

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: 15-1307	Period: From 07/01/2016 To 06/30/2017	Worksheet S Parts I-III Date/Time Prepared: 11/22/2017 3:30 pm
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PART I - COST REPORT STATUS

Provider use only 1. Electronically filed cost report Date: 11/22/2017 Time: 3:30 pm
 2. Manually submitted cost report
 3. If this is an amended report enter the number of times the provider resubmitted this cost report
 4. Medicare Utilization. Enter "F" for full or "L" for low.

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

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by ST. VINCENT WILLIAMSPORT HOSPITAL (15-1307) for the cost reporting period beginning 07/01/2016 and ending 06/30/2017 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

_____ Title

_____ Date

Cost Center Description	Title V 1.00	Title XVIII		HIT 4.00	Title XIX 5.00	
		Part A 2.00	Part B 3.00			
PART III - SETTLEMENT SUMMARY						
1.00 Hospital	0	51,243	14,276	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	-4,668	0		0	5.00
6.00 Swing bed - NF	0				0	6.00
10.00 RURAL HEALTH CLINIC I	0		35,825		0	10.00
10.01 RURAL HEALTH CLINIC II	0		-1,564		0	10.01
200.00 Total	0	46,575	48,537	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-MEDI-CARE.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-1307	Period: From 07/01/2016 To 06/30/2017	Worksheet S-2 Part I Date/Time Prepared: 11/22/2017 3:18 pm
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1.00 Hospital and Hospital Health Care Complex Address:		2.00 PO Box:		3.00 State: IN		4.00 Zip Code: 47993		County: WARREN		1.00
1.00	Street: 412 NORTH MONROE	2.00		3.00		4.00		County: WARREN		2.00
2.00	City: WILLIAMSPORT	3.00		4.00		5.00		6.00		7.00

	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	ST. VINCENT WILLIAMSPORT HOSPITAL	151307	99915	1	07/01/1966	N	0	0	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	ST. VINCENT WILLIAMSPORT SWING BEDS	15Z307	99915		02/01/1988	N	0	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									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC	NORTH CLINIC	153993	99915		05/06/2001	N	0	N	15.00
15.01	Hospital-Based Health Clinic - RHC	SOUTH CLINIC	153994	99915		08/01/2001	N	0	N	15.01
16.00	Hospital-Based Health Clinic - FOHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

						From:	To:	
						1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)					07/01/2016	06/30/2017	20.00
21.00	Type of Control (see instructions)					6		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) (Pickie 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 days	Medicaid HMO days	Other Medicaid days	
							1.00
24.00	0	0	0	0	0	0	24.00

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		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of- State Medicaid paid days	Out-of- State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days		
		1.00	2.00	3.00	4.00	5.00	6.00		
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0	0		25.00
						Urban/Rural	S	Date of Geogr	
						1.00		2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.					2			26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.					2			27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.					0			35.00
						Beginning:	Ending:		
						1.00	2.00		
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.								36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.					0			37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)					N			37.01
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.								38.00
						Y/N	Y/N		
						1.00	2.00		
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)					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	XVII	XIX	
						1.00	2.00	3.00	
Prospective Payment System (PPS)-Capital									
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)					N	N	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.					N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y" for yes or "N" for no.					N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.					N	N	N	48.00
Teaching Hospitals									
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.					N			56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.								57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.					N			58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.					N			59.00
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)					N			60.00
		Y/N	IME	Direct GME	IME	Direct GME			
		1.00	2.00	3.00	4.00	5.00			
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)					0.00	0.00		61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00	0.00					61.01

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	Y/N	IME	Direct GME	IME	Direct GME		
	1.00	2.00	3.00	4.00	5.00		
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)	0.00	0.00				61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)	0.00	0.00				61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).	0.00	0.00				61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)	0.00	0.00				61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)	0.00	0.00				61.06
		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count		
		1.00	2.00	3.00	4.00		
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column 4, direct GME FTE unweighted count.			0.00	0.00		61.10
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column 4, direct GME FTE unweighted count.			0.00	0.00		61.20
					1.00		
62.00	ACA Provisions Affecting the Health Resources and Services Administration (HRSA) 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
63.00	Teaching Hospitals that Claim Residents in Nonprovider Settings Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions)				N		63.00
				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
				1.00	2.00	3.00	
64.00	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. 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	

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	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
70.00	Inpatient Psychiatric Facility PPS 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 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
75.00	Inpatient Rehabilitation Facility PPS 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 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

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				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.			N	86.00	
87.00	Is this hospital a "subclause (11)" LTCH classified under section 1886(d)(1)(B)(iv)(II)? Enter "Y" for yes or "N" for no.			N	87.00	
		V		XIX		
		1.00		2.00		
Title V and XIX Services						
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.			N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.			N	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.				Y	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.			N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.			N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00		0.00		95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.			N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00		0.00		97.00
Rural Providers						
105.00	Does this hospital qualify as a critical access hospital (CAH)?			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. 1, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. 11.			N	107.00	
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.			N	108.00	
		Physical	Occupational	Speech	Respiratory	
		1.00	2.00	3.00	4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	Y	N	N	N	
				1.00		
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (410A Demo) for the current cost reporting period? Enter "Y" for yes or "N" for no.			N		110.00
				1.00	2.00	3.00
Miscellaneous Cost Reporting Information						
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.			N		0
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.			N	116.00	
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.			Y	117.00	
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.			1	118.00	
		Premiums		Losses		Insurance
		1.00		2.00		3.00
118.01	List amounts of malpractice premiums and paid losses:	137,508		0		0

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		1.00	2.00		
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02	
119.00	DO NOT USE THIS LINE			119.00	
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00	
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00	
122.00	Does the cost report contain state health or similar taxes? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	Y	5.00	122.00	
Transplant Center Information					
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00	
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00	
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00	
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00	
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00	
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00	
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00	
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00	
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			133.00	
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00	
All Providers					
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	15H046	140.00	
		1.00	2.00	3.00	
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.					
141.00	Name: ST. VINCENT HEALTH	Contractor's Name: WPS		Contractor's Number: 08101	
142.00	Street: 10330 N. MERIDIAN ST. SUITE 420	PO Box:			
143.00	City: INDIANAPOLIS	State: IN	Zip Code: 46290		
			1.00		
144.00	Are provider based physicians' costs included in Worksheet A?		Y	144.00	
		1.00	2.00		
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.	N	N	145.00	
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N		146.00	
			1.00		
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.		N	147.00	
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.		N	148.00	
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.		N	149.00	
		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
156.00	Subprovider - IPF	N	N	N	N
157.00	Subprovider - IRF	N	N	N	N
158.00	SUBPROVIDER				
159.00	SNF	N	N	N	N
160.00	HOME HEALTH AGENCY	N	N	N	N
161.00	CMHC		N	N	N

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-1307		Period: From 07/01/2016 To 06/30/2017		Worksheet S-2 Part I Date/Time Prepared: 11/22/2017 3:18 pm		
							1.00	
Multi campus								
165.00	Is this hospital part of a Multi campus 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.						N	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)							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)						Y	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)							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. 1, 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	0171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 15-1307		Period: From 07/01/2016 To 06/30/2017		Worksheet S-2 Part II Date/Time Prepared: 11/22/2017 3:18 pm	
				Y/N	Date		
				1.00	2.00		
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.							
COMPLETED BY ALL HOSPITALS							
Provider Organization and Operation							
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)			N			1.00
				Y/N	Date	V/I	
				1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.			N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)			N			3.00
				Y/N	Type	Date	
				1.00	2.00	3.00	
Financial Data and Reports							
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.			N			4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.			N			5.00
				Y/N	Legal Oper.		
				1.00	2.00		
Approved Educational Activities							
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?			N			6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.			N			7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.			N			8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.			N			9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.			N			10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.			N			11.00
						Y/N	
						1.00	
Bad Debts							
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.					Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.					N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.					N	14.00
Bed Complement							
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.					N	15.00
				Part A		Part B	
				Y/N	Date	Y/N	Date
				1.00	2.00	3.00	4.00
PS&R Data							
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)			Y	10/03/2017	Y	10/03/2017
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: 15-1307

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

Worksheet S-2
Part II
Date/Time Prepared:
11/22/2017 3:18 pm

		Description		Y/N	Y/N	
		0		1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.			N		21.00
					1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)						
Capital Related Cost						
22.00	Have assets been relieved for Medicare purposes? If yes, see instructions				N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				N	25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				N	27.00
Interest Expense						
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				N	31.00
Purchased Services						
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				N	33.00
Provider-Based Physicians						
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				N	35.00
				Y/N	Date	
				1.00	2.00	
Home Office Costs						
36.00	Were home office costs claimed on the cost report?			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.	JILL			HILL	41.00
42.00	Enter the employer/company name of the cost report preparer.	ST. VINCENT HEALTH				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	3175833519			JILL.HILL1@ASCENSION.ORG	43.00

		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.	REIMBURSEMENT MANAGER	41.00
42.00	Enter the employer/company name of the cost report preparer.		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.		43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 15-1307

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

Worksheet S-3
Part I
Date/Time Prepared:
11/22/2017 3:18 pm

Component	Worksheet A	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P	
	Line Number				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	16	5,840	31,776.00	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)		16	5,840	31,776.00	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)		16	5,840	31,776.00	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						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC	88.00				0	26.00
26.01 RURAL HEALTH CLINIC II	88.01				0	26.01
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		16				27.00
28.00 Observation Bed Days					0	28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)		0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 15-1307

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

Worksheet S-3
Part I
Date/Time Prepared:
11/22/2017 3:18 pm

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
	Title XVII I	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)	953	32	1,324			1.00
2.00 HMO and other (see instructions)	128	75				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	359	0	403			5.00
6.00 Hospital Adults & Peds. Swing Bed NF		0	40			6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	1,312	32	1,767			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)	1,312	32	1,767	0.00	114.33	14.00
15.00 CAH visits	27,697	1,272	75,913			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						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	0	0	0			24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC	3,291	430	17,690	0.00	15.95	26.00
26.01 RURAL HEALTH CLINIC II	5,492	252	16,319	0.00	18.12	26.01
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00 Total (sum of lines 14-26)				0.00	148.40	27.00
28.00 Observation Bed Days		0	814			28.00
29.00 Ambulance Trips	398					29.00
30.00 Employee discount days (see instruction)			0			30.00
31.00 Employee discount days - IRF			0			31.00
32.00 Labor & delivery days (see instructions)	0	0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00 LTCH non-covered days	0					33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 15-1307

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

Worksheet S-3
Part I
Date/Time Prepared:
11/22/2017 3:18 pm

Component	Full Time Equivalents	Discharges			Total All Patients		
		Nonpaid Workers	Title V	Title XVIII			Title XIX
		11.00	12.00	13.00			14.00
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	310	10	445	1.00
2.00 HMO and other (see instructions)				42	24		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		310	10	445	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							22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)							23.00
24.00 HOSPICE							24.00
24.10 HOSPICE (non-distinct part)							24.10
25.00 CMHC - CMHC							25.00
26.00 RURAL HEALTH CLINIC	0.00						26.00
26.01 RURAL HEALTH CLINIC II	0.00						26.01
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00						26.25
27.00 Total (sum of lines 14-26)	0.00						27.00
28.00 Observation Bed Days							28.00
29.00 Ambulance Trips							29.00
30.00 Employee discount days (see instruction)							30.00
31.00 Employee discount days - IRF							31.00
32.00 Labor & delivery days (see instructions)							32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)							32.01
33.00 LTCH non-covered days							33.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provider CCN: 15-1307 Component CCN: 15-3993		Period: From 07/01/2016 To 06/30/2017		Worksheet S-8 Date/Time Prepared: 11/22/2017 3:18 pm	
				RHC I		Cost	
				1.00			
1.00	Clinic Address and Identification Street			1731 RINGER LANE		1.00	
				City		State	
				1.00		2.00	
				ZIP Code		3.00	
2.00	City, State, ZIP Code, County			WILLIAMSPORT IN		47993 2.00	
				1.00			
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban					0 3.00	
				Grant Award		Date	
				1.00		2.00	
Source of Federal Funds							
4.00	Community Health Center (Section 330(d), PHS Act)					4.00	
5.00	Migrant Health Center (Section 329(d), PHS Act)					5.00	
6.00	Health Services for the Homeless (Section 340(d), PHS Act)					6.00	
7.00	Appalachian Regional Commission					7.00	
8.00	Look-Alikes					8.00	
9.00	OTHER (SPECIFY)					9.00	
9.01						9.01	
9.02						9.02	
9.03						9.03	
9.04						9.04	
9.05						9.05	
9.06						9.06	
9.07						9.07	
9.08						9.08	
9.09						9.09	
9.10						9.10	
				1.00		2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2. (Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N		0 10.00	
				Sunday		Monday	
				from		to	
				1.00		2.00	
				Monday		Tuesday	
				from		from	
				3.00		4.00	
				4.00		5.00	
11.00	Facility hours of operations (1) Clinic			07:00		19:00 07:00 11.00	
				1.00		2.00	
12.00	Have you received an approval for an exception to the productivity standard?			N		12.00	
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.			N		0 13.00	
				Provider name		CCN number	
				1.00		2.00	
14.00	RHC/FQHC name, CCN number					14.00	
				Y/N		V	
				1.00		2.00	
				XVIII		XIX	
				3.00		4.00	
				Total Visits		5.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)					15.00	

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provider CCN: 15-1307 Component CCN: 15-3993		Period: From 07/01/2016 To 06/30/2017		Worksheet S-8 Date/Time Prepared: 11/22/2017 3:18 pm		
		RHC I		Cost				
		County						
		4.00						
2.00	City, State, ZIP Code, County	WARREN						2.00
		Tuesday		Wednesday		Thursday		
		to		to		to		
		6.00		7.00		8.00		
		9.00		10.00				
11.00	Facility hours of operations (1) Clinic	19:00	07:00	19:00	07:00	19:00	11.00	
		Friday		Saturday				
		from		from		to		
		11.00		12.00		13.00		
		14.00						
11.00	Facility hours of operations (1) Clinic	07:00	19:00				11.00	

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provider CCN: 15-1307 Component CCN: 15-3994		Period: From 07/01/2016 To 06/30/2017		Worksheet S-8 Date/Time Prepared: 11/22/2017 3:18 pm	
				RHC II		Cost	
				1.00			
1.00	Clinic Address and Identification Street			440 W. SONGER LANE		1.00	
				City		State	
				1.00		2.00	
2.00	City, State, ZIP Code, County			VEEDERSBURG IN		47987 2.00	
				1.00			
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban					0 3.00	
				Grant Award		Date	
				1.00		2.00	
4.00	Source of Federal Funds Community Health Center (Section 330(d), PHS Act)					4.00	
5.00	Migrant Health Center (Section 329(d), PHS Act)					5.00	
6.00	Health Services for the Homeless (Section 340(d), PHS Act)					6.00	
7.00	Appalachian Regional Commission					7.00	
8.00	Look-Alikes					8.00	
9.00	OTHER (SPECIFY)					9.00	
9.01						9.01	
9.02						9.02	
9.03						9.03	
9.04						9.04	
9.05						9.05	
9.06						9.06	
9.07						9.07	
9.08						9.08	
9.09						9.09	
9.10						9.10	
				1.00		2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2. (Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N		0 10.00	
				Sunday		Monday	
				from to		from to	
				1.00 2.00		3.00 4.00	
				Tuesday		from	
				1.00		2.00	
11.00	Facility hours of operations (1) Clinic			08:00 17:00		08:00 11.00	
				1.00		2.00	
12.00	Have you received an approval for an exception to the productivity standard?			N		12.00	
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.			N		0 13.00	
				Provider name		CCN number	
				1.00		2.00	
14.00	RHC/FQHC name, CCN number					14.00	
				Y/N		V	
				1.00		2.00	
				XVIII		XIX	
				3.00		4.00	
				Total Visits		5.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)					15.00	

