00
5.00	Medical Social Services	0	0		0	0		5.00
6.00	Home Health Aide	0	0		0	0		6.00
7.00	Total (sum of lines 1-6)	0	344		0	263,525		7.00

	Cost Center Description							
		6.00	7.00	8.00	9.00	10.00	11.00	
	Limitation Cost Computation							
8.00	Skilled Nursing Care							8.00
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: 15-1310 HHA CCN: 15-7061 | Period: From 01/01/2017 To 12/31/2017 | Worksheet H-3 Part I Date/Time Prepared: 5/29/2018 9:58 am

Title XVIII | Home Health Agency I | PPS

	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	92,664	1.00
2.00	Physical Therapy	144,646	2.00
3.00	Occupational Therapy	26,215	3.00
4.00	Speech Pathology	0	4.00
5.00	Medical Social Services	0	5.00
6.00	Home Health Aide	0	6.00
7.00	Total (sum of lines 1-6)	263,525	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: 15-1310 | HHA CCN: 15-7061 | Period: From 01/01/2017 To 12/31/2017 | Worksheet H-3 Part II | Date/Time Prepared: 5/29/2018 9:58 am

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	0.475115	0	0	col. 2, line 2.00		1.00
2.00	Occupational Therapy	67.00	0.608112	0	0	col. 2, line 3.00		2.00
3.00	Speech Pathology	68.00	1.692450	0	0	col. 2, line 4.00		3.00
4.00	Cost of Medical Supplies	71.00	0.315989	0	0	col. 2, line 15.00		4.00
5.00	Cost of Drugs	73.00	0.278454	0	0	col. 2, line 16.00		5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT

Provider CCN: 15-1310 | HHA CCN: 15-7061 | Period: From 01/01/2017 To 12/31/2017 | Worksheet H-4 Part I-II | Date/Time Prepared: 5/29/2018 9:58 am

Title XVIII | Home Health Agency I | PPS

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

		Part A Services	Part B Services	
		1.00	2.00	
	PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT			
10.00	Total reasonable cost (see instructions)	0	0	10.00
11.00	Total PPS Reimbursement - Full Episodes without Outliers	0	68,340	11.00
12.00	Total PPS Reimbursement - Full Episodes with Outliers	0	4,915	12.00
13.00	Total PPS Reimbursement - LUPA Episodes	0	2,436	13.00
14.00	Total PPS Reimbursement - PEP Episodes	0	1,313	14.00
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers	0	136	15.00
16.00	Total PPS Outlier Reimbursement - PEP Episodes	0	0	16.00
17.00	Total Other Payments	0	0	17.00
18.00	DME Payments	0	0	18.00
19.00	Oxygen Payments	0	0	19.00
20.00	Prosthetic and Orthotic Payments	0	0	20.00
21.00	Part B deductibles billed to Medicare patients (exclude coinsurance)		0	21.00
22.00	Subtotal (sum of lines 10 thru 20 minus line 21)	0	77,140	22.00
23.00	Excess reasonable cost (from line 8)	0	0	23.00
24.00	Subtotal (line 22 minus line 23)	0	77,140	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	77,140	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	77,140	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	0	30.50
30.99	Demonstration payment adjustment amount before sequestration	0	0	30.99
31.00	Subtotal (see instructions)	0	77,140	31.00
31.01	Sequestration adjustment (see instructions)	0	1,540	31.01
31.02	Demonstration payment adjustment amount after sequestration	0	0	31.02
32.00	Interim payments (see instructions)	0	75,600	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: 15-1310 | HHA CCN: 15-7061 | Period: From 01/01/2017 To 12/31/2017 | Worksheet H-5 | Date/Time Prepared: 5/29/2018 9:58 am

Home Health Agency I | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		0		75,600	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		75,600	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		75,600	7.00

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

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS

Provider CCN: 15-1310 | Hospice CCN: 15-1545 | Period: From 01/01/2017 To 12/31/2017 | Worksheet O | Date/Time Prepared: 5/29/2018 9:58 am

