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: 15-0030	Period: From 01/01/2017 To 12/31/2017	Worksheet S Parts I-III Date/Time Prepared: 5/30/2018 9:14 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 5/30/2018 Time: 9:14 am
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by HENRY COUNTY MEMORIAL HOSPITAL (15-0030) for the cost reporting period beginning 01/01/2017 and ending 12/31/2017 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

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

_____
Title

_____
Date

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	-117,559	-72,928	0	29,059	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
4.00	SUBPROVIDER I						4.00
5.00	Swing bed - SNF	0	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
10.00	NEW CASTLE FAMILY & INTERNAL MED	0		919,066		0	10.00
10.01	NCFIM- NORTHFIELD PARK II	0		40,343		0	10.01
11.00	FEDERALLY QUALIFIED HEALTH CENTER I	0		0		0	11.00
200.00	Total	0	-117,559	886,481	0	29,059	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0030 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-2 Part I Date/Time Prepared: 5/30/2018 9:13 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 1000 NORTH 16TH STREET	PO Box:			1.00
2.00	City: NEW CASTLE	State: IN	Zip Code: 47392-	County: HENRY	2.00

		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
	Hospital and Hospital-Based Component Identification:									
3.00	Hospital	HENRY COUNTY MEMORIAL HOSPITAL	150030	99915	1	07/01/1996	N	P	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA	HCMH HOME CARE	157430	99915		06/14/1995	N	P	N	12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice	HOSP-BASED HOSPICE	151564	99915		08/31/1998				14.00
15.00	Hospital-Based Health Clinic - RHC	NEW CASTLE FAMILY AND INTERNAL MED	158520	99915		04/11/2017	N	O	O	15.00
15.01	Hospital-Based Health Clinic - RHC II	NCFIM - NORHTFIELD PARK	158525	99915		12/04/2017	N	O	O	15.01
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

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

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	137	1,081	0	0	461	0	24.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0030 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-2 Part I | Date/Time Prepared: 5/30/2018 9:13 am

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

		Urban/Rural S	Date of Geogr	
		1.00	2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	1		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.	1		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.	1		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)			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.	01/01/2017	12/31/2017	38.00

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0030 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-2 Part I Date/Time Prepared: 5/30/2018 9:13 am

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0030 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-2 Part I Date/Time Prepared: 5/30/2018 9:13 am

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

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

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

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

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

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

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

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

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

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

		1.00	2.00	3.00	
	Miscellaneous Cost Reporting Information				
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	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:	1	0	0	118.01

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0030 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-2 Part I Date/Time Prepared: 5/30/2018 9:13 am

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

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

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

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

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

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

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

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

		1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act		
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.	Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)	0	168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)		168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	9.99	169.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-0030	Period: From 01/01/2017 To 12/31/2017	Worksheet S-2 Part I Date/Time Prepared: 5/30/2018 9:13 am

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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-0030 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-2 Part II | Date/Time Prepared: 5/30/2018 9:13 am

			Y/N	Date	
			1.00	2.00	
	General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.				
	COMPLETED BY ALL HOSPITALS				
	Provider Organization and Operation				
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)		N		1.00
		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N			3.00
		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00
			Y/N	Legal Oper.	
			1.00	2.00	
	Approved Educational Activities				
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?		N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.		N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.		N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.		N		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.		N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.		N		11.00
				Y/N	
				1.00	
	Bad Debts				
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.			Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.			N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.			N	14.00
	Bed Complement				
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			N	15.00
		Part A		Part B	
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
	PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	Y	04/10/2018	Y	04/10/2018
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N	
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N	
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N	

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-0030 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-2 Part II | Date/Time Prepared: 5/30/2018 9:13 am

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

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

		1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)		
	Capital Related Cost		
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions	N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.	N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions	N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.	N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.	N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.	N	27.00
	Interest Expense		
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.	Y	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.	N	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.	N	35.00

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

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	KYLE	SMITH	41.00
42.00	Enter the employer/company name of the cost report preparer.	BLUE & CO., LLC		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317-713-7957	KCSMITH@BLUEANDCO.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-0030	Period: From 01/01/2017 To 12/31/2017	Worksheet S-2 Part II Date/Time Prepared: 5/30/2018 9:13 am

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-0030 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-3 Part I | Date/Time Prepared: 5/30/2018 9:13 am

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	38	13,870	0.00	0	1.00
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		38	13,870	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	10	3,650	0.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		48	17,520	0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF	41.00	0	0		0	17.00
18.00	SUBPROVIDER	42.00	0	0		0	18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	101.00				0	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	116.00	0	0			24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	NEW CASTLE FAMILY & INTERNAL MED	88.00				0	26.00
26.01	NCFIM- NORTHFIELD PARK	88.01				0	26.01
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		48				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00
33.01	LTCH site neutral days and discharges						33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-0030 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-3 Part I | Date/Time Prepared: 5/30/2018 9:13 am

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	3,056	97	6,212			1.00
2.00	HMO and other (see instructions)	0	1,514				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	3,056	97	6,212			7.00
8.00	INTENSIVE CARE UNIT	974	6	1,645			8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY		34	720			13.00
14.00	Total (see instructions)	4,030	137	8,577	0.00	378.85	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF	0	0	0	0.00	0.00	17.00
18.00	SUBPROVIDER		0	0	0.00	0.00	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	4,959	0	11,233	0.00	14.21	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	0	0	0	0.00	0.00	24.00
24.10	HOSPICE (non-distinct part)	0	0	0			24.10
25.00	CMHC - CMHC						25.00
26.00	NEW CASTLE FAMILY & INTERNAL MED	6,475	2,306	17,301	0.00	44.00	26.00
26.01	NCFIM- NORTHFIELD PARK	271	132	942	0.00	7.14	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	444.20	27.00
28.00	Observation Bed Days		31	924			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	28	70			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-0030 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-3 Part I | Date/Time Prepared: 5/30/2018 9:13 am

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	1,107	28	2,356	1.00
2.00	HMO and other (see instructions)			0	404		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	1,107	28	2,356	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF	0.00	0	0	0	0	17.00
18.00	SUBPROVIDER	0.00	0		0	0	18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0.00					22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	0.00					24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	NEW CASTLE FAMILY & INTERNAL MED	0.00					26.00
26.01	NCFIM- NORTHFIELD PARK	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			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0030 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-3 Part II | Date/Time Prepared: 5/30/2018 9:13 am

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA							
	SALARIES							
1.00	Total salaries (see instructions)	200.00	38,611,321	-132,338	38,478,983	1,235,751.00	31.14	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician and Non Physician-Part B		0	0	0	0.00	0.00	5.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		3,369,237	0	3,369,237	103,289.00	32.62	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		9,794,269	155,642	9,949,911	260,528.00	38.19	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		910,158	0	910,158	20,532.00	44.33	11.00
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00	12.00
13.00	Contract labor: Physician-Part A - Administrative		235,004	0	235,004	1,951.00	120.45	13.00
14.00	Home office and/or related orgainzation salaries and wage-related costs		0	0	0	0.00	0.00	14.00
14.01	Home office salaries		0	0	0	0.00	0.00	14.01
14.02	Related organization salaries		0	0	0	0.00	0.00	14.02
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
	WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		9,622,246	0	9,622,246			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		1,543,296	0	1,543,296			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		0	0	0			21.00
22.00	Physician Part A - Administrative		0	0	0			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		0	0	0			23.00
24.00	Wage-related costs (RHC/FQHC)		895,830	0	895,830			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
25.50	Home office wage-related (core)		0	0	0			25.50
25.51	Related organization wage-related (core)		0	0	0			25.51
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0			25.52
25.53	Home office & Contract Physicians Part A - Teaching - wage-related (core)		0	0	0			25.53

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0030 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-3 Part II Date/Time Prepared: 5/30/2018 9:13 am

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	234,274	0	234,274	8,095.00	28.94	26.00
27.00	Administrative & General	5.00	5,365,896	67,000	5,432,896	161,490.00	33.64	27.00
28.00	Administrative & General under contract (see inst.)		249,941	0	249,941	1,196.00	208.98	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	1,092,807	0	1,092,807	41,863.00	26.10	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	512,643	-16,813	495,830	43,694.00	11.35	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	730,366	-517,828	212,538	13,236.00	16.06	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	301,860	301,860	18,828.00	16.03	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	1,677,682	0	1,677,682	40,034.00	41.91	38.00
39.00	Central Services and Supply	14.00	440,114	0	440,114	16,349.00	26.92	39.00
40.00	Pharmacy	15.00	0	0	0	0.00	0.00	40.00
41.00	Medical Records & Medical Records Library	16.00	700,065	0	700,065	33,242.00	21.06	41.00
42.00	Social Service	17.00	0	0	0	0.00	0.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0030 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-3 Part III Date/Time Prepared: 5/30/2018 9:13 am

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)		35,492,025	-132,338	35,359,687	1,133,658.00	31.19	1.00
2.00	Excluded area salaries (see instructions)		9,794,269	155,642	9,949,911	260,528.00	38.19	2.00
3.00	Subtotal salaries (line 1 minus line 2)		25,697,756	-287,980	25,409,776	873,130.00	29.10	3.00
4.00	Subtotal other wages & related costs (see inst.)		1,145,162	0	1,145,162	22,483.00	50.93	4.00
5.00	Subtotal wage-related costs (see inst.)		9,622,246	0	9,622,246	0.00	37.87	5.00
6.00	Total (sum of lines 3 thru 5)		36,465,164	-287,980	36,177,184	895,613.00	40.39	6.00
7.00	Total overhead cost (see instructions)		11,003,788	-165,781	10,838,007	378,027.00	28.67	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 15-0030 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-3 Part IV Date/Time Prepared: 5/30/2018 9:13 am

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	1,760,658	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	6,398,640	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)	0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	0	8.02
8.03	Health Insurance (Purchased)	0	8.03
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	245,353	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	187,722	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	522,967	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	321,170	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	0	16.00
	TAXES		
17.00	FICA-Employers Portion Only	2,582,004	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	2,858	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
	OTHER		
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	40,000	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	12,061,372	24.00
	Part B - Other than Core Related Cost		
25.00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST | Provider CCN: 15-0030 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-3 Part V | Date/Time Prepared: 5/30/2018 9:13 am

	Cost Center Description	Contract Labor	Benefit Cost	
		1.00	2.00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	910,158	12,061,372	1.00
2.00	Hospital	910,158	12,061,372	2.00
3.00	Subprovider - IPF			3.00
4.00	Subprovider - IRF	0	0	4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA	0	0	11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice	0	0	13.00
14.00	Hospital-Based Health Clinic RHC	0	0	14.00
14.01	Hospital-Based Health Clinic RHC 1	0	0	14.01
15.00	Hospital-Based Health Clinic FQHC	0	0	15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis			17.00
18.00	Other	0	0	18.00

HOME HEALTH AGENCY STATISTICAL DATA | Provider CCN: 15-0030 | Component CCN: 15-7430 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-4 | Date/Time Prepared: 5/30/2018 9:13 am

Home Health Agency I | PPS

		1.00	
0.00	County		0.00

		Title V	Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	5.00	
	HOME HEALTH AGENCY STATISTICAL DATA						
1.00	Home Health Aide Hours	0	0	0	0	0	1.00
2.00	Unduplicated Census Count (see instructions)	0.00	281.00	0.00	0.00	0.00	2.00

		Enter the number of hours in your normal work week	Number of Employees (Full Time Equivalent)			
			Staff	Contract	Total	
		0	1.00	2.00	3.00	
	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES					
3.00	Administrator and Assistant Administrator(s)	0.00	0.00	0.00	0.00	3.00
4.00	Director(s) and Assistant Director(s)		0.00	0.00	0.00	4.00
5.00	Other Administrative Personnel		0.00	0.00	0.00	5.00
6.00	Direct Nursing Service		0.00	0.00	0.00	6.00
7.00	Nursing Supervisor		0.00	0.00	0.00	7.00
8.00	Physical Therapy Service		0.00	0.00	0.00	8.00
9.00	Physical Therapy Supervisor		0.00	0.00	0.00	9.00
10.00	Occupational Therapy Service		0.00	0.00	0.00	10.00
11.00	Occupational Therapy Supervisor		0.00	0.00	0.00	11.00
12.00	Speech Pathology Service		0.00	0.00	0.00	12.00
13.00	Speech Pathology Supervisor		0.00	0.00	0.00	13.00
14.00	Medical Social Service		0.00	0.00	0.00	14.00
15.00	Medical Social Service Supervisor		0.00	0.00	0.00	15.00
16.00	Home Health Aide		0.00	0.00	0.00	16.00
17.00	Home Health Aide Supervisor		0.00	0.00	0.00	17.00
18.00	Other (specify)		0.00	0.00	0.00	18.00
	HOME HEALTH AGENCY CBSA CODES					
19.00	Enter in column 1 the number of CBSAs where you provided services during the cost reporting period.		2			19.00
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).		34620			20.00
20.01			99915			20.01

		Full Episodes					
		Without Outliers	With Outliers	LUPA Episodes	PEP Only Episodes	Total (cols. 1-4)	
		1.00	2.00	3.00	4.00	5.00	
	PPS ACTIVITY DATA						
21.00	Skilled Nursing Visits	1,755	245	52	40	2,092	21.00
22.00	Skilled Nursing Visit Charges	501,814	69,583	14,928	11,426	597,751	22.00
23.00	Physical Therapy Visits	1,929	42	10	18	1,999	23.00
24.00	Physical Therapy Visit Charges	564,217	12,306	2,930	5,274	584,727	24.00
25.00	Occupational Therapy Visits	406	28	1	8	443	25.00
26.00	Occupational Therapy Visit Charges	113,891	7,879	287	2,296	124,353	26.00
27.00	Speech Pathology Visits	16	0	0	0	16	27.00
28.00	Speech Pathology Visit Charges	4,614	0	0	0	4,614	28.00
29.00	Medical Social Service Visits	0	0	0	0	0	29.00
30.00	Medical Social Service Visit Charges	0	0	0	0	0	30.00
31.00	Home Health Aide Visits	318	82	1	8	409	31.00
32.00	Home Health Aide Visit Charges	43,688	11,274	138	1,104	56,204	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	4,424	397	64	74	4,959	33.00
34.00	Other Charges	0	0	0	0	0	34.00
35.00	Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)	1,228,224	101,042	18,283	20,100	1,367,649	35.00
36.00	Total Number of Episodes (standard/non outlier)	286		25	6	317	36.00
37.00	Total Number of Outlier Episodes		11		1	12	37.00
38.00	Total Non-Routine Medical Supply Charges	1,153	835	145	1	2,134	38.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 15-0030 | Component CCN: 15-8520 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-8 | Date/Time Prepared: 5/30/2018 9:13 am

RHC I | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			2200 FOREST RIDGE PARKWAY		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	NEW CASTLE		IN	47362	2.00
					1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0	3.00
			Grant Award		Date	
			1.00		2.00	
	Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)					4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)					5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)					6.00
7.00	Appalachian Regional Commission					7.00
8.00	Look-Alikes					8.00
9.00	OTHER (SPECIFY)					9.00
				1.00	2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N	0	10.00

		Sunday		Monday		Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
	Facility hours of operations (1)						
11.00	CLINIC			07:30	17:00	07:30	11.00

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

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

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

			County				
			4.00				
2.00	City, State, ZIP Code, County		HENRY				2.00
		Tuesday	Wednesday		Thursday		
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)						
11.00	CLINIC	17:00	07:30	17:00	07:30	17:00	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 15-0030 | Component CCN: 15-8520 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-8 | Date/Time Prepared: 5/30/2018 9:13 am

RHC I | Cost

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	CLINIC	07:30	17:00				11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 15-0030 | Component CCN: 15-8525 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-8 | Date/Time Prepared: 5/30/2018 9:13 am

RHC II | Cost

					1.00	
	Clinic Address and Identification					
1.00	Street				152 WITTENBRAKER AVE, SUITE 500	1.00
		City			State	ZIP Code
		1.00			2.00	3.00
2.00	City, State, ZIP Code, County	NEW CASTLE			IN	47362 2.00
						1.00
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban					0 3.00
				Grant Award		Date
				1.00		2.00
	Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)					4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)					5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)					6.00
7.00	Appalachian Regional Commission					7.00
8.00	Look-Alikes					8.00
9.00	OTHER (SPECIFY)					9.00
					1.00	2.00
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)				N	0 10.00

		Sunday		Monday		Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
	Facility hours of operations (1)						
11.00	CLINIC			07:30	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	XVIII	XIX	Total Visits	
		1.00	2.00	3.00	4.00	5.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)						15.00

			County				
			4.00				
2.00	City, State, ZIP Code, County		HENRY				2.00
		Tuesday	Wednesday		Thursday		
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)						
11.00	CLINIC	17:00	07:30	17:00	07:30	17:00	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA	Provider CCN: 15-0030 Component CCN: 15-8525	Period: From 01/01/2017 To 12/31/2017	Worksheet S-8 Date/Time Prepared: 5/30/2018 9:13 am
		RHC II	Cost

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	CLINIC	07:30	17:00				11.00

HOSPITAL-BASED HOSPICE IDENTIFICATION DATA | Provider CCN: 15-0030 | Hospice CCN: 15-1564 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-9 PARTS I THROUGH IV Date/Time Prepared: 5/30/2018 9:13 am

Hospice I

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

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

		Title XVIII	Title XIX	Other	Total (sum of cols. 1 through 3)	
		1.00	2.00	3.00	4.00	
	PART III - ENROLLMENT DAYS FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2015					
10.00	Hospice Continuous Home Care	0	0	0	0	10.00
11.00	Hospice Routine Home Care	4,897	0	315	5,212	11.00
12.00	Hospice Inpatient Respite Care	48	0	0	48	12.00
13.00	Hospice General Inpatient Care	24	0	4	28	13.00
14.00	Total Hospice Days	4,969	0	319	5,288	14.00
	PART IV - CONTRACTED STATISTICAL DATA FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2015					
15.00	Hospice Inpatient Respite Care	0	0	0	0	15.00
16.00	Hospice General Inpatient Care	0	0	0	0	16.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 15-0030 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-10 | Date/Time Prepared: 5/30/2018 9:13 am

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.349314	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	6,442,791	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?	Y	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	27,694,756	6.00
7.00	Medicaid cost (line 1 times line 6)	9,674,166	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)	3,231,375	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)	3,231,375	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)	997,569	0	997,569	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	348,465	0	348,465	21.00
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	348,465	0	348,465	23.00

		1.00	
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	2,711,683	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	144,621	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	222,495	27.01
28.00	Non-Medicare bad debt expense (see instructions)	2,489,188	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	947,382	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	1,295,847	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	4,527,222	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0030 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A | Date/Time Prepared: 5/30/2018 9:13 am

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		5,050,640	5,050,640	-42,669	5,007,971	1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		0	0	626,577	626,577	2.00
3.00	00300	OTHER CAPITAL RELATED COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	234,274	8,488,913	8,723,187	132,338	8,855,525	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5,365,896	9,684,814	15,050,710	67,000	15,117,710	5.00
7.00	00700	OPERATION OF PLANT	1,092,807	1,651,437	2,744,244	-3,895	2,740,349	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	363,436	363,436	0	363,436	8.00
9.00	00900	HOUSEKEEPING	512,643	298,634	811,277	-26,607	784,670	9.00
10.00	01000	DIETARY	730,366	611,285	1,341,651	-951,228	390,423	10.00
11.00	01100	CAFETERIA	0	0	0	554,504	554,504	11.00
13.00	01300	NURSING ADMINISTRATION	1,677,682	370,023	2,047,705	0	2,047,705	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	440,114	365,061	805,175	0	805,175	14.00
15.00	01500	PHARMACY	0	3,838,985	3,838,985	-137,335	3,701,650	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	700,065	255,613	955,678	0	955,678	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,497,814	534,301	4,032,115	-706,718	3,325,397	30.00
31.00	03100	INTENSIVE CARE UNIT	1,038,837	174,016	1,212,853	-880	1,211,973	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	0	0	583,529	583,529	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,121,068	1,959,109	4,080,177	-1,172,347	2,907,830	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	123,189	123,189	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,476,539	801,395	2,277,934	-255,867	2,022,067	54.00
57.00	05700	CT SCAN	147,179	752,867	900,046	0	900,046	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	92,102	477,679	569,781	0	569,781	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	1,748,885	1,945,233	3,694,118	0	3,694,118	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	380,632	115,724	496,356	-1,649	494,707	65.00
66.00	06600	PHYSICAL THERAPY	1,346,716	1,047,688	2,394,404	-472	2,393,932	66.00
67.00	06700	OCCUPATIONAL THERAPY	160,606	11,416	172,022	0	172,022	67.00
68.00	06800	SPEECH PATHOLOGY	58,991	4,305	63,296	0	63,296	68.00
69.00	06900	ELECTROCARDIOLOGY	131,065	122,868	253,933	0	253,933	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	4,674,129	4,674,129	-3,354,514	1,319,615	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	4,300,382	4,300,382	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950	CARDIAC REHAB	136,830	17,041	153,871	0	153,871	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	NEW CASTLE FAMILY & INTERNAL MED	2,917,432	1,422,190	4,339,622	383,071	4,722,693	88.00
88.01	08801	NCFIM- NORTHFIELD PARK	574,004	387,490	961,494	-525,642	435,852	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00	09100	EMERGENCY	2,234,505	1,011,317	3,245,822	0	3,245,822	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	1,071,897	343,361	1,415,258	0	1,415,258	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		0	0	0	0	113.00
114.00	11400	UTILIZATION REVIEW-SNF	0	0	0	0	0	114.00
116.00	11600	HOSPICE	377,156	321,943	699,099	0	699,099	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	30,266,105	47,102,913	77,369,018	-409,233	76,959,785	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	905,434	662,865	1,568,299	-25,800	1,542,499	192.00
194.00	07950	HOSPITALIST	4,813	155,226	160,039	0	160,039	194.00
194.01	07951	RENTAL	0	0	0	42,669	42,669	194.01
194.02	07952	CMHS	0	0	0	0	0	194.02
194.03	07953	MCH	0	0	0	0	0	194.03
194.04	07954	WIC	0	0	0	0	0	194.04
194.05	07955	OTHER NONREIMBURSABLE COSTS	0	127,698	127,698	0	127,698	194.05
194.06	07956	RHC- FOREST RIDGE	1,089,137	541,237	1,630,374	142,571	1,772,945	194.06
194.07	07957	PHILLIPS HALL	0	0	0	0	0	194.07
194.08	07958	OB DRS	0	0	0	0	0	194.08
194.09	07959	THE WATERS	0	0	0	423,331	423,331	194.09
194.10	07960	CAMBRIDGE CITY	559,083	248,786	807,869	0	807,869	194.10
194.11	07961	WELL BEING	390,394	171,474	561,868	0	561,868	194.11
194.12	07962	ACTIVATE HEALTH EMPLOYER CLINIC	138,635	98,095	236,730	0	236,730	194.12
194.13	07963	NEW CASTLE PEDIATRICS	3,176,763	1,195,212	4,371,975	-27,000	4,344,975	194.13
194.14	07964	HENRY COUNTY RADIOLOGY	153,012	1,181,335	1,334,347	0	1,334,347	194.14
194.15	07965	HENRY COUNTY ANESTHESIOLOGY	1,817,181	395,289	2,212,470	-146,538	2,065,932	194.15
194.16	07966	NEW CASTLE IMMEDICATE CARE & FAMILY	110,764	71,861	182,625	0	182,625	194.16