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 15-1307	Period: From 07/01/2016 To 06/30/2017	Worksheet S-10 Date/Time Prepared: 11/22/2017 3:18 pm
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				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)			0.271387	1.00	
Medicaid (see instructions for each line)						
2.00	Net revenue from Medicaid			310,064	2.00	
3.00	Did you receive DSH or supplemental payments from Medicaid?			N	3.00	
4.00	If line 3 is yes, does line 2 include all DSH or supplemental payments from Medicaid?				4.00	
5.00	If line 4 is no, then enter DSH or supplemental payments from Medicaid			0	5.00	
6.00	Medicaid charges			14,791,166	6.00	
7.00	Medicaid cost (line 1 times line 6)			4,014,130	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)			3,704,066	8.00	
Children's Health Insurance Program (CHIP) (see instructions for each line)						
9.00	Net revenue from stand-alone CHIP			0	9.00	
10.00	Stand-alone CHIP charges			0	10.00	
11.00	Stand-alone CHIP cost (line 1 times line 10)			0	11.00	
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)			0	12.00	
Other state or local government indigent care program (see instructions for each line)						
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)			0	13.00	
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)			0	14.00	
15.00	State or local indigent care program cost (line 1 times line 14)			0	15.00	
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)			0	16.00	
Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)						
17.00	Private grants, donations, or endowment income restricted to funding charity care			0	17.00	
18.00	Government grants, appropriations or transfers for support of hospital operations			0	18.00	
19.00	Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)			3,704,066	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)	3,031,717	935,110	3,966,827	20.00	
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	822,769	935,110	1,757,879	21.00	
22.00	Payments received from patients for amounts previously written off as charity care	81,458	0	81,458	22.00	
23.00	Cost of charity care (line 21 minus line 22)	741,311	935,110	1,676,421	23.00	
				1.00		
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?			N	24.00	
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit			0	25.00	
26.00	Total bad debt expense for the entire hospital complex (see instructions)			1,464,453	26.00	
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)			392,560	27.00	
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)			603,939	27.01	
28.00	Non-Medicare bad debt expense (line 26 minus line 27.01)			860,514	28.00	
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)			444,911	29.00	
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)			2,121,332	30.00	
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)			5,825,398	31.00	

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 15-1307

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

Worksheet A
Date/Time Prepared:
11/22/2017 3:18 pm

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassification (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		179,171	179,171	-1,906	177,265	1.00
2.00	00200		717,373	717,373	0	717,373	2.00
3.00	00300		0	0	0	0	3.00
4.00	00400	145,163	2,705,764	2,850,927	0	2,850,927	4.00
5.00	00500	1,785,667	1,838,419	3,624,086	1,906	3,625,992	5.00
6.00	00600	0	0	0	0	0	6.00
7.00	00700	0	661,517	661,517	0	661,517	7.00
8.00	00800	0	0	0	0	0	8.00
9.00	00900	0	226,452	226,452	0	226,452	9.00
10.00	01000	0	24,436	24,436	0	24,436	10.00
11.00	01100	0	0	0	0	0	11.00
12.00	01200	0	0	0	0	0	12.00
13.00	01300	174,303	8,534	182,837	0	182,837	13.00
14.00	01400	0	9,655	9,655	0	9,655	14.00
15.00	01500	174,283	394,406	568,689	0	568,689	15.00
16.00	01600	364,565	132,087	496,652	0	496,652	16.00
17.00	01700	0	0	0	0	0	17.00
19.00	01900	0	0	0	0	0	19.00
20.00	02000	0	0	0	0	0	20.00
21.00	02100	0	0	0	0	0	21.00
22.00	02200	0	0	0	0	0	22.00
23.00	02300	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	996,264	262,747	1,259,011	-2,122	1,256,889	30.00
43.00	04300	0	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	533,477	295,405	828,882	-42,757	786,125	50.00
53.00	05300	0	0	0	0	0	53.00
54.00	05400	596,400	364,853	961,253	0	961,253	54.00
60.00	06000	28,419	1,093,342	1,121,761	0	1,121,761	60.00
65.00	06500	20,449	16,329	36,778	0	36,778	65.00
66.00	06600	208,700	108,115	316,815	-52	316,763	66.00
68.00	06800	0	0	0	0	0	68.00
71.00	07100	0	9,485	9,485	55,653	65,138	71.00
72.00	07200	0	69,155	69,155	0	69,155	72.00
73.00	07300	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	1,031,797	524,397	1,556,194	54,993	1,611,187	88.00
88.01	08801	1,201,039	481,179	1,682,218	-54,993	1,627,225	88.01
91.00	09100	991,492	1,141,692	2,133,184	-10,722	2,122,462	91.00
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	398,879	42,425	441,304	0	441,304	95.00
SPECIAL PURPOSE COST CENTERS							
118.00		8,650,897	11,306,938	19,957,835	0	19,957,835	118.00
NONREIMBURSABLE COST CENTERS							
193.00	19300	0	0	0	0	0	193.00
193.01	19301	301,813	40,008	341,821	0	341,821	193.01
193.02	19303	0	17	17	0	17	193.02
194.00	07950	2,907	303,611	306,518	0	306,518	194.00
200.00		8,955,617	11,650,574	20,606,191	0	20,606,191	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 15-1307

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

Worksheet A
Date/Time Prepared:
11/22/2017 3:18 pm

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	-136,205	41,060	1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	0	717,373	2.00
3.00	00300	OTHER CAPITAL RELATED COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	456,172	3,307,099	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-266,941	3,359,051	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	6.00
7.00	00700	OPERATION OF PLANT	-1,939	659,578	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	8.00
9.00	00900	HOUSEKEEPING	0	226,452	9.00
10.00	01000	DIETARY	-10,990	13,446	10.00
11.00	01100	CAFETERIA	0	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	182,837	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	9,655	14.00
15.00	01500	PHARMACY	-1,574	567,115	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-9,434	487,218	16.00
17.00	01700	SOCIAL SERVICE	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	22.00
23.00	02300	PARAMED ED PRGM	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	0	1,256,889	30.00
43.00	04300	NURSERY	0	0	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-234,112	552,013	50.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-49,387	911,866	54.00
60.00	06000	LABORATORY	0	1,121,761	60.00
65.00	06500	RESPIRATORY THERAPY	0	36,778	65.00
66.00	06600	PHYSICAL THERAPY	-5,306	311,457	66.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	65,138	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	69,155	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	-18,592	1,592,595	88.00
88.01	08801	RURAL HEALTH CLINIC II	-37,308	1,589,917	88.01
91.00	09100	EMERGENCY	0	2,122,462	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0	441,304	95.00
SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1-117)	-315,616	19,642,219	118.00
NONREIMBURSABLE COST CENTERS					
193.00	19300	NONPAID WORKERS	0	0	193.00
193.01	19301	ORTHO CLINIC	0	341,821	193.01
193.02	19303	COMMUNITY MED CLINIC	0	17	193.02
194.00	07950	MARKETING	102,445	408,963	194.00
200.00		TOTAL (SUM OF LINES 118-199)	-213,171	20,393,020	200.00

RECLASSIFICATIONS

Provider CCN: 15-1307

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

Worksheet A-6

Date/Time Prepared:
11/22/2017 3:18 pm

Increases					
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
A - INTEREST					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	1,906	1.00
	TOTALS		0	1,906	
B - RHC RECLASSES					
1.00	RURAL HEALTH CLINIC	88.00	101,779	0	1.00
2.00	RURAL HEALTH CLINIC II	88.01	46,786	0	2.00
	TOTALS		148,565	0	
C - MEDICAL SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	55,653	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
	TOTALS		0	55,653	
500.00	Grand Total: Increases		148,565	57,559	500.00

RECLASSIFICATIONS

Provider CCN: 15-1307

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

Worksheet A-6

Date/Time Prepared:
11/22/2017 3:18 pm

Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
A - INTEREST						
1.00	NEW CAP REL COSTS-BLDG & FI XT	1.00	0	1,906	11	1.00
	TOTALS		0	1,906		
B - RHC RECLASSES						
1.00	RURAL HEALTH CLINIC II	88.01	101,779	0	0	1.00
2.00	RURAL HEALTH CLINIC	88.00	46,786	0	0	2.00
	TOTALS		148,565	0		
C - MEDICAL SUPPLIES						
1.00	ADULTS & PEDIATRICS	30.00	0	2,122	0	1.00
2.00	OPERATING ROOM	50.00	0	42,757	0	2.00
3.00	PHYSICAL THERAPY	66.00	0	52	0	3.00
4.00	EMERGENCY	91.00	0	10,722	0	4.00
	TOTALS		0	55,653		
500.00	Grand Total: Decreases		148,565	57,559		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-1307

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

Worksheet A-7
Part I
Date/Time Prepared:
11/22/2017 3:18 pm

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
			1.00	2.00	3.00		
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	174,050	0	0	0	0	1.00
2.00	Land Improvements	106,181	52,898	0	52,898	0	2.00
3.00	Buildings and Fixtures	7,874,174	417,462	0	417,462	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	0	1,649,197	0	1,649,197	0	5.00
6.00	Movable Equipment	5,212,978	0	0	0	1,337,757	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	13,367,383	2,119,557	0	2,119,557	1,337,757	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	13,367,383	2,119,557	0	2,119,557	1,337,757	10.00
		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	174,050	0				1.00
2.00	Land Improvements	159,079	0				2.00
3.00	Buildings and Fixtures	8,291,636	0				3.00
4.00	Building Improvements	0	0				4.00
5.00	Fixed Equipment	1,649,197	0				5.00
6.00	Movable Equipment	3,875,221	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	14,149,183	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	14,149,183	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-1307

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

Worksheet A-7
Part II
Date/Time Prepared:
11/22/2017 3:18 pm

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	NEW CAP REL COSTS-BLDG & FIXT	20,802	0	138,111	8,925	11,333	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	437,118	279,908	0	347	0	2.00
3.00	Total (sum of lines 1-2)	457,920	279,908	138,111	9,272	11,333	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	179,171				1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	717,373				2.00
3.00	Total (sum of lines 1-2)	0	896,544				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-1307

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

Worksheet A-7
Part III
Date/Time Prepared:
11/22/2017 3:18 pm

Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL			
	Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance		
	1.00	2.00	3.00	4.00	5.00		
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	10,273,962	0	10,273,962	0.723486	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	3,926,671	0	3,926,671	0.276514	0	2.00
3.00	Total (sum of lines 1-2)	14,200,633	0	14,200,633	1.000000	0	3.00
Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL			
	Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease		
	6.00	7.00	8.00	9.00	10.00		
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	20,802	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	437,118	279,908	2.00
3.00	Total (sum of lines 1-2)	0	0	0	457,920	279,908	3.00
Cost Center Description	SUMMARY OF CAPITAL						
	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)		
	11.00	12.00	13.00	14.00	15.00		
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	8,925	11,333	0	41,060	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	347	0	0	717,373	2.00
3.00	Total (sum of lines 1-2)	0	9,272	11,333	0	758,433	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 15-1307

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

Worksheet A-8

Date/Time Prepared:
11/22/2017 3:18 pm

Line #	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
				1.00	2.00		
1.00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-135,479	NEW CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00	Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)			NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)	B	-1,896	ADMINISTRATIVE & GENERAL	5.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-283,499			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	790,513			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests		0		0.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts		0		0.00	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	-5,306	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - NEW CAP REL COSTS-BLDG & FIXT			NEW CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - NEW CAP REL COSTS-MVBLE EQUIP			NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist			NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00	Physicians' assistant				0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)			ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
			Cost Center	Line #		
			1.00	2.00		
33.00 CHARITABLE CONTRIBUTIONS	A	-590	ADMINISTRATIVE & GENERAL	5.00	0	33.00
34.00 ALCOHOL EXPENSE	A	-52	ADMINISTRATIVE & GENERAL	5.00	0	34.00
35.00		0		0.00	0	35.00
36.00 LOBBYING	A	-812	ADMINISTRATIVE & GENERAL	5.00	0	36.00
37.00 PROVIDER TAX	A	-632,016	ADMINISTRATIVE & GENERAL	5.00	0	37.00
38.00		0		0.00	0	38.00
39.00 CREDENTIALING	B	-8,645	ADMINISTRATIVE & GENERAL	5.00	0	39.00
40.00		0		0.00	0	40.00
41.00 FOOD SERVICES	B	-10,990	DIETARY	10.00	0	41.00
41.01 PHARMACY SERVICES	B	-1,574	PHARMACY	15.00	0	41.01
42.00 MED. RECORD COPY REVENUE	B	-9,434	MEDICAL RECORDS & LIBRARY	16.00	0	42.00
43.00		0		0.00	0	43.00
43.01 MISSION POINT SAVINGS	B	-22,994	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	43.01
43.02		0		0.00	0	43.02
45.00 INCENTIVE ACCRUAL ADJUSTMENT	A	165,503	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	45.00
45.01		0		0.00	0	45.01
45.02 NON-RHC SALARIES	A	-18,592	RURAL HEALTH CLINIC	88.00	0	45.02
45.03 NON-RHC SALARIES	A	-37,308	RURAL HEALTH CLINIC II	88.01	0	45.03
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-213,171				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: 15-1307

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

Worksheet A-8-1

Date/Time Prepared: 11/22/2017 3:18 pm

Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5		
1.00	2.00	3.00	4.00	5.00		
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:						
1.00	5.00	ADMINISTRATIVE & GENERAL	HO	1,442,030	1,064,950	1.00
2.00	194.00	MARKETING	HO	102,445	0	2.00
3.00	193.02	COMMUNITY MED CLINIC	SVH CHARGEBACKS	17	17	3.00
3.01	4.00	EMPLOYEE BENEFITS DEPARTMENT	SVH CHARGEBACKS	350,254	350,254	3.01
4.00	5.00	ADMINISTRATIVE & GENERAL	SVH CHARGEBACKS	1,414,526	1,414,526	4.00
4.01	13.00	NURSING ADMINISTRATION	SVH CHARGEBACKS	1,692	1,692	4.01
4.02	15.00	PHARMACY	SVH CHARGEBACKS	41,319	41,319	4.02
4.03	16.00	MEDICAL RECORDS & LIBRARY	SVH CHARGEBACKS	453,569	453,569	4.03
4.04	30.00	ADULTS & PEDIATRICS	SVH CHARGEBACKS	104,242	104,242	4.04
4.05	0.00			0	0	4.05
4.06	54.00	RADIOLOGY-DIAGNOSTIC	SVH CHARGEBACKS	29,484	29,484	4.06
4.07	65.00	RESPIRATORY THERAPY	SVH CHARGEBACKS	3,300	3,300	4.07
4.08	88.00	RURAL HEALTH CLINIC	SVH CHARGEBACKS	157,290	157,290	4.08
4.09	88.01	RURAL HEALTH CLINIC II	SVH CHARGEBACKS	179,619	179,619	4.09
4.10	91.00	EMERGENCY	SVH CHARGEBACKS	2,710	2,710	4.10
4.11	193.01	ORTHO CLINIC	SVH CHARGEBACKS	18,327	18,327	4.11
4.12	4.00	EMPLOYEE BENEFITS DEPARTMENT	SELF INSURANCE	1,672,226	1,552,743	4.12
4.13	1.00	NEW CAP REL COSTS-BLDG & FIX	ASCENSION INTEREST	135,479	136,205	4.13
4.14	5.00	ADMINISTRATIVE & GENERAL	ASCENSION INTEREST	1,896	1,906	4.14
4.15	7.00	OPERATION OF PLANT	MEDXCEL	266,213	268,152	4.15
4.16	4.00	EMPLOYEE BENEFITS DEPARTMENT	ASCENSION - PENSION	356,392	80,704	4.16
4.17	4.00	EMPLOYEE BENEFITS DEPARTMENT	HO	0	81,508	4.17
4.18	0.00			0	0	4.18
4.19	0.00			0	0	4.19
4.20	0.00			0	0	4.20
4.21	0.00			0	0	4.21
4.22	0.00			0	0	4.22
4.23	0.00			0	0	4.23
4.24	0.00			0	0	4.24
4.25	0.00			0	0	4.25
4.26	0.00			0	0	4.26
4.27	0.00			0	0	4.27
4.28	0.00			0	0	4.28
5.00	0			6,733,030	5,942,517	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.

