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: 15-1319	Period: From 10/01/2016 To 09/30/2017	Worksheet S Parts I-III Date/Time Prepared: 2/26/2018 1:26 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 2/26/2018 Time: 1:26 pm
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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

PART II - CERTIFICATION

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

CERTIFICATION BY 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 GIBSON GENERAL HOSPITAL (15-1319) for the cost reporting period beginning 10/01/2016 and ending 09/30/2017 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

[ ] 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	-329,422	-50,200	0	5,230	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	33,529	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
7.00	SKILLED NURSING FACILITY	0	0	0		0	7.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
10.00	RURAL HEALTH CLINIC I	0		0		0	10.00
200.00	Total	0	-295,893	-50,200	0	5,230	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1319 | Period: From 10/01/2016 To 09/30/2017 | Worksheet S-2 Part I | Date/Time Prepared: 2/26/2018 1:23 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 1800 SHERMAN DRIVE	PO Box:			1.00
2.00	City: PRINCETON	State: IN	Zip Code: 47670-	County: GIBSON	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	GIBSON GENERAL HOSPITAL	151319	99915	1	12/16/2003	N	O	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	GIBSON GENERAL SWING BED	15Z319	99915		12/16/2003	N	O	N	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA	GIBSON HOME HEALTH	157445	99915		10/19/1995	N	P	N	12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC	GIBSON GENERAL FAMILY MEDICINE	158524	99915		09/11/2017	N	O	O	15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	10/01/2016	09/30/2017	20.00
21.00	Type of Control (see instructions)	2		21.00
	Inpatient PPS Information			
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	N	N	22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	N	N	22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N	22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or “N” for no.	N	N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	2	N	23.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1319 | Period: From 10/01/2016 To 09/30/2017 | Worksheet S-2 Part I Date/Time Prepared: 2/26/2018 1:23 pm

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

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

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

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

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		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).		0.00	0.00			61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)		0.00	0.00			61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)		0.00	0.00			61.06

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1319 | Period: From 10/01/2016 To 09/30/2017 | Worksheet S-2 Part I Date/Time Prepared: 2/26/2018 1:23 pm

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

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

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

		1.00	2.00	3.00	
	Inpatient Psychiatric Facility PPS				
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	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 a "subclause (II)" LTCH classified under section 1886(d)(1)(B)(iv)(II)? Enter "Y" for yes or "N" for no.	N	87.00

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

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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:	45,667	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.	Y		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: 15-1319	Period: From 10/01/2016 To 09/30/2017	Worksheet S-2 Part I Date/Time Prepared: 2/26/2018 1:23 pm

		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	HB0778	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: DEACONESS HEALTH SYSTEM	Contractor's Name: WISCONSIN PHYSICIANS SERVICES	Contractor's Number: 08101	141.00
142.00	Street: 600 MARY STREET	PO Box:		142.00
143.00	City: EVANSVILLE	State: IN	Zip Code: 47710	143.00

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

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

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

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-1319	Period: From 10/01/2016 To 09/30/2017	Worksheet S-2 Part I Date/Time Prepared: 2/26/2018 1:23 pm

		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: 15-1319 | Period: From 10/01/2016 To 09/30/2017 | Worksheet S-2 Part II | Date/Time Prepared: 2/26/2018 1:23 pm

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

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

		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	01/24/2018	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	01/02/2018	Y	01/02/2018	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-1319 | Period: From 10/01/2016 To 09/30/2017 | Worksheet S-2 Part II Date/Time Prepared: 2/26/2018 1:23 pm

		Description		Y/N	Y/N	
		0		1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
	Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions				N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				N	27.00
	Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				N	31.00
	Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				N	33.00
	Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				N	35.00
				Y/N	Date	
				1.00	2.00	
	Home Office Costs					
36.00	Were home office costs claimed on the cost report?			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.	AUSTIN		FISHER		41.00
42.00	Enter the employer/company name of the cost report preparer.	BLUE & CO.				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317-275-7438		AFISHER@BLUEANDCO.COM		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-1319	Period: From 10/01/2016 To 09/30/2017	Worksheet S-2 Part II Date/Time Prepared: 2/26/2018 1:23 pm

		3.00		
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	SENIOR ACCOUNTANT		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: 15-1319 | Period: From 10/01/2016 To 09/30/2017 | Worksheet S-3 Part I Date/Time Prepared: 2/26/2018 1:23 pm

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	20	7,300	26,112.00	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)		20	7,300	26,112.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	5	1,825	2,016.00	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						13.00
14.00	Total (see instructions)		25	9,125	28,128.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	44.00	0	0		0	19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	101.00				0	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	88.00				0	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		25				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00
33.01	LTCH site neutral days and discharges						33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-1319 | Period: From 10/01/2016 To 09/30/2017 | Worksheet S-3 Part I | Date/Time Prepared: 2/26/2018 1:23 pm

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	779	11	1,088			1.00
2.00	HMO and other (see instructions)	184	36				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	678	0	678			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	248			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,457	11	2,014			7.00
8.00	INTENSIVE CARE UNIT	16	0	84			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)	1,473	11	2,098	0.00	219.12	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	0	0	0	0.00	0.00	19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	2,310	0	3,745	0.00	5.20	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	0	0	0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	0	0	34	0.00	0.05	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	224.37	27.00
28.00	Observation Bed Days		0	527			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-1319 | Period: From 10/01/2016 To 09/30/2017 | Worksheet S-3 Part I | Date/Time Prepared: 2/26/2018 1:23 pm

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	214	3	327	1.00
2.00	HMO and other (see instructions)			39	9		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	214	3	327	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	0.00					19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0.00					22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	0.00					26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01

HOME HEALTH AGENCY STATISTICAL DATA | Provider CCN: 15-1319 | Component CCN: 15-7445 | Period: From 10/01/2016 To 09/30/2017 | Worksheet S-4 | Date/Time Prepared: 2/26/2018 1:23 pm

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	84.00	0.00	0.00	0.00	2.00
				Number of Employees (Full Time Equivalent)			
		Enter the number of hours in your normal work week		Staff	Contract	Total	
		0		1.00	2.00	3.00	
	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES						
3.00	Administrator and Assistant Administrator(s)		40.00	0.00	0.00	0.00	3.00
4.00	Director(s) and Assistant Director(s)			0.00	0.00	0.00	4.00
5.00	Other Administrative Personnel			1.07	0.00	1.07	5.00
6.00	Direct Nursing Service			2.60	0.00	2.60	6.00
7.00	Nursing Supervisor			0.00	0.00	0.00	7.00
8.00	Physical Therapy Service			0.54	0.00	0.54	8.00
9.00	Physical Therapy Supervisor			0.00	0.00	0.00	9.00
10.00	Occupational Therapy Service			0.09	0.00	0.09	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			0.90	0.00	0.90	16.00
17.00	Home Health Aide Supervisor			0.00	0.00	0.00	17.00
18.00	Other (specify)			0.00	0.00	0.00	18.00
	HOME HEALTH AGENCY CBSA CODES						
19.00	Enter in column 1 the number of CBSAs where you provided services during the cost reporting period.			1			19.00
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).			99915			20.00
		Full Episodes					
		Without Outliers	With Outliers	LUPA Episodes	PEP Only Episodes	Total (cols. 1-4)	
		1.00	2.00	3.00	4.00	5.00	
	PPS ACTIVITY DATA						
21.00	Skilled Nursing Visits	1,038	76	40	16	1,170	21.00
22.00	Skilled Nursing Visit Charges	165,651	12,160	6,400	2,560	186,771	22.00
23.00	Physical Therapy Visits	694	13	9	9	725	23.00
24.00	Physical Therapy Visit Charges	138,990	2,665	1,845	1,845	145,345	24.00
25.00	Occupational Therapy Visits	98	3	0	0	101	25.00
26.00	Occupational Therapy Visit Charges	20,090	615	0	0	20,705	26.00
27.00	Speech Pathology Visits	27	0	0	0	27	27.00
28.00	Speech Pathology Visit Charges	5,535	0	0	0	5,535	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	257	22	1	7	287	31.00
32.00	Home Health Aide Visit Charges	19,275	1,650	75	525	21,525	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	2,114	114	50	32	2,310	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)	349,541	17,090	8,320	4,930	379,881	35.00
36.00	Total Number of Episodes (standard/non outlier)	112		17	1	130	36.00
37.00	Total Number of Outlier Episodes		3		1	4	37.00
38.00	Total Non-Routine Medical Supply Charges	10,398	844	884	208	12,334	38.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 15-1319 | Component CCN: 15-8524 | Period: From 10/01/2016 To 09/30/2017 | Worksheet S-8 | Date/Time Prepared: 2/26/2018 1:23 pm

RHC I | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			7851 S. PROFESSIONAL DR.		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	FORT BRANCH		IN	47648	2.00
					1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0	3.00
			Grant Award		Date	
			1.00		2.00	
	Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)					4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)					5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)					6.00
7.00	Appalachian Regional Commission					7.00
8.00	Look-Alikes					8.00
9.00	OTHER (SPECIFY)					9.00
				1.00	2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N	0	10.00

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

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 15-1319 | Component CCN: 15-8524 | Period: From 10/01/2016 To 09/30/2017 | Worksheet S-8 | Date/Time Prepared: 2/26/2018 1:23 pm

RHC I | Cost

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	Clinic	08:00	17:00				11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 15-1319 | Period: From 10/01/2016 To 09/30/2017 | Worksheet S-10 | Date/Time Prepared: 2/26/2018 1:23 pm