Hospice I

		SALARIES	OTHER	SUBTOTAL (col. 1 plus col. 2)	RECLASSIFI-CATIONS	SUBTOTAL	
		1.00	2.00	3.00	4.00	5.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT*		0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP*		0	0	0	0	2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT*	0	0	0	0	0	3.00
4.00	ADMINISTRATIVE & GENERAL*	8,421	88,627	97,048	0	97,048	4.00
5.00	PLANT OPERATION & MAINTENANCE*	0	0	0	0	0	5.00
6.00	LAUNDRY & LINEN SERVICE*	0	0	0	0	0	6.00
7.00	HOUSEKEEPING*	0	0	0	0	0	7.00
8.00	DIETARY*	0	0	0	0	0	8.00
9.00	NURSING ADMINISTRATION*	0	0	0	0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES*	0	1,427	1,427	0	1,427	10.00
11.00	MEDICAL RECORDS*	0	0	0	0	0	11.00
12.00	STAFF TRANSPORTATION*	0	6,824	6,824	0	6,824	12.00
13.00	VOLUNTEER SERVICE COORDINATION*	0	0	0	0	0	13.00
14.00	PHARMACY*	0	11,562	11,562	0	11,562	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES*	0	0	0	0	0	15.00
16.00	OTHER GENERAL SERVICE*	0	0	0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES						17.00
	DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED**		0	0	0	0	25.00
26.00	PHYSICIAN SERVICES**	0	0	0	0	0	26.00
27.00	NURSE PRACTITIONER**	3,200	0	3,200	0	3,200	27.00
28.00	REGISTERED NURSE**	34,811	0	34,811	0	34,811	28.00
29.00	LPN/LVN**	0	0	0	0	0	29.00
30.00	PHYSICAL THERAPY**	36	0	36	0	36	30.00
31.00	OCCUPATIONAL THERAPY**	0	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY**	0	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES**	9,994	0	9,994	0	9,994	33.00
34.00	SPIRITUAL COUNSELING**	0	0	0	0	0	34.00
35.00	DIETARY COUNSELING**	0	0	0	0	0	35.00
36.00	COUNSELING - OTHER**	0	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES**	9,847	0	9,847	0	9,847	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN**	0	0	0	0	0	38.00
39.00	PATIENT TRANSPORTATION**	0	0	0	0	0	39.00
40.00	IMAGING SERVICES**	0	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS**	0	0	0	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE**	0	0	0	0	0	42.00
42.50	DRUGS CHARGED TO PATIENTS**	0	0	0	0	0	42.50
43.00	OUTPATIENT SERVICES**	0	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY**	0	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY**	0	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)**	0	0	0	0	0	46.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM *	0	0	0	0	0	60.00
61.00	VOLUNTEER PROGRAM *	0	0	0	0	0	61.00
62.00	FUNDRAISING*	0	0	0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS*	0	0	0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM*	0	0	0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES*	0	0	0	0	0	65.00
66.00	RESIDENTIAL CARE*	0	0	0	0	0	66.00
67.00	ADVERTISING*	0	0	0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING*	0	0	0	0	0	68.00
69.00	THRIFT STORE*	0	0	0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD*	0	0	0	0	0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)*	0	0	0	0	0	71.00
100.00	TOTAL	66,309	108,440	174,749	0	174,749	100.00

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

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS

Provider CCN: 15-1310 | Hospice CCN: 15-1545 | Period: From 01/01/2017 To 12/31/2017 | Worksheet O | Date/Time Prepared: 5/29/2018 9:58 am

Hospice I

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)		
		6.00	7.00		
	GENERAL SERVICE COST CENTERS				
1.00	CAP REL COSTS-BLDG & FIXT*	0	0		1.00
2.00	CAP REL COSTS-MVBLE EQUIP*	0	0		2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT*	0	0		3.00
4.00	ADMINISTRATIVE & GENERAL*	0	97,048		4.00
5.00	PLANT OPERATION & MAINTENANCE*	0	0		5.00
6.00	LAUNDRY & LINEN SERVICE*	0	0		6.00
7.00	HOUSEKEEPING*	0	0		7.00
8.00	DIETARY*	0	0		8.00
9.00	NURSING ADMINISTRATION*	0	0		9.00
10.00	ROUTINE MEDICAL SUPPLIES*	0	1,427		10.00
11.00	MEDICAL RECORDS*	0	0		11.00
12.00	STAFF TRANSPORTATION*	0	6,824		12.00
13.00	VOLUNTEER SERVICE COORDINATION*	0	0		13.00
14.00	PHARMACY*	0	11,562		14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES*	0	0		15.00
16.00	OTHER GENERAL SERVICE*	0	0		16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES				17.00
	DIRECT PATIENT CARE SERVICE COST CENTERS				
25.00	INPATIENT CARE-CONTRACTED**	0	0		25.00
26.00	PHYSICIAN SERVICES**	0	0		26.00
27.00	NURSE PRACTITIONER**	0	3,200		27.00
28.00	REGISTERED NURSE**	0	34,811		28.00
29.00	LPN/LVN**	0	0		29.00
30.00	PHYSICAL THERAPY**	0	36		30.00
31.00	OCCUPATIONAL THERAPY**	0	0		31.00
32.00	SPEECH/LANGUAGE PATHOLOGY**	0	0		32.00
33.00	MEDICAL SOCIAL SERVICES**	0	9,994		33.00
34.00	SPIRITUAL COUNSELING**	0	0		34.00
35.00	DIETARY COUNSELING**	0	0		35.00
36.00	COUNSELING - OTHER**	0	0		36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES**	0	9,847		37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN**	0	0		38.00
39.00	PATIENT TRANSPORTATION**	0	0		39.00
40.00	IMAGING SERVICES**	0	0		40.00
41.00	LABS & DIAGNOSTICS**	0	0		41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE**	0	0		42.00
42.50	DRUGS CHARGED TO PATIENTS**	0	0		42.50
43.00	OUTPATIENT SERVICES**	0	0		43.00
44.00	PALLIATIVE RADIATION THERAPY**	0	0		44.00
45.00	PALLIATIVE CHEMOTHERAPY**	0	0		45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)**	0	0		46.00
	NONREIMBURSABLE COST CENTERS				
60.00	BEREAVEMENT PROGRAM *	0	0		60.00
61.00	VOLUNTEER PROGRAM *	0	0		61.00
62.00	FUNDRAISING*	0	0		62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS*	0	0		63.00
64.00	PALLIATIVE CARE PROGRAM*	0	0		64.00
65.00	OTHER PHYSICIAN SERVICES*	0	0		65.00
66.00	RESIDENTIAL CARE*	0	0		66.00
67.00	ADVERTISING*	0	0		67.00
68.00	TELEHEALTH/TELEMONITORING*	0	0		68.00
69.00	THRIFT STORE*	0	0		69.00
70.00	NURSING FACILITY ROOM & BOARD*	0	0		70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)*	0	0		71.00
100.00	TOTAL	0	174,749		100.00