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0030 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A | Date/Time Prepared: 5/30/2018 9:13 am

	Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
		1.00	2.00	3.00	4.00	5.00	
200.00	TOTAL (SUM OF LINES 118 through 199)	38,611,321	51,951,991	90,563,312	0	90,563,312	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0030 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A | Date/Time Prepared: 5/30/2018 9:13 am

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	-75,311	4,932,660		1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	0	626,577		2.00
3.00	00300	OTHER CAPITAL RELATED COSTS	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,576,973	10,432,498		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-3,135,569	11,982,141		5.00
7.00	00700	OPERATION OF PLANT	0	2,740,349		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	363,436		8.00
9.00	00900	HOUSEKEEPING	0	784,670		9.00
10.00	01000	DIETARY	-107,172	283,251		10.00
11.00	01100	CAFETERIA	-357,293	197,211		11.00
13.00	01300	NURSING ADMINISTRATION	0	2,047,705		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	805,175		14.00
15.00	01500	PHARMACY	-757,373	2,944,277		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-6,265	949,413		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-559	3,324,838		30.00
31.00	03100	INTENSIVE CARE UNIT	0	1,211,973		31.00
41.00	04100	SUBPROVIDER - IRF	0	0		41.00
42.00	04200	SUBPROVIDER	0	0		42.00
43.00	04300	NURSERY	0	583,529		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	2,907,830		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	123,189		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-15,151	2,006,916		54.00
57.00	05700	CT SCAN	-518,671	381,375		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	-324,445	245,336		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	-2,997	3,691,121		60.00
60.01	06001	BLOOD LABORATORY	0	0		60.01
65.00	06500	RESPIRATORY THERAPY	-14,811	479,896		65.00
66.00	06600	PHYSICAL THERAPY	-803,543	1,590,389		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	172,022		67.00
68.00	06800	SPEECH PATHOLOGY	0	63,296		68.00
69.00	06900	ELECTROCARDIOLOGY	0	253,933		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,319,615		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	4,300,382		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
76.00	03950	CARDIAC REHAB	0	153,871		76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	NEW CASTLE FAMILY & INTERNAL MED	-553,184	4,169,509		88.00
88.01	08801	NCFIM- NORTHFIELD PARK	-245,876	189,976		88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0		89.00
91.00	09100	EMERGENCY	-13,881	3,231,941		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY	-15,593	1,399,665		101.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
114.00	11400	UTILIZATION REVIEW-SNF	0	0		114.00
116.00	11600	HOSPICE	-10,366	688,733		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-5,381,087	71,578,698		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	1,542,499		192.00
194.00	07950	HOSPITALIST	0	160,039		194.00
194.01	07951	RENTAL	0	42,669		194.01
194.02	07952	CMHS	0	0		194.02
194.03	07953	MCH	0	0		194.03
194.04	07954	WIC	0	0		194.04
194.05	07955	OTHER NONREIMBURSABLE COSTS	0	127,698		194.05
194.06	07956	RHC- FOREST RIDGE	0	1,772,945		194.06
194.07	07957	PHILLIPS HALL	0	0		194.07
194.08	07958	OB DRS	0	0		194.08
194.09	07959	THE WATERS	0	423,331		194.09
194.10	07960	CAMBRIDGE CITY	0	807,869		194.10
194.11	07961	WELL BEING	0	561,868		194.11
194.12	07962	ACTIVATE HEALTH EMPLOYER CLINIC	0	236,730		194.12
194.13	07963	NEW CASTLE PEDIATRICS	0	4,344,975		194.13
194.14	07964	HENRY COUNTY RADIOLOGY	0	1,334,347		194.14
194.15	07965	HENRY COUNTY ANESTHESIOLOGY	0	2,065,932		194.15
194.16	07966	NEW CASTLE IMMEDICATE CARE & FAMILY	0	182,625		194.16
200.00		TOTAL (SUM OF LINES 118 through 199)	-5,381,087	85,182,225		200.00

RECLASSIFICATIONS | Provider CCN: 15-0030 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-6 | Date/Time Prepared: 5/30/2018 9:13 am

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - OB/NURSERY/L&D				
1.00	NURSERY	43.00	504,498	79,031	1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	106,505	16,684	2.00
	0		611,003	95,715	
	B - CAFETERIA				
1.00	CAFETERIA	11.00	301,860	252,644	1.00
	0		301,860	252,644	
	C - WATERS EXCLUSIONS				
1.00	THE WATERS	194.09	232,781	190,550	1.00
2.00		0.00	0	0	2.00
	0		232,781	190,550	
	D - DEPRECIATION POB				
1.00	RENTAL	194.01	0	42,669	1.00
	0		0	42,669	
	E - EQUIPMENT RENTAL				
1.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	626,577	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
	0		0	626,577	
	F - IMPLANTABLE DEVICES				
1.00	IMPL. DEV. CHARGED TO PATIENT	72.00	0	4,300,382	1.00
	0		0	4,300,382	
	I - MEDICAL DIRECTOR RECLASS				
1.00	ADMINISTRATIVE & GENERAL	5.00	67,000	0	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
	0		67,000	0	
	J - VERO/RIFF RECLASS				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	132,338	1.00
2.00		0.00	0	0	2.00
	TOTALS		0	132,338	
	K - RHC STAFF RECLASS				
1.00	NEW CASTLE FAMILY & INTERNAL MED	88.00	328,333	54,738	1.00
2.00	RHC- FOREST RIDGE	194.06	122,199	20,372	2.00
	TOTALS		450,532	75,110	
	L - MED SUPPLIES RECLASS				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	945,868	1.00
	TOTALS		0	945,868	
500.00	Grand Total: Increases		1,663,176	6,661,853	500.00

RECLASSIFICATIONS | Provider CCN: 15-0030 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-6 | Date/Time Prepared: 5/30/2018 9:13 am

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - OB/NURSERY/L&D						
1.00	ADULTS & PEDIATRICS	30.00	611,003	95,715	0		1.00
2.00		0.00	0	0	0		2.00
	0		611,003	95,715			
	B - CAFETERIA						
1.00	DIETARY	10.00	301,860	252,644	0		1.00
	0		301,860	252,644			
	C - WATERS EXCLUSIONS						
1.00	HOUSEKEEPING	9.00	16,813	9,794	0		1.00
2.00	DIETARY	10.00	215,968	180,756	0		2.00
	0		232,781	190,550			
	D - DEPRECIATION POB						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	42,669	9		1.00
	0		0	42,669			
	E - EQUIPMENT RENTAL						
1.00	OPERATION OF PLANT	7.00	0	3,895	9		1.00
2.00	PHARMACY	15.00	0	137,335	0		2.00
3.00	INTENSIVE CARE UNIT	31.00	0	880	0		3.00
4.00	OPERATING ROOM	50.00	0	226,479	0		4.00
5.00	RADIOLOGY-DIAGNOSTIC	54.00	0	255,867	0		5.00
6.00	RESPIRATORY THERAPY	65.00	0	1,649	0		6.00
7.00	PHYSICAL THERAPY	66.00	0	472	0		7.00
	0		0	626,577			
	F - IMPLANTABLE DEVICES						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	4,300,382	0		1.00
	0		0	4,300,382			
	I - MEDICAL DIRECTOR RECLASS						
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	25,000	0	0		1.00
2.00	NEW CASTLE PEDIATRICS	194.13	27,000	0	0		2.00
3.00	HENRY COUNTY ANESTHESIOLOGY	194.15	15,000	0	0		3.00
	0		67,000	0			
	J - VERO/RIFF RECLASS						
1.00	HENRY COUNTY ANESTHESIOLOGY	194.15	131,538	0	0		1.00
2.00	PHYSICIANS' PRIVATE OFFICES	192.00	800	0	0		2.00
	TOTALS		132,338	0			
	K - RHC STAFF RECLASS						
1.00	NCFIM- NORTHFIELD PARK	88.01	450,532	75,110	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		450,532	75,110			
	L - MED SUPPLIES RECLASS						
1.00	OPERATING ROOM	50.00	0	945,868	0		1.00
	TOTALS		0	945,868			
500.00	Grand Total: Decreases		1,795,514	6,529,515			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0030 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-7 Part I | Date/Time Prepared: 5/30/2018 9:13 am

		Beginning Balances	Acquisitions: Purchases	Acquisitions: Donation	Acquisitions: Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	46,000	0	0	0	0	1.00
2.00	Land Improvements	1,807,282	521,427	0	521,427	260,393	2.00
3.00	Buildings and Fixtures	41,824,817	16,012,109	0	16,012,109	17,136,021	3.00
4.00	Building Improvements	258,814	16,584	0	16,584	0	4.00
5.00	Fixed Equipment	15,793,813	4,236,470	0	4,236,470	1,246,057	5.00
6.00	Movable Equipment	41,466,732	2,364,471	0	2,364,471	4,905,631	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	101,197,458	23,151,061	0	23,151,061	23,548,102	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	101,197,458	23,151,061	0	23,151,061	23,548,102	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	46,000	0	1.00
2.00	Land Improvements	2,068,316	0	2.00
3.00	Buildings and Fixtures	40,700,905	0	3.00
4.00	Building Improvements	275,398	0	4.00
5.00	Fixed Equipment	18,784,226	0	5.00
6.00	Movable Equipment	38,925,572	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	100,800,417	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	100,800,417	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0030 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-7 Part II Date/Time Prepared: 5/30/2018 9:13 am

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	NEW CAP REL COSTS-BLDG & FIXT	4,761,974	0	288,666	0	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	4,761,974	0	288,666	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL			
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)		
		14.00	15.00		
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2				
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	5,050,640		1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0		2.00
3.00	Total (sum of lines 1-2)	0	5,050,640		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0030 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-7 Part III Date/Time Prepared: 5/30/2018 9:13 am

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	COMPUTATION OF RATIOS: Capitalized Leases	COMPUTATION OF RATIOS: Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	ALLOCATION OF OTHER CAPITAL: Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	42,815,221	0	42,815,221	0.424752	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	57,985,196	0	57,985,196	0.575248	0	2.00
3.00	Total (sum of lines 1-2)	100,800,417	0	100,800,417	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	ALLOCATION OF OTHER CAPITAL: Other Capital-Related Costs	ALLOCATION OF OTHER CAPITAL: Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	SUMMARY OF CAPITAL: Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	4,719,305	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	626,577	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	5,345,882	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	SUMMARY OF CAPITAL: Insurance (see instructions)	SUMMARY OF CAPITAL: Taxes (see instructions)	SUMMARY OF CAPITAL: Other Capital-Related Costs (see instructions)	SUMMARY OF CAPITAL: Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	213,355	0	0	0	4,932,660	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	626,577	2.00
3.00	Total (sum of lines 1-2)	213,355	0	0	0	5,559,237	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0030 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-8 | Date/Time Prepared: 5/30/2018 9:13 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)	A	-75,311	NEW CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00	Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-31,115	ADMINISTRATIVE & GENERAL	5.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-2,289			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	-2,221,682			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-357,293	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-6,265	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	UTILIZATION REVIEW-SNF	114.00		25.00
26.00	Depreciation - NEW CAP REL COSTS-BLDG & FIXT		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - NEW CAP REL COSTS-MVBLE EQUIP		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0030 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-8 | Date/Time Prepared: 5/30/2018 9:13 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	OTHER OP REV - HUMAN RESOURSEC - MIS	B	-190	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.00
34.00	OTHER OP REV	B	-708,060	ADMINISTRATIVE & GENERAL	5.00	0	34.00
35.00	OTHER OP REV - COPIES RECEIPTS	B	-3	ADMINISTRATIVE & GENERAL	5.00	0	35.00
36.00	OTHER OP REV - PHY REAPP FEES	B	-26,150	ADMINISTRATIVE & GENERAL	5.00	0	36.00
36.01	DIETARY-OTHER OP REV	B	-5,383	DIETARY	10.00	0	36.01
36.02	OTHER OP REV - DIETARY - OUTSIDE SAL	B	-72,348	DIETARY	10.00	0	36.02
38.00	OTHER OP REV - DIETARY TRANSFERS	B	-29,441	DIETARY	10.00	0	38.00
38.01	OTHER OP REV - PHARMACY	B	-757,373	PHARMACY	15.00	0	38.01
38.02	OTHER OP REV - PCU - HLTH PROG REC	B	-559	ADULTS & PEDIATRICS	30.00	0	38.02
40.00	CT SCAN-OTHER OP REV	B	-49	CT SCAN	57.00	0	40.00
40.01	OTHER OP REV - LABORATORY-LAB DRUG S	B	-749	LABORATORY	60.00	0	40.01
40.02	OTHER OP REV-LABORATORY	B	41	LABORATORY	60.00	0	40.02
40.03	OTHER OP REV - ATH TRAINING - HLTH P	B	-84,696	PHYSICAL THERAPY	66.00	0	40.03
41.00	OTHER OP REV - ATH TRAINING - OUTSID	B	-7,057	PHYSICAL THERAPY	66.00	0	41.00
42.00	OTHER OP REV - AQUATICS - HLTH PROG	B	-21,562	PHYSICAL THERAPY	66.00	0	42.00
43.00	OTHER OP REV - PHYSICAL THER - HLTH	B	-612	PHYSICAL THERAPY	66.00	0	43.00
44.00	OTHER OP REV - PHYSICAL THER - EE	B	-9,566	PHYSICAL THERAPY	66.00	0	44.00
44.01	OTHER OP REV - PHYSICAL THER - FIT F	B	-73,639	PHYSICAL THERAPY	66.00	0	44.01
44.02	NC FAMILY INTERNAL MEDICINE-OTHER OP	B	-215,250	NEW CASTLE FAMILY & INTERNAL MED	88.00	0	44.02
45.00	NC FAMILY INTERNAL MEDICINE-OTHER OP	B	-12,170	NEW CASTLE FAMILY & INTERNAL MED	88.00	0	45.00
45.01	NC FAMILY INTERNAL MEDICINE-OTHER OP	B	-741	NEW CASTLE FAMILY & INTERNAL MED	88.00	0	45.01
45.02	PUBLIC RELATIONS	A	-2,000	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	45.02
45.03	PUBLIC RELATIONS	A	-108,722	ADMINISTRATIVE & GENERAL	5.00	0	45.03
45.04	PUBLIC RELATIONS	A	-1,676	RADIOLOGY-DIAGNOSTIC	54.00	0	45.04
45.05	PUBLIC RELATIONS	A	-5,717	NEW CASTLE FAMILY & INTERNAL MED	88.00	0	45.05
45.07	PUBLIC RELATIONS	A	-2,574	NCFIM- NORTHFIELD PARK	88.01	0	45.07
45.09	PUBLIC RELATIONS	A	-13,881	EMERGENCY	91.00	0	45.09
45.10	PUBLIC RELATIONS	A	-5,670	HOME HEALTH AGENCY	101.00	0	45.10
45.11	PUBLIC RELATIONS	A	-438	HOSPICE	116.00	0	45.11
45.16	AHA & IHA DUES	A	-6,417	ADMINISTRATIVE & GENERAL	5.00	0	45.16
45.17	BENEFIT EXPENSE	A	1,579,163	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	45.17
45.18	HAF EXPENSE	A	-2,093,643	ADMINISTRATIVE & GENERAL	5.00	0	45.18
45.19	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	45.19
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-5,381,087				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: 15-0030 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-8-1 | Date/Time Prepared: 5/30/2018 9:13 am

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	54.00	RADIOLOGY-DIAGNOSTIC		5,489	18,964	1.00
2.00	57.00	CT SCAN		175,658	694,280	2.00
3.00	58.00	MAGNETIC RESONANCE IMAGING (		125,555	450,000	3.00
3.01	66.00	PHYSICAL THERAPY		191,230	797,641	3.01
4.00	5.00	ADMINISTRATIVE & GENERAL		0	161,459	4.00
4.01	65.00	RESPIRATORY THERAPY		25,700	40,511	4.01
4.02	88.00	NEW CASTLE FAMILY & INTERNAL		139,967	459,273	4.02
4.03	88.01	NCFIM- NORTHFIELD PARK		8,298	251,600	4.03
4.04	101.00	HOME HEALTH AGENCY		11,727	21,650	4.04
4.05	116.00	HOSPICE		11,722	21,650	4.05
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			695,346	2,917,028	5.00

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

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

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

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

6.00	G	HENRY COUNTY HO	100.00	HOSPITAL FOUNDA	0.00	6.00
7.00			0.00		0.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:	MISC				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: 15-0030 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-8-1 | Date/Time Prepared: 5/30/2018 9:13 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	-13,475	0		1.00
2.00	-518,622	0		2.00
3.00	-324,445	0		3.00
3.01	-606,411	0		3.01
4.00	-161,459	0		4.00
4.01	-14,811	0		4.01
4.02	-319,306	0		4.02
4.03	-243,302	0		4.03
4.04	-9,923	0		4.04
4.05	-9,928	0		4.05
5.00	-2,221,682			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	MISC		6.00
7.00			7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 15-0030 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-8-2 | Date/Time Prepared: 5/30/2018 9:13 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	60.00	LABORATORY	80,004	0	80,004	260,300	621	1.00
2.00	0.00		0	0	0	0	0	2.00
3.00	0.00		0	0	0	0	0	3.00
4.00	0.00		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			80,004	0	80,004		621	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	60.00	LABORATORY	77,715	3,886	0	0	0	1.00
2.00	0.00		0	0	0	0	0	2.00
3.00	0.00		0	0	0	0	0	3.00
4.00	0.00		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			77,715	3,886	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	60.00	LABORATORY	0	77,715	2,289	2,289		1.00
2.00	0.00		0	0	0	0		2.00
3.00	0.00		0	0	0	0		3.00
4.00	0.00		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	77,715	2,289	2,289		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0030 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part I Date/Time Prepared: 5/30/2018 9:13 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS NEW BLDG & FIXT	CAPITAL RELATED COSTS NEW MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	4,932,660	4,932,660				1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	626,577		626,577			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	10,432,498	26,257	3,130	10,461,885		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	11,982,141	620,465	73,965	1,486,179	14,162,750	5.00
7.00	00700	OPERATION OF PLANT	2,740,349	1,334,577	159,093	298,938	4,532,957	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	363,436	66,000	7,868	0	437,304	8.00
9.00	00900	HOUSEKEEPING	784,670	38,334	4,570	135,635	963,209	9.00
10.00	01000	DIETARY	283,251	139,253	16,600	58,140	497,244	10.00
11.00	01100	CAFETERIA	197,211	38,045	4,535	82,574	322,365	11.00
13.00	01300	NURSING ADMINISTRATION	2,047,705	76,475	9,117	458,932	2,592,229	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	805,175	137,999	16,451	120,394	1,080,019	14.00
15.00	01500	PHARMACY	2,944,277	30,135	3,592	0	2,978,004	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	949,413	56,758	6,766	191,503	1,204,440	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,324,838	570,845	68,050	789,690	4,753,423	30.00
31.00	03100	INTENSIVE CARE UNIT	1,211,973	223,812	26,680	284,175	1,746,640	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	583,529	59,189	7,056	138,006	787,780	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,907,830	316,223	37,697	580,220	3,841,970	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	123,189	30,077	3,585	29,135	185,986	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,006,916	218,429	26,039	403,909	2,655,293	54.00
57.00	05700	CT SCAN	381,375	8,450	1,007	40,261	431,093	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	245,336	10,321	1,230	25,195	282,082	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	3,691,121	159,375	18,999	478,409	4,347,904	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	479,896	33,492	3,993	104,122	621,503	65.00
66.00	06600	PHYSICAL THERAPY	1,590,389	22,013	2,624	368,396	1,983,422	66.00
67.00	06700	OCCUPATIONAL THERAPY	172,022	2,045	244	43,934	218,245	67.00
68.00	06800	SPEECH PATHOLOGY	63,296	3,723	444	16,137	83,600	68.00
69.00	06900	ELECTROCARDIOLOGY	253,933	0	0	35,853	289,786	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,319,615	0	0	0	1,319,615	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	4,300,382	0	0	0	4,300,382	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950	CARDIAC REHAB	153,871	13,717	1,635	37,430	206,653	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	NEW CASTLE FAMILY & INTERNAL MED	4,169,509	0	0	887,882	5,057,391	88.00
88.01	08801	NCFIM- NORTHFIELD PARK	189,976	0	0	33,776	223,752	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00	09100	EMERGENCY	3,231,941	203,883	24,305	611,251	4,071,380	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	1,399,665	0	0	293,218	1,692,883	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	688,733	0	0	103,171	791,904	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	71,578,698	4,439,892	529,275	8,136,465	68,663,208	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	19,466	0	0	19,466	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,542,499	0	0	240,625	1,783,124	192.00
194.00	07950	HOSPITALIST	160,039	0	0	1,317	161,356	194.00
194.01	07951	RENTAL	42,669	0	40,880	0	83,549	194.01
194.02	07952	CMHS	0	0	0	0	0	194.02
194.03	07953	MCH	0	0	0	0	0	194.03
194.04	07954	WIC	0	0	0	0	0	194.04
194.05	07955	OTHER NONREIMBURSABLE COSTS	127,698	0	0	0	127,698	194.05
194.06	07956	RHC- FOREST RIDGE	1,772,945	0	0	331,362	2,104,307	194.06
194.07	07957	PHILLIPS HALL	0	0	0	0	0	194.07
194.08	07958	OB DRS	0	0	0	0	0	194.08
194.09	07959	THE WATERS	423,331	473,302	56,422	63,677	1,016,732	194.09
194.10	07960	CAMBRIDGE CITY	807,869	0	0	152,938	960,807	194.10
194.11	07961	WELL BEING	561,868	0	0	106,793	668,661	194.11
194.12	07962	ACTIVATE HEALTH EMPLOYER CLINIC	236,730	0	0	37,924	274,654	194.12
194.13	07963	NEW CASTLE PEDIATRICS	4,344,975	0	0	861,621	5,206,596	194.13
194.14	07964	HENRY COUNTY RADIOLOGY	1,334,347	0	0	41,857	1,376,204	194.14

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0030 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part I Date/Time Prepared: 5/30/2018 9:13 am