			1.00	
	Uncompensated and indigent care cost computation			
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)		0.400457	1.00
	Medicaid (see instructions for each line)			
2.00	Net revenue from Medicaid		1,195,037	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?		N	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?			4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid		0	5.00
6.00	Medicaid charges		9,049,683	6.00
7.00	Medicaid cost (line 1 times line 6)		3,624,009	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)		2,428,972	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)		2,428,972	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)	997,774	0	997,774	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	399,566	0	399,566	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)	399,566	0	399,566	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)		3,934,980	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)		273,951	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)		421,463	27.01
28.00	Non-Medicare bad debt expense (line 26 minus line 27.01)		3,513,517	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)		1,554,524	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		1,954,090	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		4,383,062	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1319 | Period: From 10/01/2016 To 09/30/2017 | Worksheet A | Date/Time Prepared: 2/26/2018 1:23 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		1,456,660	1,456,660	292,159	1,748,819	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		0	0	0	0	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	141,992	16,655	158,647	601,334	759,981	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,486,894	3,462,222	4,949,116	50,165	4,999,281	5.00
7.00	00700	OPERATION OF PLANT	115,752	815,107	930,859	28,904	959,763	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	40,266	45,501	85,767	-2,807	82,960	8.00
9.00	00900	HOUSEKEEPING	264,694	146,715	411,409	-13,931	397,478	9.00
10.00	01000	DIETARY	389,976	386,667	776,643	-385,922	390,721	10.00
11.00	01100	CAFETERIA	0	0	0	371,221	371,221	11.00
13.00	01300	NURSING ADMINISTRATION	157,488	15,467	172,955	0	172,955	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	249,799	146,214	396,013	-7,128	388,885	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,075,706	522,744	1,598,450	-82,659	1,515,791	30.00
31.00	03100	INTENSIVE CARE UNIT	65,053	69,909	134,962	-6,795	128,167	31.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	643,143	681,562	1,324,705	-130,908	1,193,797	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	613,494	649,248	1,262,742	-10,633	1,252,109	54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0	122,820	122,820	0	122,820	54.03
60.00	06000	LABORATORY	641,832	737,501	1,379,333	-13,060	1,366,273	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	58,837	58,837	0	58,837	62.00
65.00	06500	RESPIRATORY THERAPY	398,637	409,515	808,152	-19,410	788,742	65.00
66.00	06600	PHYSICAL THERAPY	667,062	281,886	948,948	-18,442	930,506	66.00
67.00	06700	OCCUPATIONAL THERAPY	229,967	51,023	280,990	-3,381	277,609	67.00
68.00	06800	SPEECH PATHOLOGY	118,623	31,547	150,170	-2,933	147,237	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	182,442	182,442	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	148,130	148,130	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	113,271	1,341,195	1,454,466	-152	1,454,314	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	12,154	12,154	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	DIABETES	0	6,000	6,000	0	6,000	90.01
90.02	09002	OP PSYCH	0	0	0	0	0	90.02
90.03	09003	PAIN MANAGEMENT	134,814	129,635	264,449	-16,799	247,650	90.03
91.00	09100	EMERGENCY	778,171	744,947	1,523,118	-21,861	1,501,257	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	297,885	141,081	438,966	-7,728	431,238	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		295,898	295,898	-295,898	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	8,624,519	12,766,556	21,391,075	646,062	22,037,137	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	MOB	3,335,442	2,035,168	5,370,610	-569,942	4,800,668	194.00
194.01	07951	FOUNDATION	51,064	3,973	55,037	0	55,037	194.01
194.02	07952	ASC	0	0	0	0	0	194.02
194.03	07953	SNF - PERRY CO.	1,283,835	522,982	1,806,817	-76,120	1,730,697	194.03
200.00		TOTAL (SUM OF LINES 118 through 199)	13,294,860	15,328,679	28,623,539	0	28,623,539	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1319 | Period: From 10/01/2016 To 09/30/2017 | Worksheet A | Date/Time Prepared: 2/26/2018 1:23 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	-14,946	1,733,873		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	0		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	887,197	1,647,178		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,879,845	6,879,126		5.00
7.00	00700	OPERATION OF PLANT	94,381	1,054,144		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	82,960		8.00
9.00	00900	HOUSEKEEPING	0	397,478		9.00
10.00	01000	DIETARY	0	390,721		10.00
11.00	01100	CAFETERIA	-137,150	234,071		11.00
13.00	01300	NURSING ADMINISTRATION	60,876	233,831		13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	40,468	429,353		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-53,899	1,461,892		30.00
31.00	03100	INTENSIVE CARE UNIT	0	128,167		31.00
44.00	04400	SKILLED NURSING FACILITY	0	0		44.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	1,193,797		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-812	1,251,297		54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0	122,820		54.03
60.00	06000	LABORATORY	0	1,366,273		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	58,837		62.00
65.00	06500	RESPIRATORY THERAPY	-70,637	718,105		65.00
66.00	06600	PHYSICAL THERAPY	0	930,506		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	277,609		67.00
68.00	06800	SPEECH PATHOLOGY	0	147,237		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	182,442		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	148,130		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	310,329	1,764,643		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	12,154		88.00
90.00	09000	CLINIC	0	0		90.00
90.01	09001	DIABETES	0	6,000		90.01
90.02	09002	OP PSYCH	0	0		90.02
90.03	09003	PAIN MANAGEMENT	-3,981	243,669		90.03
91.00	09100	EMERGENCY	0	1,501,257		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
		OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY	0	431,238		101.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,991,671	25,028,808		118.00
		NONREIMBURSABLE COST CENTERS				
194.00	07950	MOB	0	4,800,668		194.00
194.01	07951	FOUNDATION	0	55,037		194.01
194.02	07952	ASC	0	0		194.02
194.03	07953	SNF - PERRY CO.	0	1,730,697		194.03
200.00		TOTAL (SUM OF LINES 118 through 199)	2,991,671	31,615,210		200.00

RECLASSIFICATIONS | Provider CCN: 15-1319 | Period: From 10/01/2016 To 09/30/2017 | Worksheet A-6 | Date/Time Prepared: 2/26/2018 1:23 pm

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	C - CAFETERIA				
1.00	CAFETERIA	11.00	186,586	184,635	1.00
	0		186,586	184,635	
	D - MED SUPPLY CHG PTS				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	182,442	1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	148,130	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
	0		0	330,572	
	F - BUSINESS HEALTH SER				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	49,964	42,447	1.00
	0		49,964	42,447	
	G - INTEREST				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	292,159	1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	3,739	2.00
	0		0	295,898	
	I - QUALITY SERVICES				
1.00	ADMINISTRATIVE & GENERAL	5.00	31,405	16,452	1.00
	0		31,405	16,452	
	J - HEALTH INSURANCE				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	323,287	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
	0		0	323,287	
	K - WELLNESS CENTER				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	136,179	49,457	1.00
	0		136,179	49,457	
	M - SNF OPERATION OF PLANT				
1.00	OPERATION OF PLANT	7.00	35,072	0	1.00
	0		35,072	0	
	N - MALPRACTICE				
1.00	ADMINISTRATIVE & GENERAL	5.00	0	45,223	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
	0		0	45,223	
	O - MOB COLLECTION EXPENSE				
1.00	ADMINISTRATIVE & GENERAL	5.00	0	4,470	1.00
	0		0	4,470	
	P - RHC RECLASS				
1.00	RURAL HEALTH CLINIC	88.00	6,718	5,436	1.00
	TOTALS		6,718	5,436	
500.00	Grand Total: Increases		445,924	1,297,877	500.00

RECLASSIFICATIONS | Provider CCN: 15-1319 | Period: From 10/01/2016 To 09/30/2017 | Worksheet A-6 | Date/Time Prepared: 2/26/2018 1:23 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	C - CAFETERIA						
1.00	DIETARY	10.00	186,586	184,635	0		1.00
	0		186,586	184,635			
	D - MED SUPPLY CHG PTS						
1.00	ADULTS & PEDIATRICS	30.00	0	1,657	0		1.00
2.00	INTENSIVE CARE UNIT	31.00	0	11	0		2.00
3.00	OPERATING ROOM	50.00	0	115,790	0		3.00
4.00	LABORATORY	60.00	0	1,169	0		4.00
5.00	RESPIRATORY THERAPY	65.00	0	10,252	0		5.00
6.00	PHYSICAL THERAPY	66.00	0	2,398	0		6.00
7.00	OCCUPATIONAL THERAPY	67.00	0	32	0		7.00
8.00	DRUGS CHARGED TO PATIENTS	73.00	0	152	0		8.00
9.00	PAIN MANAGEMENT	90.03	0	12,054	0		9.00
10.00	EMERGENCY	91.00	0	4,620	0		10.00
11.00	HOME HEALTH AGENCY	101.00	0	308	0		11.00
12.00	MOB	194.00	0	181,811	0		12.00
13.00	SNF - PERRY CO.	194.03	0	318	0		13.00
	0		0	330,572			
	F - BUSINESS HEALTH SER						
1.00	MOB	194.00	49,964	42,447	0		1.00
	0		49,964	42,447			
	G - INTEREST						
1.00	INTEREST EXPENSE	113.00	0	295,898	10		1.00
2.00		0.00	0	0	0		2.00
	0		0	295,898			
	I - QUALITY SERVICES						
1.00	ADULTS & PEDIATRICS	30.00	31,405	16,452	0		1.00
	0		31,405	16,452			
	J - HEALTH INSURANCE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	51,124	0		1.00
2.00	OPERATION OF PLANT	7.00	0	3,568	0		2.00
3.00	LAUNDRY & LINEN SERVICE	8.00	0	2,807	0		3.00
4.00	HOUSEKEEPING	9.00	0	13,931	0		4.00
5.00	DIETARY	10.00	0	14,701	0		5.00
6.00	MEDICAL RECORDS & LIBRARY	16.00	0	7,128	0		6.00
7.00	ADULTS & PEDIATRICS	30.00	0	32,580	0		7.00
8.00	INTENSIVE CARE UNIT	31.00	0	6,784	0		8.00
9.00	OPERATING ROOM	50.00	0	13,809	0		9.00
10.00	RADIOLOGY-DIAGNOSTIC	54.00	0	10,633	0		10.00
11.00	LABORATORY	60.00	0	11,891	0		11.00
12.00	RESPIRATORY THERAPY	65.00	0	9,158	0		12.00
13.00	PHYSICAL THERAPY	66.00	0	16,044	0		13.00
14.00	OCCUPATIONAL THERAPY	67.00	0	3,349	0		14.00
15.00	SPEECH PATHOLOGY	68.00	0	2,933	0		15.00
16.00	PAIN MANAGEMENT	90.03	0	4,670	0		16.00
17.00	EMERGENCY	91.00	0	17,241	0		17.00
18.00	HOME HEALTH AGENCY	101.00	0	7,420	0		18.00
19.00	MOB	194.00	0	55,402	0		19.00
20.00	SNF - PERRY CO.	194.03	0	38,114	0		20.00
	0		0	323,287			
	K - WELLNESS CENTER						
1.00	MOB	194.00	136,179	49,457	0		1.00
	0		136,179	49,457			
	M - SNF OPERATION OF PLANT						
1.00	SNF - PERRY CO.	194.03	35,072	0	0		1.00
	0		35,072	0			
	N - MALPRACTICE						
1.00	OPERATION OF PLANT	7.00	0	2,600	0		1.00
2.00	ADULTS & PEDIATRICS	30.00	0	565	0		2.00
3.00	OPERATING ROOM	50.00	0	1,309	0		3.00
4.00	PAIN MANAGEMENT	90.03	0	75	0		4.00
5.00	MOB	194.00	0	38,058	0		5.00
6.00	SNF - PERRY CO.	194.03	0	2,616	0		6.00
	0		0	45,223			
	O - MOB COLLECTION EXPENSE						
1.00	MOB	194.00	0	4,470	0		1.00
	0		0	4,470			
	P - RHC RECLASS						
1.00	MOB	194.00	6,718	5,436	0		1.00
	TOTALS		6,718	5,436			
500.00	Grand Total: Decreases		445,924	1,297,877			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1319 | Period: From 10/01/2016 To 09/30/2017 | Worksheet A-7 Part I | Date/Time Prepared: 2/26/2018 1:23 pm