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

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

Provider CCN: 15-1310 | Hospice CCN: 15-1545 | Period: From 01/01/2017 To 12/31/2017 | Worksheet O-1 | Date/Time Prepared: 5/29/2018 9:58 am

Hospice I

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

* Transfer the amount in column 7 to Wkst. O-5, column 1, line 50.

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

* Transfer the amount in column 7 to Wkst. O-5, column 1, line 50.

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

Provider CCN: 15-1310 | Hospice CCN: 15-1545 | Period: From 01/01/2017 To 12/31/2017 | Worksheet O-2 | Date/Time Prepared: 5/29/2018 9:58 am

Hospice I

		SALARIES	OTHER	SUBTOTAL (col. 1 + col. 2)	RECLASSIFI-CATIONS	SUBTOTAL	
		1.00	2.00	3.00	4.00	5.00	
	DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED						25.00
26.00	PHYSICIAN SERVICES	0	0	0	0	0	26.00
27.00	NURSE PRACTITIONER	3,145	0	3,145	0	3,145	27.00
28.00	REGISTERED NURSE	34,207	0	34,207	0	34,207	28.00
29.00	LPN/LVN	0	0	0	0	0	29.00
30.00	PHYSICAL THERAPY	36	0	36	0	36	30.00
31.00	OCCUPATIONAL THERAPY	0	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	9,822	0	9,822	0	9,822	33.00
34.00	SPIRITUAL COUNSELING	0	0	0	0	0	34.00
35.00	DIETARY COUNSELING	0	0	0	0	0	35.00
36.00	COUNSELING - OTHER	0	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	9,677	0	9,677	0	9,677	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	0	0	0	38.00
39.00	PATIENT TRANSPORTATION	0	0	0	0	0	39.00
40.00	IMAGING SERVICES	0	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	0	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	0	0	0	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	42.50
43.00	OUTPATIENT SERVICES	0	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	0	0	0	46.00
100.00	TOTAL *	56,887	0	56,887	0	56,887	100.00

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

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)		
		6.00	7.00		
	DIRECT PATIENT CARE SERVICE COST CENTERS				
25.00	INPATIENT CARE-CONTRACTED				25.00
26.00	PHYSICIAN SERVICES	0	0		26.00
27.00	NURSE PRACTITIONER	0	3,145		27.00
28.00	REGISTERED NURSE	0	34,207		28.00
29.00	LPN/LVN	0	0		29.00
30.00	PHYSICAL THERAPY	0	36		30.00
31.00	OCCUPATIONAL THERAPY	0	0		31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0		32.00
33.00	MEDICAL SOCIAL SERVICES	0	9,822		33.00
34.00	SPIRITUAL COUNSELING	0	0		34.00
35.00	DIETARY COUNSELING	0	0		35.00
36.00	COUNSELING - OTHER	0	0		36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	9,677		37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0		38.00
39.00	PATIENT TRANSPORTATION	0	0		39.00
40.00	IMAGING SERVICES	0	0		40.00
41.00	LABS & DIAGNOSTICS	0	0		41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0		42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0		42.50
43.00	OUTPATIENT SERVICES	0	0		43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0		44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0		45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0		46.00
100.00	TOTAL *	0	56,887		100.00