Symbol (1)	Name	Percentage of Ownership	Related Organization(s) and/or Home Office	
			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	G	SVH	100.00	ST. VINCENT HEALTH	100.00	6.00
7.00	G	ASCENSION	100.00	ASCENSION	100.00	7.00
8.00	A	TRIMEDX	100.00	TRIMEDX	100.00	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:	HOME OFFICE				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: 15-1307

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

Worksheet A-8-1

Date/Time Prepared:
11/22/2017 3:18 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00	377,080	0		1.00
2.00	102,445	0		2.00
3.00	0	0		3.00
3.01	0	0		3.01
4.00	0	0		4.00
4.01	0	0		4.01
4.02	0	0		4.02
4.03	0	0		4.03
4.04	0	0		4.04
4.05	0	0		4.05
4.06	0	0		4.06
4.07	0	0		4.07
4.08	0	0		4.08
4.09	0	0		4.09
4.10	0	0		4.10
4.11	0	0		4.11
4.12	119,483	0		4.12
4.13	-726	11		4.13
4.14	-10	0		4.14
4.15	-1,939	0		4.15
4.16	275,688	0		4.16
4.17	-81,508	0		4.17
4.18	0	0		4.18
4.19	0	0		4.19
4.20	0	0		4.20
4.21	0	0		4.21
4.22	0	0		4.22
4.23	0	0		4.23
4.24	0	0		4.24
4.25	0	0		4.25
4.26	0	0		4.26
4.27	0	0		4.27
4.28	0	0		4.28
5.00	790,513			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	ADMINISTRATION		6.00
7.00	ADMINISTRATION		7.00
8.00	TECHNOLOGY MGNT		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: 15-1307

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

Worksheet A-8-2

Date/Time Prepared:
11/22/2017 3:18 pm

1.00	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	50.00	OPERATING ROOM	234,112	234,112	0	0	0	1.00
2.00	54.00	RADIOLOGY-DIAGNOSTIC	1,575	1,575	0	0	0	2.00
3.00	54.00	RADIOLOGY-DIAGNOSTIC	47,812	47,812	0	0	0	3.00
4.00	91.00	EMERGENCY	954,383	0	954,383	0	0	4.00
5.00	0.00		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			1,237,882	283,499	954,383			200.00

1.00	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	50.00	OPERATING ROOM	0	0	0	0	0	1.00
2.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	2.00
3.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	3.00
4.00	91.00	EMERGENCY	0	0	0	0	0	4.00
5.00	0.00		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

1.00	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	50.00	OPERATING ROOM	0	0	0	234,112	1.00
2.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	1,575	2.00
3.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	47,812	3.00
4.00	91.00	EMERGENCY	0	0	0	0	4.00
5.00	0.00		0	0	0	0	5.00
6.00	0.00		0	0	0	0	6.00
7.00	0.00		0	0	0	0	7.00
8.00	0.00		0	0	0	0	8.00
9.00	0.00		0	0	0	0	9.00
10.00	0.00		0	0	0	0	10.00
200.00			0	0	0	283,499	200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 15-1307		Period: From 07/01/2016 To 06/30/2017		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 11/22/2017 3:18 pm	
		Physical Therapy		Cost			
				1.00			
PART I - GENERAL INFORMATION							
1.00	Total number of weeks worked (excluding aides) (see instructions)					52	1.00
2.00	Line 1 multiplied by 15 hours per week					780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					0	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					255	6.00
7.00	Standard travel expense rate					9.57	7.00
8.00	Optional travel expense rate per mile					0.00	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	0.00	1,709.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	0.00	52.82	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	0.00	0.00	26.41			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01
				1.00			
Part II - SALARY EQUIVALENCY COMPUTATION							
14.00	Supervisors (column 1, line 9 times column 1, line 10)					0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					0	15.00
16.00	Assistants (column 3, line 9 times column 3, line 10)					90,269	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					90,269	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)					0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)					0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)					90,269	20.00
If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.							
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)					0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					0	22.00
23.00	Total salary equivalency (see instructions)					90,269	23.00
PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE							
Standard Travel Allowance							
24.00	Therapists (line 3 times column 2, line 11)					0	24.00
25.00	Assistants (line 4 times column 3, line 11)					0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					0	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					0	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					0	28.00
Optional Travel Allowance and Optional Travel Expense							
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)					0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)					0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)					0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)					0	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE							
Standard Travel Expense							
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					6,735	37.00
38.00	Subtotal (sum of lines 36 and 37)					6,735	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					2,440	39.00
Optional Travel Allowance and Optional Travel Expense							
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.							
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 15-1307				Period: From 07/01/2016 To 06/30/2017		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 11/22/2017 3:18 pm	
								Physical Therapy	Cost
								1.00	
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)							0	46.00
		Therapists	Assistants	Aides	Trainees	Total			
		1.00	2.00	3.00	4.00	5.00			
PART V - OVERTIME COMPUTATION									
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00		47.00	
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00	0.00		48.00	
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00	0.00		49.00	
CALCULATION OF LIMIT									
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00		50.00	
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50 (see instructions)	0.00	0.00	0.00	0.00	0.00		51.00	
DETERMINATION OF OVERTIME ALLOWANCE									
52.00	Adjusted hourly salary equivalency amount (see instructions)	0.00	52.82	0.00	0.00			52.00	
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0			53.00	
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0			54.00	
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0			55.00	
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0		56.00	
								1.00	
Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT									
57.00	Salary equivalency amount (from line 23)							90,269	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))							0	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)							0	59.00
60.00	Overtime allowance (from column 5, line 56)							0	60.00
61.00	Equipment cost (see instructions)							0	61.00
62.00	Supplies (see instructions)							0	62.00
63.00	Total allowance (sum of lines 57-62)							90,269	63.00
64.00	Total cost of outside supplier services (from your records)							95,575	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)							5,306	65.00
LINE 33 CALCULATION									
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others							0	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others							0	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27							0	100.02
LINE 34 CALCULATION									
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others							0	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others							0	101.01
101.02	Line 34 = sum of lines 27 and 31							0	101.02
LINE 35 CALCULATION									
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others							0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others							0	102.01
102.02	Line 35 = sum of lines 31 and 32							0	102.02

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-1307

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

Worksheet B
Part I
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Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
		NEW BLDG & FIXT	NEW MVBLE EQUIP			
	0	1.00	2.00	4.00	4A	
GENERAL SERVICE COST CENTERS						
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT	41,060	41,060			1.00
2.00 00200	NEW CAP REL COSTS-MVBLE EQUIP	717,373		717,373		2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	3,307,099	0	0	3,307,099	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	3,359,051	4,395	76,779	670,268	4,110,493 5.00
6.00 00600	MAINTENANCE & REPAIRS	0	0	0	0	6.00
7.00 00700	OPERATION OF PLANT	659,578	5,906	103,183	0	768,667 7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	166	2,896	0	3,062 8.00
9.00 00900	HOUSEKEEPING	226,452	41	717	0	227,210 9.00
10.00 01000	DIETARY	13,446	0	0	0	13,446 10.00
11.00 01100	CAFETERIA	0	0	0	0	0 11.00
12.00 01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0 12.00
13.00 01300	NURSING ADMINISTRATION	182,837	440	7,681	65,427	256,385 13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	9,655	0	0	0	9,655 14.00
15.00 01500	PHARMACY	567,115	0	0	65,419	632,534 15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	487,218	1,413	24,683	136,843	650,157 16.00
17.00 01700	SOCIAL SERVICE	0	0	0	0	0 17.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0 19.00
20.00 02000	NURSING SCHOOL	0	0	0	0	0 20.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0 21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	0 22.00
23.00 02300	PARAMED PRGM	0	0	0	0	0 23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	1,256,889	5,031	87,907	373,959	1,723,786 30.00
43.00 04300	NURSERY	0	0	0	0	0 43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	552,013	3,451	60,300	200,246	816,010 50.00
53.00 05300	ANESTHESIOLOGY	0	0	0	0	0 53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	911,866	2,352	41,092	223,865	1,179,175 54.00
60.00 06000	LABORATORY	1,121,761	1,178	20,574	10,667	1,154,180 60.00
65.00 06500	RESPIRATORY THERAPY	36,778	713	12,466	7,676	57,633 65.00
66.00 06600	PHYSICAL THERAPY	311,457	1,613	28,185	78,338	419,593 66.00
68.00 06800	SPEECH PATHOLOGY	0	0	0	0	0 68.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	65,138	443	7,736	0	73,317 71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENT	69,155	0	0	0	69,155 72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	375	6,550	0	6,925 73.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800	RURAL HEALTH CLINIC	1,592,595	3,608	63,045	407,939	2,067,187 88.00
88.01 08801	RURAL HEALTH CLINIC II	1,589,917	5,187	90,623	430,181	2,115,908 88.01
91.00 09100	EMERGENCY	2,122,462	2,037	35,590	372,167	2,532,256 91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					0 92.00
OTHER REIMBURSABLE COST CENTERS						
95.00 09500	AMBULANCE SERVICES	441,304	2,314	40,430	149,724	633,772 95.00
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1-117)	19,642,219	40,663	710,437	3,192,719	19,520,506 118.00
NONREIMBURSABLE COST CENTERS						
193.00 19300	NONPAID WORKERS	0	0	0	0	0 193.00
193.01 19301	ORTHO CLINIC	341,821	391	6,839	113,289	462,340 193.01
193.02 19303	COMMUNITY MED CLINIC	17	0	0	0	17 193.02
194.00 07950	MARKETING	408,963	6	97	1,091	410,157 194.00
200.00	Cross Foot Adjustments					0 200.00
201.00	Negative Cost Centers		0	0	0	0 201.00
202.00	TOTAL (sum lines 118-201)	20,393,020	41,060	717,373	3,307,099	20,393,020 202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-1307

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

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Cost Center Description		ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
		5.00	6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	4,110,493				5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0			6.00
7.00	00700	OPERATION OF PLANT	194,048	0	962,715		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	773	0	7,265	11,100	8.00
9.00	00900	HOUSEKEEPING	57,359	0	1,799	0	286,368
10.00	01000	DIETARY	3,394	0	0	0	0
11.00	01100	CAFETERIA	0	0	0	0	0
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0
13.00	01300	NURSING ADMINISTRATION	64,724	0	19,269	0	4,120
14.00	01400	CENTRAL SERVICES & SUPPLY	2,437	0	0	0	0
15.00	01500	PHARMACY	159,682	0	0	0	0
16.00	01600	MEDICAL RECORDS & LIBRARY	164,131	0	61,923	0	13,242
17.00	01700	SOCIAL SERVICE	0	0	0	0	0
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0
20.00	02000	NURSING SCHOOL	0	0	0	0	0
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	0
23.00	02300	PARAMED ED PRGM	0	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	435,166	0	220,537	4,995	47,160
43.00	04300	NURSERY	0	0	0	0	0
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	206,000	0	151,279	1,887	32,350
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	297,680	0	103,090	555	22,045
60.00	06000	LABORATORY	291,370	0	51,614	0	11,037
65.00	06500	RESPIRATORY THERAPY	14,549	0	31,273	0	6,687
66.00	06600	PHYSICAL THERAPY	105,925	0	70,710	1,110	15,121
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	18,509	0	19,407	0	4,150
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	17,458	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	1,748	0	16,432	0	3,514
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	521,857	0	0	302	33,822
88.01	08801	RURAL HEALTH CLINIC II	534,157	0	0	253	48,616
91.00	09100	EMERGENCY	639,268	0	89,287	1,665	19,093
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	159,994	0	101,429	333	21,690
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1-117)	3,890,229	0	945,314	11,100	282,647
NONREIMBURSABLE COST CENTERS							
193.00	19300	NONPAID WORKERS	0	0	0	0	0
193.01	19301	ORTHO CLINIC	116,717	0	17,159	0	3,669
193.02	19303	COMMUNITY MED CLINIC	4	0	0	0	0
194.00	07950	MARKETING	103,543	0	242	0	52
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118-201)	4,110,493	0	962,715	11,100	286,368

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-1307

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

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Cost Center Description		DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
		10.00	11.00	12.00	13.00	14.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
6.00	00600						6.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000	16,840					10.00
11.00	01100	0	0				11.00
12.00	01200	0	0	0			12.00
13.00	01300	0	0	0	344,498		13.00
14.00	01400	0	0	0	0	12,092	14.00
15.00	01500	0	0	0	0	0	15.00
16.00	01600	0	0	0	0	0	16.00
17.00	01700	0	0	0	0	0	17.00
19.00	01900	0	0	0	0	0	19.00
20.00	02000	0	0	0	0	0	20.00
21.00	02100	0	0	0	0	0	21.00
22.00	02200	0	0	0	0	0	22.00
23.00	02300	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	16,840	0	0	143,170	0	30.00
43.00	04300	0	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	0	0	0	46,949	0	50.00
53.00	05300	0	0	0	0	0	53.00
54.00	05400	0	0	0	0	0	54.00
60.00	06000	0	0	0	8,553	0	60.00
65.00	06500	0	0	0	3,741	0	65.00
66.00	06600	0	0	0	23,553	0	66.00
68.00	06800	0	0	0	0	0	68.00
71.00	07100	0	0	0	0	5,865	71.00
72.00	07200	0	0	0	0	6,227	72.00
73.00	07300	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	0	0	0	0	0	88.00
88.01	08801	0	0	0	0	0	88.01
91.00	09100	0	0	0	118,532	0	91.00
92.00	09200	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	0	0	0	0	0	95.00
SPECIAL PURPOSE COST CENTERS							
118.00		16,840	0	0	344,498	12,092	118.00
NONREIMBURSABLE COST CENTERS							
193.00	19300	0	0	0	0	0	193.00
193.01	19301	0	0	0	0	0	193.01
193.02	19302	0	0	0	0	0	193.02
194.00	07950	0	0	0	0	0	194.00
200.00		0	0	0	0	0	200.00
201.00		0	0	0	0	0	201.00
202.00		16,840	0	0	344,498	12,092	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description		PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	NURSING SCHOOL	
		15.00	16.00	17.00	19.00	20.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
6.00	00600						6.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100						11.00
12.00	01200						12.00
13.00	01300						13.00
14.00	01400						14.00
15.00	01500	792,216					15.00
16.00	01600	0	889,453				16.00
17.00	01700	0	0	0			17.00
19.00	01900	0	0	0	0		19.00
20.00	02000	0	0	0		0	20.00
21.00	02100	0	0	0			21.00
22.00	02200	0	0	0			22.00
23.00	02300	0	0	0			23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	0	67,692	0	0	0	30.00
43.00	04300	0	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	0	67,884	0	0	0	50.00
53.00	05300	0	0	0	0	0	53.00
54.00	05400	0	228,120	0	0	0	54.00
60.00	06000	0	160,974	0	0	0	60.00
65.00	06500	0	12,180	0	0	0	65.00
66.00	06600	0	25,753	0	0	0	66.00
68.00	06800	0	0	0	0	0	68.00
71.00	07100	0	0	0	0	0	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	792,216	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	0	40,133	0	0	0	88.00
88.01	08801	0	35,238	0	0	0	88.01
91.00	09100	0	224,269	0	0	0	91.00
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	0	27,210	0	0	0	95.00
SPECIAL PURPOSE COST CENTERS							
118.00		792,216	889,453	0	0	0	118.00
NONREIMBURSABLE COST CENTERS							
193.00	19300	0	0	0	0	0	193.00
193.01	19301	0	0	0	0	0	193.01
193.02	19303	0	0	0	0	0	193.02
194.00	07950	0	0	0	0	0	194.00
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		792,216	889,453	0	0	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-1307

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

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Date/Time Prepared:
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Cost Center Description	INTERNS & RESIDENTS		PARAMED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments
	SERVICES-SALARY & FRINGES	SERVICES-OTHER PRGM COSTS			
	21.00	22.00			
GENERAL SERVICE COST CENTERS					
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00 00500 ADMINISTRATIVE & GENERAL					5.00
6.00 00600 MAINTENANCE & REPAIRS					6.00
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
12.00 01200 MAINTENANCE OF PERSONNEL					12.00
13.00 01300 NURSING ADMINISTRATION					13.00
14.00 01400 CENTRAL SERVICES & SUPPLY					14.00
15.00 01500 PHARMACY					15.00
16.00 01600 MEDICAL RECORDS & LIBRARY					16.00
17.00 01700 SOCIAL SERVICE					17.00
19.00 01900 NONPHYSICIAN ANESTHETISTS					19.00
20.00 02000 NURSING SCHOOL					20.00
21.00 02100 I&R SERVICES-SALARY & FRINGES APPRVD	0				21.00
22.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD		0			22.00
23.00 02300 PARAMED PRGM			0		23.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00 03000 ADULTS & PEDIATRICS	0	0	0	2,659,346	0 30.00
43.00 04300 NURSERY	0	0	0	0	0 43.00
ANCILLARY SERVICE COST CENTERS					
50.00 05000 OPERATING ROOM	0	0	0	1,322,359	0 50.00
53.00 05300 ANESTHESIOLOGY	0	0	0	0	0 53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	0	1,830,665	0 54.00
60.00 06000 LABORATORY	0	0	0	1,677,728	0 60.00
65.00 06500 RESPIRATORY THERAPY	0	0	0	126,063	0 65.00
66.00 06600 PHYSICAL THERAPY	0	0	0	661,765	0 66.00
68.00 06800 SPEECH PATHOLOGY	0	0	0	0	0 68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	121,248	0 71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0	0	92,840	0 72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	820,835	0 73.00
OUTPATIENT SERVICE COST CENTERS					
88.00 08800 RURAL HEALTH CLINIC	0	0	0	2,663,301	0 88.00
88.01 08801 RURAL HEALTH CLINIC II	0	0	0	2,734,172	0 88.01
91.00 09100 EMERGENCY	0	0	0	3,624,370	0 91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)					0 92.00
OTHER REIMBURSABLE COST CENTERS					
95.00 09500 AMBULANCE SERVICES	0	0	0	944,428	0 95.00
SPECIAL PURPOSE COST CENTERS					
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	0	19,279,120	0 118.00
NONREIMBURSABLE COST CENTERS					
193.00 19300 NONPAID WORKERS	0	0	0	0	0 193.00
193.01 19301 ORTHO CLINIC	0	0	0	599,885	0 193.01
193.02 19303 COMMUNITY MED CLINIC	0	0	0	21	0 193.02
194.00 07950 MARKETING	0	0	0	513,994	0 194.00
200.00	Cross Foot Adjustments	0	0	0	0 200.00
201.00	Negative Cost Centers	0	0	0	0 201.00
202.00	TOTAL (sum lines 118-201)	0	0	20,393,020	0 202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-1307