		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	684,802	0	0	0	0	1.00
2.00	Land Improvements	0	0	0	0	0	2.00
3.00	Buildings and Fixtures	19,903,822	0	0	0	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	14,241,503	236,003	0	236,003	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	34,830,127	236,003	0	236,003	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	34,830,127	236,003	0	236,003	0	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	684,802	0	1.00
2.00	Land Improvements	0	0	2.00
3.00	Buildings and Fixtures	19,903,822	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	14,477,506	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	35,066,130	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	35,066,130	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1319 | Period: From 10/01/2016 To 09/30/2017 | Worksheet A-7 Part II | Date/Time Prepared: 2/26/2018 1:23 pm

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	1,269,751	0	0	174,989	11,920	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	1,269,751	0	0	174,989	11,920	3.00

	Cost Center Description	SUMMARY OF CAPITAL		
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
		14.00	15.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	1,456,660	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	2.00
3.00	Total (sum of lines 1-2)	0	1,456,660	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1319 | Period: From 10/01/2016 To 09/30/2017 | Worksheet A-7 Part III | Date/Time Prepared: 2/26/2018 1:23 pm

	Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	35,066,130	0	35,066,130	1.000000	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0.000000	0	2.00
3.00	Total (sum of lines 1-2)	35,066,130	0	35,066,130	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	1,269,751	277,213	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	1,269,751	277,213	3.00

	Cost Center Description	SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	174,989	11,920	0	1,733,873	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	0	174,989	11,920	0	1,733,873	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1319 | Period: From 10/01/2016 To 09/30/2017 | Worksheet A-8 | Date/Time Prepared: 2/26/2018 1:23 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-14,946	CAP REL COSTS-BLDG & FIXT	1.00	10	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-3,046	OPERATION OF PLANT	7.00	0	7.00
8.00	Television and radio service (chapter 21)	A	-215	OPERATION OF PLANT	7.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-127,657			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	4,042,028			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-137,150	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	-9,589	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	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1319 | Period: From 10/01/2016 To 09/30/2017 | Worksheet A-8 | Date/Time Prepared: 2/26/2018 1:23 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
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	MISC INCOME	B	-33,481	ADMINISTRATIVE & GENERAL	5.00	0	33.00
33.02	PHYSICIAN RECRUITING	A	-31,735	ADMINISTRATIVE & GENERAL	5.00	0	33.02
33.03	ADVERTISING	A	-61,217	ADMINISTRATIVE & GENERAL	5.00	0	33.03
33.04	ADVERTISING	A	-2,393	PAIN MANAGEMENT	90.03	0	33.04
34.00	HAF FEE	A	-625,118	ADMINISTRATIVE & GENERAL	5.00	0	34.00
35.00	LOBBYING	A	-3,810	ADMINISTRATIVE & GENERAL	5.00	0	35.00
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		2,991,671				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: 15-1319 | Period: From 10/01/2016 To 09/30/2017 | Worksheet A-8-1 | Date/Time Prepared: 2/26/2018 1:23 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	HOME OFFICE	887,197	0	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE	2,597,547	0	2.00
3.00	7.00	OPERATION OF PLANT	HOME OFFICE	97,642	0	3.00
4.00	13.00	NURSING ADMINISTRATION	HOME OFFICE	60,876	0	4.00
4.01	73.00	DRUGS CHARGED TO PATIENTS	HOME OFFICE	310,329	0	4.01
4.02	16.00	MEDICAL RECORDS & LIBRARY	HOME OFFICE	50,057	0	4.02
4.03	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE	141,408	0	4.03
4.04	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE	313,859	416,887	4.04
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			4,458,915	416,887	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		0.00	DEACONESS HOSP	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:	HOME OFFICE				100.00

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	Provider CCN: 15-1319	Period: From 10/01/2016 To 09/30/2017	Worksheet A-8-1 Date/Time Prepared: 2/26/2018 1:23 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	887,197	0		1.00
2.00	2,597,547	0		2.00
3.00	97,642	0		3.00
4.00	60,876	0		4.00
4.01	310,329	0		4.01
4.02	50,057	0		4.02
4.03	141,408	0		4.03
4.04	-103,028	0		4.04
5.00	4,042,028			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		
	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	HOME OFFICE		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: 15-1319 | Period: From 10/01/2016 To 09/30/2017 | Worksheet A-8-2 | Date/Time Prepared: 2/26/2018 1:23 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	721	721	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	53,899	53,899	0	0	0	2.00
3.00	54.00	RADIOLOGY-DIAGNOSTIC	812	812	0	0	0	3.00
4.00	60.00	LABORATORY	40,000	0	40,000	0	0	4.00
5.00	65.00	RESPIRATORY THERAPY	70,637	70,637	0	0	0	5.00
6.00	90.03	PAIN MANAGEMENT	1,588	1,588	0	0	0	6.00
7.00	91.00	EMERGENCY	383,083	0	383,083	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			550,740	127,657	423,083		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	2.00
3.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	3.00
4.00	60.00	LABORATORY	0	0	0	0	0	4.00
5.00	65.00	RESPIRATORY THERAPY	0	0	0	0	0	5.00
6.00	90.03	PAIN MANAGEMENT	0	0	0	0	0	6.00
7.00	91.00	EMERGENCY	0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	721		1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	53,899		2.00
3.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	812		3.00
4.00	60.00	LABORATORY	0	0	0	0		4.00
5.00	65.00	RESPIRATORY THERAPY	0	0	0	70,637		5.00
6.00	90.03	PAIN MANAGEMENT	0	0	0	1,588		6.00
7.00	91.00	EMERGENCY	0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	127,657		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1319 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B Part I | Date/Time Prepared: 2/26/2018 1:23 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	1,733,873	1,733,873				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0		0			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,647,178	13,737	0	1,660,915		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	6,879,126	84,561	0	194,480	7,158,167	5.00
7.00	00700	OPERATION OF PLANT	1,054,144	328,293	0	19,319	1,401,756	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	82,960	30,842	0	5,158	118,960	8.00
9.00	00900	HOUSEKEEPING	397,478	17,408	0	33,905	448,791	9.00
10.00	01000	DIETARY	390,721	41,344	0	26,052	458,117	10.00
11.00	01100	CAFETERIA	234,071	37,862	0	23,900	295,833	11.00
13.00	01300	NURSING ADMINISTRATION	233,831	5,222	0	20,173	259,226	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	429,353	25,223	0	31,997	486,573	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,461,892	154,818	0	133,766	1,750,476	30.00
31.00	03100	INTENSIVE CARE UNIT	128,167	36,632	0	8,333	173,132	31.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,193,797	96,576	0	82,381	1,372,754	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,251,297	66,150	0	78,583	1,396,030	54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	122,820	7,947	0	0	130,767	54.03
60.00	06000	LABORATORY	1,366,273	28,950	0	82,213	1,477,436	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	58,837	0	0	0	58,837	62.00
65.00	06500	RESPIRATORY THERAPY	718,105	30,502	0	51,062	799,669	65.00
66.00	06600	PHYSICAL THERAPY	930,506	53,189	0	85,445	1,069,140	66.00
67.00	06700	OCCUPATIONAL THERAPY	277,609	15,478	0	29,457	322,544	67.00
68.00	06800	SPEECH PATHOLOGY	147,237	1,173	0	15,195	163,605	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	182,442	67,910	0	0	250,352	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	148,130	0	0	0	148,130	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,764,643	19,149	0	14,509	1,798,301	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	12,154	0	0	861	13,015	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	DIABETES	6,000	26,453	0	0	32,453	90.01
90.02	09002	OP PSYCH	0	0	0	0	0	90.02
90.03	09003	PAIN MANAGEMENT	243,669	0	0	17,268	260,937	90.03
91.00	09100	EMERGENCY	1,501,257	167,438	0	99,677	1,768,372	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	431,238	9,555	0	38,156	478,949	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	25,028,808	1,366,412	0	1,091,890	24,092,322	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	MOB	4,800,668	162,254	0	402,529	5,365,451	194.00
194.01	07951	FOUNDATION	55,037	24,769	0	6,541	86,347	194.01
194.02	07952	ASC	0	0	0	0	0	194.02
194.03	07953	SNF - PERRY CO.	1,730,697	180,438	0	159,955	2,071,090	194.03
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)	31,615,210	1,733,873	0	1,660,915	31,615,210	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1319 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B Part I | Date/Time Prepared: 2/26/2018 1:23 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	7,158,167					5.00
7.00	00700	OPERATION OF PLANT	410,270	1,812,026				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	34,818	42,751	196,529			8.00
9.00	00900	HOUSEKEEPING	131,353	24,129	0	604,273		9.00
10.00	01000	DIETARY	134,083	57,307	0	19,843	669,350	10.00
11.00	01100	CAFETERIA	86,585	52,481	0	18,172	0	11.00
13.00	01300	NURSING ADMINISTRATION	75,871	7,239	0	2,506	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	142,412	34,961	0	12,106	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	512,335	214,593	21,850	74,305	74,419	30.00
31.00	03100	INTENSIVE CARE UNIT	50,673	50,776	1,039	17,582	3,540	31.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	401,782	133,865	0	46,352	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	408,594	91,691	0	31,749	0	54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	38,273	11,016	0	3,814	0	54.03
60.00	06000	LABORATORY	432,420	40,128	0	13,895	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	17,221	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	234,050	42,279	0	14,639	0	65.00
66.00	06600	PHYSICAL THERAPY	312,919	73,725	0	25,528	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	94,403	21,454	0	7,429	0	67.00
68.00	06800	SPEECH PATHOLOGY	47,884	1,626	0	563	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	73,274	94,130	0	32,593	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	43,355	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	526,332	26,542	0	9,190	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	3,809	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	DIABETES	9,498	36,666	0	12,696	0	90.01
90.02	09002	OP PSYCH	0	0	0	0	0	90.02
90.03	09003	PAIN MANAGEMENT	76,372	0	0	0	0	90.03
91.00	09100	EMERGENCY	517,572	232,086	0	80,362	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	140,180	13,245	0	4,586	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	4,956,338	1,302,690	22,889	427,910	77,959	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	MOB	1,570,384	224,900	0	77,874	0	194.00
194.01	07951	FOUNDATION	25,272	34,332	0	11,888	0	194.01
194.02	07952	ASC	0	0	0	0	0	194.02
194.03	07953	SNF - PERRY CO.	606,173	250,104	173,640	86,601	591,391	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	7,158,167	1,812,026	196,529	604,273	669,350	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1319 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B Part I | Date/Time Prepared: 2/26/2018 1:23 pm