		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	
194.15	07965	HENRY COUNTY ANESTHESIOLOGY	2,065,932	0	0	457,006	2,522,938	194.15
194.16	07966	NEW CASTLE IMMEDICATE CARE & FAMILY	182,625	0	0	30,300	212,925	194.16
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	85,182,225	4,932,660	626,577	10,461,885	85,182,225	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0030 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part I Date/Time Prepared: 5/30/2018 9:13 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	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	14,162,750					5.00
7.00	00700	OPERATION OF PLANT	903,967	5,436,924				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	87,208	145,611	670,123			8.00
9.00	00900	HOUSEKEEPING	192,084	84,574	28,436	1,268,303		9.00
10.00	01000	DIETARY	99,161	307,225	7,637	27,250	938,517	10.00
11.00	01100	CAFETERIA	64,286	83,936	0	13,860	0	11.00
13.00	01300	NURSING ADMINISTRATION	516,945	168,723	0	18,558	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	215,378	304,459	0	4,698	0	14.00
15.00	01500	PHARMACY	593,877	66,485	0	10,101	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	240,191	125,223	0	3,759	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	947,932	1,259,415	135,150	338,043	742,022	30.00
31.00	03100	INTENSIVE CARE UNIT	348,317	493,782	30,496	22,552	196,495	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	157,100	130,586	11,163	4,463	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	766,169	697,663	120,484	100,308	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	37,090	66,357	2,357	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	529,521	481,907	48,764	34,532	0	54.00
57.00	05700	CT SCAN	85,969	18,643	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	56,253	22,772	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	867,063	351,619	847	75,173	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	123,941	73,891	0	29,834	0	65.00
66.00	06600	PHYSICAL THERAPY	395,536	48,565	13,499	129,673	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	43,523	4,512	1,259	12,920	0	67.00
68.00	06800	SPEECH PATHOLOGY	16,672	8,215	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	57,789	0	0	9,866	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	263,159	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	857,586	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950	CARDIAC REHAB	41,211	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	NEW CASTLE FAMILY & INTERNAL MED	1,008,550	0	0	0	0	88.00
88.01	08801	NCFIM- NORTHFIELD PARK	44,621	0	0	0	0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00	09100	EMERGENCY	811,919	449,814	120,043	90,912	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	337,596	0	0	41,345	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	157,922	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	10,868,536	5,393,977	520,135	967,847	938,517	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	3,882	42,947	0	6,578	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	355,592	0	333	0	0	192.00
194.00	07950	HOSPITALIST	32,178	0	0	0	0	194.00
194.01	07951	RENTAL	16,661	0	0	276,964	0	194.01
194.02	07952	CMHS	0	0	0	0	0	194.02
194.03	07953	MCH	0	0	0	0	0	194.03
194.04	07954	WIC	0	0	0	0	0	194.04
194.05	07955	OTHER NONREIMBURSABLE COSTS	25,466	0	14,190	0	0	194.05
194.06	07956	RHC- FOREST RIDGE	419,643	0	4,166	0	0	194.06
194.07	07957	PHILLIPS HALL	0	0	5,442	16,914	0	194.07
194.08	07958	OB DRS	0	0	8,992	0	0	194.08
194.09	07959	THE WATERS	202,758	0	116,865	0	0	194.09
194.10	07960	CAMBRIDGE CITY	191,605	0	0	0	0	194.10
194.11	07961	WELL BEING	133,345	0	0	0	0	194.11
194.12	07962	ACTIVATE HEALTH EMPLOYER CLINIC	54,772	0	0	0	0	194.12
194.13	07963	NEW CASTLE PEDIATRICS	1,038,279	0	0	0	0	194.13
194.14	07964	HENRY COUNTY RADIOLOGY	274,444	0	0	0	0	194.14
194.15	07965	HENRY COUNTY ANESTHESIOLOGY	503,127	0	0	0	0	194.15
194.16	07966	NEW CASTLE IMMEDICATE CARE & FAMILY	42,462	0	0	0	0	194.16
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	14,162,750	5,436,924	670,123	1,268,303	938,517	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0030 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part I | Date/Time Prepared: 5/30/2018 9:13 am

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	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
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	484,447					11.00
13.00	01300	NURSING ADMINISTRATION	32,756	3,329,211				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	13,792	0	1,618,346			14.00
15.00	01500	PHARMACY	0	0	3,765	3,652,232		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	27,584	0	3,883	0	1,605,080	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	79,307	1,078,478	47,497	0	164,104	30.00
31.00	03100	INTENSIVE CARE UNIT	24,136	328,232	14,021	0	70,067	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	12,068	164,116	0	0	47,479	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	63,788	867,470	85,008	0	263,672	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,724	23,445	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	39,652	0	32,358	0	197,293	54.00
57.00	05700	CT SCAN	3,448	0	9,925	0	70,528	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	3,448	0	4,038	0	21,665	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	58,616	0	179,654	0	260,906	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	10,344	0	1,954	0	19,361	65.00
66.00	06600	PHYSICAL THERAPY	41,376	0	9,163	0	13,829	66.00
67.00	06700	OCCUPATIONAL THERAPY	3,448	0	0	0	1,383	67.00
68.00	06800	SPEECH PATHOLOGY	1,724	0	4	0	461	68.00
69.00	06900	ELECTROCARDIOLOGY	3,448	0	5,555	0	14,751	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	269,866	0	36,877	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	881,319	0	64,996	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	3,652,232	0	73.00
76.00	03950	CARDIAC REHAB	5,172	70,335	984	0	1,844	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	NEW CASTLE FAMILY & INTERNAL MED	0	0	7,516	0	0	88.00
88.01	08801	NCFIM- NORTHFIELD PARK	0	0	1,643	0	0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00	09100	EMERGENCY	58,616	797,135	50,174	0	339,270	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	5,475	0	9,680	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	0	0	4,544	0	6,914	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	484,447	3,329,211	1,618,346	3,652,232	1,605,080	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	HOSPITALIST	0	0	0	0	0	194.00
194.01	07951	RENTAL	0	0	0	0	0	194.01
194.02	07952	CMHS	0	0	0	0	0	194.02
194.03	07953	MCH	0	0	0	0	0	194.03
194.04	07954	WIC	0	0	0	0	0	194.04
194.05	07955	OTHER NONREIMBURSABLE COSTS	0	0	0	0	0	194.05
194.06	07956	RHC- FOREST RIDGE	0	0	0	0	0	194.06
194.07	07957	PHILLIPS HALL	0	0	0	0	0	194.07
194.08	07958	OB DRS	0	0	0	0	0	194.08
194.09	07959	THE WATERS	0	0	0	0	0	194.09
194.10	07960	CAMBRIDGE CITY	0	0	0	0	0	194.10
194.11	07961	WELL BEING	0	0	0	0	0	194.11
194.12	07962	ACTIVATE HEALTH EMPLOYER CLINIC	0	0	0	0	0	194.12
194.13	07963	NEW CASTLE PEDIATRICS	0	0	0	0	0	194.13
194.14	07964	HENRY COUNTY RADIOLOGY	0	0	0	0	0	194.14
194.15	07965	HENRY COUNTY ANESTHESIOLOGY	0	0	0	0	0	194.15
194.16	07966	NEW CASTLE IMMEDICATE CARE & FAMILY	0	0	0	0	0	194.16
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0030 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part I Date/Time Prepared: 5/30/2018 9:13 am

	Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		11.00	13.00	14.00	15.00	16.00	
202.00	TOTAL (sum lines 118 through 201)	484,447	3,329,211	1,618,346	3,652,232	1,605,080	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0030 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part I | Date/Time Prepared: 5/30/2018 9:13 am

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	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
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	9,545,371	0	9,545,371		30.00
31.00	03100	INTENSIVE CARE UNIT	3,274,738	0	3,274,738		31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0		41.00
42.00	04200	SUBPROVIDER	0	0	0		42.00
43.00	04300	NURSERY	1,314,755	0	1,314,755		43.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	6,806,532	0	6,806,532		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	316,959	0	316,959		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,019,320	0	4,019,320		54.00
57.00	05700	CT SCAN	619,606	0	619,606		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	390,258	0	390,258		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0		59.00
60.00	06000	LABORATORY	6,141,782	0	6,141,782		60.00
60.01	06001	BLOOD LABORATORY	0	0	0		60.01
65.00	06500	RESPIRATORY THERAPY	880,828	0	880,828		65.00
66.00	06600	PHYSICAL THERAPY	2,635,063	0	2,635,063		66.00
67.00	06700	OCCUPATIONAL THERAPY	285,290	0	285,290		67.00
68.00	06800	SPEECH PATHOLOGY	110,676	0	110,676		68.00
69.00	06900	ELECTROCARDIOLOGY	381,195	0	381,195		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,889,517	0	1,889,517		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	6,104,283	0	6,104,283		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,652,232	0	3,652,232		73.00
76.00	03950	CARDIAC REHAB	326,199	0	326,199		76.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	NEW CASTLE FAMILY & INTERNAL MED	6,073,457	0	6,073,457		88.00
88.01	08801	NCFIM- NORTHFIELD PARK	270,016	0	270,016		88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		89.00
91.00	09100	EMERGENCY	6,789,263	0	6,789,263		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0			92.00
		OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY	2,086,979	0	2,086,979		101.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
114.00	11400	UTILIZATION REVIEW-SNF					114.00
116.00	11600	HOSPICE	961,284	0	961,284		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	64,875,603	0	64,875,603		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	72,873	0	72,873		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2,139,049	0	2,139,049		192.00
194.00	07950	HOSPITALIST	193,534	0	193,534		194.00
194.01	07951	RENTAL	377,174	0	377,174		194.01
194.02	07952	CMHS	0	0	0		194.02
194.03	07953	MCH	0	0	0		194.03
194.04	07954	WIC	0	0	0		194.04
194.05	07955	OTHER NONREIMBURSABLE COSTS	167,354	0	167,354		194.05
194.06	07956	RHC- FOREST RIDGE	2,528,116	0	2,528,116		194.06
194.07	07957	PHILLIPS HALL	22,356	0	22,356		194.07
194.08	07958	OB DRS	8,992	0	8,992		194.08
194.09	07959	THE WATERS	1,336,355	0	1,336,355		194.09
194.10	07960	CAMBRIDGE CITY	1,152,412	0	1,152,412		194.10
194.11	07961	WELL BEING	802,006	0	802,006		194.11
194.12	07962	ACTIVATE HEALTH EMPLOYER CLINIC	329,426	0	329,426		194.12
194.13	07963	NEW CASTLE PEDIATRICS	6,244,875	0	6,244,875		194.13
194.14	07964	HENRY COUNTY RADIOLOGY	1,650,648	0	1,650,648		194.14
194.15	07965	HENRY COUNTY ANESTHESIOLOGY	3,026,065	0	3,026,065		194.15
194.16	07966	NEW CASTLE IMMEDICATE CARE & FAMILY	255,387	0	255,387		194.16

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0030 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part I Date/Time Prepared: 5/30/2018 9:13 am

	Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
		24.00	25.00	26.00		
200.00	Cross Foot Adjustments	0	0	0		200.00
201.00	Negative Cost Centers	0	0	0		201.00
202.00	TOTAL (sum lines 118 through 201)	85,182,225	0	85,182,225		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0030 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part II | Date/Time Prepared: 5/30/2018 9:13 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS NEW BLDG & FIXT	CAPITAL RELATED COSTS NEW MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		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	26,257	3,130	29,387	29,387	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	620,465	73,965	694,430	4,188	5.00
7.00	00700	OPERATION OF PLANT	0	1,334,577	159,093	1,493,670	839	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	66,000	7,868	73,868	0	8.00
9.00	00900	HOUSEKEEPING	0	38,334	4,570	42,904	381	9.00
10.00	01000	DIETARY	0	139,253	16,600	155,853	163	10.00
11.00	01100	CAFETERIA	0	38,045	4,535	42,580	232	11.00
13.00	01300	NURSING ADMINISTRATION	0	76,475	9,117	85,592	1,288	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	137,999	16,451	154,450	338	14.00
15.00	01500	PHARMACY	0	30,135	3,592	33,727	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	56,758	6,766	63,524	538	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	570,845	68,050	638,895	2,217	30.00
31.00	03100	INTENSIVE CARE UNIT	0	223,812	26,680	250,492	798	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	59,189	7,056	66,245	387	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	316,223	37,697	353,920	1,629	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	30,077	3,585	33,662	82	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	218,429	26,039	244,468	1,134	54.00
57.00	05700	CT SCAN	0	8,450	1,007	9,457	113	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	10,321	1,230	11,551	71	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	159,375	18,999	178,374	1,343	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	33,492	3,993	37,485	292	65.00
66.00	06600	PHYSICAL THERAPY	0	22,013	2,624	24,637	1,034	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	2,045	244	2,289	123	67.00
68.00	06800	SPEECH PATHOLOGY	0	3,723	444	4,167	45	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	101	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950	CARDIAC REHAB	0	13,717	1,635	15,352	105	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	NEW CASTLE FAMILY & INTERNAL MED	0	0	0	0	2,493	88.00
88.01	08801	NCFIM- NORTHFIELD PARK	0	0	0	0	95	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00	09100	EMERGENCY	0	203,883	24,305	228,188	1,716	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	823	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	0	0	0	0	290	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	4,439,892	529,275	4,969,167	22,858	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	19,466	0	19,466	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	676	192.00
194.00	07950	HOSPITALIST	0	0	0	0	4	194.00
194.01	07951	RENTAL	0	0	40,880	40,880	0	194.01
194.02	07952	CMHS	0	0	0	0	0	194.02
194.03	07953	MCH	0	0	0	0	0	194.03
194.04	07954	WIC	0	0	0	0	0	194.04
194.05	07955	OTHER NONREIMBURSABLE COSTS	0	0	0	0	0	194.05
194.06	07956	RHC- FOREST RIDGE	0	0	0	0	930	194.06
194.07	07957	PHILLIPS HALL	0	0	0	0	0	194.07
194.08	07958	OB DRS	0	0	0	0	0	194.08
194.09	07959	THE WATERS	0	473,302	56,422	529,724	179	194.09
194.10	07960	CAMBRIDGE CITY	0	0	0	0	429	194.10
194.11	07961	WELL BEING	0	0	0	0	300	194.11
194.12	07962	ACTIVATE HEALTH EMPLOYER CLINIC	0	0	0	0	106	194.12
194.13	07963	NEW CASTLE PEDIATRICS	0	0	0	0	2,419	194.13
194.14	07964	HENRY COUNTY RADIOLOGY	0	0	0	0	118	194.14
194.15	07965	HENRY COUNTY ANESTHESIOLOGY	0	0	0	0	1,283	194.15

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0030 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part II Date/Time Prepared: 5/30/2018 9:13 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS NEW BLDG & FIXT	CAPITAL RELATED COSTS NEW MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
194.16	07966	NEW CASTLE IMMEDICATE CARE & FAMILY	0	0	0	0	85	194.16
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	4,932,660	626,577	5,559,237	29,387	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0030 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part II Date/Time Prepared: 5/30/2018 9:13 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	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	698,618					5.00
7.00	00700	OPERATION OF PLANT	44,591	1,539,100				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	4,302	41,220	119,390			8.00
9.00	00900	HOUSEKEEPING	9,475	23,942	5,066	81,768		9.00
10.00	01000	DIETARY	4,891	86,970	1,361	1,757	250,995	10.00
11.00	01100	CAFETERIA	3,171	23,761	0	894	0	11.00
13.00	01300	NURSING ADMINISTRATION	25,500	47,763	0	1,196	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	10,624	86,187	0	303	0	14.00
15.00	01500	PHARMACY	29,295	18,821	0	651	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	11,848	35,448	0	242	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	46,759	356,519	24,078	21,795	198,445	30.00
31.00	03100	INTENSIVE CARE UNIT	17,182	139,781	5,433	1,454	52,550	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	7,749	36,967	1,989	288	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	37,793	197,496	21,466	6,467	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,830	18,785	420	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	26,120	136,420	8,688	2,226	0	54.00
57.00	05700	CT SCAN	4,241	5,277	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	2,775	6,446	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	42,770	99,537	151	4,846	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	6,114	20,917	0	1,923	0	65.00
66.00	06600	PHYSICAL THERAPY	19,511	13,748	2,405	8,360	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,147	1,277	224	833	0	67.00
68.00	06800	SPEECH PATHOLOGY	822	2,325	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	2,851	0	0	636	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	12,981	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	42,303	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950	CARDIAC REHAB	2,033	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	NEW CASTLE FAMILY & INTERNAL MED	49,750	0	0	0	0	88.00
88.01	08801	NCFIM- NORTHFIELD PARK	2,201	0	0	0	0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00	09100	EMERGENCY	40,050	127,335	21,387	5,861	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	16,653	0	0	2,666	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	7,790	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	536,122	1,526,942	92,668	62,398	250,995	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	191	12,158	0	424	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	17,541	0	59	0	0	192.00
194.00	07950	HOSPITALIST	1,587	0	0	0	0	194.00
194.01	07951	RENTAL	822	0	0	17,856	0	194.01
194.02	07952	CMHS	0	0	0	0	0	194.02
194.03	07953	MCH	0	0	0	0	0	194.03
194.04	07954	WIC	0	0	0	0	0	194.04
194.05	07955	OTHER NONREIMBURSABLE COSTS	1,256	0	2,528	0	0	194.05
194.06	07956	RHC- FOREST RIDGE	20,700	0	742	0	0	194.06
194.07	07957	PHILLIPS HALL	0	0	970	1,090	0	194.07
194.08	07958	OB DRS	0	0	1,602	0	0	194.08
194.09	07959	THE WATERS	10,002	0	20,821	0	0	194.09
194.10	07960	CAMBRIDGE CITY	9,451	0	0	0	0	194.10
194.11	07961	WELL BEING	6,578	0	0	0	0	194.11
194.12	07962	ACTIVATE HEALTH EMPLOYER CLINIC	2,702	0	0	0	0	194.12
194.13	07963	NEW CASTLE PEDIATRICS	51,215	0	0	0	0	194.13
194.14	07964	HENRY COUNTY RADIOLOGY	13,538	0	0	0	0	194.14
194.15	07965	HENRY COUNTY ANESTHESIOLOGY	24,818	0	0	0	0	194.15
194.16	07966	NEW CASTLE IMMEDICATE CARE & FAMILY	2,095	0	0	0	0	194.16
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	698,618	1,539,100	119,390	81,768	250,995	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0030 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part II Date/Time Prepared: 5/30/2018 9:13 am

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	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
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	70,638					11.00
13.00	01300	NURSING ADMINISTRATION	4,776	166,115				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,011	0	253,913			14.00
15.00	01500	PHARMACY	0	0	591	83,085		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,022	0	609	0	116,231	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	11,564	53,812	7,452	0	11,883	30.00
31.00	03100	INTENSIVE CARE UNIT	3,519	16,378	2,200	0	5,074	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	1,760	8,189	0	0	3,438	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	9,301	43,283	13,337	0	19,094	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	251	1,170	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,782	0	5,077	0	14,287	54.00
57.00	05700	CT SCAN	503	0	1,557	0	5,107	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	503	0	633	0	1,569	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	8,547	0	28,187	0	18,893	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	1,508	0	307	0	1,402	65.00
66.00	06600	PHYSICAL THERAPY	6,033	0	1,438	0	1,001	66.00
67.00	06700	OCCUPATIONAL THERAPY	503	0	0	0	100	67.00
68.00	06800	SPEECH PATHOLOGY	251	0	1	0	33	68.00
69.00	06900	ELECTROCARDIOLOGY	503	0	872	0	1,068	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	42,341	0	2,670	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	138,276	0	4,707	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	83,085	0	73.00
76.00	03950	CARDIAC REHAB	754	3,509	154	0	134	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	NEW CASTLE FAMILY & INTERNAL MED	0	0	1,179	0	0	88.00
88.01	08801	NCFIM- NORTHFIELD PARK	0	0	258	0	0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00	09100	EMERGENCY	8,547	39,774	7,872	0	24,569	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	859	0	701	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	0	0	713	0	501	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	70,638	166,115	253,913	83,085	116,231	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	HOSPITALIST	0	0	0	0	0	194.00
194.01	07951	RENTAL	0	0	0	0	0	194.01
194.02	07952	CMHS	0	0	0	0	0	194.02
194.03	07953	MCH	0	0	0	0	0	194.03
194.04	07954	WIC	0	0	0	0	0	194.04
194.05	07955	OTHER NONREIMBURSABLE COSTS	0	0	0	0	0	194.05
194.06	07956	RHC- FOREST RIDGE	0	0	0	0	0	194.06
194.07	07957	PHILLIPS HALL	0	0	0	0	0	194.07
194.08	07958	OB DRS	0	0	0	0	0	194.08
194.09	07959	THE WATERS	0	0	0	0	0	194.09
194.10	07960	CAMBRIDGE CITY	0	0	0	0	0	194.10
194.11	07961	WELL BEING	0	0	0	0	0	194.11
194.12	07962	ACTIVATE HEALTH EMPLOYER CLINIC	0	0	0	0	0	194.12
194.13	07963	NEW CASTLE PEDIATRICS	0	0	0	0	0	194.13
194.14	07964	HENRY COUNTY RADIOLOGY	0	0	0	0	0	194.14
194.15	07965	HENRY COUNTY ANESTHESIOLOGY	0	0	0	0	0	194.15
194.16	07966	NEW CASTLE IMMEDICATE CARE & FAMILY	0	0	0	0	0	194.16
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0030 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part II Date/Time Prepared: 5/30/2018 9:13 am

	Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		11.00	13.00	14.00	15.00	16.00	
202.00	TOTAL (sum lines 118 through 201)	70,638	166,115	253,913	83,085	116,231	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0030 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part II | Date/Time Prepared: 5/30/2018 9:13 am

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	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
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	1,373,419	0	1,373,419		30.00
31.00	03100	INTENSIVE CARE UNIT	494,861	0	494,861		31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0		41.00
42.00	04200	SUBPROVIDER	0	0	0		42.00
43.00	04300	NURSERY	127,012	0	127,012		43.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	703,786	0	703,786		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	56,200	0	56,200		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	444,202	0	444,202		54.00
57.00	05700	CT SCAN	26,255	0	26,255		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	23,548	0	23,548		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0		59.00
60.00	06000	LABORATORY	382,648	0	382,648		60.00
60.01	06001	BLOOD LABORATORY	0	0	0		60.01
65.00	06500	RESPIRATORY THERAPY	69,948	0	69,948		65.00
66.00	06600	PHYSICAL THERAPY	78,167	0	78,167		66.00
67.00	06700	OCCUPATIONAL THERAPY	7,496	0	7,496		67.00
68.00	06800	SPEECH PATHOLOGY	7,644	0	7,644		68.00
69.00	06900	ELECTROCARDIOLOGY	6,031	0	6,031		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	57,992	0	57,992		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	185,286	0	185,286		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	83,085	0	83,085		73.00
76.00	03950	CARDIAC REHAB	22,041	0	22,041		76.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	NEW CASTLE FAMILY & INTERNAL MED	53,422	0	53,422		88.00
88.01	08801	NCFIM- NORTHFIELD PARK	2,554	0	2,554		88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		89.00
91.00	09100	EMERGENCY	505,299	0	505,299		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0			92.00
		OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY	21,702	0	21,702		101.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
114.00	11400	UTILIZATION REVIEW-SNF					114.00
116.00	11600	HOSPICE	9,294	0	9,294		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	4,741,892	0	4,741,892		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	32,239	0	32,239		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	18,276	0	18,276		192.00
194.00	07950	HOSPITALIST	1,591	0	1,591		194.00
194.01	07951	RENTAL	59,558	0	59,558		194.01
194.02	07952	CMHS	0	0	0		194.02
194.03	07953	MCH	0	0	0		194.03
194.04	07954	WIC	0	0	0		194.04
194.05	07955	OTHER NONREIMBURSABLE COSTS	3,784	0	3,784		194.05
194.06	07956	RHC- FOREST RIDGE	22,372	0	22,372		194.06
194.07	07957	PHILLIPS HALL	2,060	0	2,060		194.07
194.08	07958	OB DRS	1,602	0	1,602		194.08
194.09	07959	THE WATERS	560,726	0	560,726		194.09
194.10	07960	CAMBRIDGE CITY	9,880	0	9,880		194.10
194.11	07961	WELL BEING	6,878	0	6,878		194.11
194.12	07962	ACTIVATE HEALTH EMPLOYER CLINIC	2,808	0	2,808		194.12
194.13	07963	NEW CASTLE PEDIATRICS	53,634	0	53,634		194.13
194.14	07964	HENRY COUNTY RADIOLOGY	13,656	0	13,656		194.14
194.15	07965	HENRY COUNTY ANESTHESIOLOGY	26,101	0	26,101		194.15
194.16	07966	NEW CASTLE IMMEDICATE CARE & FAMILY	2,180	0	2,180		194.16

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0030 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part II Date/Time Prepared: 5/30/2018 9:13 am

	Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
		24.00	25.00	26.00		
200.00	Cross Foot Adjustments	0	0	0		200.00
201.00	Negative Cost Centers	0	0	0		201.00
202.00	TOTAL (sum lines 118 through 201)	5,559,237	0	5,559,237		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0030 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B-1 | Date/Time Prepared: 5/30/2018 9:13 am

		Cost Center Description	CAPITAL RELATED COSTS					
			NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	255,678					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		272,444				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,361	1,361	38,244,709			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	32,161	32,161	5,432,896	-14,162,750	71,019,475	5.00
7.00	00700	OPERATION OF PLANT	69,176	69,176	1,092,807	0	4,532,957	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	3,421	3,421	0	0	437,304	8.00
9.00	00900	HOUSEKEEPING	1,987	1,987	495,830	0	963,209	9.00
10.00	01000	DIETARY	7,218	7,218	212,538	0	497,244	10.00
11.00	01100	CAFETERIA	1,972	1,972	301,860	0	322,365	11.00
13.00	01300	NURSING ADMINISTRATION	3,964	3,964	1,677,682	0	2,592,229	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	7,153	7,153	440,114	0	1,080,019	14.00
15.00	01500	PHARMACY	1,562	1,562	0	0	2,978,004	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,942	2,942	700,065	0	1,204,440	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	29,589	29,589	2,886,811	0	4,753,423	30.00
31.00	03100	INTENSIVE CARE UNIT	11,601	11,601	1,038,837	0	1,746,640	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	3,068	3,068	504,498	0	787,780	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	16,391	16,391	2,121,068	0	3,841,970	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,559	1,559	106,505	0	185,986	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	11,322	11,322	1,476,539	0	2,655,293	54.00
57.00	05700	CT SCAN	438	438	147,179	0	431,093	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	535	535	92,102	0	282,082	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	8,261	8,261	1,748,885	0	4,347,904	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	1,736	1,736	380,632	0	621,503	65.00
66.00	06600	PHYSICAL THERAPY	1,141	1,141	1,346,716	0	1,983,422	66.00
67.00	06700	OCCUPATIONAL THERAPY	106	106	160,606	0	218,245	67.00
68.00	06800	SPEECH PATHOLOGY	193	193	58,991	0	83,600	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	131,065	0	289,786	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	1,319,615	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	4,300,382	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950	CARDIAC REHAB	711	711	136,830	0	206,653	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	NEW CASTLE FAMILY & INTERNAL MED	0	0	3,245,765	0	5,057,391	88.00
88.01	08801	NCFIM- NORTHFIELD PARK	0	0	123,472	0	223,752	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00	09100	EMERGENCY	10,568	10,568	2,234,505	0	4,071,380	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	1,071,897	0	1,692,883	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	0	0	377,156	0	791,904	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	230,136	230,136	29,743,851	-14,162,750	54,500,458	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,009	0	0	0	19,466	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	879,634	0	1,783,124	192.00
194.00	07950	HOSPITALIST	0	0	4,813	0	161,356	194.00
194.01	07951	RENTAL	0	17,775	0	0	83,549	194.01
194.02	07952	CMHS	0	0	0	0	0	194.02
194.03	07953	MCH	0	0	0	0	0	194.03
194.04	07954	WIC	0	0	0	0	0	194.04
194.05	07955	OTHER NONREIMBURSABLE COSTS	0	0	0	0	127,698	194.05
194.06	07956	RHC- FOREST RIDGE	0	0	1,211,336	0	2,104,307	194.06
194.07	07957	PHILLIPS HALL	0	0	0	0	0	194.07
194.08	07958	OB DRS	0	0	0	0	0	194.08
194.09	07959	THE WATERS	24,533	24,533	232,781	0	1,016,732	194.09
194.10	07960	CAMBRIDGE CITY	0	0	559,083	0	960,807	194.10
194.11	07961	WELL BEING	0	0	390,394	0	668,661	194.11
194.12	07962	ACTIVATE HEALTH EMPLOYER CLINIC	0	0	138,635	0	274,654	194.12
194.13	07963	NEW CASTLE PEDIATRICS	0	0	3,149,763	0	5,206,596	194.13
194.14	07964	HENRY COUNTY RADIOLOGY	0	0	153,012	0	1,376,204	194.14

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0030 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B-1 | Date/Time Prepared: 5/30/2018 9:13 am

		Cost Center Description	CAPITAL RELATED COSTS					
			NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
194.15	07965	HENRY COUNTY ANESTHESIOLOGY	0	0	1,670,643	0	2,522,938	194.15
194.16	07966	NEW CASTLE IMMEDICATE CARE & FAMILY	0	0	110,764	0	212,925	194.16
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)	4,932,660	626,577	10,461,885		14,162,750	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	19.292469	2.299838	0.273551		0.199421	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			29,387		698,618	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000768		0.009837	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0030 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B-1 | Date/Time Prepared: 5/30/2018 9:13 am

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (PATIENT DAYS)	CAFETERIA (FTE'S)	
			7.00	8.00	9.00	10.00	11.00	
		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
7.00	00700	OPERATION OF PLANT	127,736					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	3,421	705,361				8.00
9.00	00900	HOUSEKEEPING	1,987	29,931	5,399			9.00
10.00	01000	DIETARY	7,218	8,039	116	7,857		10.00
11.00	01100	CAFETERIA	1,972	0	59	0	281	11.00
13.00	01300	NURSING ADMINISTRATION	3,964	0	79	0	19	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	7,153	0	20	0	8	14.00
15.00	01500	PHARMACY	1,562	0	43	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,942	0	16	0	16	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	29,589	142,258	1,439	6,212	46	30.00
31.00	03100	INTENSIVE CARE UNIT	11,601	32,100	96	1,645	14	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	3,068	11,750	19	0	7	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	16,391	126,819	427	0	37	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,559	2,481	0	0	1	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	11,322	51,328	147	0	23	54.00
57.00	05700	CT SCAN	438	0	0	0	2	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	535	0	0	0	2	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	8,261	892	320	0	34	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	1,736	0	127	0	6	65.00
66.00	06600	PHYSICAL THERAPY	1,141	14,209	552	0	24	66.00
67.00	06700	OCCUPATIONAL THERAPY	106	1,325	55	0	2	67.00
68.00	06800	SPEECH PATHOLOGY	193	0	0	0	1	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	42	0	2	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950	CARDIAC REHAB	0	0	0	0	3	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	NEW CASTLE FAMILY & INTERNAL MED	0	0	0	0	0	88.00
88.01	08801	NCFIM- NORTHFIELD PARK	0	0	0	0	0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00	09100	EMERGENCY	10,568	126,355	387	0	34	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	176	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	126,727	547,487	4,120	7,857	281	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,009	0	28	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	350	0	0	0	192.00
194.00	07950	HOSPITALIST	0	0	0	0	0	194.00
194.01	07951	RENTAL	0	0	1,179	0	0	194.01
194.02	07952	CMHS	0	0	0	0	0	194.02
194.03	07953	MCH	0	0	0	0	0	194.03
194.04	07954	WIC	0	0	0	0	0	194.04
194.05	07955	OTHER NONREIMBURSABLE COSTS	0	14,936	0	0	0	194.05
194.06	07956	RHC- FOREST RIDGE	0	4,385	0	0	0	194.06
194.07	07957	PHILLIPS HALL	0	5,728	72	0	0	194.07
194.08	07958	OB DRS	0	9,465	0	0	0	194.08
194.09	07959	THE WATERS	0	123,010	0	0	0	194.09
194.10	07960	CAMBRIDGE CITY	0	0	0	0	0	194.10
194.11	07961	WELL BEING	0	0	0	0	0	194.11
194.12	07962	ACTIVATE HEALTH EMPLOYER CLINIC	0	0	0	0	0	194.12
194.13	07963	NEW CASTLE PEDIATRICS	0	0	0	0	0	194.13
194.14	07964	HENRY COUNTY RADIOLOGY	0	0	0	0	0	194.14
194.15	07965	HENRY COUNTY ANESTHESIOLOGY	0	0	0	0	0	194.15
194.16	07966	NEW CASTLE IMMEDICATE CARE & FAMILY	0	0	0	0	0	194.16
200.00		Cross Foot Adjustments						200.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0030 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B-1 | Date/Time Prepared: 5/30/2018 9:13 am

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (PATIENT DAYS)	CAFETERIA (FTE'S)	
			7.00	8.00	9.00	10.00	11.00	
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	5,436,924	670,123	1,268,303	938,517	484,447	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	42.563756	0.950043	234.914429	119.449790	1,724.010676	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	1,539,100	119,390	81,768	250,995	70,638	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	12.049070	0.169261	15.145027	31.945399	251.380783	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0030 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B-1 | Date/Time Prepared: 5/30/2018 9:13 am

		Cost Center Description	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)		
			13.00	14.00	15.00	16.00		
		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
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	142					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	7,896,696				14.00
15.00	01500	PHARMACY	0	18,371	100			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	18,946	0	3,482		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	46	231,762	0	356		30.00
31.00	03100	INTENSIVE CARE UNIT	14	68,416	0	152		31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0		41.00
42.00	04200	SUBPROVIDER	0	0	0	0		42.00
43.00	04300	NURSERY	7	0	0	103		43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	37	414,796	0	572		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1	0	0	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	157,891	0	428		54.00
57.00	05700	CT SCAN	0	48,427	0	153		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	19,702	0	47		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0		59.00
60.00	06000	LABORATORY	0	876,617	0	566		60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0		60.01
65.00	06500	RESPIRATORY THERAPY	0	9,533	0	42		65.00
66.00	06600	PHYSICAL THERAPY	0	44,711	0	30		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	3		67.00
68.00	06800	SPEECH PATHOLOGY	0	21	0	1		68.00
69.00	06900	ELECTROCARDIOLOGY	0	27,107	0	32		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,316,807	0	80		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	4,300,382	0	141		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	100	0		73.00
76.00	03950	CARDIAC REHAB	3	4,799	0	4		76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	NEW CASTLE FAMILY & INTERNAL MED	0	36,675	0	0		88.00
88.01	08801	NCFIM- NORTHFIELD PARK	0	8,019	0	0		88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0		89.00
91.00	09100	EMERGENCY	34	244,825	0	736		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	26,715	0	21		101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	0	22,174	0	15		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	142	7,896,696	100	3,482		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192.00
194.00	07950	HOSPITALIST	0	0	0	0		194.00
194.01	07951	RENTAL	0	0	0	0		194.01
194.02	07952	CMHS	0	0	0	0		194.02
194.03	07953	MCH	0	0	0	0		194.03
194.04	07954	WIC	0	0	0	0		194.04
194.05	07955	OTHER NONREIMBURSABLE COSTS	0	0	0	0		194.05
194.06	07956	RHC- FOREST RIDGE	0	0	0	0		194.06
194.07	07957	PHILLIPS HALL	0	0	0	0		194.07
194.08	07958	OB DRS	0	0	0	0		194.08
194.09	07959	THE WATERS	0	0	0	0		194.09
194.10	07960	CAMBRIDGE CITY	0	0	0	0		194.10
194.11	07961	WELL BEING	0	0	0	0		194.11
194.12	07962	ACTIVATE HEALTH EMPLOYER CLINIC	0	0	0	0		194.12
194.13	07963	NEW CASTLE PEDIATRICS	0	0	0	0		194.13
194.14	07964	HENRY COUNTY RADIOLOGY	0	0	0	0		194.14
194.15	07965	HENRY COUNTY ANESTHESIOLOGY	0	0	0	0		194.15
194.16	07966	NEW CASTLE IMMEDICATE CARE & FAMILY	0	0	0	0		194.16

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0030 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B-1 | Date/Time Prepared: 5/30/2018 9:13 am

		Cost Center Description	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)		
			13.00	14.00	15.00	16.00		
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)	3,329,211	1,618,346	3,652,232	1,605,080		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	23,445.147887	0.204940	36,522.320000	460.964963		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	166,115	253,913	83,085	116,231		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	1,169.823944	0.032154	830.850000	33.380528		205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0030 | Period: From 01/01/2017 To 12/31/2017 | Worksheet C Part I Date/Time Prepared: 5/30/2018 9:13 am

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		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	9,545,371		9,545,371	0	9,545,371	30.00
31.00	03100	INTENSIVE CARE UNIT	3,274,738		3,274,738	0	3,274,738	31.00
41.00	04100	SUBPROVIDER - IRF	0		0	0	0	41.00
42.00	04200	SUBPROVIDER	0		0	0	0	42.00
43.00	04300	NURSERY	1,314,755		1,314,755	0	1,314,755	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,806,532		6,806,532	0	6,806,532	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	316,959		316,959	0	316,959	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,019,320		4,019,320	0	4,019,320	54.00
57.00	05700	CT SCAN	619,606		619,606	0	619,606	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	390,258		390,258	0	390,258	58.00
59.00	05900	CARDIAC CATHETERIZATION	0		0	0	0	59.00
60.00	06000	LABORATORY	6,141,782		6,141,782	2,289	6,144,071	60.00
60.01	06001	BLOOD LABORATORY	0		0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	880,828	0	880,828	0	880,828	65.00
66.00	06600	PHYSICAL THERAPY	2,635,063	0	2,635,063	0	2,635,063	66.00
67.00	06700	OCCUPATIONAL THERAPY	285,290	0	285,290	0	285,290	67.00
68.00	06800	SPEECH PATHOLOGY	110,676	0	110,676	0	110,676	68.00
69.00	06900	ELECTROCARDIOLOGY	381,195		381,195	0	381,195	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,889,517		1,889,517	0	1,889,517	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	6,104,283		6,104,283	0	6,104,283	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,652,232		3,652,232	0	3,652,232	73.00
76.00	03950	CARDIAC REHAB	326,199		326,199	0	326,199	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	NEW CASTLE FAMILY & INTERNAL MED	6,073,457		6,073,457	0	6,073,457	88.00
88.01	08801	NCFIM- NORTHFIELD PARK	270,016		270,016	0	270,016	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0	89.00
91.00	09100	EMERGENCY	6,789,263		6,789,263	0	6,789,263	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,235,979		1,235,979		1,235,979	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	2,086,979		2,086,979		2,086,979	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	961,284		961,284		961,284	116.00
200.00		Subtotal (see instructions)	66,111,582	0	66,111,582	2,289	66,113,871	200.00
201.00		Less Observation Beds	1,235,979		1,235,979		1,235,979	201.00
202.00		Total (see instructions)	64,875,603	0	64,875,603	2,289	64,877,892	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0030 | Period: From 01/01/2017 To 12/31/2017 | Worksheet C Part I Date/Time Prepared: 5/30/2018 9:13 am

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		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	9,880,714		9,880,714			30.00
31.00	03100	INTENSIVE CARE UNIT	4,928,159		4,928,159			31.00
41.00	04100	SUBPROVIDER - IRF	0		0			41.00
42.00	04200	SUBPROVIDER	0		0			42.00
43.00	04300	NURSERY	2,121,872		2,121,872			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	7,060,985	14,341,724	21,402,709	0.318022	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	884,361	728,478	1,612,839	0.196522	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,717,654	14,560,138	16,277,792	0.246920	0.000000	54.00
57.00	05700	CT SCAN	1,711,824	19,507,216	21,219,040	0.029200	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	226,830	5,895,250	6,122,080	0.063746	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	0.000000	59.00
60.00	06000	LABORATORY	4,724,293	20,243,646	24,967,939	0.245987	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	0.000000	60.01
65.00	06500	RESPIRATORY THERAPY	3,743,598	1,675,131	5,418,729	0.162553	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	494,684	3,374,854	3,869,538	0.680976	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	7,675	353,239	360,914	0.790465	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	24,652	109,763	134,415	0.823390	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	945,220	3,205,667	4,150,887	0.091835	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,892,339	6,437,887	10,330,226	0.182911	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	12,969,991	5,263,627	18,233,618	0.334782	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,308,760	4,032,173	8,340,933	0.437869	0.000000	73.00
76.00	03950	CARDIAC REHAB	0	492,509	492,509	0.662321	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	NEW CASTLE FAMILY & INTERNAL MED	0	3,138,758	3,138,758			88.00
88.01	08801	NCFIM- NORTHFIELD PARK	0	730,683	730,683			88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0			89.00
91.00	09100	EMERGENCY	1,336,610	14,780,046	16,116,656	0.421258	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	386,308	883,973	1,270,281	0.972997	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	2,723,167	2,723,167			101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	0	1,878,397	1,878,397			116.00
200.00		Subtotal (see instructions)	61,366,529	124,356,326	185,722,855			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	61,366,529	124,356,326	185,722,855			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0030 | Period: From 01/01/2017 To 12/31/2017 | Worksheet C Part I Date/Time Prepared: 5/30/2018 9:13 am

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		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
41.00	04100	SUBPROVIDER - IRF		41.00
42.00	04200	SUBPROVIDER		42.00
43.00	04300	NURSERY		43.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.318022	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.196522	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.246920	54.00
57.00	05700	CT SCAN	0.029200	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.063746	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	59.00
60.00	06000	LABORATORY	0.246078	60.00
60.01	06001	BLOOD LABORATORY	0.000000	60.01
65.00	06500	RESPIRATORY THERAPY	0.162553	65.00
66.00	06600	PHYSICAL THERAPY	0.680976	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.790465	67.00
68.00	06800	SPEECH PATHOLOGY	0.823390	68.00
69.00	06900	ELECTROCARDIOLOGY	0.091835	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.182911	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.334782	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.437869	73.00
76.00	03950	CARDIAC REHAB	0.662321	76.00
		OUTPATIENT SERVICE COST CENTERS		
88.00	08800	NEW CASTLE FAMILY & INTERNAL MED		88.00
88.01	08801	NCFIM- NORTHFIELD PARK		88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER		89.00
91.00	09100	EMERGENCY	0.421258	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.972997	92.00
		OTHER REIMBURSABLE COST CENTERS		
101.00	10100	HOME HEALTH AGENCY		101.00
		SPECIAL PURPOSE COST CENTERS		
113.00	11300	INTEREST EXPENSE		113.00
114.00	11400	UTILIZATION REVIEW-SNF		114.00
116.00	11600	HOSPICE		116.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0030 | Period: From 01/01/2017 To 12/31/2017 | Worksheet C Part I Date/Time Prepared: 5/30/2018 9:13 am

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	9,545,371		9,545,371	0	9,545,371	30.00
31.00	03100	INTENSIVE CARE UNIT	3,274,738		3,274,738	0	3,274,738	31.00
41.00	04100	SUBPROVIDER - IRF	0		0	0	0	41.00
42.00	04200	SUBPROVIDER	0		0	0	0	42.00
43.00	04300	NURSERY	1,314,755		1,314,755	0	1,314,755	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,806,532		6,806,532	0	6,806,532	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	316,959		316,959	0	316,959	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,019,320		4,019,320	0	4,019,320	54.00
57.00	05700	CT SCAN	619,606		619,606	0	619,606	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	390,258		390,258	0	390,258	58.00
59.00	05900	CARDIAC CATHETERIZATION	0		0	0	0	59.00
60.00	06000	LABORATORY	6,141,782		6,141,782	2,289	6,144,071	60.00
60.01	06001	BLOOD LABORATORY	0		0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	880,828	0	880,828	0	880,828	65.00
66.00	06600	PHYSICAL THERAPY	2,635,063	0	2,635,063	0	2,635,063	66.00
67.00	06700	OCCUPATIONAL THERAPY	285,290	0	285,290	0	285,290	67.00
68.00	06800	SPEECH PATHOLOGY	110,676	0	110,676	0	110,676	68.00
69.00	06900	ELECTROCARDIOLOGY	381,195		381,195	0	381,195	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,889,517		1,889,517	0	1,889,517	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	6,104,283		6,104,283	0	6,104,283	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,652,232		3,652,232	0	3,652,232	73.00
76.00	03950	CARDIAC REHAB	326,199		326,199	0	326,199	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	NEW CASTLE FAMILY & INTERNAL MED	6,073,457		6,073,457	0	6,073,457	88.00
88.01	08801	NCFIM- NORTHFIELD PARK	270,016		270,016	0	270,016	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0	89.00
91.00	09100	EMERGENCY	6,789,263		6,789,263	0	6,789,263	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,235,979		1,235,979		1,235,979	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	2,086,979		2,086,979		2,086,979	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	961,284		961,284		961,284	116.00
200.00		Subtotal (see instructions)	66,111,582	0	66,111,582	2,289	66,113,871	200.00
201.00		Less Observation Beds	1,235,979		1,235,979		1,235,979	201.00
202.00		Total (see instructions)	64,875,603	0	64,875,603	2,289	64,877,892	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0030 | Period: From 01/01/2017 To 12/31/2017 | Worksheet C Part I Date/Time Prepared: 5/30/2018 9:13 am

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	9,880,714		9,880,714			30.00
31.00	03100	INTENSIVE CARE UNIT	4,928,159		4,928,159			31.00
41.00	04100	SUBPROVIDER - IRF	0		0			41.00
42.00	04200	SUBPROVIDER	0		0			42.00
43.00	04300	NURSERY	2,121,872		2,121,872			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	7,060,985	14,341,724	21,402,709	0.318022	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	884,361	728,478	1,612,839	0.196522	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,717,654	14,560,138	16,277,792	0.246920	0.000000	54.00
57.00	05700	CT SCAN	1,711,824	19,507,216	21,219,040	0.029200	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	226,830	5,895,250	6,122,080	0.063746	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	0.000000	59.00
60.00	06000	LABORATORY	4,724,293	20,243,646	24,967,939	0.245987	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	0.000000	60.01
65.00	06500	RESPIRATORY THERAPY	3,743,598	1,675,131	5,418,729	0.162553	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	494,684	3,374,854	3,869,538	0.680976	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	7,675	353,239	360,914	0.790465	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	24,652	109,763	134,415	0.823390	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	945,220	3,205,667	4,150,887	0.091835	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,892,339	6,437,887	10,330,226	0.182911	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	12,969,991	5,263,627	18,233,618	0.334782	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,308,760	4,032,173	8,340,933	0.437869	0.000000	73.00
76.00	03950	CARDIAC REHAB	0	492,509	492,509	0.662321	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	NEW CASTLE FAMILY & INTERNAL MED	0	3,138,758	3,138,758	1.934987	0.000000	88.00
88.01	08801	NCFIM- NORTHFIELD PARK	0	730,683	730,683	0.369539	0.000000	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.000000	0.000000	89.00
91.00	09100	EMERGENCY	1,336,610	14,780,046	16,116,656	0.421258	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	386,308	883,973	1,270,281	0.972997	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	2,723,167	2,723,167			101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	0	1,878,397	1,878,397			116.00
200.00		Subtotal (see instructions)	61,366,529	124,356,326	185,722,855			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	61,366,529	124,356,326	185,722,855			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0030 | Period: From 01/01/2017 To 12/31/2017 | Worksheet C Part I Date/Time Prepared: 5/30/2018 9:13 am

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
41.00	04100	SUBPROVIDER - IRF			41.00
42.00	04200	SUBPROVIDER			42.00
43.00	04300	NURSERY			43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
57.00	05700	CT SCAN	0.000000		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000		58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000		59.00
60.00	06000	LABORATORY	0.000000		60.00
60.01	06001	BLOOD LABORATORY	0.000000		60.01
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
76.00	03950	CARDIAC REHAB	0.000000		76.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	NEW CASTLE FAMILY & INTERNAL MED	0.000000		88.00
88.01	08801	NCFIM- NORTHFIELD PARK	0.000000		88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		89.00
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
		OTHER REIMBURSABLE COST CENTERS			
101.00	10100	HOME HEALTH AGENCY			101.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
114.00	11400	UTILIZATION REVIEW-SNF			114.00
116.00	11600	HOSPICE			116.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 15-0030 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part I Date/Time Prepared: 5/30/2018 9:13 am