Period:
From 07/01/2016
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Cost Center Description		Total	
		26.00	
GENERAL SERVICE COST CENTERS			
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT		1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP		2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT		4.00
5.00	00500 ADMINISTRATIVE & GENERAL		5.00
6.00	00600 MAINTENANCE & REPAIRS		6.00
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
12.00	01200 MAINTENANCE OF PERSONNEL		12.00
13.00	01300 NURSING ADMINISTRATION		13.00
14.00	01400 CENTRAL SERVICES & SUPPLY		14.00
15.00	01500 PHARMACY		15.00
16.00	01600 MEDICAL RECORDS & LIBRARY		16.00
17.00	01700 SOCIAL SERVICE		17.00
19.00	01900 NONPHYSICIAN ANESTHETISTS		19.00
20.00	02000 NURSING SCHOOL		20.00
21.00	02100 I&R SERVICES-SALARY & FRINGES APPRVD		21.00
22.00	02200 I&R SERVICES-OTHER PRGM COSTS APPRVD		22.00
23.00	02300 PARAMED ED PRGM		23.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000 ADULTS & PEDIATRICS	2,659,346	30.00
43.00	04300 NURSERY	0	43.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000 OPERATING ROOM	1,322,359	50.00
53.00	05300 ANESTHESIOLOGY	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	1,830,665	54.00
60.00	06000 LABORATORY	1,677,728	60.00
65.00	06500 RESPIRATORY THERAPY	126,063	65.00
66.00	06600 PHYSICAL THERAPY	661,765	66.00
68.00	06800 SPEECH PATHOLOGY	0	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	121,248	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	92,840	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	820,835	73.00
OUTPATIENT SERVICE COST CENTERS			
88.00	08800 RURAL HEALTH CLINIC	2,663,301	88.00
88.01	08801 RURAL HEALTH CLINIC II	2,734,172	88.01
91.00	09100 EMERGENCY	3,624,370	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		92.00
OTHER REIMBURSABLE COST CENTERS			
95.00	09500 AMBULANCE SERVICES	944,428	95.00
SPECIAL PURPOSE COST CENTERS			
118.00	SUBTOTALS (SUM OF LINES 1-117)	19,279,120	118.00
NONREIMBURSABLE COST CENTERS			
193.00	19300 NONPAID WORKERS	0	193.00
193.01	19301 ORTHO CLINIC	599,885	193.01
193.02	19303 COMMUNITY MED CLINIC	21	193.02
194.00	07950 MARKETING	513,994	194.00
200.00	Cross Foot Adjustments	0	200.00
201.00	Negative Cost Centers	0	201.00
202.00	TOTAL (sum lines 118-201)	20,393,020	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-1307

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

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Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		NEW BLDG & FIXT	NEW MVBLE EQUIP			
		1.00	2.00			
GENERAL SERVICE COST CENTERS						
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	362,189	4,395	76,779	443,363	5.00
6.00 00600	MAINTENANCE & REPAIRS	0	0	0	0	6.00
7.00 00700	OPERATION OF PLANT	0	5,906	103,183	109,089	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	166	2,896	3,062	8.00
9.00 00900	HOUSEKEEPING	0	41	717	758	9.00
10.00 01000	DIETARY	0	0	0	0	10.00
11.00 01100	CAFETERIA	0	0	0	0	11.00
12.00 01200	MAINTENANCE OF PERSONNEL	0	0	0	0	12.00
13.00 01300	NURSING ADMINISTRATION	0	440	7,681	8,121	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	14.00
15.00 01500	PHARMACY	0	0	0	0	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	1,413	24,683	26,096	16.00
17.00 01700	SOCIAL SERVICE	0	0	0	0	17.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
20.00 02000	NURSING SCHOOL	0	0	0	0	20.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	22.00
23.00 02300	PARAMED ED PRGM	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	0	5,031	87,907	92,938	30.00
43.00 04300	NURSERY	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	0	3,451	60,300	63,751	50.00
53.00 05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	2,352	41,092	43,444	54.00
60.00 06000	LABORATORY	0	1,178	20,574	21,752	60.00
65.00 06500	RESPIRATORY THERAPY	0	713	12,466	13,179	65.00
66.00 06600	PHYSICAL THERAPY	0	1,613	28,185	29,798	66.00
68.00 06800	SPEECH PATHOLOGY	0	0	0	0	68.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	443	7,736	8,179	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	375	6,550	6,925	73.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800	RURAL HEALTH CLINIC	0	3,608	63,045	66,653	88.00
88.01 08801	RURAL HEALTH CLINIC II	0	5,187	90,623	95,810	88.01
91.00 09100	EMERGENCY	0	2,037	35,590	37,627	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)				0	92.00
OTHER REIMBURSABLE COST CENTERS						
95.00 09500	AMBULANCE SERVICES	0	2,314	40,430	42,744	95.00
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1-117)	362,189	40,663	710,437	1,113,289	118.00
NONREIMBURSABLE COST CENTERS						
193.00 19300	NONPAID WORKERS	0	0	0	0	193.00
193.01 19301	ORTHO CLINIC	0	391	6,839	7,230	193.01
193.02 19303	COMMUNITY MED CLINIC	0	0	0	0	193.02
194.00 07950	MARKETING	0	6	97	103	194.00
200.00	Cross Foot Adjustments				0	200.00
201.00	Negative Cost Centers				0	201.00
202.00	TOTAL (sum lines 118-201)	362,189	41,060	717,373	1,120,622	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-1307

Period:
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To 06/30/2017

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Cost Center Description		ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
		5.00	6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	443,363				5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0			6.00
7.00	00700	OPERATION OF PLANT	20,930	0	130,019		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	83	0	981	4,126	8.00
9.00	00900	HOUSEKEEPING	6,187	0	243	0	7,188
10.00	01000	DIETARY	366	0	0	0	0
11.00	01100	CAFETERIA	0	0	0	0	0
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0
13.00	01300	NURSING ADMINISTRATION	6,981	0	2,602	0	103
14.00	01400	CENTRAL SERVICES & SUPPLY	263	0	0	0	0
15.00	01500	PHARMACY	17,223	0	0	0	0
16.00	01600	MEDICAL RECORDS & LIBRARY	17,703	0	8,363	0	332
17.00	01700	SOCIAL SERVICE	0	0	0	0	0
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0
20.00	02000	NURSING SCHOOL	0	0	0	0	0
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	0
23.00	02300	PARAMED ED PRGM	0	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	46,937	0	29,783	1,857	1,184
43.00	04300	NURSERY	0	0	0	0	0
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	22,219	0	20,431	701	812
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	32,108	0	13,923	206	553
60.00	06000	LABORATORY	31,427	0	6,971	0	277
65.00	06500	RESPIRATORY THERAPY	1,569	0	4,224	0	168
66.00	06600	PHYSICAL THERAPY	11,425	0	9,550	413	380
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,996	0	2,621	0	104
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1,883	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	189	0	2,219	0	88
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	56,287	0	0	112	849
88.01	08801	RURAL HEALTH CLINIC II	57,614	0	0	94	1,222
91.00	09100	EMERGENCY	68,959	0	12,059	619	479
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	17,257	0	13,699	124	544
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1-117)	419,606	0	127,669	4,126	7,095
NONREIMBURSABLE COST CENTERS							
193.00	19300	NONPAID WORKERS	0	0	0	0	0
193.01	19301	ORTHO CLINIC	12,589	0	2,317	0	92
193.02	19303	COMMUNITY MED CLINIC	0	0	0	0	0
194.00	07950	MARKETING	11,168	0	33	0	1,194.00
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118-201)	443,363	0	130,019	4,126	7,188

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 15-1307		Period: From 07/01/2016 To 06/30/2017		Worksheet B Part II Date/Time Prepared: 11/22/2017 3:18 pm	
Cost Center Description			DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			10.00	11.00	12.00	13.00	14.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
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	366					10.00
11.00	01100	CAFETERIA	0	0				11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0			12.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	17,807		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	263	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	366	0	0	7,401	0	30.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	2,427	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	442	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	193	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	1,217	0	66.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	128	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	135	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
91.00	09100	EMERGENCY	0	0	0	6,127	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1-117)	366	0	0	17,807	263	118.00
NONREIMBURSABLE COST CENTERS								
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	ORTHO CLINIC	0	0	0	0	0	193.01
193.02	19303	COMMUNITY MED CLINIC	0	0	0	0	0	193.02
194.00	07950	MARKETING	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	366	0	0	17,807	263	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-1307

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Cost Center Description		PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	NURSING SCHOOL	
		15.00	16.00	17.00	19.00	20.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
6.00	00600						6.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100						11.00
12.00	01200						12.00
13.00	01300						13.00
14.00	01400						14.00
15.00	01500	17,223					15.00
16.00	01600	0	52,494				16.00
17.00	01700	0	0	0			17.00
19.00	01900	0	0	0	0		19.00
20.00	02000	0	0	0		0	20.00
21.00	02100	0	0	0			21.00
22.00	02200	0	0	0			22.00
23.00	02300	0	0	0			23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	0	3,993	0			30.00
43.00	04300	0	0	0			43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	0	4,005	0			50.00
53.00	05300	0	0	0			53.00
54.00	05400	0	13,478	0			54.00
60.00	06000	0	9,497	0			60.00
65.00	06500	0	719	0			65.00
66.00	06600	0	1,519	0			66.00
68.00	06800	0	0	0			68.00
71.00	07100	0	0	0			71.00
72.00	07200	0	0	0			72.00
73.00	07300	17,223	0	0			73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	0	2,368	0			88.00
88.01	08801	0	2,079	0			88.01
91.00	09100	0	13,231	0			91.00
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	0	1,605	0			95.00
SPECIAL PURPOSE COST CENTERS							
118.00		17,223	52,494	0	0	0	118.00
NONREIMBURSABLE COST CENTERS							
193.00	19300	0	0	0			193.00
193.01	19301	0	0	0			193.01
193.02	19303	0	0	0			193.02
194.00	07950	0	0	0			194.00
200.00					0	0	200.00
201.00		0	0	0	0	0	201.00
202.00		17,223	52,494	0	0	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-1307

Period:
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To 06/30/2017

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Part II
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Cost Center Description	INTERNS & RESIDENTS		PARAMED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments		
	SERVICES-SALARY & FRINGES	SERVICES-OTHER PRGM COSTS					
	21.00	22.00					
GENERAL SERVICE COST CENTERS							
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT					1.00		
2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP					2.00		
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT					4.00		
5.00 00500 ADMINISTRATIVE & GENERAL					5.00		
6.00 00600 MAINTENANCE & REPAIRS					6.00		
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		
12.00 01200 MAINTENANCE OF PERSONNEL					12.00		
13.00 01300 NURSING ADMINISTRATION					13.00		
14.00 01400 CENTRAL SERVICES & SUPPLY					14.00		
15.00 01500 PHARMACY					15.00		
16.00 01600 MEDICAL RECORDS & LIBRARY					16.00		
17.00 01700 SOCIAL SERVICE					17.00		
19.00 01900 NONPHYSICIAN ANESTHETISTS					19.00		
20.00 02000 NURSING SCHOOL					20.00		
21.00 02100 I&R SERVICES-SALARY & FRINGES APPRVD	0				21.00		
22.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD		0			22.00		
23.00 02300 PARAMED PRGM			0		23.00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 03000 ADULTS & PEDIATRICS				184,459	0 30.00		
43.00 04300 NURSERY				0	0 43.00		
ANCILLARY SERVICE COST CENTERS							
50.00 05000 OPERATING ROOM				114,346	0 50.00		
53.00 05300 ANESTHESIOLOGY				0	0 53.00		
54.00 05400 RADIOLOGY-DIAGNOSTIC				103,712	0 54.00		
60.00 06000 LABORATORY				70,366	0 60.00		
65.00 06500 RESPIRATORY THERAPY				20,052	0 65.00		
66.00 06600 PHYSICAL THERAPY				54,302	0 66.00		
68.00 06800 SPEECH PATHOLOGY				0	0 68.00		
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS				13,028	0 71.00		
72.00 07200 IMPL. DEV. CHARGED TO PATIENT				2,018	0 72.00		
73.00 07300 DRUGS CHARGED TO PATIENTS				26,644	0 73.00		
OUTPATIENT SERVICE COST CENTERS							
88.00 08800 RURAL HEALTH CLINIC				126,269	0 88.00		
88.01 08801 RURAL HEALTH CLINIC II				156,819	0 88.01		
91.00 09100 EMERGENCY				139,101	0 91.00		
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)					0 92.00		
OTHER REIMBURSABLE COST CENTERS							
95.00 09500 AMBULANCE SERVICES				75,973	0 95.00		
SPECIAL PURPOSE COST CENTERS							
118.00	SUBTOTALS (SUM OF LINES 1-117)		0	0	0	1,087,089	0 118.00
NONREIMBURSABLE COST CENTERS							
193.00 19300 NONPAID WORKERS				0	0 193.00		
193.01 19301 ORTHO CLINIC				22,228	0 193.01		
193.02 19303 COMMUNITY MED CLINIC				0	0 193.02		
194.00 07950 MARKETING				11,305	0 194.00		
200.00	Cross Foot Adjustments	0	0	0	0 200.00		
201.00	Negative Cost Centers	0	0	0	0 201.00		
202.00	TOTAL (sum lines 118-201)	0	0	0	1,120,622	0 202.00	

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 15-1307	Period: From 07/01/2016 To 06/30/2017	Worksheet B Part II Date/Time Prepared: 11/22/2017 3:18 pm
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Cost Center Description		Total	
		26.00	
GENERAL SERVICE COST CENTERS			
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT		1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP		2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT		4.00
5.00	00500 ADMINISTRATIVE & GENERAL		5.00
6.00	00600 MAINTENANCE & REPAIRS		6.00
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
12.00	01200 MAINTENANCE OF PERSONNEL		12.00
13.00	01300 NURSING ADMINISTRATION		13.00
14.00	01400 CENTRAL SERVICES & SUPPLY		14.00
15.00	01500 PHARMACY		15.00
16.00	01600 MEDICAL RECORDS & LIBRARY		16.00
17.00	01700 SOCIAL SERVICE		17.00
19.00	01900 NONPHYSICIAN ANESTHETISTS		19.00
20.00	02000 NURSING SCHOOL		20.00
21.00	02100 I&R SERVICES-SALARY & FRINGES APPRVD		21.00
22.00	02200 I&R SERVICES-OTHER PRGM COSTS APPRVD		22.00
23.00	02300 PARAMED ED PRGM		23.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000 ADULTS & PEDIATRICS	184,459	30.00
43.00	04300 NURSERY	0	43.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000 OPERATING ROOM	114,346	50.00
53.00	05300 ANESTHESIOLOGY	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	103,712	54.00
60.00	06000 LABORATORY	70,366	60.00
65.00	06500 RESPIRATORY THERAPY	20,052	65.00
66.00	06600 PHYSICAL THERAPY	54,302	66.00
68.00	06800 SPEECH PATHOLOGY	0	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	13,028	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	2,018	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	26,644	73.00
OUTPATIENT SERVICE COST CENTERS			
88.00	08800 RURAL HEALTH CLINIC	126,269	88.00
88.01	08801 RURAL HEALTH CLINIC II	156,819	88.01
91.00	09100 EMERGENCY	139,101	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		92.00
OTHER REIMBURSABLE COST CENTERS			
95.00	09500 AMBULANCE SERVICES	75,973	95.00
SPECIAL PURPOSE COST CENTERS			
118.00	SUBTOTALS (SUM OF LINES 1-117)	1,087,089	118.00
NONREIMBURSABLE COST CENTERS			
193.00	19300 NONPAID WORKERS	0	193.00
193.01	19301 ORTHO CLINIC	22,228	193.01
193.02	19303 COMMUNITY MED CLINIC	0	193.02
194.00	07950 MARKETING	11,305	194.00
200.00	Cross Foot Adjustments	0	200.00
201.00	Negative Cost Centers	0	201.00
202.00	TOTAL (sum lines 118-201)	1,120,622	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-1307