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

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

Provider CCN: 15-1310 | Hospice CCN: 15-1545 | Period: From 01/01/2017 To 12/31/2017 | Worksheet O-3 | Date/Time Prepared: 5/29/2018 9:58 am

Hospice I

		SALARIES	OTHER	SUBTOTAL (col. 1 + col. 2)	RECLASSIFI-CATIONS	SUBTOTAL	
		1.00	2.00	3.00	4.00	5.00	
	DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED		0	0	0	0	25.00
26.00	PHYSICIAN SERVICES	0	0	0	0	0	26.00
27.00	NURSE PRACTITIONER	12	0	12	0	12	27.00
28.00	REGISTERED NURSE	131	0	131	0	131	28.00
29.00	LPN/LVN	0	0	0	0	0	29.00
30.00	PHYSICAL THERAPY	0	0	0	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	37	0	37	0	37	33.00
34.00	SPIRITUAL COUNSELING	0	0	0	0	0	34.00
35.00	DIETARY COUNSELING	0	0	0	0	0	35.00
36.00	COUNSELING - OTHER	0	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	37	0	37	0	37	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	0	0	0	38.00
39.00	PATIENT TRANSPORTATION	0	0	0	0	0	39.00
40.00	IMAGING SERVICES	0	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	0	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	0	0	0	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	42.50
43.00	OUTPATIENT SERVICES	0	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	0	0	0	46.00
100.00	TOTAL *	217	0	217	0	217	100.00

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

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)		
		6.00	7.00		
	DIRECT PATIENT CARE SERVICE COST CENTERS				
25.00	INPATIENT CARE-CONTRACTED	0	0		25.00
26.00	PHYSICIAN SERVICES	0	0		26.00
27.00	NURSE PRACTITIONER	0	12		27.00
28.00	REGISTERED NURSE	0	131		28.00
29.00	LPN/LVN	0	0		29.00
30.00	PHYSICAL THERAPY	0	0		30.00
31.00	OCCUPATIONAL THERAPY	0	0		31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0		32.00
33.00	MEDICAL SOCIAL SERVICES	0	37		33.00
34.00	SPIRITUAL COUNSELING	0	0		34.00
35.00	DIETARY COUNSELING	0	0		35.00
36.00	COUNSELING - OTHER	0	0		36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	37		37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0		38.00
39.00	PATIENT TRANSPORTATION	0	0		39.00
40.00	IMAGING SERVICES	0	0		40.00
41.00	LABS & DIAGNOSTICS	0	0		41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0		42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0		42.50
43.00	OUTPATIENT SERVICES	0	0		43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0		44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0		45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0		46.00
100.00	TOTAL *	0	217		100.00

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

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

Provider CCN: 15-1310 | Hospice CCN: 15-1545 | Period: From 01/01/2017 To 12/31/2017 | Worksheet O-4 | Date/Time Prepared: 5/29/2018 9:58 am

Hospice I

		SALARIES	OTHER	SUBTOTAL (col. 1 + col. 2)	RECLASSIFI-CATIONS	SUBTOTAL	
		1.00	2.00	3.00	4.00	5.00	
	DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED		0	0	0	0	25.00
26.00	PHYSICIAN SERVICES	0	0	0	0	0	26.00
27.00	NURSE PRACTITIONER	43	0	43	0	43	27.00
28.00	REGISTERED NURSE	473	0	473	0	473	28.00
29.00	LPN/LVN	0	0	0	0	0	29.00
30.00	PHYSICAL THERAPY	0	0	0	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	135	0	135	0	135	33.00
34.00	SPIRITUAL COUNSELING	0	0	0	0	0	34.00
35.00	DIETARY COUNSELING	0	0	0	0	0	35.00
36.00	COUNSELING - OTHER	0	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	133	0	133	0	133	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	0	0	0	38.00
39.00	PATIENT TRANSPORTATION	0	0	0	0	0	39.00
40.00	IMAGING SERVICES	0	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	0	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	0	0	0	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	42.50
43.00	OUTPATIENT SERVICES	0	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	0	0	0	46.00
100.00	TOTAL *	784	0	784	0	784	100.00