Title XVIII | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	1,373,419	0	1,373,419	7,136	192.46	30.00
31.00	INTENSIVE CARE UNIT	494,861		494,861	1,645	300.83	31.00
41.00	SUBPROVIDER - IRF	0	0	0	0	0.00	41.00
42.00	SUBPROVIDER	0	0	0	0	0.00	42.00
43.00	NURSERY	127,012		127,012	720	176.41	43.00
200.00	Total (lines 30 through 199)	1,995,292		1,995,292	9,501		200.00

	Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)	
		6.00	7.00	
	INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	ADULTS & PEDIATRICS	3,056	588,158	30.00
31.00	INTENSIVE CARE UNIT	974	293,008	31.00
41.00	SUBPROVIDER - IRF	0	0	41.00
42.00	SUBPROVIDER	0	0	42.00
43.00	NURSERY	0	0	43.00
200.00	Total (lines 30 through 199)	4,030	881,166	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-0030 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part II Date/Time Prepared: 5/30/2018 9:13 am

Title XVIII | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	703,786	21,402,709	0.032883	2,673,979	87,928	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	56,200	1,612,839	0.034845	4,170	145	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	444,202	16,277,792	0.027289	1,067,351	29,127	54.00
57.00	05700	CT SCAN	26,255	21,219,040	0.001237	1,012,336	1,252	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	23,548	6,122,080	0.003846	122,614	472	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	06000	LABORATORY	382,648	24,967,939	0.015326	2,845,600	43,612	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	69,948	5,418,729	0.012909	1,817,164	23,458	65.00
66.00	06600	PHYSICAL THERAPY	78,167	3,869,538	0.020201	259,082	5,234	66.00
67.00	06700	OCCUPATIONAL THERAPY	7,496	360,914	0.020769	278	6	67.00
68.00	06800	SPEECH PATHOLOGY	7,644	134,415	0.056869	20,925	1,190	68.00
69.00	06900	ELECTROCARDIOLOGY	6,031	4,150,887	0.001453	815,539	1,185	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	57,992	10,330,226	0.005614	1,923,867	10,801	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	185,286	18,233,618	0.010162	5,932,243	60,283	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	83,085	8,340,933	0.009961	2,751,778	27,410	73.00
76.00	03950	CARDIAC REHAB	22,041	492,509	0.044752	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	NEW CASTLE FAMILY & INTERNAL MED	53,422	3,138,758	0.017020	0	0	88.00
88.01	08801	NCFIM- NORTHFIELD PARK	2,554	730,683	0.003495	0	0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00
91.00	09100	EMERGENCY	505,299	16,116,656	0.031353	541,911	16,991	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	177,836	1,270,281	0.139997	81,955	11,473	92.00
200.00		Total (lines 50 through 199)	2,893,440	164,190,546		21,870,792	320,567	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0030 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part III Date/Time Prepared: 5/30/2018 9:13 am

Title XVIII | Hospital | PPS

		Cost Center Description	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
			1A	1.00	2A	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
200.00		Total (lines 30 through 199)	0	0	0	0	0	200.00

		Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
			4.00	5.00	6.00	7.00	8.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	7,136	0.00	3,056	30.00
31.00	03100	INTENSIVE CARE UNIT		0	1,645	0.00	974	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0.00	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0.00	0	42.00
43.00	04300	NURSERY		0	720	0.00	0	43.00
200.00		Total (lines 30 through 199)		0	9,501		4,030	200.00

		Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
			9.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	31.00
41.00	04100	SUBPROVIDER - IRF	0	41.00
42.00	04200	SUBPROVIDER	0	42.00
43.00	04300	NURSERY	0	43.00
200.00		Total (lines 30 through 199)	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0030 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part IV Date/Time Prepared: 5/30/2018 9:13 am

Title XVIII | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950	CARDIAC REHAB	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	NEW CASTLE FAMILY & INTERNAL MED	0	0	0	0	0	88.00
88.01	08801	NCFIM- NORTHFIELD PARK	0	0	0	0	0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0		0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0030 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part IV | Date/Time Prepared: 5/30/2018 9:13 am

Title XVIII | Hospital | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	21,402,709	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	1,612,839	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	16,277,792	0.000000	54.00
57.00	05700	CT SCAN	0	0	0	21,219,040	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	6,122,080	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	24,967,939	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0.000000	60.01
65.00	06500	RESPIRATORY THERAPY	0	0	0	5,418,729	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	3,869,538	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	360,914	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	134,415	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	4,150,887	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	10,330,226	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	18,233,618	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	8,340,933	0.000000	73.00
76.00	03950	CARDIAC REHAB	0	0	0	492,509	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	NEW CASTLE FAMILY & INTERNAL MED	0	0	0	3,138,758	0.000000	88.00
88.01	08801	NCFIM- NORTHFIELD PARK	0	0	0	730,683	0.000000	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0.000000	89.00
91.00	09100	EMERGENCY	0	0	0	16,116,656	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	1,270,281	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	164,190,546		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0030 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part IV | Date/Time Prepared: 5/30/2018 9:13 am

Title XVIII | Hospital | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	2,673,979	0	4,010,372	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	4,170	0	1,205	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	1,067,351	0	4,678,665	0	54.00
57.00	05700	CT SCAN	0.000000	1,012,336	0	5,964,144	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	122,614	0	1,783,155	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY	0.000000	2,845,600	0	1,859,867	0	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0.000000	1,817,164	0	248,116	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	259,082	0	6,926	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	278	0	1,286	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	20,925	0	669	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	815,539	0	1,744,847	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	1,923,867	0	1,645,084	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000	5,932,243	0	1,704,775	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	2,751,778	0	2,097,935	0	73.00
76.00	03950	CARDIAC REHAB	0.000000	0	0	198,994	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	NEW CASTLE FAMILY & INTERNAL MED	0.000000	0	0	0	0	88.00
88.01	08801	NCFIM- NORTHFIELD PARK	0.000000	0	0	0	0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	0	0	0	89.00
91.00	09100	EMERGENCY	0.000000	541,911	0	3,446,184	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	81,955	0	493,748	0	92.00
200.00		Total (lines 50 through 199)		21,870,792	0	29,885,972	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0030 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part V Date/Time Prepared: 5/30/2018 9:13 am

Title XVIII | Hospital | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.318022	4,010,372	0	0	1,275,387	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.196522	1,205	0	0	237	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.246920	4,678,665	0	0	1,155,256	54.00
57.00	05700	CT SCAN	0.029200	5,964,144	0	0	174,153	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.063746	1,783,155	0	0	113,669	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY	0.245987	1,859,867	0	0	457,503	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0.162553	248,116	0	0	40,332	65.00
66.00	06600	PHYSICAL THERAPY	0.680976	6,926	0	0	4,716	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.790465	1,286	0	0	1,017	67.00
68.00	06800	SPEECH PATHOLOGY	0.823390	669	0	0	551	68.00
69.00	06900	ELECTROCARDIOLOGY	0.091835	1,744,847	0	0	160,238	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.182911	1,645,084	0	0	300,904	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.334782	1,704,775	0	0	570,728	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.437869	2,097,935	0	3,774	918,621	73.00
76.00	03950	CARDIAC REHAB	0.662321	198,994	0	0	131,798	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	NEW CASTLE FAMILY & INTERNAL MED	0.000000				0	88.00
88.01	08801	NCFIM- NORTHFIELD PARK	0.000000				0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000				0	89.00
91.00	09100	EMERGENCY	0.421258	3,446,184	0	0	1,451,733	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.972997	493,748	0	0	480,415	92.00
200.00		Subtotal (see instructions)		29,885,972	0	3,774	7,237,258	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		29,885,972	0	3,774	7,237,258	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0030 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part V Date/Time Prepared: 5/30/2018 9:13 am

Title XVIII | Hospital | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	0	0		60.00
60.01	06001	BLOOD LABORATORY	0	0		60.01
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,653		73.00
76.00	03950	CARDIAC REHAB	0	0		76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	NEW CASTLE FAMILY & INTERNAL MED	0	0		88.00
88.01	08801	NCFIM- NORTHFIELD PARK	0	0		88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0		89.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
200.00		Subtotal (see instructions)	0	1,653		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	1,653		202.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0030	Period: From 01/01/2017 To 12/31/2017	Worksheet D-1 Date/Time Prepared: 5/30/2018 9:13 am
	Title XVIII	Hospital	PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	7,136	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	7,136	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)	6,212	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	3,056	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	9,545,371	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	9,545,371	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	9,545,371	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)	1,337.64	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	4,087,828	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)	4,087,828	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0030 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-1 | Date/Time Prepared: 5/30/2018 9:13 am

Title XVIII | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	3,274,738	1,645	1,990.72	974	1,938,961	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)	6,267,375	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	12,294,164	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)	881,166	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	320,567	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	1,201,733	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	11,092,431	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)	924	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,337.64	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,235,979	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0030 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-1 | Date/Time Prepared: 5/30/2018 9:13 am

Title XVIII | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	1,373,419	9,545,371	0.143883	1,235,979	177,836	90.00
91.00	Nursing School cost	0	9,545,371	0.000000	1,235,979	0	91.00
92.00	Allied health cost	0	9,545,371	0.000000	1,235,979	0	92.00
93.00	All other Medical Education	0	9,545,371	0.000000	1,235,979	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0030	Period: From 01/01/2017 To 12/31/2017	Worksheet D-1 Date/Time Prepared: 5/30/2018 9:13 am
	Title XIX	Hospital	Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	7,136	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	7,136	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)	6,212	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	97	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)	720	15.00
16.00	Nursery days (title V or XIX only)	34	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	9,545,371	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	9,545,371	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	9,545,371	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)	1,337.64	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	129,751	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)	129,751	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0030 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-1 | Date/Time Prepared: 5/30/2018 9:13 am

Title XIX | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	1,314,755	720	1,826.05	34	62,086	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	3,274,738	1,645	1,990.72	6	11,944	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)	79,136	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	282,917	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)	924	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,337.64	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,235,979	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0030 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-1 | Date/Time Prepared: 5/30/2018 9:13 am

Title XIX | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	1,373,419	9,545,371	0.143883	1,235,979	177,836	90.00
91.00	Nursing School cost	0	9,545,371	0.000000	1,235,979	0	91.00
92.00	Allied health cost	0	9,545,371	0.000000	1,235,979	0	92.00
93.00	All other Medical Education	0	9,545,371	0.000000	1,235,979	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0030 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-3 | Date/Time Prepared: 5/30/2018 9:13 am

Title XVIII | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		4,212,913		30.00
31.00	03100	INTENSIVE CARE UNIT		2,615,793		31.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
42.00	04200	SUBPROVIDER		0		42.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.318022	2,673,979	850,384	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.196522	4,170	819	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.246920	1,067,351	263,550	54.00
57.00	05700	CT SCAN	0.029200	1,012,336	29,560	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.063746	122,614	7,816	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	06000	LABORATORY	0.246078	2,845,600	700,240	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0.162553	1,817,164	295,385	65.00
66.00	06600	PHYSICAL THERAPY	0.680976	259,082	176,429	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.790465	278	220	67.00
68.00	06800	SPEECH PATHOLOGY	0.823390	20,925	17,229	68.00
69.00	06900	ELECTROCARDIOLOGY	0.091835	815,539	74,895	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.182911	1,923,867	351,896	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.334782	5,932,243	1,986,008	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.437869	2,751,778	1,204,918	73.00
76.00	03950	CARDIAC REHAB	0.662321	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	NEW CASTLE FAMILY & INTERNAL MED	0.000000		0	88.00
88.01	08801	NCFIM- NORTHFIELD PARK	0.000000		0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0	89.00
91.00	09100	EMERGENCY	0.421258	541,911	228,284	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.972997	81,955	79,742	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		21,870,792	6,267,375	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)		21,870,792		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0030 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-3 | Date/Time Prepared: 5/30/2018 9:13 am

Title XIX | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		167,503		30.00
31.00	03100	INTENSIVE CARE UNIT		40,218		31.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
42.00	04200	SUBPROVIDER		0		42.00
43.00	04300	NURSERY		0		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.318022	50,285	15,992	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.196522	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.246920	9,777	2,414	54.00
57.00	05700	CT SCAN	0.029200	13,988	408	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.063746	2,857	182	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	06000	LABORATORY	0.245987	55,885	13,747	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0.162553	34,838	5,663	65.00
66.00	06600	PHYSICAL THERAPY	0.680976	2,324	1,583	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.790465	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.823390	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.091835	5,728	526	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.182911	74,825	13,686	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.334782	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.437869	42,387	18,560	73.00
76.00	03950	CARDIAC REHAB	0.662321	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	NEW CASTLE FAMILY & INTERNAL MED	1.934987	0	0	88.00
88.01	08801	NCFIM- NORTHFIELD PARK	0.369539	0	0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	0	89.00
91.00	09100	EMERGENCY	0.421258	15,133	6,375	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.972997	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		308,027	79,136	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)		308,027		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0030	Period: From 01/01/2017 To 12/31/2017	Worksheet E Part A Date/Time Prepared: 5/30/2018 9:13 am
	Title XVIII	Hospital	PPS

		1.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS		
1.00	DRG Amounts Other than Outlier Payments	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)	6,099,629	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	2,480,634	1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)	0	1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)	0	1.04
2.00	Outlier payments for discharges. (see instructions)	539	2.00
2.01	Outlier reconciliation amount	0	2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)	0	2.02
3.00	Managed Care Simulated Payments	0	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)	45.47	4.00
	Indirect Medical Education Adjustment		
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)	0.00	5.00
6.00	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)	0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)	0.00	7.00
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.	0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).	0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.	0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)	0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see instructions)	0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records	0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.	0.00	11.00
12.00	Current year allowable FTE (see instructions)	0.00	12.00
13.00	Total allowable FTE count for the prior year.	0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.	0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.	0.00	15.00
16.00	Adjustment for residents in initial years of the program	0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure	0.00	17.00
18.00	Adjusted rolling average FTE count	0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).	0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)	0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)	0.000000	21.00
22.00	IME payment adjustment (see instructions)	0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)	0	22.01
	Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA		
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C).	0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)	0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)	0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)	0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)	0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)	0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)	0	28.01
29.00	Total IME payment (sum of lines 22 and 28)	0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)	0	29.01
	Disproportionate Share Adjustment		
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	4.38	30.00
31.00	Percentage of Medicaid patient days (see instructions)	19.42	31.00
32.00	Sum of lines 30 and 31	23.80	32.00
33.00	Allowable disproportionate share percentage (see instructions)	8.85	33.00
34.00	Disproportionate share adjustment (see instructions)	189,838	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0030	Period: From 01/01/2017 To 12/31/2017	Worksheet E Part A Date/Time Prepared: 5/30/2018 9:13 am
	Title XVIII	Hospital	PPS

		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	Uncompensated Care Adjustment			
35.00	Total uncompensated care amount (see instructions)	0	0	35.00
35.01	Factor 3 (see instructions)	0.000000000	0.000000000	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	347,255	493,544	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	259,728	124,400	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	384,128		36.00
	Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)			
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)	0		40.00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0		41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0		41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)	0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)	0.00		45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)	0		46.00
47.00	Subtotal (see instructions)	9,154,768		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)	11,101,491		48.00

		Amount	
		1.00	
49.00	Total payment for inpatient operating costs (see instructions)	10,614,810	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)	696,176	50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)	0	51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).	0	52.00
53.00	Nursing and Allied Health Managed Care payment	0	53.00
54.00	Special add-on payments for new technologies	0	54.00
54.01	Islet isolation add-on payment	0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)	0	55.00
56.00	Cost of physicians' services in a teaching hospital (see intructions)	0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).	0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)	0	58.00
59.00	Total (sum of amounts on lines 49 through 58)	11,310,986	59.00
60.00	Primary payer payments	0	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)	11,310,986	61.00
62.00	Deductibles billed to program beneficiaries	1,107,904	62.00
63.00	Coinsurance billed to program beneficiaries	2,632	63.00
64.00	Allowable bad debts (see instructions)	59,262	64.00
65.00	Adjusted reimbursable bad debts (see instructions)	38,520	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	54,790	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	10,238,970	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)	0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96).(For SCH see instructions)	0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	70.00
70.50	Rural Community Hospital Demonstration Project (§410A Demonstration) adjustment (see instructions)	0	70.50
70.87	Demonstration payment adjustment amount before sequestration	0	70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)	0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)		70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)	17,809	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)	-110	70.91
70.92	Bundled Model 1 discount amount (see instructions)	0	70.92
70.93	HVBP payment adjustment amount (see instructions)	103,751	70.93
70.94	HRR adjustment amount (see instructions)	-744	70.94
70.95	Recovery of accelerated depreciation	0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0030	Period: From 01/01/2017 To 12/31/2017	Worksheet E Part A Date/Time Prepared: 5/30/2018 9:13 am
	Title XVIII	Hospital	PPS

		FFY (yyyy)	Amount	
		0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	2017	523,518	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	2018	131,438	70.97
70.98	Low Volume Payment-3		0	70.98
70.99	HAC adjustment amount (see instructions)		0	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		11,014,632	71.00
71.01	Sequestration adjustment (see instructions)		220,293	71.01
71.02	Demonstration payment adjustment amount after sequestration		0	71.02
72.00	Interim payments		10,911,898	72.00
73.00	Tentative settlement (for contractor use only)		0	73.00
74.00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 73)		-117,559	74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		170,930	75.00
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)			
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2 (see instructions)		0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00
95.00	Time value of money for operating expenses (see instructions)		0	95.00
96.00	Time value of money for capital related expenses (see instructions)		0	96.00

		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	HSP Bonus Payment Amount			
100.00	HSP bonus amount (see instructions)	1,092,031	368,011	100.00
	HVBP Adjustment for HSP Bonus Payment			
101.00	HVBP adjustment factor (see instructions)	1.0129161580	1.0100652060	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)	14,105	3,704	102.00
	HRR Adjustment for HSP Bonus Payment			
103.00	HRR adjustment factor (see instructions)	1.0000	0.9997	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)	0	-110	104.00
	Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment			
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
	Cost Reimbursement			
201.00	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)			201.00
202.00	Medicare discharges (see instructions)			202.00
203.00	Case-mix adjustment factor (see instructions)			203.00
	Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)			
204.00	Medicare target amount			204.00
205.00	Case-mix adjusted target amount (line 203 times line 204)			205.00
206.00	Medicare inpatient routine cost cap (line 202 times line 205)			206.00
	Adjustment to Medicare Part A Inpatient Reimbursement			
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)			208.00
209.00	Adjustment to Medicare IPPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
211.00	Total adjustment to Medicare IPPS payments (see instructions)			211.00
	Comparision of PPS versus Cost Reimbursement			
212.00	Total adjustment to Medicare Part A IPPS payments (from line 211)			212.00
213.00	Low-volume adjustment (see instructions)			213.00
218.00	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)			218.00

LOW VOLUME CALCULATION EXHIBIT 4 | Provider CCN: 15-0030 | Period: From 01/01/2017 To 12/31/2017 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 5/30/2018 9:13 am

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		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	6,099,629	0	6,099,629		6,099,629	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	2,480,634	0		2,480,634	2,480,634	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00	539	0	539	0	539	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0	2.01
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	0	4.00
	Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	0	6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	0	9.01
	Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0885	0.0885	0.0885	0.0885		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	189,838	0	134,954	54,884	189,838	11.00
11.01	Uncompensated care payments	36.00	384,128	0	259,728	124,400	384,128	11.01
	Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	9,154,768	0	6,494,850	2,659,918	9,154,768	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	11,101,491	0	7,914,974	3,186,517	11,101,491	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	10,614,810	0	7,559,943	3,054,867	10,614,810	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	696,176	0	494,173	202,003	696,176	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	0	17.00
17.01	Net organ aquisition cost							17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0	17.02

LOW VOLUME CALCULATION EXHIBIT 4 | Provider CCN: 15-0030 | Period: From 01/01/2017 To 12/31/2017 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 5/30/2018 9:13 am

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		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0	18.00
19.00	SUBTOTAL			0	8,054,116	3,256,870	11,310,986	19.00
		W/S L, line	(Amounts from L)					
		0	1.00	2.00	3.00	4.00	5.00	
20.00	Capital DRG other than outlier	1.00	695,890	0	493,887	202,003	695,890	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	286	0	286	0	286	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	696,176	0	494,173	202,003	696,176	26.00
		W/S E, Part A line	(Amounts to E, Part A)					
		0	1.00	2.00	3.00	4.00	5.00	
27.00	Low volume adjustment factor				0.065000	0.040357		27.00
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			523,518		523,518	28.00
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				131,438	131,438	29.00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 | Provider CCN: 15-0030 | Period: From 01/01/2017 To 12/31/2017 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 5/30/2018 9:13 am

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		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	1.00	2.00	3.00	4.00	
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	6,099,629	6,099,629		6,099,629	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	2,480,634		2,480,634	2,480,634	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00	539	539	0	539	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	2.01
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	4.00
	Indirect Medical Education Adjustment						
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA						
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	9.01
	Disproportionate Share Adjustment						
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0885	0.0885	0.0885		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	189,838	134,954	54,884	189,838	11.00
11.01	Uncompensated care payments	36.00	384,128	259,728	124,400	384,128	11.01
	Additional payment for high percentage of ESRD beneficiary discharges						
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	9,154,768	6,494,850	2,659,918	9,154,768	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	11,101,491	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	10,614,810	7,954,892	2,659,918	10,614,810	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	696,176	494,173	202,003	696,176	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	17.00
17.01	Net organ acquisition cost						17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	18.00
19.00	SUBTOTAL			8,449,065	2,861,921	11,310,986	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 | Provider CCN: 15-0030 | Period: From 01/01/2017 To 12/31/2017 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 5/30/2018 9:13 am

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		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	695,890	493,887	202,003	695,890	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	286	286	0	286	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	696,176	494,173	202,003	696,176	26.00
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
		0	1.00	2.00	3.00	4.00	
27.00							27.00
28.00	Low volume adjustment prior to October 1	70.96	523,518	523,518		523,518	28.00
29.00	Low volume adjustment on or after October 1	70.97	131,438		131,438	131,438	29.00
30.00	HVBP payment adjustment (see instructions)	70.93	103,751	78,783	24,968	103,751	30.00
30.01	HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	17,809	14,105	3,704	17,809	30.01
31.00	HRR adjustment (see instructions)	70.94	-744	0	-744	-744	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	-110	0	-110	-110	31.01
						(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3.00	4.00	
32.00	HAC Reduction Program adjustment (see instructions)	70.99		0	0	0	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		N				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0030	Period: From 01/01/2017 To 12/31/2017	Worksheet E Part B Date/Time Prepared: 5/30/2018 9:13 am
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		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	1,653	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	7,237,258	2.00
3.00	OPPS payments	6,957,078	3.00
4.00	Outlier payment (see instructions)	7,401	4.00
4.01	Outlier reconciliation amount (see instructions)	0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	1,653	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	3,774	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)	3,774	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	3,774	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	2,121	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (see instructions)	1,653	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	6,964,479	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	1,372,670	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	5,593,462	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	5,593,462	30.00
31.00	Primary payer payments	3,132	31.00
32.00	Subtotal (line 30 minus line 31)	5,590,330	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)	163,233	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	106,101	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	160,054	36.00
37.00	Subtotal (see instructions)	5,696,431	37.00
38.00	MSP-LCC reconciliation amount from PS&R	1,068	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		39.50
39.97	Demonstration payment adjustment amount before sequestration	0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	5,695,363	40.00
40.01	Sequestration adjustment (see instructions)	113,907	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
41.00	Interim payments	5,654,384	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	-72,928	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: 15-0030 | Period: From 01/01/2017 To 12/31/2017 | Worksheet E-1 Part I Date/Time Prepared: 5/30/2018 9:13 am