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

Worksheet B-1

Date/Time Prepared:
11/22/2017 3:18 pm

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)				
	1.00	2.00				
GENERAL SERVICE COST CENTERS						
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT	52,024				1.00
2.00 00200	NEW CAP REL COSTS-MVBLE EQUIP		52,024			2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	8,810,454		4.00
5.00 00500	ADMINISTRATIVE & GENERAL	5,568	5,568	1,785,667	-4,110,493	16,282,527
6.00 00600	MAINTENANCE & REPAIRS	0	0	0	0	0
7.00 00700	OPERATION OF PLANT	7,483	7,483	0	0	768,667
8.00 00800	LAUNDRY & LINEN SERVICE	210	210	0	0	3,062
9.00 00900	HOUSEKEEPING	52	52	0	0	227,210
10.00 01000	DIETARY	0	0	0	0	13,446
11.00 01100	CAFETERIA	0	0	0	0	0
12.00 01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0
13.00 01300	NURSING ADMINISTRATION	557	557	174,303	0	256,385
14.00 01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	9,655
15.00 01500	PHARMACY	0	0	174,283	0	632,534
16.00 01600	MEDICAL RECORDS & LIBRARY	1,790	1,790	364,565	0	650,157
17.00 01700	SOCIAL SERVICE	0	0	0	0	0
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0
20.00 02000	NURSING SCHOOL	0	0	0	0	0
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	0
23.00 02300	PARAMED ED PRGM	0	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	6,375	6,375	996,264	0	1,723,786
43.00 04300	NURSERY	0	0	0	0	0
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	4,373	4,373	533,477	0	816,010
53.00 05300	ANESTHESIOLOGY	0	0	0	0	0
54.00 05400	RADIOLOGY-DIAGNOSTIC	2,980	2,980	596,400	0	1,179,175
60.00 06000	LABORATORY	1,492	1,492	28,419	0	1,154,180
65.00 06500	RESPIRATORY THERAPY	904	904	20,449	0	57,633
66.00 06600	PHYSICAL THERAPY	2,044	2,044	208,700	0	419,593
68.00 06800	SPEECH PATHOLOGY	0	0	0	0	0
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	561	561	0	0	73,317
72.00 07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	69,155
73.00 07300	DRUGS CHARGED TO PATIENTS	475	475	0	0	6,925
OUTPATIENT SERVICE COST CENTERS						
88.00 08800	RURAL HEALTH CLINIC	4,572	4,572	1,086,790	0	2,067,187
88.01 08801	RURAL HEALTH CLINIC II	6,572	6,572	1,146,046	0	2,115,908
91.00 09100	EMERGENCY	2,581	2,581	991,492	0	2,532,256
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					
OTHER REIMBURSABLE COST CENTERS						
95.00 09500	AMBULANCE SERVICES	2,932	2,932	398,879	0	633,772
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1-117)	51,521	51,521	8,505,734	-4,110,493	15,410,013
NONREIMBURSABLE COST CENTERS						
193.00 19300	NONPAID WORKERS	0	0	0	0	0
193.01 19301	ORTHO CLINIC	496	496	301,813	0	462,340
193.02 19303	COMMUNITY MED CLINIC	0	0	0	0	17
194.00 07950	MARKETING	7	7	2,907	0	410,157
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)	41,060	717,373	3,307,099		4,110,493
203.00	Unit cost multiplier (Wkst. B, Part I)	0.789251	13.789270	0.375361		0.252448
204.00	Cost to be allocated (per Wkst. B, Part II)			0		443,363
205.00	Unit cost multiplier (Wkst. B, Part II)			0.000000		0.027229

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-1307

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

Worksheet B-1

Date/Time Prepared:
11/22/2017 3:18 pm

Cost Center Description		MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	
		6.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
6.00	00600	0					6.00
7.00	00700		27,829				7.00
8.00	00800		210	81,406			8.00
9.00	00900	0	52	0	38,711		9.00
10.00	01000	0	0	0	0	100	10.00
11.00	01100	0	0	0	0	0	11.00
12.00	01200	0	0	0	0	0	12.00
13.00	01300	0	557	0	557	0	13.00
14.00	01400	0	0	0	0	0	14.00
15.00	01500	0	0	0	0	0	15.00
16.00	01600	0	1,790	0	1,790	0	16.00
17.00	01700	0	0	0	0	0	17.00
19.00	01900	0	0	0	0	0	19.00
20.00	02000	0	0	0	0	0	20.00
21.00	02100	0	0	0	0	0	21.00
22.00	02200	0	0	0	0	0	22.00
23.00	02300	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	0	6,375	36,633	6,375	100	30.00
43.00	04300	0	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	0	4,373	13,839	4,373	0	50.00
53.00	05300	0	0	0	0	0	53.00
54.00	05400	0	2,980	4,070	2,980	0	54.00
60.00	06000	0	1,492	0	1,492	0	60.00
65.00	06500	0	904	0	904	0	65.00
66.00	06600	0	2,044	8,141	2,044	0	66.00
68.00	06800	0	0	0	0	0	68.00
71.00	07100	0	561	0	561	0	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	475	0	475	0	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	0	0	2,218	4,572	0	88.00
88.01	08801	0	0	1,852	6,572	0	88.01
91.00	09100	0	2,581	12,211	2,581	0	91.00
92.00	09200	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	0	2,932	2,442	2,932	0	95.00
SPECIAL PURPOSE COST CENTERS							
118.00		0	27,326	81,406	38,208	100	118.00
NONREIMBURSABLE COST CENTERS							
193.00	19300	0	0	0	0	0	193.00
193.01	19301	0	496	0	496	0	193.01
193.02	19303	0	0	0	0	0	193.02
194.00	07950	0	7	0	7	0	194.00
200.00							200.00
201.00							201.00
202.00		0	962,715	11,100	286,368	16,840	202.00
203.00		0.000000	34.593949	0.136354	7.397587	168.400000	203.00
204.00		0	130,019	4,126	7,188	366	204.00
205.00		0.000000	4.672069	0.050684	0.185684	3.660000	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-1307

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

Worksheet B-1

Date/Time Prepared:
11/22/2017 3:18 pm

Cost Center Description		CAFETERIA (MEALS SERVED)	MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINISTRATION (DIRECT NRSNG HRS)	CENTRAL SERVICES & SUPPLY (DIRECT COSTS)	PHARMACY (COSTED REQUIS.)	
		11.00	12.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
6.00	00600						6.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	0					11.00
12.00	01200	0	0				12.00
13.00	01300	0	0	96,506			13.00
14.00	01400	0	0	0	134,294		14.00
15.00	01500	0	0	0	0	100	15.00
16.00	01600	0	0	0	0	0	16.00
17.00	01700	0	0	0	0	0	17.00
19.00	01900	0	0	0	0	0	19.00
20.00	02000	0	0	0	0	0	20.00
21.00	02100	0	0	0	0	0	21.00
22.00	02200	0	0	0	0	0	22.00
23.00	02300	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	0	0	40,107	0	0	30.00
43.00	04300	0	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	0	0	13,152	0	0	50.00
53.00	05300	0	0	0	0	0	53.00
54.00	05400	0	0	0	0	0	54.00
60.00	06000	0	0	2,396	0	0	60.00
65.00	06500	0	0	1,048	0	0	65.00
66.00	06600	0	0	6,598	0	0	66.00
68.00	06800	0	0	0	0	0	68.00
71.00	07100	0	0	0	65,139	0	71.00
72.00	07200	0	0	0	69,155	0	72.00
73.00	07300	0	0	0	0	100	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	0	0	0	0	0	88.00
88.01	08801	0	0	0	0	0	88.01
91.00	09100	0	0	33,205	0	0	91.00
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	0	0	0	0	0	95.00
SPECIAL PURPOSE COST CENTERS							
118.00		0	0	96,506	134,294	100	118.00
NONREIMBURSABLE COST CENTERS							
193.00	19300	0	0	0	0	0	193.00
193.01	19301	0	0	0	0	0	193.01
193.02	19303	0	0	0	0	0	193.02
194.00	07950	0	0	0	0	0	194.00
200.00							200.00
201.00							201.00
202.00		0	0	344,498	12,092	792,216	202.00
203.00		0.000000	0.000000	3.569706	0.090041	7,922.160000	203.00
204.00		0	0	17,807	263	17,223	204.00
205.00		0.000000	0.000000	0.184517	0.001958	172.230000	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-1307

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

Worksheet B-1

Date/Time Prepared: 11/22/2017 3:18 pm

Cost Center Description	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TIME SPENT)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	NURSING SCHOOL (ASSIGNED TIME)	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES (ASSIGNED TIME)	
	16.00	17.00	19.00	20.00	21.00	
GENERAL SERVICE COST CENTERS						
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00 00500 ADMINISTRATIVE & GENERAL						5.00
6.00 00600 MAINTENANCE & REPAIRS						6.00
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
12.00 01200 MAINTENANCE OF PERSONNEL						12.00
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	66,167,432					16.00
17.00 01700 SOCIAL SERVICE	0	0				17.00
19.00 01900 NONPHYSICIAN ANESTHETISTS	0	0	0			19.00
20.00 02000 NURSING SCHOOL	0	0		0		20.00
21.00 02100 I&R SERVICES-SALARY & FRINGES APPRVD	0	0			0	21.00
22.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0				22.00
23.00 02300 PARAMED ED PRGM	0	0				23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000 ADULTS & PEDIATRICS	5,035,853	0	0	0	0	30.00
43.00 04300 NURSERY	0	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	5,050,160	0	0	0	0	50.00
53.00 05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	16,968,408	0	0	0	0	54.00
60.00 06000 LABORATORY	11,975,479	0	0	0	0	60.00
65.00 06500 RESPIRATORY THERAPY	906,116	0	0	0	0	65.00
66.00 06600 PHYSICAL THERAPY	1,915,862	0	0	0	0	66.00
68.00 06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	2,985,620	0	0	0	0	88.00
88.01 08801 RURAL HEALTH CLINIC II	2,621,450	0	0	0	0	88.01
91.00 09100 EMERGENCY	16,684,230	0	0	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS						
95.00 09500 AMBULANCE SERVICES	2,024,254	0	0	0	0	95.00
SPECIAL PURPOSE COST CENTERS						
118.00 SUBTOTALS (SUM OF LINES 1-117)	66,167,432	0	0	0	0	118.00
NONREIMBURSABLE COST CENTERS						
193.00 19300 NONPAID WORKERS	0	0	0	0	0	193.00
193.01 19301 ORTHO CLINIC	0	0	0	0	0	193.01
193.02 19303 COMMUNITY MED CLINIC	0	0	0	0	0	193.02
194.00 07950 MARKETING	0	0	0	0	0	194.00
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)	889,453	0	0	0	0	202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	0.013442	0.000000	0.000000	0.000000	0.000000	203.00
204.00 Cost to be allocated (per Wkst. B, Part II)	52,494	0	0	0	0	204.00
205.00 Unit cost multiplier (Wkst. B, Part II)	0.000793	0.000000	0.000000	0.000000	0.000000	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-1307

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

Worksheet B-1
Date/Time Prepared:
11/22/2017 3:18 pm

Cost Center Description	INTERNS & RESIDENTS	PARAMED PRGM (ASSIGNED TIME)	PARAMED PRGM (ASSIGNED TIME)	
	SERVICES-OTHER PRGM COSTS (ASSIGNED TIME)			
	22.00			
GENERAL SERVICE COST CENTERS				
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT				1.00
2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP				2.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00 00500 ADMINISTRATIVE & GENERAL				5.00
6.00 00600 MAINTENANCE & REPAIRS				6.00
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
12.00 01200 MAINTENANCE OF PERSONNEL				12.00
13.00 01300 NURSING ADMINISTRATION				13.00
14.00 01400 CENTRAL SERVICES & SUPPLY				14.00
15.00 01500 PHARMACY				15.00
16.00 01600 MEDICAL RECORDS & LIBRARY				16.00
17.00 01700 SOCIAL SERVICE				17.00
19.00 01900 NONPHYSICIAN ANESTHETISTS				19.00
20.00 02000 NURSING SCHOOL				20.00
21.00 02100 I&R SERVICES-SALARY & FRINGES APPRVD				21.00
22.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD	0			22.00
23.00 02300 PARAMED PRGM		0		23.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00 03000 ADULTS & PEDIATRICS	0	0		30.00
43.00 04300 NURSERY	0	0		43.00
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATING ROOM	0	0		50.00
53.00 05300 ANESTHESIOLOGY	0	0		53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0		54.00
60.00 06000 LABORATORY	0	0		60.00
65.00 06500 RESPIRATORY THERAPY	0	0		65.00
66.00 06600 PHYSICAL THERAPY	0	0		66.00
68.00 06800 SPEECH PATHOLOGY	0	0		68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		73.00
OUTPATIENT SERVICE COST CENTERS				
88.00 08800 RURAL HEALTH CLINIC	0	0		88.00
88.01 08801 RURAL HEALTH CLINIC II	0	0		88.01
91.00 09100 EMERGENCY	0	0		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)				92.00
OTHER REIMBURSABLE COST CENTERS				
95.00 09500 AMBULANCE SERVICES	0	0		95.00
SPECIAL PURPOSE COST CENTERS				
118.00	SUBTOTALS (SUM OF LINES 1-117)			118.00
NONREIMBURSABLE COST CENTERS				
193.00 19300 NONPAID WORKERS	0	0		193.00
193.01 19301 ORTHO CLINIC	0	0		193.01
193.02 19303 COMMUNITY MED CLINIC	0	0		193.02
194.00 07950 MARKETING	0	0		194.00
200.00	Cross Foot Adjustments			200.00
201.00	Negative Cost Centers			201.00
202.00	0	0		202.00
	Cost to be allocated (per Wkst. B, Part I)			
203.00	0.000000	0.000000		203.00
	Unit cost multiplier (Wkst. B, Part I)			
204.00	0	0		204.00
	Cost to be allocated (per Wkst. B, Part II)			
205.00	0.000000	0.000000		205.00
	Unit cost multiplier (Wkst. B, Part II)			

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-1307

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

Worksheet C
Part I
Date/Time Prepared:
11/22/2017 3:18 pm

		Title XVIII		Hospital		Cost
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
			Total Costs	RCE Disallowance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS		2,659,346		0	30.00
43.00	04300 NURSERY		0		0	43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM		1,322,359		0	50.00
53.00	05300 ANESTHESIOLOGY		0		0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC		1,830,665		0	54.00
60.00	06000 LABORATORY		1,677,728		0	60.00
65.00	06500 RESPIRATORY THERAPY	0	126,063		0	65.00
66.00	06600 PHYSICAL THERAPY	0	661,765		0	66.00
68.00	06800 SPEECH PATHOLOGY	0	0		0	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		121,248		0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT		92,840		0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS		820,835		0	73.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC		2,663,301		0	88.00
88.01	08801 RURAL HEALTH CLINIC II		2,734,172		0	88.01
91.00	09100 EMERGENCY		3,624,370		0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		850,150		0	92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES		944,428		0	95.00
200.00	Subtotal (see instructions)	0	20,129,270		0	200.00
201.00	Less Observation Beds		850,150			201.00
202.00	Total (see instructions)	0	19,279,120		0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-1307

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

Worksheet C
Part I
Date/Time Prepared:
11/22/2017 3:18 pm

		Title XVIII			Hospital	Cost	
Cost Center Description		Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
		Inpatient	Outpatient	Total (col. 6 + col. 7)			
		6.00	7.00	8.00			
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	3,690,854		3,690,854		30.00
43.00	04300	NURSERY	0		0		43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	166,305	4,883,855	5,050,160	0.261845	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	582,281	16,386,127	16,968,408	0.107887	54.00
60.00	06000	LABORATORY	886,692	11,088,787	11,975,479	0.140097	60.00
65.00	06500	RESPIRATORY THERAPY	28,358	802,882	831,240	0.151657	65.00
66.00	06600	PHYSICAL THERAPY	306,107	1,609,756	1,915,863	0.345414	66.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	553,944	892,532	1,446,476	0.083823	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	84,298	424,148	508,446	0.182596	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	989,533	2,002,284	2,991,817	0.274360	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	2,985,620	2,985,620		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	2,621,450	2,621,450		88.01
91.00	09100	EMERGENCY	255,592	16,428,638	16,684,230	0.217233	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	108,607	1,236,392	1,344,999	0.632082	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	4,030	2,020,224	2,024,254	0.466556	95.00
200.00		Subtotal (see instructions)	7,656,601	63,382,695	71,039,296		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	7,656,601	63,382,695	71,039,296		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-1307	Period: From 07/01/2016 To 06/30/2017	Worksheet C Part I Date/Time Prepared: 11/22/2017 3:18 pm
		Title XVIII	Hospital	Cost