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

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)		
		6.00	7.00		
	DIRECT PATIENT CARE SERVICE COST CENTERS				
25.00	INPATIENT CARE-CONTRACTED	0	0		25.00
26.00	PHYSICIAN SERVICES	0	0		26.00
27.00	NURSE PRACTITIONER	0	43		27.00
28.00	REGISTERED NURSE	0	473		28.00
29.00	LPN/LVN	0	0		29.00
30.00	PHYSICAL THERAPY	0	0		30.00
31.00	OCCUPATIONAL THERAPY	0	0		31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0		32.00
33.00	MEDICAL SOCIAL SERVICES	0	135		33.00
34.00	SPIRITUAL COUNSELING	0	0		34.00
35.00	DIETARY COUNSELING	0	0		35.00
36.00	COUNSELING - OTHER	0	0		36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	133		37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0		38.00
39.00	PATIENT TRANSPORTATION	0	0		39.00
40.00	IMAGING SERVICES	0	0		40.00
41.00	LABS & DIAGNOSTICS	0	0		41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0		42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0		42.50
43.00	OUTPATIENT SERVICES	0	0		43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0		44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0		45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0		46.00
100.00	TOTAL *	0	784		100.00

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

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

Provider CCN: 15-1310 Hospice CCN: 15-1545

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

Worksheet O-5

Date/Time Prepared: 5/29/2018 9:58 am

Hospice I

	Descriptions	HOSPICE DIRECT EXPENSES (see instructions)	GENERAL SERVICE EXPENSES FROM WKST B PART I (see instructions)	TOTAL EXPENSES (sum of cols. 1 + 2)	
		1.00	2.00	3.00	
	GENERAL SERVICE COST CENTERS				
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	0	17,391	17,391	3.00
4.00	ADMINISTRATIVE & GENERAL	97,048	92,216	189,264	4.00
5.00	PLANT OPERATION & MAINTENANCE	0	0	0	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0	6.00
7.00	HOUSEKEEPING	0	0	0	7.00
8.00	DIETARY	0	0	0	8.00
9.00	NURSING ADMINISTRATION	0	0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES	1,427	383	1,810	10.00
11.00	MEDICAL RECORDS	0	0	0	11.00
12.00	STAFF TRANSPORTATION	6,824		6,824	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0		0	13.00
14.00	PHARMACY	11,562	0	11,562	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0		0	15.00
16.00	OTHER GENERAL SERVICE	0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES		0	0	17.00
	LEVEL OF CARE				
50.00	HOSPICE CONTINUOUS HOME CARE	0		0	50.00
51.00	HOSPICE ROUTINE HOME CARE	56,887		56,887	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	217		217	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	784		784	53.00
	NONREIMBURSABLE COST CENTERS				
60.00	BEREAVEMENT PROGRAM	0		0	60.00
61.00	VOLUNTEER PROGRAM	0		0	61.00
62.00	FUNDRAISING	0		0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0		0	63.00
64.00	PALLIATIVE CARE PROGRAM	0		0	64.00
65.00	OTHER PHYSICIAN SERVICES	0		0	65.00
66.00	RESIDENTIAL CARE	0		0	66.00
67.00	ADVERTISING	0		0	67.00
68.00	TELEHEALTH/TELEMONITORING	0		0	68.00
69.00	THRIFT STORE	0		0	69.00
70.00	NURSING FACILITY ROOM & BOARD	0		0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0		0	71.00
99.00	NEGATIVE COST CENTER	0		0	99.00
100.00	TOTAL	174,749	109,990	284,739	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN: 15-1310
Hospice CCN: 15-1545

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

Worksheet O-6
Part I
Date/Time Prepared: 5/29/2018 9:58 am

Hospice I

	Descriptions	TOTAL EXPENSES	CAP REL BLDG & FIX	CAP REL MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	SUBTOTAL	
		0	1.00	2.00	3.00	3A	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0		0			2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	17,391	0	0	17,391		3.00
4.00	ADMINISTRATIVE & GENERAL	189,264	0	0	8,017	197,281	4.00
5.00	PLANT OPERATION & MAINTENANCE	0	0	0	0	0	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0	0	0	6.00
7.00	HOUSEKEEPING	0	0	0	0	0	7.00
8.00	DIETARY	0	0	0	0	0	8.00
9.00	NURSING ADMINISTRATION	0	0	0	0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES	1,810	0	0	0	1,810	10.00
11.00	MEDICAL RECORDS	0	0	0	0	0	11.00
12.00	STAFF TRANSPORTATION	6,824	0	0	0	6,824	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0	0	0	0	0	13.00
14.00	PHARMACY	11,562	0	0	0	11,562	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0	0	0	0	15.00
16.00	OTHER GENERAL SERVICE	0	0	0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES		0	0		0	17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0			0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	56,887			9,212	66,099	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	217	0	0	35	252	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	784	0	0	127	911	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0	0	0	0	0	60.00
61.00	VOLUNTEER PROGRAM	0	0	0	0	0	61.00
62.00	FUNDRAISING	0	0	0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0	0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0	0	0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES	0	0	0	0	0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0	0	0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING	0	0	0	0	0	68.00
69.00	THRIFT STORE	0	0	0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD	0				0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER	0	0	0	0		99.00
100.00	TOTAL	284,739	0	0	17,391	284,739	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN: 15-1310
Hospice CCN: 15-1545