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		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		10,271,913		5,476,309	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	12/31/2017	36,934	12/31/2017	178,075	3.01
3.02		07/07/2017	35,500		0	3.02
3.03			0		0	3.03
3.04		12/31/2017	436,113		0	3.04
3.05		12/31/2017	131,438		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)		639,985		178,075	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)		10,911,898		5,654,384	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		117,559		72,928	6.02
7.00	Total Medicare program liability (see instructions)		10,794,339		5,581,456	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: 15-0030	Period: From 01/01/2017 To 12/31/2017	Worksheet E-1 Part II Date/Time Prepared: 5/30/2018 9:13 am
	Title XVIII	Hospital	PPS

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

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0030	Period: From 01/01/2017 To 12/31/2017	Worksheet E-3 Part VII Date/Time Prepared: 5/30/2018 9:13 am
	Title XIX	Hospital	Cost

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	282,917		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)	282,917	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)	282,917	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	207,720		8.00
9.00	Ancillary service charges	308,027	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)	515,747	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)	515,747	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	232,830	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)	282,917	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)	282,917	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)	282,917	0	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	282,917	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	282,917	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)	282,917	0	40.00
41.00	Interim payments	253,858	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	29,059	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: 15-0030 | Period: From 01/01/2017 To 12/31/2017 | Worksheet G | Date/Time Prepared: 5/30/2018 9:13 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	-1,451,713	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	16,230,548	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	715,864	0	0	0	7.00
8.00	Prepaid expenses	1,061,003	0	0	0	8.00
9.00	Other current assets	1,545,598	0	0	0	9.00
10.00	Due from other funds	46,298,434	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	64,399,734	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	46,000	0	0	0	12.00
13.00	Land improvements	2,068,316	0	0	0	13.00
14.00	Accumulated depreciation	-1,389,099	0	0	0	14.00
15.00	Buildings	40,575,749	0	0	0	15.00
16.00	Accumulated depreciation	-28,029,655	0	0	0	16.00
17.00	Leasehold improvements	1,098,114	0	0	0	17.00
18.00	Accumulated depreciation	-986,045	0	0	0	18.00
19.00	Fixed equipment	18,784,226	0	0	0	19.00
20.00	Accumulated depreciation	-13,908,595	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	39,568,068	0	0	0	23.00
24.00	Accumulated depreciation	-24,074,134	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)	33,752,945	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	10,714,778	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	7,393,010	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	18,107,788	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	116,260,467	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	7,901,792	0	0	0	37.00
38.00	Salaries, wages, and fees payable	4,361,517	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	947,100	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	19,208,234	0	0	0	43.00
44.00	Other current liabilities	0	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	32,418,643	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	14,696,939	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	14,696,939	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	47,115,582	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	69,144,885				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	69,144,885	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	116,260,467	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-0030 | Period: From 01/01/2017 To 12/31/2017 | Worksheet G-1 | Date/Time Prepared: 5/30/2018 9:13 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		73,650,344		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-4,505,459				2.00
3.00	Total (sum of line 1 and line 2)		69,144,885		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		69,144,885		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		69,144,885		0		19.00

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

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 15-0030 | Period: From 01/01/2017 To 12/31/2017 | Worksheet G-2 Parts I & II Date/Time Prepared: 5/30/2018 9:13 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	12,002,586		12,002,586	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF	0		0	3.00
4.00	SUBPROVIDER	0		0	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)	12,002,586		12,002,586	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	4,928,159		4,928,159	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)	4,928,159		4,928,159	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	16,930,745		16,930,745	17.00
18.00	Ancillary services	42,712,866	100,221,302	142,934,168	18.00
19.00	Outpatient services	1,722,918	15,664,019	17,386,937	19.00
20.00	NEW CASTLE FAMILY & INTERNAL MED	0	3,138,758	3,138,758	20.00
20.01	NCFIM- NORTHFIELD PARK	0	730,683	730,683	20.01
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		2,723,167	2,723,167	22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE	0	1,878,397	1,878,397	26.00
27.00	NONREIMBURSABLE	741	1,484,345	1,485,086	27.00
27.01	OTHER	0	9,658	9,658	27.01
27.02	PRO FEES	0	19,143,860	19,143,860	27.02
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	61,367,270	144,994,189	206,361,459	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		90,563,312		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		90,563,312		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 15-0030 | Period: From 01/01/2017 To 12/31/2017 | Worksheet G-3 | Date/Time Prepared: 5/30/2018 9:13 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	206,361,459	1.00
2.00	Less contractual allowances and discounts on patients' accounts	123,593,733	2.00
3.00	Net patient revenues (line 1 minus line 2)	82,767,726	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	90,563,312	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-7,795,586	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	1,234,457	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	INVESTMENT INCOME	6,243,116	24.00
24.01	OTHER NONOPERATING	-4,187,446	24.01
25.00	Total other income (sum of lines 6-24)	3,290,127	25.00
26.00	Total (line 5 plus line 25)	-4,505,459	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-4,505,459	29.00

ANALYSIS OF HOSPITAL-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 15-0030 | HHA CCN: 15-7430 | Period: From 01/01/2017 To 12/31/2017 | Worksheet H | Date/Time Prepared: 5/30/2018 9:13 am

Home Health Agency I | PPS

		Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased Services	Other Costs	Total (sum of cols. 1 thru 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures			0		0	0	1.00
2.00	Capital Related - Movable Equipment			0		0	0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0	0	0	3.00
4.00	Transportation	0	0	0	0	0	0	4.00
5.00	Administrative and General	116,581	0	70,325	0	273,036	459,942	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	577,946	0	0	0	0	577,946	6.00
7.00	Physical Therapy	293,654	0	0	0	0	293,654	7.00
8.00	Occupational Therapy	53,116	0	0	0	0	53,116	8.00
9.00	Speech Pathology	4,914	0	0	0	0	4,914	9.00
10.00	Medical Social Services	0	0	0	0	0	0	10.00
11.00	Home Health Aide	25,686	0	0	0	0	25,686	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	1,071,897	0	70,325	0	273,036	1,415,258	24.00

		Reclassification	Reclassified Trial Balance (col. 6 + col.7)	Adjustments	Net Expenses for Allocation (col. 8 + col. 9)			
		7.00	8.00	9.00	10.00			
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0	0	0			1.00
2.00	Capital Related - Movable Equipment	0	0	0	0			2.00
3.00	Plant Operation & Maintenance	0	0	0	0			3.00
4.00	Transportation	0	0	0	0			4.00
5.00	Administrative and General	0	459,942	-15,593	444,349			5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	577,946	0	577,946			6.00
7.00	Physical Therapy	0	293,654	0	293,654			7.00
8.00	Occupational Therapy	0	53,116	0	53,116			8.00
9.00	Speech Pathology	0	4,914	0	4,914			9.00
10.00	Medical Social Services	0	0	0	0			10.00
11.00	Home Health Aide	0	25,686	0	25,686			11.00
12.00	Supplies (see instructions)	0	0	0	0			12.00
13.00	Drugs	0	0	0	0			13.00
14.00	DME	0	0	0	0			14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0			15.00
16.00	Respiratory Therapy	0	0	0	0			16.00
17.00	Private Duty Nursing	0	0	0	0			17.00
18.00	Clinic	0	0	0	0			18.00
19.00	Health Promotion Activities	0	0	0	0			19.00
20.00	Day Care Program	0	0	0	0			20.00
21.00	Home Delivered Meals Program	0	0	0	0			21.00
22.00	Homemaker Service	0	0	0	0			22.00
23.00	All Others (specify)	0	0	0	0			23.00
23.50	Telemedicine	0	0	0	0			23.50
24.00	Total (sum of lines 1-23)	0	1,415,258	-15,593	1,399,665			24.00

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

COST ALLOCATION - HHA GENERAL SERVICE COST | Provider CCN: 15-0030 | HHA CCN: 15-7430 | Period: From 01/01/2017 To 12/31/2017 | Worksheet H-1 Part I | Date/Time Prepared: 5/30/2018 9:13 am

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		Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Capital Related Costs: Bldgs & Fixtures	Capital Related Costs: Movable Equipment	Plant Operation & Maintenance	Transportation	Subtotal (cols. 0-4)	
		0	1.00	2.00	3.00	4.00	4A.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0				0	1.00
2.00	Capital Related - Movable Equipment	0		0			0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0		0	3.00
4.00	Transportation	0	0	0	0	0		4.00
5.00	Administrative and General	444,349	0	0	0	0	444,349	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	577,946	0	0	0	0	577,946	6.00
7.00	Physical Therapy	293,654	0	0	0	0	293,654	7.00
8.00	Occupational Therapy	53,116	0	0	0	0	53,116	8.00
9.00	Speech Pathology	4,914	0	0	0	0	4,914	9.00
10.00	Medical Social Services	0	0	0	0	0	0	10.00
11.00	Home Health Aide	25,686	0	0	0	0	25,686	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0		0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	1,399,665	0	0	0	0	1,399,665	24.00

		Administrative & General	Total (cols. 4A + 5)	
		5.00	6.00	
	GENERAL SERVICE COST CENTERS			
1.00	Capital Related - Bldg. & Fixtures			1.00
2.00	Capital Related - Movable Equipment			2.00
3.00	Plant Operation & Maintenance			3.00
4.00	Transportation			4.00
5.00	Administrative and General	444,349		5.00
	HHA REIMBURSABLE SERVICES			
6.00	Skilled Nursing Care	268,822	846,768	6.00
7.00	Physical Therapy	136,588	430,242	7.00
8.00	Occupational Therapy	24,706	77,822	8.00
9.00	Speech Pathology	2,286	7,200	9.00
10.00	Medical Social Services	0	0	10.00
11.00	Home Health Aide	11,947	37,633	11.00
12.00	Supplies (see instructions)	0	0	12.00
13.00	Drugs	0	0	13.00
14.00	DME	0	0	14.00
	HHA NONREIMBURSABLE SERVICES			
15.00	Home Dialysis Aide Services	0	0	15.00
16.00	Respiratory Therapy	0	0	16.00
17.00	Private Duty Nursing	0	0	17.00
18.00	Clinic	0	0	18.00
19.00	Health Promotion Activities	0	0	19.00
20.00	Day Care Program	0	0	20.00
21.00	Home Delivered Meals Program	0	0	21.00
22.00	Homemaker Service	0	0	22.00
23.00	All Others (specify)	0	0	23.00
23.50	Telemedicine	0	0	23.50
24.00	Total (sum of lines 1-23)		1,399,665	24.00

COST ALLOCATION - HHA STATISTICAL BASIS | Provider CCN: 15-0030 | HHA CCN: 15-7430 | Period: From 01/01/2017 To 12/31/2017 | Worksheet H-1 Part II | Date/Time Prepared: 5/30/2018 9:13 am

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		Capital Related Costs						
		Bldgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)	Plant Operation & Maintenance (SQUARE FEET)	Transportation (MILEAGE)	Reconciliation	Administrative & General (ACCUM. COST)	
		1.00	2.00	3.00	4.00	5A.00	5.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0				0		1.00
2.00	Capital Related - Movable Equipment		0			0		2.00
3.00	Plant Operation & Maintenance	0	0	0		0		3.00
4.00	Transportation (see instructions)	0	0	0	0			4.00
5.00	Administrative and General	0	0	0	0	-444,349	955,316	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	0	577,946	6.00
7.00	Physical Therapy	0	0	0	0	0	293,654	7.00
8.00	Occupational Therapy	0	0	0	0	0	53,116	8.00
9.00	Speech Pathology	0	0	0	0	0	4,914	9.00
10.00	Medical Social Services	0	0	0	0	0	0	10.00
11.00	Home Health Aide	0	0	0	0	0	25,686	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	0	12.00
13.00	Drugs	0	0	0		0	0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	0	0	0	0	-444,349	955,316	24.00
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0	0		444,349	25.00
26.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000		0.465133	26.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 15-0030
HHA CCN: 15-7430

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

Worksheet H-2 Part I
Date/Time Prepared: 5/30/2018 9:13 am

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	Cost Center Description	HHA Trial Balance (1)	CAPITAL RELATED COSTS NEW BLDG & FIXT	CAPITAL RELATED COSTS NEW MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	
		0	1.00	2.00	4.00	4A	5.00	
1.00	Administrative and General	0	0	0	293,218	293,218	58,474	1.00
2.00	Skilled Nursing Care	846,768	0	0	0	846,768	168,863	2.00
3.00	Physical Therapy	430,242	0	0	0	430,242	85,799	3.00
4.00	Occupational Therapy	77,822	0	0	0	77,822	15,519	4.00
5.00	Speech Pathology	7,200	0	0	0	7,200	1,436	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	37,633	0	0	0	37,633	7,505	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	1,399,665	0	0	293,218	1,692,883	337,596	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.					0.000000		21.00

	Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
		7.00	8.00	9.00	10.00	11.00	13.00	
1.00	Administrative and General	0	0	41,345	0	0	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	0	0	41,345	0	0	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 15-0030 | HHA CCN: 15-7430 | Period: From 01/01/2017 To 12/31/2017 | Worksheet H-2 Part I | Date/Time Prepared: 5/30/2018 9:13 am

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	Cost Center Description	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	
		14.00	15.00	16.00	24.00	25.00	26.00	
1.00	Administrative and General	5,475	0	9,680	408,192	0	408,192	1.00
2.00	Skilled Nursing Care	0	0	0	1,015,631	0	1,015,631	2.00
3.00	Physical Therapy	0	0	0	516,041	0	516,041	3.00
4.00	Occupational Therapy	0	0	0	93,341	0	93,341	4.00
5.00	Speech Pathology	0	0	0	8,636	0	8,636	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	45,138	0	45,138	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	5,475	0	9,680	2,086,979	0	2,086,979	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

	Cost Center Description	Allocated HHA A&G (see Part II)	Total HHA Costs					
		27.00	28.00					
1.00	Administrative and General							1.00
2.00	Skilled Nursing Care	246,947	1,262,578					2.00
3.00	Physical Therapy	125,474	641,515					3.00
4.00	Occupational Therapy	22,696	116,037					4.00
5.00	Speech Pathology	2,100	10,736					5.00
6.00	Medical Social Services	0	0					6.00
7.00	Home Health Aide	10,975	56,113					7.00
8.00	Supplies (see instructions)	0	0					8.00
9.00	Drugs	0	0					9.00
10.00	DME	0	0					10.00
11.00	Home Dialysis Aide Services	0	0					11.00
12.00	Respiratory Therapy	0	0					12.00
13.00	Private Duty Nursing	0	0					13.00
14.00	Clinic	0	0					14.00
15.00	Health Promotion Activities	0	0					15.00
16.00	Day Care Program	0	0					16.00
17.00	Home Delivered Meals Program	0	0					17.00
18.00	Homemaker Service	0	0					18.00
19.00	All Others (specify)	0	0					19.00
19.50	Telemedicine	0	0					19.50
20.00	Total (sum of lines 1-19) (2)	408,192	2,086,979					20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.	0.243147						21.00

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 15-0030 HHA CCN: 15-7430

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

Worksheet H-2 Part II Date/Time Prepared: 5/30/2018 9:13 am

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	Cost Center Description	CAPITAL RELATED COSTS NEW BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS NEW MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
		1.00	2.00	4.00	5A	5.00	7.00	
1.00	Administrative and General	0	0	1,071,897	0	293,218	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	846,768	0	2.00
3.00	Physical Therapy	0	0	0	0	430,242	0	3.00
4.00	Occupational Therapy	0	0	0	0	77,822	0	4.00
5.00	Speech Pathology	0	0	0	0	7,200	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	37,633	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	0	0	1,071,897		1,692,883	0	20.00
21.00	Total cost to be allocated	0	0	293,218		337,596	0	21.00
22.00	Unit cost multiplier	0.000000	0.000000	0.273551		0.199421	0.000000	22.00

	Cost Center Description	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (PATIENT DAYS)	CAFETERIA (FTE'S)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	
		8.00	9.00	10.00	11.00	13.00	14.00	
1.00	Administrative and General	0	176	0	0	0	26,715	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	0	176	0	0	0	26,715	20.00
21.00	Total cost to be allocated	0	41,345	0	0	0	5,475	21.00
22.00	Unit cost multiplier	0.000000	234.914773	0.000000	0.000000	0.000000	0.204941	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 15-0030 | HHA CCN: 15-7430 | Period: From 01/01/2017 To 12/31/2017 | Worksheet H-2 Part II | Date/Time Prepared: 5/30/2018 9:13 am

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	Cost Center Description	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)			
		15.00	16.00			
1.00	Administrative and General	0	21			1.00
2.00	Skilled Nursing Care	0	0			2.00
3.00	Physical Therapy	0	0			3.00
4.00	Occupational Therapy	0	0			4.00
5.00	Speech Pathology	0	0			5.00
6.00	Medical Social Services	0	0			6.00
7.00	Home Health Aide	0	0			7.00
8.00	Supplies (see instructions)	0	0			8.00
9.00	Drugs	0	0			9.00
10.00	DME	0	0			10.00
11.00	Home Dialysis Aide Services	0	0			11.00
12.00	Respiratory Therapy	0	0			12.00
13.00	Private Duty Nursing	0	0			13.00
14.00	Clinic	0	0			14.00
15.00	Health Promotion Activities	0	0			15.00
16.00	Day Care Program	0	0			16.00
17.00	Home Delivered Meals Program	0	0			17.00
18.00	Homemaker Service	0	0			18.00
19.00	All Others (specify)	0	0			19.00
19.50	Telemedicine	0	0			19.50
20.00	Total (sum of lines 1-19)	0	21			20.00
21.00	Total cost to be allocated	0	9,680			21.00
22.00	Unit cost multiplier	0.000000	460.952381			22.00

APPORTIONMENT OF PATIENT SERVICE COSTS | Provider CCN: 15-0030 | HHA CCN: 15-7430 | Period: From 01/01/2017 To 12/31/2017 | Worksheet H-3 Part I | Date/Time Prepared: 5/30/2018 9:13 am

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	Cost Center Description	From, Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Visits	Average Cost Per Visit (col. 3 ÷ col. 4)	
		0	1.00	2.00	3.00	4.00	5.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	2.00	1,262,578		1,262,578	4,546	277.73	1.00
2.00	Physical Therapy	3.00	641,515	0	641,515	4,362	147.07	2.00
3.00	Occupational Therapy	4.00	116,037	0	116,037	789	147.07	3.00
4.00	Speech Pathology	5.00	10,736	0	10,736	73	147.07	4.00
5.00	Medical Social Services	6.00	0		0	0	0.00	5.00
6.00	Home Health Aide	7.00	56,113		56,113	1,463	38.35	6.00
7.00	Total (sum of lines 1-6)		2,086,979	0	2,086,979	11,233		7.00

	Cost Center Description	Cost Limits	CBSA No. (1)	Program Visits: Part A	Program Visits: Part B Not Subject to Deductibles & Coinsurance	Program Visits: Part B Subject to Deductibles		
		0	1.00	2.00	3.00	4.00	5.00	
	Limitation Cost Computation							
8.00	Skilled Nursing Care		34620	0	24			8.00
8.01	Skilled Nursing Care		99915	0	2,068			8.01
9.00	Physical Therapy		34620	0	49			9.00
9.01	Physical Therapy		99915	0	1,950			9.01
10.00	Occupational Therapy		34620	0	6			10.00
10.01	Occupational Therapy		99915	0	437			10.01
11.00	Speech Pathology		34620	0	0			11.00
11.01	Speech Pathology		99915	0	16			11.01
12.00	Medical Social Services		34620	0	0			12.00
12.01	Medical Social Services		99915	0	0			12.01
13.00	Home Health Aide		34620	0	0			13.00
13.01	Home Health Aide		99915	0	409			13.01
14.00	Total (sum of lines 8-13)			0	4,959			14.00

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

	Cost Center Description	Program Visits: Part A	Program Visits: Part B Not Subject to Deductibles & Coinsurance	Program Visits: Part B Subject to Deductibles & Coinsurance	Cost of Services: Part A	Cost of Services: Part B Not Subject to Deductibles & Coinsurance	Cost of Services: Part B Subject to Deductibles & Coinsurance	
		6.00	7.00	8.00	9.00	10.00	11.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	0	2,092		0	581,011		1.00
2.00	Physical Therapy	0	1,999		0	293,993		2.00
3.00	Occupational Therapy	0	443		0	65,152		3.00
4.00	Speech Pathology	0	16		0	2,353		4.00
5.00	Medical Social Services	0	0		0	0		5.00
6.00	Home Health Aide	0	409		0	15,685		6.00
7.00	Total (sum of lines 1-6)	0	4,959		0	958,194		7.00

APPORTIONMENT OF PATIENT SERVICE COSTS | Provider CCN: 15-0030 | HHA CCN: 15-7430 | Period: From 01/01/2017 To 12/31/2017 | Worksheet H-3 Part I | Date/Time Prepared: 5/30/2018 9:13 am

Title XVIII | Home Health Agency I | PPS

	Cost Center Description							
		6.00	7.00	8.00	9.00	10.00	11.00	
	Limitation Cost Computation							
8.00	Skilled Nursing Care							8.00
8.01	Skilled Nursing Care							8.01
9.00	Physical Therapy							9.00
9.01	Physical Therapy							9.01
10.00	Occupational Therapy							10.00
10.01	Occupational Therapy							10.01
11.00	Speech Pathology							11.00
11.01	Speech Pathology							11.01
12.00	Medical Social Services							12.00
12.01	Medical Social Services							12.01
13.00	Home Health Aide							13.00
13.01	Home Health Aide							13.01
14.00	Total (sum of lines 8-13)							14.00

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

	Cost Center Description	Total Program Cost (sum of cols. 9-10)						
		12.00						
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	581,011						1.00
2.00	Physical Therapy	293,993						2.00
3.00	Occupational Therapy	65,152						3.00
4.00	Speech Pathology	2,353						4.00
5.00	Medical Social Services	0						5.00
6.00	Home Health Aide	15,685						6.00
7.00	Total (sum of lines 1-6)	958,194						7.00

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

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 15-0030
HHA CCN: 15-7430

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

Worksheet H-3 Part II
Date/Time Prepared: 5/30/2018 9:13 am

Title XVIII | Home Health Agency I | PPS

	Cost Center Description	From Wkst. C, Part I, col. 9, line	Cost to Charge Ratio	Total HHA Charge (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)	Transfer to Part I as Indicated		
		0	1.00	2.00	3.00	4.00		
	PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS							
1.00	Physical Therapy	66.00	0.680976	0	0	col. 2, line 2.00		1.00
2.00	Occupational Therapy	67.00	0.790465	0	0	col. 2, line 3.00		2.00
3.00	Speech Pathology	68.00	0.823390	0	0	col. 2, line 4.00		3.00
4.00	Cost of Medical Supplies	71.00	0.182911	0	0	col. 2, line 15.00		4.00
5.00	Cost of Drugs	73.00	0.437869	0	0	col. 2, line 16.00		5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT

Provider CCN: 15-0030 | HHA CCN: 15-7430 | Period: From 01/01/2017 To 12/31/2017 | Worksheet H-4 Part I-II | Date/Time Prepared: 5/30/2018 9:13 am

Title XVIII | Home Health Agency I | PPS

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

		Part A Services	Part B Services	
		1.00	2.00	
	PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT			
10.00	Total reasonable cost (see instructions)	0	0	10.00
11.00	Total PPS Reimbursement - Full Episodes without Outliers	0	794,515	11.00
12.00	Total PPS Reimbursement - Full Episodes with Outliers	0	28,819	12.00
13.00	Total PPS Reimbursement - LUPA Episodes	0	9,439	13.00
14.00	Total PPS Reimbursement - PEP Episodes	0	6,588	14.00
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers	0	2,439	15.00
16.00	Total PPS Outlier Reimbursement - PEP Episodes	0	1,572	16.00
17.00	Total Other Payments	0	0	17.00
18.00	DME Payments	0	0	18.00
19.00	Oxygen Payments	0	0	19.00
20.00	Prosthetic and Orthotic Payments	0	0	20.00
21.00	Part B deductibles billed to Medicare patients (exclude coinsurance)		0	21.00
22.00	Subtotal (sum of lines 10 thru 20 minus line 21)	0	843,372	22.00
23.00	Excess reasonable cost (from line 8)	0	0	23.00
24.00	Subtotal (line 22 minus line 23)	0	843,372	24.00
25.00	Coinsurance billed to program patients (from your records)		0	25.00
26.00	Net cost (line 24 minus line 25)	0	843,372	26.00
27.00	Reimbursable bad debts (from your records)			27.00
28.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)			28.00
29.00	Total costs - current cost reporting period (line 26 plus line 27)	0	843,372	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	0	30.50
30.99	Demonstration payment adjustment amount before sequestration	0	0	30.99
31.00	Subtotal (see instructions)	0	843,372	31.00
31.01	Sequestration adjustment (see instructions)	0	16,826	31.01
31.02	Demonstration payment adjustment amount after sequestration	0	2,043	31.02
32.00	Interim payments (see instructions)	0	824,503	32.00
33.00	Tentative settlement (for contractor use only)	0	0	33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 32, and 33)	0	0	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	35.00

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

Provider CCN: 15-0030 | HHA CCN: 15-7430 | Period: From 01/01/2017 To 12/31/2017 | Worksheet H-5 | Date/Time Prepared: 5/30/2018 9:13 am

Home Health Agency I | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		0		824,503	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01			0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50			0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate, line 32)		0		824,503	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01			0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50			0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		2,043	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		0		826,546	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS

Provider CCN: 15-0030 | Hospice CCN: 15-1564 | Period: From 01/01/2017 To 12/31/2017 | Worksheet O | Date/Time Prepared: 5/30/2018 9:13 am

Hospice I

		SALARIES	OTHER	SUBTOTAL (col. 1 plus col. 2)	RECLASSIFI-CATIONS	SUBTOTAL	
		1.00	2.00	3.00	4.00	5.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT*		0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP*		0	0	0	0	2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT*	0	6,200	6,200	0	6,200	3.00
4.00	ADMINISTRATIVE & GENERAL*	69,744	242,660	312,404	0	312,404	4.00
5.00	PLANT OPERATION & MAINTENANCE*	0	43,931	43,931	0	43,931	5.00
6.00	LAUNDRY & LINEN SERVICE*	0	0	0	0	0	6.00
7.00	HOUSEKEEPING*	0	0	0	0	0	7.00
8.00	DIETARY*	0	0	0	0	0	8.00
9.00	NURSING ADMINISTRATION*	0	0	0	0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES*	0	0	0	0	0	10.00
11.00	MEDICAL RECORDS*	0	0	0	0	0	11.00
12.00	STAFF TRANSPORTATION*	0	0	0	0	0	12.00
13.00	VOLUNTEER SERVICE COORDINATION*	0	0	0	0	0	13.00
14.00	PHARMACY*	0	29,152	29,152	0	29,152	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES*	0	0	0	0	0	15.00
16.00	OTHER GENERAL SERVICE*	0	0	0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES						17.00
	DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED**		0	0	0	0	25.00
26.00	PHYSICIAN SERVICES**	23,500	0	23,500	0	23,500	26.00
27.00	NURSE PRACTITIONER**	0	0	0	0	0	27.00
28.00	REGISTERED NURSE**	221,104	0	221,104	0	221,104	28.00
29.00	LPN/LVN**	0	0	0	0	0	29.00
30.00	PHYSICAL THERAPY**	0	0	0	0	0	30.00
31.00	OCCUPATIONAL THERAPY**	0	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY**	0	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES**	38,929	0	38,929	0	38,929	33.00
34.00	SPIRITUAL COUNSELING**	0	0	0	0	0	34.00
35.00	DIETARY COUNSELING**	0	0	0	0	0	35.00
36.00	COUNSELING - OTHER**	0	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES**	23,879	0	23,879	0	23,879	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN**	0	0	0	0	0	38.00
39.00	PATIENT TRANSPORTATION**	0	0	0	0	0	39.00
40.00	IMAGING SERVICES**	0	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS**	0	0	0	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE**	0	0	0	0	0	42.00
42.50	DRUGS CHARGED TO PATIENTS**	0	0	0	0	0	42.50
43.00	OUTPATIENT SERVICES**	0	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY**	0	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY**	0	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)**	0	0	0	0	0	46.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM *	0	0	0	0	0	60.00
61.00	VOLUNTEER PROGRAM *	0	0	0	0	0	61.00
62.00	FUNDRAISING*	0	0	0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS*	0	0	0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM*	0	0	0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES*	0	0	0	0	0	65.00
66.00	RESIDENTIAL CARE*	0	0	0	0	0	66.00
67.00	ADVERTISING*	0	0	0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING*	0	0	0	0	0	68.00
69.00	THRIFT STORE*	0	0	0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD*	0	0	0	0	0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)*	0	0	0	0	0	71.00
100.00	TOTAL	377,156	321,943	699,099	0	699,099	100.00

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

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS

Provider CCN: 15-0030 | Hospice CCN: 15-1564 | Period: From 01/01/2017 To 12/31/2017 | Worksheet O | Date/Time Prepared: 5/30/2018 9:13 am

Hospice I

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)		
		6.00	7.00		
	GENERAL SERVICE COST CENTERS				
1.00	CAP REL COSTS-BLDG & FIXT*	0	0		1.00
2.00	CAP REL COSTS-MVBLE EQUIP*	0	0		2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT*	0	6,200		3.00
4.00	ADMINISTRATIVE & GENERAL*	-10,366	302,038		4.00
5.00	PLANT OPERATION & MAINTENANCE*	0	43,931		5.00
6.00	LAUNDRY & LINEN SERVICE*	0	0		6.00
7.00	HOUSEKEEPING*	0	0		7.00
8.00	DIETARY*	0	0		8.00
9.00	NURSING ADMINISTRATION*	0	0		9.00
10.00	ROUTINE MEDICAL SUPPLIES*	0	0		10.00
11.00	MEDICAL RECORDS*	0	0		11.00
12.00	STAFF TRANSPORTATION*	0	0		12.00
13.00	VOLUNTEER SERVICE COORDINATION*	0	0		13.00
14.00	PHARMACY*	0	29,152		14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES*	0	0		15.00
16.00	OTHER GENERAL SERVICE*	0	0		16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES				17.00
	DIRECT PATIENT CARE SERVICE COST CENTERS				
25.00	INPATIENT CARE-CONTRACTED**	0	0		25.00
26.00	PHYSICIAN SERVICES**	0	23,500		26.00
27.00	NURSE PRACTITIONER**	0	0		27.00
28.00	REGISTERED NURSE**	0	221,104		28.00
29.00	LPN/LVN**	0	0		29.00
30.00	PHYSICAL THERAPY**	0	0		30.00
31.00	OCCUPATIONAL THERAPY**	0	0		31.00
32.00	SPEECH/LANGUAGE PATHOLOGY**	0	0		32.00
33.00	MEDICAL SOCIAL SERVICES**	0	38,929		33.00
34.00	SPIRITUAL COUNSELING**	0	0		34.00
35.00	DIETARY COUNSELING**	0	0		35.00
36.00	COUNSELING - OTHER**	0	0		36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES**	0	23,879		37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN**	0	0		38.00
39.00	PATIENT TRANSPORTATION**	0	0		39.00
40.00	IMAGING SERVICES**	0	0		40.00
41.00	LABS & DIAGNOSTICS**	0	0		41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE**	0	0		42.00
42.50	DRUGS CHARGED TO PATIENTS**	0	0		42.50
43.00	OUTPATIENT SERVICES**	0	0		43.00
44.00	PALLIATIVE RADIATION THERAPY**	0	0		44.00
45.00	PALLIATIVE CHEMOTHERAPY**	0	0		45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)**	0	0		46.00
	NONREIMBURSABLE COST CENTERS				
60.00	BEREAVEMENT PROGRAM *	0	0		60.00
61.00	VOLUNTEER PROGRAM *	0	0		61.00
62.00	FUNDRAISING*	0	0		62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS*	0	0		63.00
64.00	PALLIATIVE CARE PROGRAM*	0	0		64.00
65.00	OTHER PHYSICIAN SERVICES*	0	0		65.00
66.00	RESIDENTIAL CARE*	0	0		66.00
67.00	ADVERTISING*	0	0		67.00
68.00	TELEHEALTH/TELEMONITORING*	0	0		68.00
69.00	THRIFT STORE*	0	0		69.00
70.00	NURSING FACILITY ROOM & BOARD*	0	0		70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)*	0	0		71.00
100.00	TOTAL	-10,366	688,733		100.00

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

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

Provider CCN: 15-0030 Hospice CCN: 15-1564 | Period: From 01/01/2017 To 12/31/2017 | Worksheet O-2 | Date/Time Prepared: 5/30/2018 9:13 am

Hospice I

		SALARIES	OTHER	SUBTOTAL (col. 1 + col. 2)	RECLASSIFI-CATIONS	SUBTOTAL	
		1.00	2.00	3.00	4.00	5.00	
	DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED						25.00
26.00	PHYSICIAN SERVICES	23,163	0	23,163	0	23,163	26.00
27.00	NURSE PRACTITIONER	0	0	0	0	0	27.00
28.00	REGISTERED NURSE	217,926	0	217,926	0	217,926	28.00
29.00	LPN/LVN	0	0	0	0	0	29.00
30.00	PHYSICAL THERAPY	0	0	0	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	38,370	0	38,370	0	38,370	33.00
34.00	SPIRITUAL COUNSELING	0	0	0	0	0	34.00
35.00	DIETARY COUNSELING	0	0	0	0	0	35.00
36.00	COUNSELING - OTHER	0	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	23,536	0	23,536	0	23,536	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	0	0	0	38.00
39.00	PATIENT TRANSPORTATION	0	0	0	0	0	39.00
40.00	IMAGING SERVICES	0	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	0	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	0	0	0	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	42.50
43.00	OUTPATIENT SERVICES	0	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	0	0	0	46.00
100.00	TOTAL *	302,995	0	302,995	0	302,995	100.00

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

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)		
		6.00	7.00		
	DIRECT PATIENT CARE SERVICE COST CENTERS				
25.00	INPATIENT CARE-CONTRACTED				25.00
26.00	PHYSICIAN SERVICES	0	23,163		26.00
27.00	NURSE PRACTITIONER	0	0		27.00
28.00	REGISTERED NURSE	0	217,926		28.00
29.00	LPN/LVN	0	0		29.00
30.00	PHYSICAL THERAPY	0	0		30.00
31.00	OCCUPATIONAL THERAPY	0	0		31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0		32.00
33.00	MEDICAL SOCIAL SERVICES	0	38,370		33.00
34.00	SPIRITUAL COUNSELING	0	0		34.00
35.00	DIETARY COUNSELING	0	0		35.00
36.00	COUNSELING - OTHER	0	0		36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	23,536		37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0		38.00
39.00	PATIENT TRANSPORTATION	0	0		39.00
40.00	IMAGING SERVICES	0	0		40.00
41.00	LABS & DIAGNOSTICS	0	0		41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0		42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0		42.50
43.00	OUTPATIENT SERVICES	0	0		43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0		44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0		45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0		46.00
100.00	TOTAL *	0	302,995		100.00

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

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

Provider CCN: 15-0030 | Hospice CCN: 15-1564 | Period: From 01/01/2017 To 12/31/2017 | Worksheet O-3 | Date/Time Prepared: 5/30/2018 9:13 am

Hospice I

		SALARIES	OTHER	SUBTOTAL (col. 1 + col. 2)	RECLASSIFI-CATIONS	SUBTOTAL	
		1.00	2.00	3.00	4.00	5.00	
	DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED		0	0	0	0	25.00
26.00	PHYSICIAN SERVICES	213	0	213	0	213	26.00
27.00	NURSE PRACTITIONER	0	0	0	0	0	27.00
28.00	REGISTERED NURSE	2,007	0	2,007	0	2,007	28.00
29.00	LPN/LVN	0	0	0	0	0	29.00
30.00	PHYSICAL THERAPY	0	0	0	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	353	0	353	0	353	33.00
34.00	SPIRITUAL COUNSELING	0	0	0	0	0	34.00
35.00	DIETARY COUNSELING	0	0	0	0	0	35.00
36.00	COUNSELING - OTHER	0	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	217	0	217	0	217	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	0	0	0	38.00
39.00	PATIENT TRANSPORTATION	0	0	0	0	0	39.00
40.00	IMAGING SERVICES	0	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	0	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	0	0	0	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	42.50
43.00	OUTPATIENT SERVICES	0	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	0	0	0	46.00
100.00	TOTAL *	2,790	0	2,790	0	2,790	100.00

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

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)		
		6.00	7.00		
	DIRECT PATIENT CARE SERVICE COST CENTERS				
25.00	INPATIENT CARE-CONTRACTED	0	0		25.00
26.00	PHYSICIAN SERVICES	0	213		26.00
27.00	NURSE PRACTITIONER	0	0		27.00
28.00	REGISTERED NURSE	0	2,007		28.00
29.00	LPN/LVN	0	0		29.00
30.00	PHYSICAL THERAPY	0	0		30.00
31.00	OCCUPATIONAL THERAPY	0	0		31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0		32.00
33.00	MEDICAL SOCIAL SERVICES	0	353		33.00
34.00	SPIRITUAL COUNSELING	0	0		34.00
35.00	DIETARY COUNSELING	0	0		35.00
36.00	COUNSELING - OTHER	0	0		36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	217		37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0		38.00
39.00	PATIENT TRANSPORTATION	0	0		39.00
40.00	IMAGING SERVICES	0	0		40.00
41.00	LABS & DIAGNOSTICS	0	0		41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0		42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0		42.50
43.00	OUTPATIENT SERVICES	0	0		43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0		44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0		45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0		46.00
100.00	TOTAL *	0	2,790		100.00

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

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

Provider CCN: 15-0030 | Hospice CCN: 15-1564 | Period: From 01/01/2017 To 12/31/2017 | Worksheet O-4 | Date/Time Prepared: 5/30/2018 9:13 am

Hospice I

		SALARIES	OTHER	SUBTOTAL (col. 1 + col. 2)	RECLASSIFI-CATIONS	SUBTOTAL	
		1.00	2.00	3.00	4.00	5.00	
	DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED		0	0	0	0	25.00
26.00	PHYSICIAN SERVICES	124	0	124	0	124	26.00
27.00	NURSE PRACTITIONER	0	0	0	0	0	27.00
28.00	REGISTERED NURSE	1,171	0	1,171	0	1,171	28.00
29.00	LPN/LVN	0	0	0	0	0	29.00
30.00	PHYSICAL THERAPY	0	0	0	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	206	0	206	0	206	33.00
34.00	SPIRITUAL COUNSELING	0	0	0	0	0	34.00
35.00	DIETARY COUNSELING	0	0	0	0	0	35.00
36.00	COUNSELING - OTHER	0	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	126	0	126	0	126	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	0	0	0	38.00
39.00	PATIENT TRANSPORTATION	0	0	0	0	0	39.00
40.00	IMAGING SERVICES	0	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	0	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	0	0	0	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	42.50
43.00	OUTPATIENT SERVICES	0	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	0	0	0	46.00
100.00	TOTAL *	1,627	0	1,627	0	1,627	100.00

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

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)		
		6.00	7.00		
	DIRECT PATIENT CARE SERVICE COST CENTERS				
25.00	INPATIENT CARE-CONTRACTED	0	0		25.00
26.00	PHYSICIAN SERVICES	0	124		26.00
27.00	NURSE PRACTITIONER	0	0		27.00
28.00	REGISTERED NURSE	0	1,171		28.00
29.00	LPN/LVN	0	0		29.00
30.00	PHYSICAL THERAPY	0	0		30.00
31.00	OCCUPATIONAL THERAPY	0	0		31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0		32.00
33.00	MEDICAL SOCIAL SERVICES	0	206		33.00
34.00	SPIRITUAL COUNSELING	0	0		34.00
35.00	DIETARY COUNSELING	0	0		35.00
36.00	COUNSELING - OTHER	0	0		36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	126		37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0		38.00
39.00	PATIENT TRANSPORTATION	0	0		39.00
40.00	IMAGING SERVICES	0	0		40.00
41.00	LABS & DIAGNOSTICS	0	0		41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0		42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0		42.50
43.00	OUTPATIENT SERVICES	0	0		43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0		44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0		45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0		46.00
100.00	TOTAL *	0	1,627		100.00

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

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

Provider CCN: 15-0030 Hospice CCN: 15-1564

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

Worksheet O-5

Date/Time Prepared: 5/30/2018 9:13 am

Hospice I

	Descriptions	HOSPICE DIRECT EXPENSES (see instructions)	GENERAL SERVICE EXPENSES FROM WKST B PART I (see instructions)	TOTAL EXPENSES (sum of cols. 1 + 2)	
		1.00	2.00	3.00	
	GENERAL SERVICE COST CENTERS				
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	6,200	103,171	109,371	3.00
4.00	ADMINISTRATIVE & GENERAL	302,038	157,922	459,960	4.00
5.00	PLANT OPERATION & MAINTENANCE	43,931	0	43,931	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0	6.00
7.00	HOUSEKEEPING	0	0	0	7.00
8.00	DIETARY	0	0	0	8.00
9.00	NURSING ADMINISTRATION	0	0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	4,544	4,544	10.00
11.00	MEDICAL RECORDS	0	6,914	6,914	11.00
12.00	STAFF TRANSPORTATION	0		0	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0		0	13.00
14.00	PHARMACY	29,152	0	29,152	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0		0	15.00
16.00	OTHER GENERAL SERVICE	0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES		0	0	17.00
	LEVEL OF CARE				
50.00	HOSPICE CONTINUOUS HOME CARE	0		0	50.00
51.00	HOSPICE ROUTINE HOME CARE	302,995		302,995	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	2,790		2,790	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	1,627		1,627	53.00
	NONREIMBURSABLE COST CENTERS				
60.00	BEREAVEMENT PROGRAM	0		0	60.00
61.00	VOLUNTEER PROGRAM	0		0	61.00
62.00	FUNDRAISING	0		0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0		0	63.00
64.00	PALLIATIVE CARE PROGRAM	0		0	64.00
65.00	OTHER PHYSICIAN SERVICES	0		0	65.00
66.00	RESIDENTIAL CARE	0		0	66.00
67.00	ADVERTISING	0		0	67.00
68.00	TELEHEALTH/TELEMONITORING	0		0	68.00
69.00	THRIFT STORE	0		0	69.00
70.00	NURSING FACILITY ROOM & BOARD	0		0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0		0	71.00
99.00	NEGATIVE COST CENTER	0		0	99.00
100.00	TOTAL	688,733	272,551	961,284	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS | Provider CCN: 15-0030 | Hospice CCN: 15-1564 | Period: From 01/01/2017 To 12/31/2017 | Worksheet O-6 Part I | Date/Time Prepared: 5/30/2018 9:13 am

Hospice I

	Descriptions	TOTAL EXPENSES	CAP REL BLDG & FIX	CAP REL MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	SUBTOTAL	
		0	1.00	2.00	3.00	3A	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0		0			2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	109,371	0	0	109,371		3.00
4.00	ADMINISTRATIVE & GENERAL	459,960	0	0	0	459,960	4.00
5.00	PLANT OPERATION & MAINTENANCE	43,931	0	0	0	43,931	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0	0	0	6.00
7.00	HOUSEKEEPING	0	0	0	0	0	7.00
8.00	DIETARY	0	0	0	0	0	8.00
9.00	NURSING ADMINISTRATION	0	0	0	0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES	4,544	0	0	0	4,544	10.00
11.00	MEDICAL RECORDS	6,914	0	0	0	6,914	11.00
12.00	STAFF TRANSPORTATION	0	0	0	0	0	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0	0	0	0	0	13.00
14.00	PHARMACY	29,152	0	0	0	29,152	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0	0	0	0	15.00
16.00	OTHER GENERAL SERVICE	0	0	0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES		0	0		0	17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0			0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	302,995			107,799	410,794	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	2,790	0	0	993	3,783	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	1,627	0	0	579	2,206	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0	0	0	0	0	60.00
61.00	VOLUNTEER PROGRAM	0	0	0	0	0	61.00
62.00	FUNDRAISING	0	0	0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0	0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0	0	0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES	0	0	0	0	0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0	0	0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING	0	0	0	0	0	68.00
69.00	THRIFT STORE	0	0	0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD	0				0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER	0	0	0	0		99.00
100.00	TOTAL	961,284	0	0	109,371	961,284	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN: 15-0030
Hospice CCN: 15-1564

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

Worksheet O-6 Part I
Date/Time Prepared: 5/30/2018 9:13 am

Hospice I

	Descriptions	ADMINISTRATIVE & GENERAL	PLANT OPERATION & MAINTENANCE	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		4.00	5.00	6.00	7.00	8.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL	459,960					4.00
5.00	PLANT OPERATION & MAINTENANCE	40,306	84,237				5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0			6.00
7.00	HOUSEKEEPING	0	0		0		7.00
8.00	DIETARY	0	0		0	0	8.00
9.00	NURSING ADMINISTRATION	0	0		0		9.00
10.00	ROUTINE MEDICAL SUPPLIES	4,169	0		0		10.00
11.00	MEDICAL RECORDS	6,344	0		0		11.00
12.00	STAFF TRANSPORTATION	0	0		0		12.00
13.00	VOLUNTEER SERVICE COORDINATION	0	0		0		13.00
14.00	PHARMACY	26,747	0		0		14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0		0		15.00
16.00	OTHER GENERAL SERVICE	0	0		0		16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0	0		0		17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0					50.00
51.00	HOSPICE ROUTINE HOME CARE	376,899					51.00
52.00	HOSPICE INPATIENT RESPITE CARE	3,471	53,203	0	0	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	2,024	31,034	0	0	0	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0	0		0		60.00
61.00	VOLUNTEER PROGRAM	0	0		0		61.00
62.00	FUNDRAISING	0	0		0		62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0		0		63.00
64.00	PALLIATIVE CARE PROGRAM	0	0		0		64.00
65.00	OTHER PHYSICIAN SERVICES	0	0		0		65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0	0		0		67.00
68.00	TELEHEALTH/TELEMONITORING	0	0		0		68.00
69.00	THRIFT STORE	0	0		0		69.00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER	0	0	0	0	0	99.00
100.00	TOTAL	459,960	84,237	0	0	0	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN: 15-0030
Hospice CCN: 15-1564