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			11.00	13.00	16.00	24.00	25.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	453,071					11.00
13.00	01300	NURSING ADMINISTRATION	8,582	353,424				13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	13,613	0	689,665			16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	56,910	94,356	24,349	2,823,593	0	30.00
31.00	03100	INTENSIVE CARE UNIT	3,545	6,906	730	307,923	0	31.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	35,049	22,688	55,692	2,068,182	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	33,433	0	121,518	2,083,015	0	54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0	0	3,708	187,578	0	54.03
60.00	06000	LABORATORY	34,977	0	101,944	2,100,800	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	1,297	77,355	0	62.00
65.00	06500	RESPIRATORY THERAPY	21,724	0	33,188	1,145,549	0	65.00
66.00	06600	PHYSICAL THERAPY	36,352	0	58,513	1,576,177	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	12,532	0	19,661	478,023	0	67.00
68.00	06800	SPEECH PATHOLOGY	6,464	0	8,007	228,149	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	5,217	455,566	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	4,750	196,235	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,173	3,033	52,190	2,421,761	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	184	17,008	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	DIABETES	0	0	330	91,643	0	90.01
90.02	09002	OP PSYCH	0	0	0	0	0	90.02
90.03	09003	PAIN MANAGEMENT	6,062	11,279	9,111	363,761	0	90.03
91.00	09100	EMERGENCY	42,407	73,292	88,468	2,802,559	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	16,234	19,231	7,029	679,454	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	334,057	230,785	595,886	20,104,331	0	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	MOB	48,179	17,071	72,951	7,376,810	0	194.00
194.01	07951	FOUNDATION	2,783	0	0	160,622	0	194.01
194.02	07952	ASC	0	0	0	0	0	194.02
194.03	07953	SNF - PERRY CO.	68,052	105,568	20,828	3,973,447	0	194.03
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	453,071	353,424	689,665	31,615,210	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1319 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B Part I | Date/Time Prepared: 2/26/2018 1:23 pm

		Cost Center Description	Total		
			26.00		
		GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.00	00500	ADMINISTRATIVE & GENERAL			5.00
7.00	00700	OPERATION OF PLANT			7.00
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
13.00	01300	NURSING ADMINISTRATION			13.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	2,823,593		30.00
31.00	03100	INTENSIVE CARE UNIT	307,923		31.00
44.00	04400	SKILLED NURSING FACILITY	0		44.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	2,068,182		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,083,015		54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	187,578		54.03
60.00	06000	LABORATORY	2,100,800		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	77,355		62.00
65.00	06500	RESPIRATORY THERAPY	1,145,549		65.00
66.00	06600	PHYSICAL THERAPY	1,576,177		66.00
67.00	06700	OCCUPATIONAL THERAPY	478,023		67.00
68.00	06800	SPEECH PATHOLOGY	228,149		68.00
69.00	06900	ELECTROCARDIOLOGY	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	455,566		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	196,235		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,421,761		73.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	17,008		88.00
90.00	09000	CLINIC	0		90.00
90.01	09001	DIABETES	91,643		90.01
90.02	09002	OP PSYCH	0		90.02
90.03	09003	PAIN MANAGEMENT	363,761		90.03
91.00	09100	EMERGENCY	2,802,559		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
		OTHER REIMBURSABLE COST CENTERS			
101.00	10100	HOME HEALTH AGENCY	679,454		101.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	20,104,331		118.00
		NONREIMBURSABLE COST CENTERS			
194.00	07950	MOB	7,376,810		194.00
194.01	07951	FOUNDATION	160,622		194.01
194.02	07952	ASC	0		194.02
194.03	07953	SNF - PERRY CO.	3,973,447		194.03
200.00		Cross Foot Adjustments	0		200.00
201.00		Negative Cost Centers	0		201.00
202.00		TOTAL (sum lines 118 through 201)	31,615,210		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1319 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B Part II Date/Time Prepared: 2/26/2018 1:23 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	13,737	0	13,737	13,737	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	84,561	0	84,561	1,608	5.00
7.00	00700	OPERATION OF PLANT	0	328,293	0	328,293	160	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	30,842	0	30,842	43	8.00
9.00	00900	HOUSEKEEPING	0	17,408	0	17,408	280	9.00
10.00	01000	DIETARY	0	41,344	0	41,344	215	10.00
11.00	01100	CAFETERIA	0	37,862	0	37,862	198	11.00
13.00	01300	NURSING ADMINISTRATION	0	5,222	0	5,222	167	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	25,223	0	25,223	265	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	154,818	0	154,818	1,106	30.00
31.00	03100	INTENSIVE CARE UNIT	0	36,632	0	36,632	69	31.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	96,576	0	96,576	681	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	66,150	0	66,150	650	54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0	7,947	0	7,947	0	54.03
60.00	06000	LABORATORY	0	28,950	0	28,950	680	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	30,502	0	30,502	422	65.00
66.00	06600	PHYSICAL THERAPY	0	53,189	0	53,189	706	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	15,478	0	15,478	244	67.00
68.00	06800	SPEECH PATHOLOGY	0	1,173	0	1,173	126	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	67,910	0	67,910	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	19,149	0	19,149	120	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	7	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	DIABETES	0	26,453	0	26,453	0	90.01
90.02	09002	OP PSYCH	0	0	0	0	0	90.02
90.03	09003	PAIN MANAGEMENT	0	0	0	0	143	90.03
91.00	09100	EMERGENCY	0	167,438	0	167,438	824	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	9,555	0	9,555	315	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	1,366,412	0	1,366,412	9,029	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	MOB	0	162,254	0	162,254	3,332	194.00
194.01	07951	FOUNDATION	0	24,769	0	24,769	54	194.01
194.02	07952	ASC	0	0	0	0	0	194.02
194.03	07953	SNF - PERRY CO.	0	180,438	0	180,438	1,322	194.03
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	1,733,873	0	1,733,873	13,737	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1319 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B Part II | Date/Time Prepared: 2/26/2018 1:23 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	86,169					5.00
7.00	00700	OPERATION OF PLANT	4,938	333,391				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	419	7,866	39,170			8.00
9.00	00900	HOUSEKEEPING	1,581	4,439	0	23,708		9.00
10.00	01000	DIETARY	1,614	10,544	0	779	54,496	10.00
11.00	01100	CAFETERIA	1,042	9,656	0	713	0	11.00
13.00	01300	NURSING ADMINISTRATION	913	1,332	0	98	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,714	6,432	0	475	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,167	39,482	4,355	2,915	6,059	30.00
31.00	03100	INTENSIVE CARE UNIT	610	9,342	207	690	288	31.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,836	24,630	0	1,819	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,918	16,870	0	1,246	0	54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	461	2,027	0	150	0	54.03
60.00	06000	LABORATORY	5,205	7,383	0	545	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	207	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	2,817	7,779	0	574	0	65.00
66.00	06600	PHYSICAL THERAPY	3,767	13,565	0	1,002	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,136	3,947	0	291	0	67.00
68.00	06800	SPEECH PATHOLOGY	576	299	0	22	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	882	17,319	0	1,279	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	522	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,335	4,883	0	361	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	46	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	DIABETES	114	6,746	0	498	0	90.01
90.02	09002	OP PSYCH	0	0	0	0	0	90.02
90.03	09003	PAIN MANAGEMENT	919	0	0	0	0	90.03
91.00	09100	EMERGENCY	6,230	42,701	0	3,153	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	1,687	2,437	0	180	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	59,656	239,679	4,562	16,790	6,347	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	MOB	18,913	41,379	0	3,055	0	194.00
194.01	07951	FOUNDATION	304	6,317	0	466	0	194.01
194.02	07952	ASC	0	0	0	0	0	194.02
194.03	07953	SNF - PERRY CO.	7,296	46,016	34,608	3,397	48,149	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	86,169	333,391	39,170	23,708	54,496	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1319 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B Part II | Date/Time Prepared: 2/26/2018 1:23 pm