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

Worksheet O-6
Part I
Date/Time Prepared: 5/29/2018 9:58 am

Hospice I

	Descriptions	ADMINISTRATIVE & GENERAL	PLANT OPERATION & MAINTENANCE	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		4.00	5.00	6.00	7.00	8.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL	197,281					4.00
5.00	PLANT OPERATION & MAINTENANCE	0	0				5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0			6.00
7.00	HOUSEKEEPING	0	0		0		7.00
8.00	DIETARY	0	0		0	0	8.00
9.00	NURSING ADMINISTRATION	0	0		0		9.00
10.00	ROUTINE MEDICAL SUPPLIES	4,083	0		0		10.00
11.00	MEDICAL RECORDS	0	0		0		11.00
12.00	STAFF TRANSPORTATION	15,393	0		0		12.00
13.00	VOLUNTEER SERVICE COORDINATION	0	0		0		13.00
14.00	PHARMACY	26,081	0		0		14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0		0		15.00
16.00	OTHER GENERAL SERVICE	0	0		0		16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0	0		0		17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0					50.00
51.00	HOSPICE ROUTINE HOME CARE	149,101					51.00
52.00	HOSPICE INPATIENT RESPITE CARE	568	0	0	0	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	2,055	0	0	0	0	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0	0		0		60.00
61.00	VOLUNTEER PROGRAM	0	0		0		61.00
62.00	FUNDRAISING	0	0		0		62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0		0		63.00
64.00	PALLIATIVE CARE PROGRAM	0	0		0		64.00
65.00	OTHER PHYSICIAN SERVICES	0	0		0		65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0	0		0		67.00
68.00	TELEHEALTH/TELEMONITORING	0	0		0		68.00
69.00	THRIFT STORE	0	0		0		69.00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER	0	0	0	0	0	99.00
100.00	TOTAL	197,281	0	0	0	0	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN: 15-1310
Hospice CCN: 15-1545

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

Worksheet O-6 Part I
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Hospice I

	Descriptions	NURSING ADMINISTRATION	ROUTINE MEDICAL SUPPLIES	MEDICAL RECORDS	STAFF TRANSPORTATION	VOLUNTEER SERVICE COORDINATION	
		9.00	10.00	11.00	12.00	13.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5.00
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPING						7.00
8.00	DIETARY						8.00
9.00	NURSING ADMINISTRATION	0					9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	5,893				10.00
11.00	MEDICAL RECORDS	0		0			11.00
12.00	STAFF TRANSPORTATION	0			22,217		12.00
13.00	VOLUNTEER SERVICE COORDINATION	0			0	0	13.00
14.00	PHARMACY	0			0	0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0			0	0	15.00
16.00	OTHER GENERAL SERVICE	0			0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES						17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0	0	0	0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	0	5,761	0	21,829	0	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	22	0	85	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	110	0	303	0	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0			0	0	60.00
61.00	VOLUNTEER PROGRAM	0			0	0	61.00
62.00	FUNDRAISING	0			0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0			0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0			0	0	64.00
65.00	OTHER PHYSICIAN SERVICES	0			0	0	65.00
66.00	RESIDENTIAL CARE	0			0	0	66.00
67.00	ADVERTISING	0			0	0	67.00
68.00	TELEHEALTH/TELEMONITORING	0			0	0	68.00
69.00	THRIFT STORE	0			0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0			0	0	71.00
99.00	NEGATIVE COST CENTER	0	0	0	0	0	99.00
100.00	TOTAL	0	5,893	0	22,217	0	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS | Provider CCN: 15-1310 | Hospice CCN: 15-1545 | Period: From 01/01/2017 To 12/31/2017 | Worksheet O-6 Part I | Date/Time Prepared: 5/29/2018 9:58 am