Cost Center Description		PPS Inpatient Ratio		
		11.00		
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS			30.00
43.00	04300 NURSERY			43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.000000		50.00
53.00	05300 ANESTHESIOLOGY	0.000000		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	06000 LABORATORY	0.000000		60.00
65.00	06500 RESPIRATORY THERAPY	0.000000		65.00
66.00	06600 PHYSICAL THERAPY	0.000000		66.00
68.00	06800 SPEECH PATHOLOGY	0.000000		68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.000000		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000		73.00
OUTPATIENT SERVICE COST CENTERS				
88.00	08800 RURAL HEALTH CLINIC			88.00
88.01	08801 RURAL HEALTH CLINIC II			88.01
91.00	09100 EMERGENCY	0.000000		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
OTHER REIMBURSABLE COST CENTERS				
95.00	09500 AMBULANCE SERVICES	0.000000		95.00
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: 15-1307

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

Worksheet C
Part I
Date/Time Prepared:
11/22/2017 3:18 pm

		Title XIX		Hospital		Cost
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
			Total Costs	RCE Disallowance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS		2,659,346		2,659,346	30.00
43.00	04300 NURSERY		0		0	43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM		1,322,359		1,322,359	50.00
53.00	05300 ANESTHESIOLOGY		0		0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC		1,830,665		1,830,665	54.00
60.00	06000 LABORATORY		1,677,728		1,677,728	60.00
65.00	06500 RESPIRATORY THERAPY	0	126,063		126,063	65.00
66.00	06600 PHYSICAL THERAPY	0	661,765		661,765	66.00
68.00	06800 SPEECH PATHOLOGY	0	0		0	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		121,248		121,248	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT		92,840		92,840	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS		820,835		820,835	73.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC		2,663,301		2,663,301	88.00
88.01	08801 RURAL HEALTH CLINIC II		2,734,172		2,734,172	88.01
91.00	09100 EMERGENCY		3,624,370		3,624,370	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		850,150		850,150	92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES		944,428		944,428	95.00
200.00	Subtotal (see instructions)		20,129,270	0	20,129,270	200.00
201.00	Less Observation Beds		850,150		850,150	201.00
202.00	Total (see instructions)		19,279,120	0	19,279,120	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-1307

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

Worksheet C
Part I
Date/Time Prepared:
11/22/2017 3:18 pm

		Title XIX			Hospital	Cost	
Cost Center Description		Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
		Inpatient	Outpatient	Total (col. 6 + col. 7)			
		6.00	7.00	8.00	9.00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	3,690,854		3,690,854		30.00
43.00	04300	NURSERY	0		0		43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	166,305	4,883,855	5,050,160	0.261845	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	582,281	16,386,127	16,968,408	0.107887	54.00
60.00	06000	LABORATORY	886,692	11,088,787	11,975,479	0.140097	60.00
65.00	06500	RESPIRATORY THERAPY	28,358	802,882	831,240	0.151657	65.00
66.00	06600	PHYSICAL THERAPY	306,107	1,609,756	1,915,863	0.345414	66.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	553,944	892,532	1,446,476	0.083823	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	84,298	424,148	508,446	0.182596	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	989,533	2,002,284	2,991,817	0.274360	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	2,985,620	2,985,620	0.892043	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	2,621,450	2,621,450	1.043000	88.01
91.00	09100	EMERGENCY	255,592	16,428,638	16,684,230	0.217233	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	108,607	1,236,392	1,344,999	0.632082	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	4,030	2,020,224	2,024,254	0.466556	95.00
200.00		Subtotal (see instructions)	7,656,601	63,382,695	71,039,296		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	7,656,601	63,382,695	71,039,296		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-1307	Period: From 07/01/2016 To 06/30/2017	Worksheet C Part I Date/Time Prepared: 11/22/2017 3:18 pm
		Title XIX	Hospital	Cost

Cost Center Description		PPS Inpatient Ratio		
		11.00		
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS			30.00
43.00	04300 NURSERY			43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.000000		50.00
53.00	05300 ANESTHESIOLOGY	0.000000		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	06000 LABORATORY	0.000000		60.00
65.00	06500 RESPIRATORY THERAPY	0.000000		65.00
66.00	06600 PHYSICAL THERAPY	0.000000		66.00
68.00	06800 SPEECH PATHOLOGY	0.000000		68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.000000		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000		73.00
OUTPATIENT SERVICE COST CENTERS				
88.00	08800 RURAL HEALTH CLINIC	0.000000		88.00
88.01	08801 RURAL HEALTH CLINIC II	0.000000		88.01
91.00	09100 EMERGENCY	0.000000		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
OTHER REIMBURSABLE COST CENTERS				
95.00	09500 AMBULANCE SERVICES	0.000000		95.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS	Provider CCN: 15-1307	Period: From 07/01/2016 To 06/30/2017	Worksheet D Part II Date/Time Prepared: 11/22/2017 3:18 pm
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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	114,346	5,050,160	0.022642	120,850	2,736	50.00
53.00	05300 ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	103,712	16,968,408	0.006112	312,730	1,911	54.00
60.00	06000 LABORATORY	70,366	11,975,479	0.005876	468,908	2,755	60.00
65.00	06500 RESPIRATORY THERAPY	20,052	831,240	0.024123	15,303	369	65.00
66.00	06600 PHYSICAL THERAPY	54,302	1,915,863	0.028343	115,410	3,271	66.00
68.00	06800 SPEECH PATHOLOGY	0	0	0.000000	0	0	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	13,028	1,446,476	0.009007	293,474	2,643	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	2,018	508,446	0.003969	84,298	335	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	26,644	2,991,817	0.008906	502,235	4,473	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	126,269	2,985,620	0.042292	0	0	88.00
88.01	08801 RURAL HEALTH CLINIC II	156,819	2,621,450	0.059821	0	0	88.01
91.00	09100 EMERGENCY	139,101	16,684,230	0.008337	32,097	268	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	58,969	1,344,999	0.043843	6,224	273	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES						95.00
200.00	Total (lines 50-199)	885,626	65,324,188		1,951,529	19,034	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-1307	Period: From 07/01/2016 To 06/30/2017	Worksheet D Part IV Date/Time Prepared: 11/22/2017 3:18 pm
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Cost Center Description	Title XVIII				Hospital		Total Cost (sum of col 1 through col 4)	
	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Cost			
	1.00	2.00	3.00	4.00	5.00			
ANCILLARY SERVICE COST CENTERS								
50.00 05000 OPERATING ROOM	0	0	0	0	0		0	50.00
53.00 05300 ANESTHESIOLOGY	0	0	0	0	0		0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0		0	54.00
60.00 06000 LABORATORY	0	0	0	0	0		0	60.00
65.00 06500 RESPIRATORY THERAPY	0	0	0	0	0		0	65.00
66.00 06600 PHYSICAL THERAPY	0	0	0	0	0		0	66.00
68.00 06800 SPEECH PATHOLOGY	0	0	0	0	0		0	68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0		0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0		0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0		0	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00 08800 RURAL HEALTH CLINIC	0	0	0	0	0		0	88.00
88.01 08801 RURAL HEALTH CLINIC II	0	0	0	0	0		0	88.01
91.00 09100 EMERGENCY	0	0	0	0	0		0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0		0	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00 09500 AMBULANCE SERVICES								95.00
200.00 Total (Lines 50-199)	0	0	0	0	0		0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-1307	Period: From 07/01/2016 To 06/30/2017	Worksheet D Part IV Date/Time Prepared: 11/22/2017 3:18 pm
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Cost Center Description		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Cost
		6.00	7.00	8.00	9.00	10.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	5,050,160	0.000000	0.000000	120,850	50.00
53.00	05300 ANESTHESIOLOGY	0	0	0.000000	0.000000	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	16,968,408	0.000000	0.000000	312,730	54.00
60.00	06000 LABORATORY	0	11,975,479	0.000000	0.000000	468,908	60.00
65.00	06500 RESPIRATORY THERAPY	0	831,240	0.000000	0.000000	15,303	65.00
66.00	06600 PHYSICAL THERAPY	0	1,915,863	0.000000	0.000000	115,410	66.00
68.00	06800 SPEECH PATHOLOGY	0	0	0.000000	0.000000	0	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,446,476	0.000000	0.000000	293,474	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	508,446	0.000000	0.000000	84,298	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	2,991,817	0.000000	0.000000	502,235	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	0	2,985,620	0.000000	0.000000	0	88.00
88.01	08801 RURAL HEALTH CLINIC II	0	2,621,450	0.000000	0.000000	0	88.01
91.00	09100 EMERGENCY	0	16,684,230	0.000000	0.000000	32,097	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	1,344,999	0.000000	0.000000	6,224	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES						95.00
200.00	Total (lines 50-199)	0	65,324,188			1,951,529	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-1307	Period: From 07/01/2016 To 06/30/2017	Worksheet D Part IV Date/Time Prepared: 11/22/2017 3:18 pm
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Cost Center Description		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	Cost
		11.00	12.00	13.00	
Title XVIII Hospital					
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0	0	0	50.00
53.00	05300 ANESTHESIOLOGY	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	54.00
60.00	06000 LABORATORY	0	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	66.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0	0	0	88.00
88.01	08801 RURAL HEALTH CLINIC II	0	0	0	88.01
91.00	09100 EMERGENCY	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES				95.00
200.00	Total (lines 50-199)	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-1307	Period: From 07/01/2016 To 06/30/2017	Worksheet D Part V Date/Time Prepared: 11/22/2017 3:18 pm
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Title XVIII		Hospital		Cost		
Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs		
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0.261845	0	1,942,614	0	50.00
53.00	05300 ANESTHESIOLOGY	0.000000	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.107887	0	5,322,265	0	54.00
60.00	06000 LABORATORY	0.140097	0	4,880,173	0	60.00
65.00	06500 RESPIRATORY THERAPY	0.151657	0	366,467	0	65.00
66.00	06600 PHYSICAL THERAPY	0.345414	0	662,626	0	66.00
68.00	06800 SPEECH PATHOLOGY	0.000000	0	0	0	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.083823	0	420,594	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.182596	0	130,638	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.274360	0	1,030,314	4,828	73.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC	0.000000				88.00
88.01	08801 RURAL HEALTH CLINIC II	0.000000				88.01
91.00	09100 EMERGENCY	0.217233	0	4,328,346	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.632082	0	703,188	0	92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES	0.466556		0		95.00
200.00	Subtotal (see instructions)		0	19,787,225	4,828	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	19,787,225	4,828	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 15-1307	Period: From 07/01/2016 To 06/30/2017	Worksheet D Part V Date/Time Prepared: 11/22/2017 3:18 pm
		Title XVIII	Hospital	Cost

Cost Center Description	Costs			Cost
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	508,664	0	50.00
53.00	05300 ANESTHESIOLOGY	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	574,203	0	54.00
60.00	06000 LABORATORY	683,698	0	60.00
65.00	06500 RESPIRATORY THERAPY	55,577	0	65.00
66.00	06600 PHYSICAL THERAPY	228,880	0	66.00
68.00	06800 SPEECH PATHOLOGY	0	0	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	35,255	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	23,854	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	282,677	1,325	73.00
OUTPATIENT SERVICE COST CENTERS				
88.00	08800 RURAL HEALTH CLINIC	0	0	88.00
88.01	08801 RURAL HEALTH CLINIC II	0	0	88.01
91.00	09100 EMERGENCY	940,260	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	444,472	0	92.00
OTHER REIMBURSABLE COST CENTERS				
95.00	09500 AMBULANCE SERVICES	0	0	95.00
200.00	Subtotal (see instructions)	3,777,540	1,325	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges	0	0	201.00
202.00	Net Charges (line 200 +/- line 201)	3,777,540	1,325	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-1307 Component CCN: 15-Z307	Period: From 07/01/2016 To 06/30/2017	Worksheet D Part V Date/Time Prepared: 11/22/2017 3:18 pm
Title XVIII		Swing Beds - SNF	Cost

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs	PPS Services (see inst.)
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0.261845	0	0	0	0	50.00
53.00 05300 ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.107887	0	0	0	0	54.00
60.00 06000 LABORATORY	0.140097	0	0	0	0	60.00
65.00 06500 RESPIRATORY THERAPY	0.151657	0	0	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0.345414	0	0	0	0	66.00
68.00 06800 SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.083823	0	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0.182596	0	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0.274360	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0.000000					88.00
88.01 08801 RURAL HEALTH CLINIC II	0.000000					88.01
91.00 09100 EMERGENCY	0.217233	0	0	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.632082	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
95.00 09500 AMBULANCE SERVICES	0.466556		0	0		95.00
200.00 Subtotal (see instructions)		0	0	0	0	200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges			0	0	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: 15-1307 Component CCN: 15-Z307	Period: From 07/01/2016 To 06/30/2017	Worksheet D Part V Date/Time Prepared: 11/22/2017 3:18 pm
Title XVIII		Swing Beds - SNF	Cost

Cost Center Description	Costs			Cost	
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)			
	6.00	7.00			
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
60.00	06000	LABORATORY	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	88.01
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0	0	95.00
200.00		Subtotal (see instructions)	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	202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 15-1307		Period: From 07/01/2016 To 06/30/2017		Worksheet D Part III Date/Time Prepared: 11/22/2017 3:18 pm	
Cost Center Description			Title XIX			Hospital		Cost
			Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
200.00		Total (lines 30-199)	0	0	0	0	0	200.00
Cost Center Description			Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)		
			6.00	7.00	8.00	9.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	2,138	0.00	32	0		30.00
43.00	04300	NURSERY	0	0.00	0	0		43.00
200.00		Total (lines 30-199)	2,138		32	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-1307	Period: From 07/01/2016 To 06/30/2017	Worksheet D Part IV Date/Time Prepared: 11/22/2017 3:18 pm
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Cost Center Description	Title XIX				Hospital	Cost
	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)	
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	0	0	0	0	50.00
53.00 05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00 06000 LABORATORY	0	0	0	0	0	60.00
65.00 06500 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
68.00 06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01 08801 RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
91.00 09100 EMERGENCY	0	0	0	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
95.00 09500 AMBULANCE SERVICES						95.00
200.00 Total (Lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-1307	Period: From 07/01/2016 To 06/30/2017	Worksheet D Part IV Date/Time Prepared: 11/22/2017 3:18 pm
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Cost Center Description	Title XIX			Hospital		Cost
	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
	6.00	7.00	8.00	9.00	10.00	
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	5,050,160	0.000000	0.000000	0 50.00
53.00	05300 ANESTHESIOLOGY	0	0	0.000000	0.000000	0 53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	16,968,408	0.000000	0.000000	26,102 54.00
60.00	06000 LABORATORY	0	11,975,479	0.000000	0.000000	35,944 60.00
65.00	06500 RESPIRATORY THERAPY	0	831,240	0.000000	0.000000	1,933 65.00
66.00	06600 PHYSICAL THERAPY	0	1,915,863	0.000000	0.000000	5,915 66.00
68.00	06800 SPEECH PATHOLOGY	0	0	0.000000	0.000000	0 68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,446,476	0.000000	0.000000	14,575 71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	508,446	0.000000	0.000000	0 72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	2,991,817	0.000000	0.000000	36,089 73.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC	0	2,985,620	0.000000	0.000000	0 88.00
88.01	08801 RURAL HEALTH CLINIC II	0	2,621,450	0.000000	0.000000	0 88.01
91.00	09100 EMERGENCY	0	16,684,230	0.000000	0.000000	36,387 91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	1,344,999	0.000000	0.000000	0 92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES					
200.00	Total (lines 50-199)	0	65,324,188			156,945 200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1307