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			11.00	13.00	16.00	24.00	25.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	49,471					11.00
13.00	01300	NURSING ADMINISTRATION	937	8,669				13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,486	0	35,595			16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,214	2,314	1,257	224,687	0	30.00
31.00	03100	INTENSIVE CARE UNIT	387	169	38	48,432	0	31.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,827	556	2,875	135,800	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,650	0	6,270	99,754	0	54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0	0	191	10,776	0	54.03
60.00	06000	LABORATORY	3,819	0	5,262	51,844	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	67	274	0	62.00
65.00	06500	RESPIRATORY THERAPY	2,372	0	1,713	46,179	0	65.00
66.00	06600	PHYSICAL THERAPY	3,969	0	3,020	79,218	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,368	0	1,015	23,479	0	67.00
68.00	06800	SPEECH PATHOLOGY	706	0	413	3,315	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	269	87,659	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	245	767	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	674	74	2,694	34,290	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	10	63	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	DIABETES	0	0	17	33,828	0	90.01
90.02	09002	OP PSYCH	0	0	0	0	0	90.02
90.03	09003	PAIN MANAGEMENT	662	277	470	2,471	0	90.03
91.00	09100	EMERGENCY	4,630	1,798	4,566	231,340	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	1,772	472	363	16,781	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	36,473	5,660	30,755	1,130,957	0	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	MOB	5,260	419	3,765	238,377	0	194.00
194.01	07951	FOUNDATION	304	0	0	32,214	0	194.01
194.02	07952	ASC	0	0	0	0	0	194.02
194.03	07953	SNF - PERRY CO.	7,434	2,590	1,075	332,325	0	194.03
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	49,471	8,669	35,595	1,733,873	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1319 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B Part II | Date/Time Prepared: 2/26/2018 1:23 pm

		Cost Center Description	Total		
			26.00		
		GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.00	00500	ADMINISTRATIVE & GENERAL			5.00
7.00	00700	OPERATION OF PLANT			7.00
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
13.00	01300	NURSING ADMINISTRATION			13.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	224,687		30.00
31.00	03100	INTENSIVE CARE UNIT	48,432		31.00
44.00	04400	SKILLED NURSING FACILITY	0		44.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	135,800		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	99,754		54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	10,776		54.03
60.00	06000	LABORATORY	51,844		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	274		62.00
65.00	06500	RESPIRATORY THERAPY	46,179		65.00
66.00	06600	PHYSICAL THERAPY	79,218		66.00
67.00	06700	OCCUPATIONAL THERAPY	23,479		67.00
68.00	06800	SPEECH PATHOLOGY	3,315		68.00
69.00	06900	ELECTROCARDIOLOGY	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	87,659		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	767		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	34,290		73.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	63		88.00
90.00	09000	CLINIC	0		90.00
90.01	09001	DIABETES	33,828		90.01
90.02	09002	OP PSYCH	0		90.02
90.03	09003	PAIN MANAGEMENT	2,471		90.03
91.00	09100	EMERGENCY	231,340		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
		OTHER REIMBURSABLE COST CENTERS			
101.00	10100	HOME HEALTH AGENCY	16,781		101.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,130,957		118.00
		NONREIMBURSABLE COST CENTERS			
194.00	07950	MOB	238,377		194.00
194.01	07951	FOUNDATION	32,214		194.01
194.02	07952	ASC	0		194.02
194.03	07953	SNF - PERRY CO.	332,325		194.03
200.00		Cross Foot Adjustments	0		200.00
201.00		Negative Cost Centers	0		201.00
202.00		TOTAL (sum lines 118 through 201)	1,733,873		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1319 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B-1 | Date/Time Prepared: 2/26/2018 1:23 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	91,634					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		91,634				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	726	726	12,966,725			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	4,469	4,469	1,518,299	-7,158,167	24,457,043	5.00
7.00	00700	OPERATION OF PLANT	17,350	17,350	150,824	0	1,401,756	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,630	1,630	40,266	0	118,960	8.00
9.00	00900	HOUSEKEEPING	920	920	264,694	0	448,791	9.00
10.00	01000	DIETARY	2,185	2,185	203,390	0	458,117	10.00
11.00	01100	CAFETERIA	2,001	2,001	186,586	0	295,833	11.00
13.00	01300	NURSING ADMINISTRATION	276	276	157,488	0	259,226	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,333	1,333	249,799	0	486,573	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	8,182	8,182	1,044,301	0	1,750,476	30.00
31.00	03100	INTENSIVE CARE UNIT	1,936	1,936	65,053	0	173,132	31.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,104	5,104	643,143	0	1,372,754	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,496	3,496	613,494	0	1,396,030	54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	420	420	0	0	130,767	54.03
60.00	06000	LABORATORY	1,530	1,530	641,832	0	1,477,436	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	58,837	62.00
65.00	06500	RESPIRATORY THERAPY	1,612	1,612	398,637	0	799,669	65.00
66.00	06600	PHYSICAL THERAPY	2,811	2,811	667,062	0	1,069,140	66.00
67.00	06700	OCCUPATIONAL THERAPY	818	818	229,967	0	322,544	67.00
68.00	06800	SPEECH PATHOLOGY	62	62	118,623	0	163,605	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,589	3,589	0	0	250,352	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	148,130	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,012	1,012	113,271	0	1,798,301	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	6,718	0	13,015	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	DIABETES	1,398	1,398	0	0	32,453	90.01
90.02	09002	OP PSYCH	0	0	0	0	0	90.02
90.03	09003	PAIN MANAGEMENT	0	0	134,814	0	260,937	90.03
91.00	09100	EMERGENCY	8,849	8,849	778,171	0	1,768,372	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	505	505	297,885	0	478,949	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	72,214	72,214	8,524,317	-7,158,167	16,934,155	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	MOB	8,575	8,575	3,142,581	0	5,365,451	194.00
194.01	07951	FOUNDATION	1,309	1,309	51,064	0	86,347	194.01
194.02	07952	ASC	0	0	0	0	0	194.02
194.03	07953	SNF - PERRY CO.	9,536	9,536	1,248,763	0	2,071,090	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,733,873	0	1,660,915		7,158,167	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	18.921721	0.000000	0.128091		0.292683	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			13,737		86,169	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.001059		0.003523	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1319 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B-1 | Date/Time Prepared: 2/26/2018 1:23 pm

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (PATIENT DAYS)	CAFETERIA (GROSS SALARIES)	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	69,089					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,630	15,884				8.00
9.00	00900	HOUSEKEEPING	920	0	66,539			9.00
10.00	01000	DIETARY	2,185	0	2,185	15,884		10.00
11.00	01100	CAFETERIA	2,001	0	2,001	0	8,313,873	11.00
13.00	01300	NURSING ADMINISTRATION	276	0	276	0	157,488	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,333	0	1,333	0	249,799	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	8,182	1,766	8,182	1,766	1,044,301	30.00
31.00	03100	INTENSIVE CARE UNIT	1,936	84	1,936	84	65,053	31.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,104	0	5,104	0	643,143	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,496	0	3,496	0	613,494	54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	420	0	420	0	0	54.03
60.00	06000	LABORATORY	1,530	0	1,530	0	641,832	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	1,612	0	1,612	0	398,637	65.00
66.00	06600	PHYSICAL THERAPY	2,811	0	2,811	0	667,062	66.00
67.00	06700	OCCUPATIONAL THERAPY	818	0	818	0	229,967	67.00
68.00	06800	SPEECH PATHOLOGY	62	0	62	0	118,623	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,589	0	3,589	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,012	0	1,012	0	113,271	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	DIABETES	1,398	0	1,398	0	0	90.01
90.02	09002	OP PSYCH	0	0	0	0	0	90.02
90.03	09003	PAIN MANAGEMENT	0	0	0	0	111,230	90.03
91.00	09100	EMERGENCY	8,849	0	8,849	0	778,171	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	505	0	505	0	297,885	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	49,669	1,850	47,119	1,850	6,129,956	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	MOB	8,575	0	8,575	0	884,090	194.00
194.01	07951	FOUNDATION	1,309	0	1,309	0	51,064	194.01
194.02	07952	ASC	0	0	0	0	0	194.02
194.03	07953	SNF - PERRY CO.	9,536	14,034	9,536	14,034	1,248,763	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,812,026	196,529	604,273	669,350	453,071	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	26.227417	12.372765	9.081486	42.139889	0.054496	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	333,391	39,170	23,708	54,496	49,471	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	4.825529	2.466004	0.356302	3.430874	0.005950	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1319 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B-1 | Date/Time Prepared: 2/26/2018 1:23 pm