Hospice I

	Descriptions	PHARMACY	PHYSICIAN ADMINISTRATIVE SERVICES	OTHER GENERAL SERVICE	PATIENT/ RESIDENTIAL CARE SERVICES	TOTAL	
		14.00	15.00	16.00	17.00	18.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5.00
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPING						7.00
8.00	DIETARY						8.00
9.00	NURSING ADMINISTRATION						9.00
10.00	ROUTINE MEDICAL SUPPLIES						10.00
11.00	MEDICAL RECORDS						11.00
12.00	STAFF TRANSPORTATION						12.00
13.00	VOLUNTEER SERVICE COORDINATION						13.00
14.00	PHARMACY	37,643					14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0				15.00
16.00	OTHER GENERAL SERVICE	0		0			16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES				0		17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0	0	0		0	50.00
51.00	HOSPICE ROUTINE HOME CARE	36,989	0	0		279,779	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	142	0	0	0	1,069	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	512	0	0	0	3,891	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0		0		0	60.00
61.00	VOLUNTEER PROGRAM	0		0		0	61.00
62.00	FUNDRAISING	0		0		0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0		0		0	63.00
64.00	PALLIATIVE CARE PROGRAM	0		0		0	64.00
65.00	OTHER PHYSICIAN SERVICES	0		0		0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0		0		0	67.00
68.00	TELEHEALTH/TELEMONITORING	0		0		0	68.00
69.00	THRIFT STORE	0		0		0	69.00
70.00	NURSING FACILITY ROOM & BOARD					0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER	0	0	0	0	0	99.00
100.00	TOTAL	37,643	0	0	0	284,739	100.00

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

Provider CCN: 15-1310
Hospice CCN: 15-1545

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

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	Cost Center Descriptions	CAP REL BLDG & FIX (SQUARE FEET)	CAP REL MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	RECONCILIATION	ADMINISTRATIVE & GENERAL (ACCUMULATED COSTS)	
		1.00	2.00	3.00	4A	4.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0					1.00
2.00	CAP REL COSTS-MVBLE EQUIP		0				2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	0	0	18,268			3.00
4.00	ADMINISTRATIVE & GENERAL	0	0	8,421	-197,281	87,458	4.00
5.00	PLANT OPERATION & MAINTENANCE	0	0	0	0	0	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0	0	0	6.00
7.00	HOUSEKEEPING	0	0	0	0	0	7.00
8.00	DIETARY	0	0	0	0	0	8.00
9.00	NURSING ADMINISTRATION	0	0	0	0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	0	0	0	1,810	10.00
11.00	MEDICAL RECORDS	0	0	0	0	0	11.00
12.00	STAFF TRANSPORTATION	0	0	0	0	6,824	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0	0	0	0	0	13.00
14.00	PHARMACY	0	0	0	0	11,562	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0	0	0	0	15.00
16.00	OTHER GENERAL SERVICE	0	0	0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0	0		0	0	17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE			0	0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE			9,677	0	66,099	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0	37	0	252	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	133	0	911	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0	0	0	0	0	60.00
61.00	VOLUNTEER PROGRAM	0	0	0	0	0	61.00
62.00	FUNDRAISING	0	0	0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0	0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0	0	0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES	0	0	0	0	0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0	0	0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING	0	0	0	0	0	68.00
69.00	THRIFT STORE	0	0	0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD				0		70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER						99.00
100.00	COST TO BE ALLOCATED (per Wkst. O-6, Part I)	0	0	17,391		197,281	100.00
101.00	UNIT COST MULTIPLIER	0.000000	0.000000	0.951993		2.255723	101.00

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

Provider CCN: 15-1310
Hospice CCN: 15-1545

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

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

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

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

Provider CCN: 15-1310
Hospice CCN: 15-1545

Period:
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	Cost Center Descriptions	ROUTINE MEDICAL SUPPLIES (PATIENT DAYS)	MEDICAL RECORDS (PATIENT DAYS)	STAFF TRANSPORTATION (MILEAGE)	VOLUNTEER SERVICE COORDINATION (HOURS OF SERVICE)	PHARMACY (CHARGES)	
		10.00	11.00	12.00	13.00	14.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5.00
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPING						7.00
8.00	DIETARY						8.00
9.00	NURSING ADMINISTRATION						9.00
10.00	ROUTINE MEDICAL SUPPLIES	1,345					10.00
11.00	MEDICAL RECORDS		0				11.00
12.00	STAFF TRANSPORTATION			6,825			12.00
13.00	VOLUNTEER SERVICE COORDINATION			0	0		13.00
14.00	PHARMACY			0	0	315,275	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES			0	0	0	15.00
16.00	OTHER GENERAL SERVICE			0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES						17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0	0	0	0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	1,315	0	6,706	0	309,799	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	5	0	26	0	1,190	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	25	0	93	0	4,286	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM			0	0	0	60.00
61.00	VOLUNTEER PROGRAM			0	0	0	61.00
62.00	FUNDRAISING			0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS			0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM			0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES			0	0	0	65.00
66.00	RESIDENTIAL CARE			0	0	0	66.00
67.00	ADVERTISING			0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING			0	0	0	68.00
69.00	THRIFT STORE			0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)			0	0	0	71.00
99.00	NEGATIVE COST CENTER						99.00
100.00	COST TO BE ALLOCATED (per Wkst. O-6, Part I)	5,893	0	22,217	0	37,643	100.00
101.00	UNIT COST MULTIPLIER	4.381413	0.000000	3.255238	0.000000	0.119397	101.00