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

Worksheet D
Part IV
Date/Time Prepared:
11/22/2017 3:18 pm

Cost Center Description		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	Hospital	Cost
		11.00	12.00	13.00		
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	0	0		50.00
53.00	05300 ANESTHESIOLOGY	0	0	0		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
60.00	06000 LABORATORY	0	0	0		60.00
65.00	06500 RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600 PHYSICAL THERAPY	0	0	0		66.00
68.00	06800 SPEECH PATHOLOGY	0	0	0		68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	0	0		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0		73.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC	0	0	0		88.00
88.01	08801 RURAL HEALTH CLINIC II	0	0	0		88.01
91.00	09100 EMERGENCY	0	0	0		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES					95.00
200.00	Total (lines 50-199)	0	0	0		200.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-1307	Period: From 07/01/2016 To 06/30/2017	Worksheet D-1 Date/Time Prepared: 11/22/2017 3:18 pm
Cost Center Description		Title XVIII	Hospital	Cost
		1.00		
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		2,581	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		2,138	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)		1,324	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		201	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)		202	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		20	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)		20	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		953	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)		179	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)		180	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)		2,659,346	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)		2,746	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)		2,746	25.00
26.00	Total swing-bed cost (see instructions)		426,389	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		2,232,957	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		2,232,957	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)		1,044.41	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		995,323	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)		995,323	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 15-1307	Period: From 07/01/2016 To 06/30/2017	Worksheet D-1 Date/Time Prepared: 11/22/2017 3:18 pm	
Cost Center Description			Title XVIII		Hospital	Cost
	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	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)				361,954	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)				1,357,277	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)				186,949	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)				187,994	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)				374,943	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)				814	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)				1,044.41	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)				850,150	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-1307		Period: From 07/01/2016 To 06/30/2017		Worksheet D-1 Date/Time Prepared: 11/22/2017 3:18 pm	
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	184,459	2,659,346	0.069363	850,150	58,969	90.00
91.00	Nursing School cost	0	2,659,346	0.000000	850,150	0	91.00
92.00	Allied health cost	0	2,659,346	0.000000	850,150	0	92.00
93.00	All other Medical Education	0	2,659,346	0.000000	850,150	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-1307	Period: From 07/01/2016 To 06/30/2017	Worksheet D-1 Date/Time Prepared: 11/22/2017 3:18 pm
Cost Center Description		Title XIX	Hospital	Cost
		1.00		
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		2,581	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		2,138	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)		1,324	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		201	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)		202	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		20	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)		20	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		32	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		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)		2,659,346	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)		2,746	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)		2,746	25.00
26.00	Total swing-bed cost (see instructions)		426,389	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		2,232,957	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		2,232,957	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)		1,044.41	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		33,421	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)		33,421	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 15-1307	Period: From 07/01/2016 To 06/30/2017	Worksheet D-1 Date/Time Prepared: 11/22/2017 3:18 pm	
Cost Center Description			Title XIX	Hospital	Cost	
	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	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)				29,215	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)				62,636	49.00
PASS THROUGH COST ADJUSTMENTS						
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)				0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)				0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)				0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)				0	53.00
TARGET AMOUNT AND LIMIT COMPUTATION						
54.00	Program discharges				0	54.00
55.00	Target amount per discharge				0.00	55.00
56.00	Target amount (line 54 x line 55)				0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)				0	57.00
58.00	Bonus payment (see instructions)				0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket				0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket				0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)				0	61.00
62.00	Relief payment (see instructions)				0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)				0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST						
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)				0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)				0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)				0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)				0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)				0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)				0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY						
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)					70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					71.00
72.00	Program routine service cost (line 9 x line 71)					72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)					73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)					74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)					75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)					76.00
77.00	Program capital-related costs (line 9 x line 76)					77.00
78.00	Inpatient routine service cost (line 74 minus line 77)					78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)					79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)					80.00
81.00	Inpatient routine service cost per diem limitation					81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)					82.00
83.00	Reasonable inpatient routine service costs (see instructions)					83.00
84.00	Program inpatient ancillary services (see instructions)					84.00
85.00	Utilization review - physician compensation (see instructions)					85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)					86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
87.00	Total observation bed days (see instructions)				814	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)				1,044.41	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)				850,150	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-1307		Period: From 07/01/2016 To 06/30/2017		Worksheet D-1 Date/Time Prepared: 11/22/2017 3:18 pm	
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	184,459	2,659,346	0.069363	850,150	58,969	90.00
91.00	Nursing School cost	0	2,659,346	0.000000	850,150	0	91.00
92.00	Allied health cost	0	2,659,346	0.000000	850,150	0	92.00
93.00	All other Medical Education	0	2,659,346	0.000000	850,150	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-1307	Period: From 07/01/2016 To 06/30/2017	Worksheet D-3 Date/Time Prepared: 11/22/2017 3:18 pm	
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		1,787,374	30.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.261845	120,850	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.107887	312,730	54.00
60.00	06000	LABORATORY	0.140097	468,908	60.00
65.00	06500	RESPIRATORY THERAPY	0.151657	15,303	65.00
66.00	06600	PHYSICAL THERAPY	0.345414	115,410	66.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.083823	293,474	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.182596	84,298	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.274360	502,235	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0.000000		88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000		88.01
91.00	09100	EMERGENCY	0.217233	32,097	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.632082	6,224	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES			95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		1,951,529	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)		1,951,529	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-1307 Component CCN: 15-Z307	Period: From 07/01/2016 To 06/30/2017	Worksheet D-3 Date/Time Prepared: 11/22/2017 3:18 pm
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)
		1.00	2.00	3.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS		0	30.00
43.00	04300 NURSERY			43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.261845	15,808	4,139 50.00
53.00	05300 ANESTHESIOLOGY	0.000000	0	0 53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.107887	48,697	5,254 54.00
60.00	06000 LABORATORY	0.140097	83,668	11,722 60.00
65.00	06500 RESPIRATORY THERAPY	0.151657	2,448	371 65.00
66.00	06600 PHYSICAL THERAPY	0.345414	117,722	40,663 66.00
68.00	06800 SPEECH PATHOLOGY	0.000000	0	0 68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.083823	65,569	5,496 71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.182596	0	0 72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.274360	160,533	44,044 73.00
OUTPATIENT SERVICE COST CENTERS				
88.00	08800 RURAL HEALTH CLINIC	0.000000		0 88.00
88.01	08801 RURAL HEALTH CLINIC II	0.000000		0 88.01
91.00	09100 EMERGENCY	0.217233	4,316	938 91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.632082	708	448 92.00
OTHER REIMBURSABLE COST CENTERS				
95.00	09500 AMBULANCE SERVICES			95.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		499,469	113,075 200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0 201.00
202.00	Net charges (line 200 minus line 201)		499,469	113,075 202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-1307	Period: From 07/01/2016 To 06/30/2017	Worksheet D-3 Date/Time Prepared: 11/22/2017 3:18 pm	
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		81,364		30.00
43.00	04300 NURSERY		0		43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.261845	0	0	50.00
53.00	05300 ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.107887	26,102	2,816	54.00
60.00	06000 LABORATORY	0.140097	35,944	5,036	60.00
65.00	06500 RESPIRATORY THERAPY	0.151657	1,933	293	65.00
66.00	06600 PHYSICAL THERAPY	0.345414	5,915	2,043	66.00
68.00	06800 SPEECH PATHOLOGY	0.000000	0	0	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.083823	14,575	1,222	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.182596	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.274360	36,089	9,901	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.892043	0	0	88.00
88.01	08801 RURAL HEALTH CLINIC II	1.043000	0	0	88.01
91.00	09100 EMERGENCY	0.217233	36,387	7,904	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.632082	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES				95.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		156,945	29,215	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net charges (line 200 minus line 201)		156,945		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-1307	Period: From 07/01/2016 To 06/30/2017	Worksheet E Part B Date/Time Prepared: 11/22/2017 3:18 pm
		Title XVIII	Hospital	Cost
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)			3,778,865 1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)			0 2.00
3.00	PPS payments			0 3.00
4.00	Outlier payment (see instructions)			0 4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)			0.000 5.00
6.00	Line 2 times line 5			0 6.00
7.00	Sum of line 3 plus line 4 divided by line 6			0.00 7.00
8.00	Transitional corridor payment (see instructions)			0 8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200			0 9.00
10.00	Organ acquisitions			0 10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)			3,778,865 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 charge basis had such payment been made in accordance with 42 CFR §413.13(e)			0 16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0.000000 17.00
18.00	Total customary charges (see instructions)			0 18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)			0 19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)			0 20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)			3,816,654 21.00
22.00	Interns and residents (see instructions)			0 22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)			0 23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)			0 24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance (for CAH, see instructions)			44,842 25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)			2,954,362 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)			817,450 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)			817,450 30.00
31.00	Primary payer payments			263 31.00
32.00	Subtotal (line 30 minus line 31)			817,187 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)			573,217 34.00
35.00	Adjusted reimbursable bad debts (see instructions)			372,591 35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			305,390 36.00
37.00	Subtotal (see instructions)			1,189,778 37.00
38.00	MSP-LCC reconciliation amount from PS&R			0 38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)			0 39.50
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)			0 39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION			0 39.99
40.00	Subtotal (see instructions)			1,189,778 40.00
40.01	Sequestration adjustment (see instructions)			23,796 40.01
41.00	Interim payments			1,151,706 41.00
42.00	Tentative settlement (for contractors use only)			0 42.00
43.00	Balance due provider/program (see instructions)			14,276 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: 15-1307

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

Worksheet E-1
Part I
Date/Time Prepared:
11/22/2017 3:18 pm

		Title XVIII		Hospital		Cost	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		1,035,322		1,151,706	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)		1,035,322		1,151,706	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		51,243		14,276	6.01	
6.02	SETTLEMENT TO PROGRAM		0		0	6.02	
7.00	Total Medicare program liability (see instructions)		1,086,565		1,165,982	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: 15-1307
Component CCN: 15-Z307

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

Worksheet E-1
Part I
Date/Time Prepared:
11/22/2017 3:18 pm

		Title XVIII		Swing Beds - SNF		Cost	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		483,739		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)		483,739		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		0		0	6.01	
6.02	SETTLEMENT TO PROGRAM		4,668		0	6.02	
7.00	Total Medicare program liability (see instructions)		479,071		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: 15-1307	Period: From 07/01/2016 To 06/30/2017	Worksheet E-1 Part II Date/Time Prepared: 11/22/2017 3:18 pm
		Title XVIII	Hospital	Cost
				1.00
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14			445 1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12			953 2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2			128 3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12			1,324 4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			71,039,296 5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20			3,966,827 6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168			0 7.00
8.00	Calculation of the HIT incentive payment (see instructions)			0 8.00
9.00	Sequestration adjustment amount (see instructions)			0 9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)			0 10.00
INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)			0 30.00
31.00	Other Adjustment (specify)			0 31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)			0 32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

Provider CCN: 15-1307

Period:

Worksheet E-2

Component CCN: 15-Z307

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

Date/Time Prepared:
11/22/2017 3:18 pm

		Title XVIII		Swing Beds - SNF	
		Part A	Part B	Cost	
		1.00	2.00		
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient routine services - swing bed-SNF (see instructions)	378,692	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)	114,206	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	359	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)	492,898	0	8.00	
9.00	Primary payer payments (see instructions)	0	0	9.00	
10.00	Subtotal (line 8 minus line 9)	492,898	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)	492,898	0	12.00	
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	4,050	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)	488,848	0	15.00	
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00	
16.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	0	16.50	
16.55	410A RURAL DEMONSTRATION PROJECT	0		16.55	
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)	488,848	0	19.00	
19.01	Sequestration adjustment (see instructions)	9,777	0	19.01	
20.00	Interim payments	483,739	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)	-4,668	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	

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-1307	Period: From 07/01/2016 To 06/30/2017	Worksheet E-3 Part V Date/Time Prepared: 11/22/2017 3:18 pm
		Title XVIII	Hospital	Cost
		1.00		
PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT				
1.00	Inpatient services		1,357,277	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)		1,357,277	4.00
5.00	Primary payer payments		0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)		1,370,850	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)		1,370,850	19.00
20.00	Deductibles (exclude professional component)		278,460	20.00
21.00	Excess reasonable cost (from line 16)		0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)		1,092,390	22.00
23.00	Coinsurance		3,619	23.00
24.00	Subtotal (line 22 minus line 23)		1,088,771	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		30,722	25.00
26.00	Adjusted reimbursable bad debts (see instructions)		19,969	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		6,528	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)		1,108,740	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	Recovery of Accelerated Depreciation		0	29.99
30.00	Subtotal (see instructions)		1,108,740	30.00
30.01	Sequestration adjustment (see instructions)		22,175	30.01
31.00	Interim payments		1,035,322	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, 31, and 32)		51,243	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-1307	Period: From 07/01/2016 To 06/30/2017	Worksheet E-3 Part VII Date/Time Prepared: 11/22/2017 3:18 pm	
		Title XIX	Hospital	Cost	
			Inpatient	Outpatient	
			1.00	2.00	
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES					
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient hospital/SNF/NF services		62,636		1.00
2.00	Medical and other services			0	2.00
3.00	Organ acquisition (certified transplant centers only)		0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		62,636	0	4.00
5.00	Inpatient primary payer payments		0		5.00
6.00	Outpatient primary payer payments			0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		62,636	0	7.00
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable Charges					
8.00	Routine service charges		238,309		8.00
9.00	Ancillary service charges		156,945	0	9.00
10.00	Organ acquisition charges, net of revenue		0		10.00
11.00	Incentive from target amount computation		0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)		395,254	0	12.00
CUSTOMARY CHARGES					
13.00	Amount actually collected from patients liable for payment for services on a charge basis		0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)		395,254	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		332,618	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)		0	0	18.00
19.00	Interns and Residents (see instructions)		0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)		0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)		62,636	0	21.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.					
22.00	Other than outlier payments		0	0	22.00
23.00	Outlier payments		0	0	23.00
24.00	Program capital payments		0		24.00
25.00	Capital exception payments (see instructions)		0		25.00
26.00	Routine and Ancillary service other pass through costs		0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)		0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)		0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)		62,636	0	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT					
30.00	Excess of reasonable cost (from line 18)		0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		62,636	0	31.00
32.00	Deductibles		0		32.00
33.00	Coinurance		0		33.00
34.00	Allowable bad debts (see instructions)		0		34.00
35.00	Utilization review		0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		62,636	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		37.00
38.00	Subtotal (line 36 ± line 37)		62,636	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)		0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		62,636	0	40.00
41.00	Interim payments		62,636	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)		0		42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2		0	0	43.00

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

Provider CCN: 15-1307

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

Worksheet G

Date/Time Prepared:
11/22/2017 3:18 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	1,822,861	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	5,864,724	0	0	0	4.00
5.00	Other receivable	144,223	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-3,422,665	0	0	0	6.00
7.00	Inventory	258,150	0	0	0	7.00
8.00	Prepaid expenses	21,296	0	0	0	8.00
9.00	Other current assets	-376,596	0	0	0	9.00
10.00	Due from other funds	500,085	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	4,812,078	0	0	0	11.00
FIXED ASSETS						
12.00	Land	174,050	0	0	0	12.00
13.00	Land improvements	159,079	0	0	0	13.00
14.00	Accumulated depreciation	-99,574	0	0	0	14.00
15.00	Buildings	8,291,636	0	0	0	15.00
16.00	Accumulated depreciation	-4,667,994	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	1,649,197	0	0	0	19.00
20.00	Accumulated depreciation	-827,774	0	0	0	20.00
21.00	Automobiles and trucks	51,450	0	0	0	21.00
22.00	Accumulated depreciation	-51,450	0	0	0	22.00
23.00	Major movable equipment	3,875,221	0	0	0	23.00
24.00	Accumulated depreciation	-3,471,654	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)	5,082,187	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	251,935	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	6,579	485,057	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	258,514	485,057	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	10,152,779	485,057	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	594,578	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,032,292	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	52,308	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	2,212,178	0	0	0	43.00
44.00	Other current liabilities	779,396	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	4,670,752	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	3,879,937	0	0	0	48.00
49.00	Other long term liabilities	66,241	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	3,946,178	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	8,616,930	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	1,535,849				52.00
53.00	Specific purpose fund		485,057			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)	1,535,849	485,057	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	10,152,779	485,057	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 15-1307

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

Worksheet G-1

Date/Time Prepared:
11/22/2017 3:18 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		36,252,666		420,296		1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		1,943,175				2.00
3.00	Total (sum of line 1 and line 2)		38,195,841		420,296		3.00
4.00	DEFERRED PENSION COST	-444,466		0		0	4.00
5.00	CONTRIBUTIONS/DONATIONS/GRANT REVENUE	0		64,761		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)		-444,466		64,761		10.00
11.00	Subtotal (line 3 plus line 10)		37,751,375		485,057		11.00
12.00	TRANSFER FROM AFFILIATES	36,051		0		0	12.00
13.00	RELEASED CAPITAL	36,179,475		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)		36,215,526		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		1,535,849		485,057		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	DEFERRED PENSION COST		0				4.00
5.00	CONTRIBUTIONS/DONATIONS/GRANT REVENUE		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	TRANSFER FROM AFFILIATES		0				12.00
13.00	RELEASED CAPITAL		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: 15-1307