		Cost Center Description	NURSING ADMINISTRATION (NURSE SALARIES)	MEDICAL RECORDS & LIBRARY (GROSS PATIENT REVENUE)		
			13.00	16.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION	3,435,616			13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	57,416,461		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	917,230	2,027,081		30.00
31.00	03100	INTENSIVE CARE UNIT	67,136	60,811		31.00
44.00	04400	SKILLED NURSING FACILITY	0	0		44.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	220,547	4,636,383		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	10,117,980		54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0	308,669		54.03
60.00	06000	LABORATORY	0	8,486,826		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	107,981		62.00
65.00	06500	RESPIRATORY THERAPY	0	2,762,903		65.00
66.00	06600	PHYSICAL THERAPY	0	4,871,229		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,636,803		67.00
68.00	06800	SPEECH PATHOLOGY	0	666,560		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	434,340		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	395,406		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	29,479	4,344,839		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	15,326		88.00
90.00	09000	CLINIC	0	0		90.00
90.01	09001	DIABETES	0	27,482		90.01
90.02	09002	OP PSYCH	0	0		90.02
90.03	09003	PAIN MANAGEMENT	109,639	758,526		90.03
91.00	09100	EMERGENCY	712,465	7,365,000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
		OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY	186,939	585,171		101.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE				113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,243,435	49,609,316		118.00
		NONREIMBURSABLE COST CENTERS				
194.00	07950	MOB	165,945	6,073,192		194.00
194.01	07951	FOUNDATION	0	0		194.01
194.02	07952	ASC	0	0		194.02
194.03	07953	SNF - PERRY CO.	1,026,236	1,733,953		194.03
200.00		Cross Foot Adjustments				200.00
201.00		Negative Cost Centers				201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	353,424	689,665		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.102871	0.012012		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	8,669	35,595		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.002523	0.000620		205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1319 | Period: From 10/01/2016 To 09/30/2017 | Worksheet C Part I Date/Time Prepared: 2/26/2018 1:23 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,823,593		2,823,593	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	307,923		307,923	0	0	31.00
44.00	04400	SKILLED NURSING FACILITY	0		0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,068,182		2,068,182	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,083,015		2,083,015	0	0	54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	187,578		187,578	0	0	54.03
60.00	06000	LABORATORY	2,100,800		2,100,800	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	77,355		77,355	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	1,145,549	0	1,145,549	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,576,177	0	1,576,177	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	478,023	0	478,023	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	228,149	0	228,149	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0		0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	455,566		455,566	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	196,235		196,235	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,421,761		2,421,761	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	17,008		17,008	0	0	88.00
90.00	09000	CLINIC	0		0	0	0	90.00
90.01	09001	DIABETES	91,643		91,643	0	0	90.01
90.02	09002	OP PSYCH	0		0	0	0	90.02
90.03	09003	PAIN MANAGEMENT	363,761		363,761	0	0	90.03
91.00	09100	EMERGENCY	2,802,559		2,802,559	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	640,110		640,110		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	679,454		679,454		0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	20,744,441	0	20,744,441	0	0	200.00
201.00		Less Observation Beds	640,110		640,110		0	201.00
202.00		Total (see instructions)	20,104,331	0	20,104,331	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1319 | Period: From 10/01/2016 To 09/30/2017 | Worksheet C Part I Date/Time Prepared: 2/26/2018 1:23 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,815,226		1,815,226			30.00
31.00	03100	INTENSIVE CARE UNIT	60,812		60,812			31.00
44.00	04400	SKILLED NURSING FACILITY	0		0			44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	272,780	4,363,603	4,636,383	0.446077	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	292,578	9,825,402	10,117,980	0.205873	0.000000	54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	18,134	290,535	308,669	0.607700	0.000000	54.03
60.00	06000	LABORATORY	970,131	7,516,695	8,486,826	0.247537	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	24,473	83,508	107,981	0.716376	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	558,320	2,204,583	2,762,903	0.414618	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	834,407	4,036,822	4,871,229	0.323569	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	366,863	1,269,940	1,636,803	0.292047	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	45,319	621,241	666,560	0.342278	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	226,279	208,061	434,340	1.048870	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	51,357	344,049	395,406	0.496287	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	667,770	3,677,069	4,344,839	0.557388	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	15,326	15,326			88.00
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
90.01	09001	DIABETES	0	27,482	27,482	3.334655	0.000000	90.01
90.02	09002	OP PSYCH	0	0	0	0.000000	0.000000	90.02
90.03	09003	PAIN MANAGEMENT	0	757,014	757,014	0.480521	0.000000	90.03
91.00	09100	EMERGENCY	122,064	7,242,936	7,365,000	0.380524	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	10,921	796,621	807,542	0.792665	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	585,171	585,171			101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	6,337,434	43,866,058	50,203,492			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	6,337,434	43,866,058	50,203,492			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1319 | Period: From 10/01/2016 To 09/30/2017 | Worksheet C Part I Date/Time Prepared: 2/26/2018 1:23 pm

Title XVIII | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
44.00	04400	SKILLED NURSING FACILITY			44.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0.000000		54.03
60.00	06000	LABORATORY	0.000000		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000		62.00
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 PATIENT	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC			88.00
90.00	09000	CLINIC	0.000000		90.00
90.01	09001	DIABETES	0.000000		90.01
90.02	09002	OP PSYCH	0.000000		90.02
90.03	09003	PAIN MANAGEMENT	0.000000		90.03
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
		OTHER REIMBURSABLE COST CENTERS			
101.00	10100	HOME HEALTH AGENCY			101.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
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: 15-1319 | Period: From 10/01/2016 To 09/30/2017 | Worksheet C Part I Date/Time Prepared: 2/26/2018 1:23 pm

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,823,593		2,823,593	0	2,823,593	30.00
31.00	03100	INTENSIVE CARE UNIT	307,923		307,923	0	307,923	31.00
44.00	04400	SKILLED NURSING FACILITY	0		0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,068,182		2,068,182	0	2,068,182	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,083,015		2,083,015	0	2,083,015	54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	187,578		187,578	0	187,578	54.03
60.00	06000	LABORATORY	2,100,800		2,100,800	0	2,100,800	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	77,355		77,355	0	77,355	62.00
65.00	06500	RESPIRATORY THERAPY	1,145,549	0	1,145,549	0	1,145,549	65.00
66.00	06600	PHYSICAL THERAPY	1,576,177	0	1,576,177	0	1,576,177	66.00
67.00	06700	OCCUPATIONAL THERAPY	478,023	0	478,023	0	478,023	67.00
68.00	06800	SPEECH PATHOLOGY	228,149	0	228,149	0	228,149	68.00
69.00	06900	ELECTROCARDIOLOGY	0		0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	455,566		455,566	0	455,566	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	196,235		196,235	0	196,235	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,421,761		2,421,761	0	2,421,761	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	17,008		17,008	0	17,008	88.00
90.00	09000	CLINIC	0		0	0	0	90.00
90.01	09001	DIABETES	91,643		91,643	0	91,643	90.01
90.02	09002	OP PSYCH	0		0	0	0	90.02
90.03	09003	PAIN MANAGEMENT	363,761		363,761	0	363,761	90.03
91.00	09100	EMERGENCY	2,802,559		2,802,559	0	2,802,559	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	640,110		640,110		640,110	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	679,454		679,454		679,454	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	20,744,441	0	20,744,441	0	20,744,441	200.00
201.00		Less Observation Beds	640,110		640,110		640,110	201.00
202.00		Total (see instructions)	20,104,331	0	20,104,331	0	20,104,331	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1319 | Period: From 10/01/2016 To 09/30/2017 | Worksheet C Part I Date/Time Prepared: 2/26/2018 1:23 pm

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	1,815,226		1,815,226			30.00
31.00	03100	INTENSIVE CARE UNIT	60,812		60,812			31.00
44.00	04400	SKILLED NURSING FACILITY	0		0			44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	272,780	4,363,603	4,636,383	0.446077	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	292,578	9,825,402	10,117,980	0.205873	0.000000	54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	18,134	290,535	308,669	0.607700	0.000000	54.03
60.00	06000	LABORATORY	970,131	7,516,695	8,486,826	0.247537	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	24,473	83,508	107,981	0.716376	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	558,320	2,204,583	2,762,903	0.414618	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	834,407	4,036,822	4,871,229	0.323569	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	366,863	1,269,940	1,636,803	0.292047	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	45,319	621,241	666,560	0.342278	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	226,279	208,061	434,340	1.048870	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	51,357	344,049	395,406	0.496287	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	667,770	3,677,069	4,344,839	0.557388	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	15,326	15,326	1.109748	0.000000	88.00
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
90.01	09001	DIABETES	0	27,482	27,482	3.334655	0.000000	90.01
90.02	09002	OP PSYCH	0	0	0	0.000000	0.000000	90.02
90.03	09003	PAIN MANAGEMENT	0	757,014	757,014	0.480521	0.000000	90.03
91.00	09100	EMERGENCY	122,064	7,242,936	7,365,000	0.380524	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	10,921	796,621	807,542	0.792665	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	585,171	585,171			101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	6,337,434	43,866,058	50,203,492			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	6,337,434	43,866,058	50,203,492			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1319 | Period: From 10/01/2016 To 09/30/2017 | Worksheet C Part I Date/Time Prepared: 2/26/2018 1:23 pm