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

Worksheet O-6 Part I
Date/Time Prepared: 5/30/2018 9:13 am

Hospice I

	Descriptions	NURSING ADMINISTRATION	ROUTINE MEDICAL SUPPLIES	MEDICAL RECORDS	STAFF TRANSPORTATION	VOLUNTEER SERVICE COORDINATION	
		9.00	10.00	11.00	12.00	13.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5.00
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPING						7.00
8.00	DIETARY						8.00
9.00	NURSING ADMINISTRATION	0					9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	8,713				10.00
11.00	MEDICAL RECORDS	0		13,258			11.00
12.00	STAFF TRANSPORTATION	0			0		12.00
13.00	VOLUNTEER SERVICE COORDINATION	0			0	0	13.00
14.00	PHARMACY	0			0	0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0			0	0	15.00
16.00	OTHER GENERAL SERVICE	0			0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES						17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0	0	0	0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	0	8,588	13,068	0	0	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	79	120	0	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	46	70	0	0	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0			0	0	60.00
61.00	VOLUNTEER PROGRAM	0			0	0	61.00
62.00	FUNDRAISING	0			0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0			0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0			0	0	64.00
65.00	OTHER PHYSICIAN SERVICES	0			0	0	65.00
66.00	RESIDENTIAL CARE	0			0	0	66.00
67.00	ADVERTISING	0			0	0	67.00
68.00	TELEHEALTH/TELEMONITORING	0			0	0	68.00
69.00	THRIFT STORE	0			0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0			0	0	71.00
99.00	NEGATIVE COST CENTER	0	0	0	0	0	99.00
100.00	TOTAL	0	8,713	13,258	0	0	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS | Provider CCN: 15-0030 | Hospice CCN: 15-1564 | Period: From 01/01/2017 To 12/31/2017 | Worksheet O-6 Part I | Date/Time Prepared: 5/30/2018 9:13 am

Hospice I

	Descriptions	PHARMACY	PHYSICIAN ADMINISTRATIVE SERVICES	OTHER GENERAL SERVICE	PATIENT/ RESIDENTIAL CARE SERVICES	TOTAL	
		14.00	15.00	16.00	17.00	18.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5.00
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPING						7.00
8.00	DIETARY						8.00
9.00	NURSING ADMINISTRATION						9.00
10.00	ROUTINE MEDICAL SUPPLIES						10.00
11.00	MEDICAL RECORDS						11.00
12.00	STAFF TRANSPORTATION						12.00
13.00	VOLUNTEER SERVICE COORDINATION						13.00
14.00	PHARMACY	55,899					14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0				15.00
16.00	OTHER GENERAL SERVICE	0		0			16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES				0		17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0	0	0		0	50.00
51.00	HOSPICE ROUTINE HOME CARE	55,095	0	0		864,444	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	508	0	0	0	61,164	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	296	0	0	0	35,676	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0		0		0	60.00
61.00	VOLUNTEER PROGRAM	0		0		0	61.00
62.00	FUNDRAISING	0		0		0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0		0		0	63.00
64.00	PALLIATIVE CARE PROGRAM	0		0		0	64.00
65.00	OTHER PHYSICIAN SERVICES	0		0		0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0		0		0	67.00
68.00	TELEHEALTH/TELEMONITORING	0		0		0	68.00
69.00	THRIFT STORE	0		0		0	69.00
70.00	NURSING FACILITY ROOM & BOARD					0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER	0	0	0	0	0	99.00
100.00	TOTAL	55,899	0	0	0	961,284	100.00

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

Provider CCN: 15-0030
Hospice CCN: 15-1564

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

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

	Cost Center Descriptions	CAP REL BLDG & FIX (SQUARE FEET)	CAP REL MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	RECONCILIATION	ADMINISTRATIVE & GENERAL (ACCUMULATED COSTS)	
		1.00	2.00	3.00	4A	4.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0					1.00
2.00	CAP REL COSTS-MVBLE EQUIP		0				2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	0	0	109,372			3.00
4.00	ADMINISTRATIVE & GENERAL	0	0	0	-459,960	501,324	4.00
5.00	PLANT OPERATION & MAINTENANCE	0	0	0	0	43,931	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0	0	0	6.00
7.00	HOUSEKEEPING	0	0	0	0	0	7.00
8.00	DIETARY	0	0	0	0	0	8.00
9.00	NURSING ADMINISTRATION	0	0	0	0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	0	0	0	4,544	10.00
11.00	MEDICAL RECORDS	0	0	0	0	6,914	11.00
12.00	STAFF TRANSPORTATION	0	0	0	0	0	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0	0	0	0	0	13.00
14.00	PHARMACY	0	0	0	0	29,152	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0	0	0	0	15.00
16.00	OTHER GENERAL SERVICE	0	0	0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0	0		0	0	17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE			0	0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE			107,800	0	410,794	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0	993	0	3,783	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	579	0	2,206	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0	0	0	0	0	60.00
61.00	VOLUNTEER PROGRAM	0	0	0	0	0	61.00
62.00	FUNDRAISING	0	0	0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0	0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0	0	0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES	0	0	0	0	0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0	0	0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING	0	0	0	0	0	68.00
69.00	THRIFT STORE	0	0	0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD				0		70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER						99.00
100.00	COST TO BE ALLOCATED (per Wkst. O-6, Part I)	0	0	109,371		459,960	100.00
101.00	UNIT COST MULTIPLIER	0.000000	0.000000	0.999991		0.917490	101.00

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

Provider CCN: 15-0030
Hospice CCN: 15-1564

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

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

	Cost Center Descriptions	PLANT OPERATION & MAINTENANCE (SQUARE FEET)	LAUNDRY & LINEN SERVICE (IN-FACILITY DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (IN-FACILITY DAYS)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	
		5.00	6.00	7.00	8.00	9.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE	84,136					5.00
6.00	LAUNDRY & LINEN SERVICE	0	0				6.00
7.00	HOUSEKEEPING	0		0			7.00
8.00	DIETARY	0		0	0		8.00
9.00	NURSING ADMINISTRATION	0		0		0	9.00
10.00	ROUTINE MEDICAL SUPPLIES	0		0		0	10.00
11.00	MEDICAL RECORDS	0		0		0	11.00
12.00	STAFF TRANSPORTATION	0		0		0	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0		0		0	13.00
14.00	PHARMACY	0		0		0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0		0		0	15.00
16.00	OTHER GENERAL SERVICE	0		0		0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0		0			17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE					0	50.00
51.00	HOSPICE ROUTINE HOME CARE					0	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	53,139	0	0	0	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	30,997	0	0	0	0	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0		0		0	60.00
61.00	VOLUNTEER PROGRAM	0		0		0	61.00
62.00	FUNDRAISING	0		0		0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0		0		0	63.00
64.00	PALLIATIVE CARE PROGRAM	0		0		0	64.00
65.00	OTHER PHYSICIAN SERVICES	0		0		0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0		0		0	67.00
68.00	TELEHEALTH/TELEMONITORING	0		0		0	68.00
69.00	THRIFT STORE	0		0		0	69.00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER						99.00
100.00	COST TO BE ALLOCATED (per Wkst. O-6, Part I)	84,237	0	0	0	0	100.00
101.00	UNIT COST MULTIPLIER	1.001200	0.000000	0.000000	0.000000	0.000000	101.00

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

Provider CCN: 15-0030
Hospice CCN: 15-1564

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

Worksheet O-6 Part II
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Hospice I

	Cost Center Descriptions	ROUTINE MEDICAL SUPPLIES (PATIENT DAYS)	MEDICAL RECORDS (PATIENT DAYS)	STAFF TRANSPORTATION (MILEAGE)	VOLUNTEER SERVICE COORDINATION (HOURS OF SERVICE)	PHARMACY (CHARGES)	
		10.00	11.00	12.00	13.00	14.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5.00
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPING						7.00
8.00	DIETARY						8.00
9.00	NURSING ADMINISTRATION						9.00
10.00	ROUTINE MEDICAL SUPPLIES	5,288					10.00
11.00	MEDICAL RECORDS		5,288				11.00
12.00	STAFF TRANSPORTATION			0			12.00
13.00	VOLUNTEER SERVICE COORDINATION			0	0		13.00
14.00	PHARMACY			0	0	55,832	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES			0	0	0	15.00
16.00	OTHER GENERAL SERVICE			0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES						17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0	0	0	0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	5,212	5,212	0	0	55,029	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	48	48	0	0	507	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	28	28	0	0	296	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM			0	0	0	60.00
61.00	VOLUNTEER PROGRAM			0	0	0	61.00
62.00	FUNDRAISING			0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS			0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM			0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES			0	0	0	65.00
66.00	RESIDENTIAL CARE			0	0	0	66.00
67.00	ADVERTISING			0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING			0	0	0	68.00
69.00	THRIFT STORE			0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)			0	0	0	71.00
99.00	NEGATIVE COST CENTER						99.00
100.00	COST TO BE ALLOCATED (per Wkst. O-6, Part I)	8,713	13,258	0	0	55,899	100.00
101.00	UNIT COST MULTIPLIER	1.647693	2.507186	0.000000	0.000000	1.001200	101.00

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

Provider CCN: 15-0030
Hospice CCN: 15-1564

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

Worksheet O-6
Part II
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Hospice I

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

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

Provider CCN: 15-0030 Hospice CCN: 15-1564

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

Worksheet O-7

Date/Time Prepared: 5/30/2018 9:13 am

Hospice I

	Cost Center Descriptions	From Wkst. C, Part I, Col. 9 line	Cost to Charge Ratio	Charges by LOC (from Provider Records) HCHC	HRHC	HIRC	
		0	1.00	2.00	3.00	4.00	
	ANCILLARY SERVICE COST CENTERS						
1.00	PHYSICAL THERAPY	66.00	0.680976	0	0	0	1.00
2.00	OCCUPATIONAL THERAPY	67.00	0.790465	0	0	0	2.00
3.00	SPEECH PATHOLOGY	68.00	0.823390	0	0	0	3.00
4.00	DRUGS CHARGED TO PATIENTS	73.00	0.437869	0	0	0	4.00
5.00	DURABLE MEDICAL EQUIP-RENTED	96.00					5.00
6.00	LABORATORY	60.00	0.245987	0	0	0	6.00
6.01	BLOOD LABORATORY	60.01	0.000000	0	0	0	6.01
7.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0.182911	0	0	0	7.00
8.00	OTHER OUTPATIENT SERVICE COST CENTER	93.00					8.00
9.00	RADIOLOGY-THERAPEUTIC	55.00					9.00
10.00	CARDIAC REHAB	76.00	0.662321	0	0	0	10.00
11.00	Totals (sum of lines 1-11)						11.00

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

CALCULATION OF HOSPITAL-BASED HOSPICE PER DIEM COST

Provider CCN: 15-0030 | Hospice CCN: 15-1564 | Period: From 01/01/2017 To 12/31/2017 | Worksheet O-8 | Date/Time Prepared: 5/30/2018 9:13 am

Hospice I

		TITLE XVIII MEDICARE	TITLE XIX MEDICAID	TOTAL	
		1.00	2.00	3.00	
	HOSPICE CONTINUOUS HOME CARE				
1.00	Total cost (Wkst. O-6, Part I, col. 18, line 50 plus Wkst. O-7, col. 6, line 11)			0	1.00
2.00	Total unduplicated days (Wkst. S-9, col. 4, line 10)			0	2.00
3.00	Total average cost per diem (line 1 divided by line 2)			0.00	3.00
4.00	Unduplicated program days (Wkst. S-9 col. as appropriate, line 10)	0	0		4.00
5.00	Program cost (line 3 times line 4)	0	0		5.00
	HOSPICE ROUTINE HOME CARE				
6.00	Total cost (Wkst. O-6, Part I, col. 18, line 51 plus Wkst. O-7, col. 7, line 11)			864,444	6.00
7.00	Total unduplicated days (Wkst. S-9, col. 4, line 11)			5,212	7.00
8.00	Total average cost per diem (line 6 divided by line 7)			165.86	8.00
9.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 11)	4,897	0		9.00
10.00	Program cost (line 8 times line 9)	812,216	0		10.00
	HOSPICE INPATIENT RESPITE CARE				
11.00	Total cost (Wkst. O-6, Part I, col. 18, line 52 plus Wkst. O-7, col. 8, line 11)			61,164	11.00
12.00	Total unduplicated days (Wkst. S-9, col. 4, line 12)			48	12.00
13.00	Total average cost per diem (line 11 divided by line 12)			1,274.25	13.00
14.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 12)	48	0		14.00
15.00	Program cost (line 13 times line 14)	61,164	0		15.00
	HOSPICE GENERAL INPATIENT CARE				
16.00	Total cost (Wkst. O-6, Part I, col. 18, line 53 plus Wkst. O-7, col. 9, line 11)			35,676	16.00
17.00	Total unduplicated days (Wkst. S-9, col. 4, line 13)			28	17.00
18.00	Total average cost per diem (line 16 divided by line 17)			1,274.14	18.00
19.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 13)	24	0		19.00
20.00	Program cost (line 18 times line 19)	30,579	0		20.00
	TOTAL HOSPICE CARE				
21.00	Total cost (sum of line 1 + line 6 + line 11 + line 16)			961,284	21.00
22.00	Total unduplicated days (Wkst. S-9, col. 4, line 14)			5,288	22.00
23.00	Average cost per diem (line 21 divided by line 22)			181.79	23.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 15-0030	Period: From 01/01/2017 To 12/31/2017	Worksheet L Parts I-III Date/Time Prepared: 5/30/2018 9:13 am
	Title XVIII	Hospital	PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	695,890	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	286	2.00
2.01	Model 4 BPCI Capital DRG outlier payments	0	2.01
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)	21.72	3.00
4.00	Number of interns & residents (see instructions)	0.00	4.00
5.00	Indirect medical education percentage (see instructions)	0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)	0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)	0.00	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)	0.00	8.00
9.00	Sum of lines 7 and 8	0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)	0.00	10.00
11.00	Disproportionate share adjustment (see instructions)	0	11.00
12.00	Total prospective capital payments (see instructions)	696,176	12.00
		1.00	
	PART II - PAYMENT UNDER REASONABLE COST		
1.00	Program inpatient routine capital cost (see instructions)	0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)	0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)	0	3.00
4.00	Capital cost payment factor (see instructions)	0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)	0	5.00
		1.00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS		
1.00	Program inpatient capital costs (see instructions)	0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)	0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)	0	3.00
4.00	Applicable exception percentage (see instructions)	0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)	0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)	0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)	0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)	0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)	0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)	0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)	0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)	0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)	0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)	0	14.00
15.00	Current year allowable operating and capital payment (see instructions)	0	15.00
16.00	Current year operating and capital costs (see instructions)	0	16.00
17.00	Current year exception offset amount (see instructions)	0	17.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-0030 | Component CCN: 15-8520 | Period: From 01/01/2017 To 12/31/2017 | Worksheet M-1 | Date/Time Prepared: 5/30/2018 9:13 am

RHC I | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	1,071,337	25,554	1,096,891	0	1,096,891	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	501,591	0	501,591	0	501,591	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	399,258	49	399,307	0	399,307	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	30,447	0	30,447	0	30,447	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	320,888	0	320,888	0	320,888	9.00
10.00	Subtotal (sum of lines 1 through 9)	2,323,521	25,603	2,349,124	0	2,349,124	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	181	181	0	181	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	181	181	0	181	14.00
15.00	Medical Supplies	0	143,066	143,066	0	143,066	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	30,530	30,530	0	30,530	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	173,596	173,596	0	173,596	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	2,323,521	199,380	2,522,901	0	2,522,901	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
25.01	Telehealth	0	0	0	0	0	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	546,353	546,353	0	546,353	29.00
30.00	Administrative Costs	593,910	676,457	1,270,367	383,071	1,653,438	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	593,910	1,222,810	1,816,720	383,071	2,199,791	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	2,917,431	1,422,190	4,339,621	383,071	4,722,692	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-0030 | Component CCN: 15-8520 | Period: From 01/01/2017 To 12/31/2017 | Worksheet M-1 | Date/Time Prepared: 5/30/2018 9:13 am

RHC I | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	1,096,891		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	501,591		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	399,307		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	30,447		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	320,888		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	2,349,124		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	181		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	181		14.00
15.00	Medical Supplies	0	143,066		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	30,530		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	173,596		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	2,522,901		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	-319,307	227,046		29.00
30.00	Administrative Costs	-233,876	1,419,562		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-553,183	1,646,608		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-553,183	4,169,509		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-0030
Component CCN: 15-8525

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

Worksheet M-1
Date/Time Prepared: 5/30/2018 9:13 am

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	207,858	2,982	210,840	-156,889	53,951	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	135,292	0	135,292	-105,446	29,846	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	61,734	140	61,874	-50,322	11,552	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	5,463	0	5,463	0	5,463	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	69,526	0	69,526	-55,749	13,777	9.00
10.00	Subtotal (sum of lines 1 through 9)	479,873	3,122	482,995	-368,406	114,589	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	13,432	13,432	0	13,432	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	13,432	13,432	0	13,432	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	479,873	16,554	496,427	-368,406	128,021	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
25.01	Telehealth	0	0	0	0	0	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	275,241	275,241	0	275,241	29.00
30.00	Administrative Costs	94,131	95,695	189,826	-157,236	32,590	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	94,131	370,936	465,067	-157,236	307,831	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	574,004	387,490	961,494	-525,642	435,852	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-0030 | Component CCN: 15-8525 | Period: From 01/01/2017 To 12/31/2017 | Worksheet M-1 | Date/Time Prepared: 5/30/2018 9:13 am

RHC II | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	53,951		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	29,846		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	11,552		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	5,463		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	13,777		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	114,589		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	13,432		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	13,432		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	128,021		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	-243,302	31,939		29.00
30.00	Administrative Costs	-2,574	30,016		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-245,876	61,955		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-245,876	189,976		32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 15-0030 | Component CCN: 15-8520 | Period: From 01/01/2017 To 12/31/2017 | Worksheet M-2 | Date/Time Prepared: 5/30/2018 9:13 am

RHC I | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	3.86	12,361	4,200	16,212		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	3.97	4,897	2,100	8,337		3.00
4.00	Subtotal (sum of lines 1 through 3)	7.83	17,258		24,549	24,549	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	0.40	43			43	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)	8.23	17,301			24,592	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)					2,522,901	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)					2,522,901	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)					1,646,608	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					1,903,948	15.00
16.00	Total overhead (sum of lines 14 and 15)					3,550,556	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					3,550,556	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					3,550,556	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					6,073,457	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 15-0030
Component CCN: 15-8525

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

Worksheet M-2
Date/Time Prepared: 5/30/2018 9:13 am

RHC II

Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	0.14	543	4,200	588		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	0.25	322	2,100	525		3.00
4.00	Subtotal (sum of lines 1 through 3)	0.39	865		1,113	1,113	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	0.07	77			77	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)	0.46	942			1,190	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)					128,021	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)					128,021	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)					61,955	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					80,040	15.00
16.00	Total overhead (sum of lines 14 and 15)					141,995	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					141,995	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					141,995	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					270,016	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 15-0030 Component CCN: 15-8520	Period: From 01/01/2017 To 12/31/2017	Worksheet M-3 Date/Time Prepared: 5/30/2018 9:13 am
	Title XVIII	RHC I	Cost

			1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES			
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)		6,073,457	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)		188,934	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		5,884,523	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		24,592	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)		24,592	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		239.29	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)	0.00	0.00	8.00
9.00	Rate for Program covered visits (see instructions)	239.29	239.29	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	6,475	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	1,549,403	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	1,549,403	16.00
16.01	Total program charges (see instructions)(from contractor's records)		964,717	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		193,751	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		311,177	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.)		954,112	16.04
16.05	Total program cost (see instructions)	0	1,265,289	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		45,586	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		145,076	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		1,265,289	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		145,742	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		1,411,031	22.00
23.00	Allowable bad debts (see instructions)		0	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		0	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	25.50
25.99	Demonstration payment adjustment amount before sequestration		0	25.99
26.00	Net reimbursable amount (see instructions)		1,411,031	26.00
26.01	Sequestration adjustment (see instructions)		28,221	26.01
26.02	Demonstration payment adjustment amount after sequestration		0	26.02
27.00	Interim payments		463,744	27.00
28.00	Tentative settlement (for contractor use only)		0	28.00
29.00	Balance due component/program (line 26 minus lines 26.01, 26.02, 27, and 28)		919,066	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0	30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 15-0030 Component CCN: 15-8525	Period: From 01/01/2017 To 12/31/2017	Worksheet M-3 Date/Time Prepared: 5/30/2018 9:13 am
	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)		270,016	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)		14,714	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		255,302	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		1,190	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)		1,190	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		214.54	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)	0.00	0.00	8.00
9.00	Rate for Program covered visits (see instructions)	214.54	214.54	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	271	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	58,140	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	58,140	16.00
16.01	Total program charges (see instructions)(from contractor's records)		0	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		0	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		0	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.)		45,308	16.04
16.05	Total program cost (see instructions)	0	45,308	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		1,505	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		6,631	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		45,308	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		11,573	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		56,881	22.00
23.00	Allowable bad debts (see instructions)		0	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		0	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	25.50
25.99	Demonstration payment adjustment amount before sequestration		0	25.99
26.00	Net reimbursable amount (see instructions)		56,881	26.00
26.01	Sequestration adjustment (see instructions)		1,138	26.01
26.02	Demonstration payment adjustment amount after sequestration		0	26.02
27.00	Interim payments		15,400	27.00
28.00	Tentative settlement (for contractor use only)		0	28.00
29.00	Balance due component/program (line 26 minus lines 26.01, 26.02, 27, and 28)		40,343	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: 15-0030 Component CCN: 15-8520	Period: From 01/01/2017 To 12/31/2017	Worksheet M-4 Date/Time Prepared: 5/30/2018 9:13 am
	Title XVIII	RHC I	Cost

		Pneumococcal	Influenza	
		1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	2,349,124	2,349,124	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.001026	0.002906	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	2,410	6,827	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	35,610	33,636	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	38,020	40,463	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	2,522,901	2,522,901	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	3,550,556	3,550,556	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.015070	0.016038	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	53,507	56,944	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	91,527	97,407	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	516	1,462	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	177.38	66.63	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	443	1,008	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	78,579	67,163	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)		188,934	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)		145,742	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA VACCINE COST	Provider CCN: 15-0030 Component CCN: 15-8525	Period: From 01/01/2017 To 12/31/2017	Worksheet M-4 Date/Time Prepared: 5/30/2018 9:13 am
	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)	114,589	114,589	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.001268	0.003635	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	145	417	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	3,280	3,134	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	3,425	3,551	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	128,021	128,021	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	141,995	141,995	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.026753	0.027738	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	3,799	3,939	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	7,224	7,490	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	30	86	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	240.80	87.09	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	26	61	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	6,261	5,312	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)		14,714	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)		11,573	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 15-0030 Component CCN: 15-8520	Period: From 01/01/2017 To 12/31/2017	Worksheet M-5 Date/Time Prepared: 5/30/2018 9:13 am
		RHC I	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		463,744	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)		463,744	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		919,066	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		1,382,810	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: 15-0030 | Component CCN: 15-8525 | Period: From 01/01/2017 To 12/31/2017 | Worksheet M-5 | Date/Time Prepared: 5/30/2018 9:13 am

RHC II | Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		15,400	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)		15,400	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		40,343	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		55,743	7.00

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