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

Worksheet G-2
Parts I & II
Date/Time Prepared:
11/22/2017 3:18 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	4,465,047		4,465,047	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	4,465,047		4,465,047	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)	4,465,047		4,465,047	17.00
18.00	Ancillary services	3,598,854	38,196,157	41,795,011	18.00
19.00	Outpatient services	0	17,696,469	17,696,469	19.00
20.00	RURAL HEALTH CLINIC	0	2,985,620	2,985,620	20.00
20.01	RURAL HEALTH CLINIC II	0	2,621,450	2,621,450	20.01
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES	4,030	2,020,224	2,024,254	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	ORTHO CLINIC	0	828,499	828,499	27.00
27.01		0	0	0	27.01
27.02		0	0	0	27.02
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	8,067,931	64,348,419	72,416,350	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		20,606,191		29.00
30.00		0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		20,606,191		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 15-1307

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

Worksheet G-3

Date/Time Prepared:
11/22/2017 3:18 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	72,416,350	1.00
2.00	Less contractual allowances and discounts on patients' accounts	51,472,740	2.00
3.00	Net patient revenues (line 1 minus line 2)	20,943,610	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	20,606,191	4.00
5.00	Net income from service to patients (line 3 minus line 4)	337,419	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	3,640	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	446	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	8,988	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	AMBULANCE SUBSIDY	297,000	24.00
24.01	CREDENTIALING	8,450	24.01
24.02	PHARMACY SERVICES	1,574	24.02
24.03	RENTAL INCOME - ENT CLINIC	114,392	24.03
24.04	CLINICAL INCENTIVE REVENUE	25,480	24.04
24.05	OTHER	9,779	24.05
24.06	ANESTHESIOLOGY	0	24.06
24.07	COMM MED CLINIC	43	24.07
24.08	REVENUE DEDUCTIONS	68,355	24.08
24.09	ORTHO CLINIC	904	24.09
24.10	FOOD SERVICES	10,990	24.10
24.11	STATE PROGRAM REVENUE	102,000	24.11
24.12	NORTH CLINIC	8,445	24.12
24.13	SOUTH CLINIC	21,446	24.13
24.14	UNRESTR DONATION REVENUE	923,824	24.14
24.15		0	24.15
25.00	Total other income (sum of lines 6-24)	1,605,756	25.00
26.00	Total (line 5 plus line 25)	1,943,175	26.00
27.00	OTHER MISC - TRANS & STATS	0	27.00
27.01	UNREALIZED INV LOSS	0	27.01
27.02		0	27.02
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	1,943,175	29.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1307

Period: From 07/01/2016

Worksheet M-1

Component CCN: 15-3993

To 06/30/2017

Date/Time Prepared: 11/22/2017 3:18 pm

		RHC I		Cost			
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
FACILITY HEALTH CARE STAFF COSTS							
1.00	Physician	394,932	0	394,932	101,779	496,711	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	242,291	0	242,291	-46,786	195,505	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	207,730	0	207,730	0	207,730	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	186,844	0	186,844	0	186,844	9.00
10.00	Subtotal (sum of lines 1 through 9)	1,031,797	0	1,031,797	54,993	1,086,790	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	9,415	9,415	0	9,415	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	514,982	514,982	0	514,982	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	524,397	524,397	0	524,397	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	1,031,797	524,397	1,556,194	54,993	1,611,187	22.00
COSTS OTHER THAN RHC/FQHC SERVICES							
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
25.01	Telehealth	0	0	0	0	0	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs	0	0	0	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0	28.00
FACILITY OVERHEAD							
29.00	Facility Costs	0	0	0	0	0	29.00
30.00	Administrative Costs	0	0	0	0	0	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	0	0	0	0	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	1,031,797	524,397	1,556,194	54,993	1,611,187	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1307

Period: From 07/01/2016

Worksheet M-1

Component CCN: 15-3993

To 06/30/2017

Date/Time Prepared: 11/22/2017 3:18 pm

RHC I

Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
		6.00	7.00	
FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	-18,592	478,119	1.00
2.00	Physician Assistant	0	0	2.00
3.00	Nurse Practitioner	0	195,505	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	207,730	5.00
6.00	Clinical Psychologist	0	0	6.00
7.00	Clinical Social Worker	0	0	7.00
8.00	Laboratory Technician	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	186,844	9.00
10.00	Subtotal (sum of lines 1 through 9)	-18,592	1,068,198	10.00
11.00	Physician Services Under Agreement	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	12.00
13.00	Other Costs Under Agreement	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	14.00
15.00	Medical Supplies	0	9,415	15.00
16.00	Transportation (Health Care Staff)	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	17.00
18.00	Professional Liability Insurance	0	0	18.00
19.00	Other Health Care Costs	0	514,982	19.00
20.00	Allowable GME Costs			20.00
21.00	Subtotal (sum of lines 15 through 20)	0	524,397	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-18,592	1,592,595	22.00
COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0	23.00
24.00	Dental	0	0	24.00
25.00	Optometry	0	0	25.00
25.01	Telehealth	0	0	25.01
25.02	Chronic Care Management	0	0	25.02
26.00	All other nonreimbursable costs	0	0	26.00
27.00	Nonallowable GME costs			27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	28.00
FACILITY OVERHEAD				
29.00	Facility Costs	0	0	29.00
30.00	Administrative Costs	0	0	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	0	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-18,592	1,592,595	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1307

Period: From 07/01/2016

Worksheet M-1

Component CCN: 15-3994

To 06/30/2017

Date/Time Prepared: 11/22/2017 3:18 pm

		RHC II		Cost			
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
FACILITY HEALTH CARE STAFF COSTS							
1.00	Physician	562,355	0	562,355	-101,779	460,576	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	175,659	0	175,659	46,786	222,445	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	269,638	0	269,638	0	269,638	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	193,387	0	193,387	0	193,387	9.00
10.00	Subtotal (sum of lines 1 through 9)	1,201,039	0	1,201,039	-54,993	1,146,046	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	4,630	4,630	0	4,630	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	476,549	476,549	0	476,549	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	481,179	481,179	0	481,179	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	1,201,039	481,179	1,682,218	-54,993	1,627,225	22.00
COSTS OTHER THAN RHC/FQHC SERVICES							
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
25.01	Telehealth	0	0	0	0	0	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs	0	0	0	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0	28.00
FACILITY OVERHEAD							
29.00	Facility Costs	0	0	0	0	0	29.00
30.00	Administrative Costs	0	0	0	0	0	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	0	0	0	0	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	1,201,039	481,179	1,682,218	-54,993	1,627,225	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1307
Component CCN: 15-3994

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

Worksheet M-1
Date/Time Prepared:
11/22/2017 3:18 pm

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	RHC II	Cost
		6.00	7.00		
FACILITY HEALTH CARE STAFF COSTS					
1.00	Physician	-37,308	423,268		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	222,445		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	269,638		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	193,387		9.00
10.00	Subtotal (sum of lines 1 through 9)	-37,308	1,108,738		10.00
11.00	Physician Services Under Agreement	0	0		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	0		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0		14.00
15.00	Medical Supplies	0	4,630		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	476,549		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	481,179		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-37,308	1,589,917		22.00
COSTS OTHER THAN RHC/FQHC SERVICES					
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
25.01	Telehealth	0	0		25.01
25.02	Chronic Care Management	0	0		25.02
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs				27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0		28.00
FACILITY OVERHEAD					
29.00	Facility Costs	0	0		29.00
30.00	Administrative Costs	0	0		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	0		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-37,308	1,589,917		32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 15-1307 Component CCN: 15-3993	Period: From 07/01/2016 To 06/30/2017	Worksheet M-2 Date/Time Prepared: 11/22/2017 3:18 pm
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		RHC I		Cost		
	Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
	1.00	2.00	3.00	4.00	5.00	
VISITS AND PRODUCTIVITY						
Positions						
1.00	Physician	2.51	13,223	4,200	10,542	1.00
2.00	Physician Assistant	0.00	0	2,100	0	2.00
3.00	Nurse Practitioner	1.73	4,467	2,100	3,633	3.00
4.00	Subtotal (sum of lines 1 through 3)	4.24	17,690		14,175	4.00
5.00	Visiting Nurse	0.00	0		0	5.00
6.00	Clinical Psychologist	0.00	0		0	6.00
7.00	Clinical Social Worker	0.00	0		0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0		0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0		0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	4.24	17,690		17,690	8.00
9.00	Physician Services Under Agreements		0		0	9.00
					1.00	
DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)				1,592,595	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)				0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)				1,592,595	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)				1.000000	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)				0	14.00
15.00	Parent provider overhead allocated to facility (see instructions)				1,070,706	15.00
16.00	Total overhead (sum of lines 14 and 15)				1,070,706	16.00
17.00	Allowable GME overhead (see instructions)				0	17.00
18.00	Enter the amount from line 16				1,070,706	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)				1,070,706	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)				2,663,301	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 15-1307 Component CCN: 15-3994	Period: From 07/01/2016 To 06/30/2017	Worksheet M-2 Date/Time Prepared: 11/22/2017 3:18 pm
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		RHC II		Cost		
	Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
	1.00	2.00	3.00	4.00	5.00	
VISITS AND PRODUCTIVITY						
Positions						
1.00	Physician	1.66	13,678	4,200	6,972	1.00
2.00	Physician Assistant	0.00	0	2,100	0	2.00
3.00	Nurse Practitioner	1.99	2,641	2,100	4,179	3.00
4.00	Subtotal (sum of lines 1 through 3)	3.65	16,319		11,151	4.00
5.00	Visiting Nurse	0.00	0		0	5.00
6.00	Clinical Psychologist	0.00	0		0	6.00
7.00	Clinical Social Worker	0.00	0		0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0		0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0		0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	3.65	16,319		16,319	8.00
9.00	Physician Services Under Agreements		0		0	9.00
					1.00	
DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)				1,589,917	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)				0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)				1,589,917	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)				1.000000	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)				0	14.00
15.00	Parent provider overhead allocated to facility (see instructions)				1,144,255	15.00
16.00	Total overhead (sum of lines 14 and 15)				1,144,255	16.00
17.00	Allowable GME overhead (see instructions)				0	17.00
18.00	Enter the amount from line 16				1,144,255	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)				1,144,255	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)				2,734,172	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 15-1307 Component CCN: 15-3993	Period: From 07/01/2016 To 06/30/2017	Worksheet M-3 Date/Time Prepared: 11/22/2017 3:18 pm	
		Title XVIII	RHC I	Cost	
				1.00	
DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES					
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			2,663,301	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			65,007	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			2,598,294	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			17,690	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)			0	5.00
6.00	Total adjusted visits (line 4 plus line 5)			17,690	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			146.88	7.00
		Calculation of Limit (1)			
		Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)		
		1.00	2.00		
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	81.32	82.30		8.00
9.00	Rate for Program covered visits (see instructions)	146.88	146.88		9.00
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)	1,628	1,663		10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	239,121	244,261		11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0		12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0		13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0		14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)				15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *	0	483,382		16.00
16.01	Total program charges (see instructions)(from contractor's records)		535,916		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		86,302		16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		77,842		16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)		276,878		16.04
16.05	Total program cost (see instructions)	0	354,720		16.05
17.00	Primary payer amounts		0		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		59,443		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		78,034		19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		354,720		20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		33,032		21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		387,752		22.00
23.00	Allowable bad debts (see instructions)		0		23.00
23.01	Adjusted reimbursable bad debts (see instructions)		0		23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0		24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0		25.50
26.00	Net reimbursable amount (see instructions)		387,752		26.00
26.01	Sequestration adjustment (see instructions)		7,755		26.01
27.00	Interim payments		344,172		27.00
28.00	Tentative settlement (for contractor use only)		0		28.00
29.00	Balance due component/program (line 26 minus lines 26.01, 27, and 28)		35,825		29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-11, chapter I, §115.2		0		30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 15-1307 Component CCN: 15-3994	Period: From 07/01/2016 To 06/30/2017	Worksheet M-3 Date/Time Prepared: 11/22/2017 3:18 pm	
		Title XVIII	RHC II	Cost	
				1.00	
DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES					
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			2,734,172	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			38,837	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			2,695,335	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			16,319	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)			0	5.00
6.00	Total adjusted visits (line 4 plus line 5)			16,319	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			165.17	7.00
		Calculation of Limit (1)			
		Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)		
		1.00	2.00		
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	81.32	82.30		8.00
9.00	Rate for Program covered visits (see instructions)	165.17	165.17		9.00
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)	2,817	2,675		10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	465,284	441,830		11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0		12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0		13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0		14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)				15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *	0	907,114		16.00
16.01	Total program charges (see instructions)(from contractor's records)		717,721		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		5,358		16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		6,772		16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)		653,708		16.04
16.05	Total program cost (see instructions)	0	660,480		16.05
17.00	Primary payer amounts		0		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		83,207		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		125,831		19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		660,480		20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		28,239		21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		688,719		22.00
23.00	Allowable bad debts (see instructions)		0		23.00
23.01	Adjusted reimbursable bad debts (see instructions)		0		23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0		24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS)		0		25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0		25.50
26.00	Net reimbursable amount (see instructions)		688,719		26.00
26.01	Sequestration adjustment (see instructions)		13,774		26.01
27.00	Interim payments		676,509		27.00
28.00	Tentative settlement (for contractor use only)		0		28.00
29.00	Balance due component/program (line 26 minus lines 26.01, 27, and 28)		-1,564		29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0		30.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA VACCINE COST		Provider CCN: 15-1307 Component CCN: 15-3993	Period: From 07/01/2016 To 06/30/2017	Worksheet M-4 Date/Time Prepared: 11/22/2017 3:18 pm	
		Title XVIII	RHC I	Cost	
			Pneumococcal	Influenza	
			1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)		1,068,198	1,068,198	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time		0.001107	0.000151	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)		1,182	161	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)		17,499	20,031	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)		18,681	20,192	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)		1,592,595	1,592,595	6.00
7.00	Total overhead (from Wkst. M-2, line 19)		1,070,706	1,070,706	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)		0.011730	0.012679	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)		12,559	13,575	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)		31,240	33,767	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)		92	674	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)		339.57	50.10	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries		57	273	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)		19,355	13,677	14.00
15.00	Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2)			65,007	15.00
16.00	Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3, line 21)			33,032	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA VACCINE COST		Provider CCN: 15-1307 Component CCN: 15-3994	Period: From 07/01/2016 To 06/30/2017	Worksheet M-4 Date/Time Prepared: 11/22/2017 3:18 pm	
		Title XVIII	RHC II	Cost	
			Pneumococcal	Influenza	
			1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)		1,108,738	1,108,738	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time		0.000432	0.000090	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)		479	100	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)		12,554	9,451	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)		13,033	9,551	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)		1,589,917	1,589,917	6.00
7.00	Total overhead (from Wkst. M-2, line 19)		1,144,255	1,144,255	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)		0.008197	0.006007	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)		9,379	6,874	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)		22,412	16,425	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)		66	318	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)		339.58	51.65	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries		50	218	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)		16,979	11,260	14.00
15.00	Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2)			38,837	15.00
16.00	Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3, line 21)			28,239	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 15-1307 Component CCN: 15-3993	Period: From 07/01/2016 To 06/30/2017	Worksheet M-5 Date/Time Prepared: 11/22/2017 3:18 pm
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		RHC I	Cost	
		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		317,972	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00
Program to Provider				
3.01		01/19/2017	26,200	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
Provider to Program				
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		26,200	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		344,172	4.00
TO BE COMPLETED BY CONTRACTOR				
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			5.00
Program to Provider				
5.01			0	5.01
5.02			0	5.02
5.03			0	5.03
Provider to Program				
5.50			0	5.50
5.51			0	5.51
5.52			0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00
6.01	SETTLEMENT TO PROVIDER		35,825	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		379,997	7.00
		Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00 2.00	
8.00	Name of Contractor			8.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 15-1307 Component CCN: 15-3994	Period: From 07/01/2016 To 06/30/2017	Worksheet M-5 Date/Time Prepared: 11/22/2017 3:18 pm
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		RHC II	Cost	
		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		676,509	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00
Program to Provider				
3.01			0	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
Provider to Program				
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		676,509	4.00
TO BE COMPLETED BY CONTRACTOR				
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			5.00
Program to Provider				
5.01			0	5.01
5.02			0	5.02
5.03			0	5.03
Provider to Program				
5.50			0	5.50
5.51			0	5.51
5.52			0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00
6.01	SETTLEMENT TO PROVIDER		0	6.01
6.02	SETTLEMENT TO PROGRAM		1,564	6.02
7.00	Total Medicare program liability (see instructions)		674,945	7.00
		Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00 2.00	
8.00	Name of Contractor			8.00