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
44.00	04400	SKILLED NURSING FACILITY			44.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0.000000		54.03
60.00	06000	LABORATORY	0.000000		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000		62.00
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 PATIENT	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	0.000000		88.00
90.00	09000	CLINIC	0.000000		90.00
90.01	09001	DIABETES	0.000000		90.01
90.02	09002	OP PSYCH	0.000000		90.02
90.03	09003	PAIN MANAGEMENT	0.000000		90.03
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
		OTHER REIMBURSABLE COST CENTERS			
101.00	10100	HOME HEALTH AGENCY			101.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-1319 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part II Date/Time Prepared: 2/26/2018 1:23 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	135,800	4,636,383	0.029290	78,817	2,309	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	99,754	10,117,980	0.009859	120,151	1,185	54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	10,776	308,669	0.034911	9,287	324	54.03
60.00	06000	LABORATORY	51,844	8,486,826	0.006109	372,693	2,277	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	274	107,981	0.002537	12,668	32	62.00
65.00	06500	RESPIRATORY THERAPY	46,179	2,762,903	0.016714	194,803	3,256	65.00
66.00	06600	PHYSICAL THERAPY	79,218	4,871,229	0.016262	82,400	1,340	66.00
67.00	06700	OCCUPATIONAL THERAPY	23,479	1,636,803	0.014344	24,267	348	67.00
68.00	06800	SPEECH PATHOLOGY	3,315	666,560	0.004973	13,011	65	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	87,659	434,340	0.201821	95,842	19,343	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	767	395,406	0.001940	29,141	57	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	34,290	4,344,839	0.007892	188,133	1,485	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	63	15,326	0.004111	0	0	88.00
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
90.01	09001	DIABETES	33,828	27,482	1.230915	0	0	90.01
90.02	09002	OP PSYCH	0	0	0.000000	0	0	90.02
90.03	09003	PAIN MANAGEMENT	2,471	757,014	0.003264	0	0	90.03
91.00	09100	EMERGENCY	231,340	7,365,000	0.031411	8,450	265	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	50,937	807,542	0.063077	0	0	92.00
200.00		Total (lines 50 through 199)	891,994	47,742,283		1,229,663	32,286	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-1319 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part IV Date/Time Prepared: 2/26/2018 1:23 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0	0	0	0	0	54.03
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	DIABETES	0	0	0	0	0	90.01
90.02	09002	OP PSYCH	0	0	0	0	0	90.02
90.03	09003	PAIN MANAGEMENT	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
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: 15-1319 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part IV Date/Time Prepared: 2/26/2018 1:23 pm

Title XVIII | Hospital | Cost

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	4,636,383	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	10,117,980	0.000000	54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0	0	0	308,669	0.000000	54.03
60.00	06000	LABORATORY	0	0	0	8,486,826	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	107,981	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	2,762,903	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	4,871,229	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,636,803	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	666,560	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	434,340	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	395,406	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	4,344,839	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	15,326	0.000000	88.00
90.00	09000	CLINIC	0	0	0	0	0.000000	90.00
90.01	09001	DIABETES	0	0	0	27,482	0.000000	90.01
90.02	09002	OP PSYCH	0	0	0	0	0.000000	90.02
90.03	09003	PAIN MANAGEMENT	0	0	0	757,014	0.000000	90.03
91.00	09100	EMERGENCY	0	0	0	7,365,000	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	807,542	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	47,742,283		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1319 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part IV | Date/Time Prepared: 2/26/2018 1:23 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	78,817	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	120,151	0	0	0	54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0.000000	9,287	0	0	0	54.03
60.00	06000	LABORATORY	0.000000	372,693	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	12,668	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.000000	194,803	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	82,400	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	24,267	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	13,011	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	95,842	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	29,141	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	188,133	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	DIABETES	0.000000	0	0	0	0	90.01
90.02	09002	OP PSYCH	0.000000	0	0	0	0	90.02
90.03	09003	PAIN MANAGEMENT	0.000000	0	0	0	0	90.03
91.00	09100	EMERGENCY	0.000000	8,450	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		1,229,663	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1319 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part V Date/Time Prepared: 2/26/2018 1:23 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.446077	0	1,691,359	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.205873	0	2,754,392	0	0	54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0.607700	0	108,526	0	0	54.03
60.00	06000	LABORATORY	0.247537	0	2,678,693	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.716376	0	38,127	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.414618	0	795,501	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.323569	0	1,439,819	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.292047	0	252,739	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.342278	0	33,232	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1.048870	0	75,265	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.496287	0	140,578	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.557388	0	2,045,166	2,111	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	DIABETES	3.334655	0	4,396	0	0	90.01
90.02	09002	OP PSYCH	0.000000	0	0	0	0	90.02
90.03	09003	PAIN MANAGEMENT	0.480521	0	415,465	0	0	90.03
91.00	09100	EMERGENCY	0.380524	0	1,649,924	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.792665	0	354,047	0	0	92.00
200.00		Subtotal (see instructions)		0	14,477,229	2,111	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	14,477,229	2,111	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1319 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part V Date/Time Prepared: 2/26/2018 1:23 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	754,476	0		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	567,055	0		54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	65,951	0		54.03
60.00	06000	LABORATORY	663,076	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	27,313	0		62.00
65.00	06500	RESPIRATORY THERAPY	329,829	0		65.00
66.00	06600	PHYSICAL THERAPY	465,881	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	73,812	0		67.00
68.00	06800	SPEECH PATHOLOGY	11,375	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	78,943	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	69,767	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,139,951	1,177		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
90.00	09000	CLINIC	0	0		90.00
90.01	09001	DIABETES	14,659	0		90.01
90.02	09002	OP PSYCH	0	0		90.02
90.03	09003	PAIN MANAGEMENT	199,640	0		90.03
91.00	09100	EMERGENCY	627,836	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	280,641	0		92.00
200.00		Subtotal (see instructions)	5,370,205	1,177		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	5,370,205	1,177		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-1319 | Component CCN: 15-Z319 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part V Date/Time Prepared: 2/26/2018 1:23 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.446077	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.205873	0	0	0	0	54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0.607700	0	0	0	0	54.03
60.00	06000	LABORATORY	0.247537	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.716376	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.414618	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.323569	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.292047	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.342278	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1.048870	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.496287	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.557388	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	DIABETES	3.334655	0	0	0	0	90.01
90.02	09002	OP PSYCH	0.000000	0	0	0	0	90.02
90.03	09003	PAIN MANAGEMENT	0.480521	0	0	0	0	90.03
91.00	09100	EMERGENCY	0.380524	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.792665	0	0	0	0	92.00
200.00		Subtotal (see instructions)		0	0	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1319 | Component CCN: 15-Z319 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part V Date/Time Prepared: 2/26/2018 1:23 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
			6.00	7.00	
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0	0	54.03
60.00	06000	LABORATORY	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	62.00
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 PATIENT	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	0	0	88.00
90.00	09000	CLINIC	0	0	90.00
90.01	09001	DIABETES	0	0	90.01
90.02	09002	OP PSYCH	0	0	90.02
90.03	09003	PAIN MANAGEMENT	0	0	90.03
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	92.00
200.00		Subtotal (see instructions)	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	0	0	202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1319 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D-1 | Date/Time Prepared: 2/26/2018 1:23 pm

Title XVIII | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	2,541	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,615	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	1,088	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)	678	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)	248	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	779	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)	678	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	137.32	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	155.02	20.00
21.00	Total general inpatient routine service cost (see instructions)	2,823,593	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)	38,445	25.00
26.00	Total swing-bed cost (see instructions)	861,964	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	1,961,629	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	1,961,629	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)	1,214.63	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	946,197	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)	946,197	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1319 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D-1 | Date/Time Prepared: 2/26/2018 1:23 pm

Title XVIII | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	307,923	84	3,665.75	16	58,652	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)	508,905	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	1,513,754	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)	823,519	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	823,519	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)	527	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,214.63	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	640,110	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1319 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D-1 | Date/Time Prepared: 2/26/2018 1:23 pm

Title XVIII | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	224,687	2,823,593	0.079575	640,110	50,937	90.00
91.00	Nursing School cost	0	2,823,593	0.000000	640,110	0	91.00
92.00	Allied health cost	0	2,823,593	0.000000	640,110	0	92.00
93.00	All other Medical Education	0	2,823,593	0.000000	640,110	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1319 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D-1 | Date/Time Prepared: 2/26/2018 1:23 pm

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)	2,541	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,615	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	1,088	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)	678	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)	248	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	11	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	2,823,593	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)	834,889	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	1,988,704	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	1,988,704	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)	1,231.40	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	13,545	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)	13,545	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1319 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D-1 | Date/Time Prepared: 2/26/2018 1:23 pm

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)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	307,923	84	3,665.75	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	8,406	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	21,951	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)	527	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,231.40	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	648,948	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1319 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D-1 | Date/Time Prepared: 2/26/2018 1:23 pm

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	224,687	2,823,593	0.079575	648,948	51,640	90.00
91.00	Nursing School cost	0	2,823,593	0.000000	648,948	0	91.00
92.00	Allied health cost	0	2,823,593	0.000000	648,948	0	92.00
93.00	All other Medical Education	0	2,823,593	0.000000	648,948	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1319 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D-3 | Date/Time Prepared: 2/26/2018 1:23 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		667,057		30.00
31.00	03100	INTENSIVE CARE UNIT		29,365		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.446077	78,817	35,158	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.205873	120,151	24,736	54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0.607700	9,287	5,644	54.03
60.00	06000	LABORATORY	0.247537	372,693	92,255	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.716376	12,668	9,075	62.00
65.00	06500	RESPIRATORY THERAPY	0.414618	194,803	80,769	65.00
66.00	06600	PHYSICAL THERAPY	0.323569	82,400	26,662	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.292047	24,267	7,087	67.00
68.00	06800	SPEECH PATHOLOGY	0.342278	13,011	4,453	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1.048870	95,842	100,526	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.496287	29,141	14,462	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.557388	188,133	104,863	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000	CLINIC	0.000000	0	0	90.00
90.01	09001	DIABETES	3.334655	0	0	90.01
90.02	09002	OP PSYCH	0.000000	0	0	90.02
90.03	09003	PAIN MANAGEMENT	0.480521	0	0	90.03
91.00	09100	EMERGENCY	0.380524	8,450	3,215	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.792665	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		1,229,663	508,905	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		1,229,663		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-1319 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D-3