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

Provider CCN: 15-1310
Hospice CCN: 15-1545

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

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Hospice I

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

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

Provider CCN: 15-1310 Hospice CCN: 15-1545 | Period: From 01/01/2017 To 12/31/2017 | Worksheet O-7 | Date/Time Prepared: 5/29/2018 9:58 am

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	Cost Center Descriptions	From Wkst. C, Part I, Col. 9 line	Cost to Charge Ratio	Charges by LOC (from Provider Records) HCHC	HRHC	HIRC	
		0	1.00	2.00	3.00	4.00	
	ANCILLARY SERVICE COST CENTERS						
1.00	PHYSICAL THERAPY	66.00	0.475115	0	0	0	1.00
2.00	OCCUPATIONAL THERAPY	67.00	0.608112	0	0	0	2.00
3.00	SPEECH PATHOLOGY	68.00	1.692450	0	0	0	3.00
4.00	DRUGS CHARGED TO PATIENTS	73.00	0.278454	0	0	0	4.00
5.00	DURABLE MEDICAL EQUIP-RENTED	96.00					5.00
6.00	LABORATORY	60.00	0.175990	0	0	0	6.00
7.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0.315989	0	0	0	7.00
8.00	OTHER OUTPATIENT SERVICE COST CENTER	93.00					8.00
9.00	RADIOLOGY-THERAPEUTIC	55.00					9.00
10.00	OTHER ANCILLARY SERVICE COST CENTERS	76.00					10.00
11.00	Totals (sum of lines 1-11)						11.00

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

CALCULATION OF HOSPITAL-BASED HOSPICE PER DIEM COST

Provider CCN: 15-1310 | Hospice CCN: 15-1545 | Period: From 01/01/2017 To 12/31/2017 | Worksheet O-8 | Date/Time Prepared: 5/29/2018 9:58 am

Hospice I

		TITLE XVIII MEDICARE	TITLE XIX MEDICAID	TOTAL	
		1.00	2.00	3.00	
	HOSPICE CONTINUOUS HOME CARE				
1.00	Total cost (Wkst. O-6, Part I, col. 18, line 50 plus Wkst. O-7, col. 6, line 11)			0	1.00
2.00	Total unduplicated days (Wkst. S-9, col. 4, line 10)			0	2.00
3.00	Total average cost per diem (line 1 divided by line 2)			0.00	3.00
4.00	Unduplicated program days (Wkst. S-9 col. as appropriate, line 10)	0	0		4.00
5.00	Program cost (line 3 times line 4)	0	0		5.00
	HOSPICE ROUTINE HOME CARE				
6.00	Total cost (Wkst. O-6, Part I, col. 18, line 51 plus Wkst. O-7, col. 7, line 11)			279,779	6.00
7.00	Total unduplicated days (Wkst. S-9, col. 4, line 11)			1,315	7.00
8.00	Total average cost per diem (line 6 divided by line 7)			212.76	8.00
9.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 11)	1,301	14		9.00
10.00	Program cost (line 8 times line 9)	276,801	2,979		10.00
	HOSPICE INPATIENT RESPITE CARE				
11.00	Total cost (Wkst. O-6, Part I, col. 18, line 52 plus Wkst. O-7, col. 8, line 11)			1,069	11.00
12.00	Total unduplicated days (Wkst. S-9, col. 4, line 12)			5	12.00
13.00	Total average cost per diem (line 11 divided by line 12)			213.80	13.00
14.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 12)	5	0		14.00
15.00	Program cost (line 13 times line 14)	1,069	0		15.00
	HOSPICE GENERAL INPATIENT CARE				
16.00	Total cost (Wkst. O-6, Part I, col. 18, line 53 plus Wkst. O-7, col. 9, line 11)			3,891	16.00
17.00	Total unduplicated days (Wkst. S-9, col. 4, line 13)			25	17.00
18.00	Total average cost per diem (line 16 divided by line 17)			155.64	18.00
19.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 13)	18	7		19.00
20.00	Program cost (line 18 times line 19)	2,802	1,089		20.00
	TOTAL HOSPICE CARE				
21.00	Total cost (sum of line 1 + line 6 + line 11 + line 16)			284,739	21.00
22.00	Total unduplicated days (Wkst. S-9, col. 4, line 14)			1,345	22.00
23.00	Average cost per diem (line 21 divided by line 22)			211.70	23.00