Component CCN: 15-Z319 | Date/Time Prepared: 2/26/2018 1:23 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.446077	17,821	7,950	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.205873	37,366	7,693	54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0.607700	2,329	1,415	54.03
60.00	06000	LABORATORY	0.247537	181,108	44,831	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.716376	5,971	4,277	62.00
65.00	06500	RESPIRATORY THERAPY	0.414618	106,945	44,341	65.00
66.00	06600	PHYSICAL THERAPY	0.323569	196,971	63,734	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.292047	79,988	23,360	67.00
68.00	06800	SPEECH PATHOLOGY	0.342278	6,068	2,077	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1.048870	56,333	59,086	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.496287	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.557388	125,214	69,793	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000	CLINIC	0.000000	0	0	90.00
90.01	09001	DIABETES	3.334655	0	0	90.01
90.02	09002	OP PSYCH	0.000000	0	0	90.02
90.03	09003	PAIN MANAGEMENT	0.480521	0	0	90.03
91.00	09100	EMERGENCY	0.380524	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.792665	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		816,114	328,557	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)		816,114		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1319 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D-3 | Date/Time Prepared: 2/26/2018 1:23 pm

Title XIX | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		7,953		30.00
31.00	03100	INTENSIVE CARE UNIT		1,007		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.446077	3,475	1,550	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.205873	4,293	884	54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0.607700	328	199	54.03
60.00	06000	LABORATORY	0.247537	9,604	2,377	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.716376	183	131	62.00
65.00	06500	RESPIRATORY THERAPY	0.414618	4,276	1,773	65.00
66.00	06600	PHYSICAL THERAPY	0.323569	284	92	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.292047	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.342278	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1.048870	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.496287	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.557388	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	1.109748	0	0	88.00
90.00	09000	CLINIC	0.000000	0	0	90.00
90.01	09001	DIABETES	3.334655	0	0	90.01
90.02	09002	OP PSYCH	0.000000	0	0	90.02
90.03	09003	PAIN MANAGEMENT	0.480521	0	0	90.03
91.00	09100	EMERGENCY	0.380524	3,678	1,400	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.792665	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		26,121	8,406	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)		26,121		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-1319 | Period: From 10/01/2016 To 09/30/2017 | Worksheet E Part B Date/Time Prepared: 2/26/2018 1:23 pm

Title XVIII | Hospital | Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	5,371,382	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	OPPS payments	0	3.00
4.00	Outlier payment (see instructions)	0	4.00
4.01	Outlier reconciliation amount (see instructions)	0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	5,371,382	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	0	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (see instructions)	5,425,096	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	0	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	46,753	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	2,341,146	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)	3,037,197	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)	3,037,197	30.00
31.00	Primary payer payments	476	31.00
32.00	Subtotal (line 30 minus line 31)	3,036,721	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)	386,119	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	250,977	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	372,837	36.00
37.00	Subtotal (see instructions)	3,287,698	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	39.50
39.97	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)	3,287,698	40.00
40.01	Sequestration adjustment (see instructions)	65,754	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
41.00	Interim payments	3,272,144	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	-50,200	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: 15-1319 | Period: From 10/01/2016 To 09/30/2017 | Worksheet E-1 Part I Date/Time Prepared: 2/26/2018 1:23 pm

Title XVIII | Hospital | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,599,100		2,854,144	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0	03/10/2017	43,500	3.01
3.02			0	04/26/2017	88,000	3.02
3.03		05/10/2017	42,100	05/10/2017	286,500	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		42,100		418,000	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,641,200		3,272,144	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		329,422		50,200	6.02
7.00	Total Medicare program liability (see instructions)		1,311,778		3,221,944	7.00

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 15-1319 | Component CCN: 15-Z319 | Period: From 10/01/2016 To 09/30/2017 | Worksheet E-1 Part I | Date/Time Prepared: 2/26/2018 1:23 pm

Title XVIII | Swing Beds - SNF | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,084,099		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,084,099		0	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		33,529		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,117,628		0	7.00

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

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-1319	Period: From 10/01/2016 To 09/30/2017	Worksheet E-1 Part II Date/Time Prepared: 2/26/2018 1:23 pm
	Title XVIII	Hospital	Cost

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

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS | Provider CCN: 15-1319 | Component CCN: 15-Z319 | Period: From 10/01/2016 To 09/30/2017 | Worksheet E-2 | Date/Time Prepared: 2/26/2018 1:23 pm

Title XVIII | Swing Beds - SNF | Cost

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	831,754	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)			2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202, for Part B) (For CAH, see instructions)	331,843	0	3.00
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)		0.00	4.00
5.00	Program days	678	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)		0	6.00
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	1,163,597	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	1,163,597	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0	0	11.00
12.00	Subtotal (line 10 minus line 11)	1,163,597	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	23,160	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)	1,140,437	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	0	16.50
16.55	Rural community hospital demonstration project (§410A Demonstration) payment adjustment (see instructions)	0		16.55
16.99	Demonstration payment adjustment amount before sequestration	0	0	16.99
17.00	Allowable bad debts (see instructions)	0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (see instructions)	1,140,437	0	19.00
19.01	Sequestration adjustment (see instructions)	22,809	0	19.01
19.02	Demonstration payment adjustment amount after sequestration)	0	0	19.02
20.00	Interim payments	1,084,099	0	20.00
21.00	Tentative settlement (for contractor use only)	0	0	21.00
22.00	Balance due provider/program (line 19 minus lines 19.01, 20, and 21)	33,529	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	23.00
	Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment			
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
	Cost Reimbursement			
201.00	Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital))			201.00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))			202.00
203.00	Total (sum of lines 201 and 202)			203.00
204.00	Medicare swing-bed SNF discharges (see instructions)			204.00
	Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)			
205.00	Medicare swing-bed SNF target amount			205.00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)			206.00
	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement			
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)			208.00
209.00	Adjustment to Medicare swing-bed SNF PPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
	Comparision of PPS versus Cost Reimbursement			
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see instructions)			215.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1319	Period: From 10/01/2016 To 09/30/2017	Worksheet E-3 Part V Date/Time Prepared: 2/26/2018 1:23 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	1,513,754	1.00
2.00	Nursing and Allied Health Managed Care payment (see instructions)	0	2.00
3.00	Organ acquisition	0	3.00
4.00	Subtotal (sum of lines 1 through 3)	1,513,754	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	1,528,892	6.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
7.00	Routine service charges	0	7.00
8.00	Ancillary service charges	0	8.00
9.00	Organ acquisition charges, net of revenue	0	9.00
10.00	Total reasonable charges	0	10.00
	Customary charges		
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)	0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)	0.000000	13.00
14.00	Total customary charges (see instructions)	0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)	0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)	0	16.00
17.00	Cost of physicians' services in a teaching hospital (see instructions)	0	17.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)	0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)	1,528,892	19.00
20.00	Deductibles (exclude professional component)	213,317	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	1,315,575	22.00
23.00	Coinsurance	0	23.00
24.00	Subtotal (line 22 minus line 23)	1,315,575	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	35,344	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	22,974	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	32,956	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	1,338,549	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	29.50
29.99	Demonstration payment adjustment amount before sequestration	0	29.99
30.00	Subtotal (see instructions)	1,338,549	30.00
30.01	Sequestration adjustment (see instructions)	26,771	30.01
30.02	Demonstration payment adjustment amount after sequestration	0	30.02
31.00	Interim payments	1,641,200	31.00
32.00	Tentative settlement (for contractor use only)	0	32.00
33.00	Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32)	-329,422	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-1319 | Period: From 10/01/2016 To 09/30/2017 | Worksheet E-3 Part VII | Date/Time Prepared: 2/26/2018 1:23 pm

Title XIX | Hospital | Cost

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	21,951		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)	21,951	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)	21,951	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	8,960		8.00
9.00	Ancillary service charges	26,121	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)	35,081	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)	35,081	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	13,130	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)	21,951	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)	21,951	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)	21,951	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)	21,951	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	21,951	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)	21,951	0	40.00
41.00	Interim payments	16,721	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	5,230	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: 15-1319 | Period: From 10/01/2016 To 09/30/2017 | Worksheet G | Date/Time Prepared: 2/26/2018 1:23 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	3,867,933	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	5,902,512	0	0	0	4.00
5.00	Other receivable	47,108	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-2,007,488	0	0	0	6.00
7.00	Inventory	783,371	0	0	0	7.00
8.00	Prepaid expenses	248,364	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	8,841,800	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	421,244	0	0	0	12.00
13.00	Land improvements	263,558	0	0	0	13.00
14.00	Accumulated depreciation	-177,588	0	0	0	14.00
15.00	Buildings	20,009,769	0	0	0	15.00
16.00	Accumulated depreciation	-11,790,238	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	3,951,644	0	0	0	19.00
20.00	Accumulated depreciation	-3,344,569	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	9,735,971	0	0	0	23.00
24.00	Accumulated depreciation	-8,909,610	0	0	0	24.00
25.00	Minor equipment depreciable	683,944	0	0	0	25.00
26.00	Accumulated depreciation	-555,477	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)	10,288,648	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	3,163,902	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	0	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	3,163,902	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	22,294,350	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	612,017	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,636,650	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	124,283	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	757,746	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	3,130,696	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	7,822,014	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	7,822,014	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	10,952,710	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	11,341,640				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)	11,341,640	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	22,294,350	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-1319 | Period: From 10/01/2016 To 09/30/2017 | Worksheet G-1 | Date/Time Prepared: 2/26/2018 1:23 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		9,628,432		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		1,713,208				2.00
3.00	Total (sum of line 1 and line 2)		11,341,640		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)		11,341,640		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)		11,341,640		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: 15-1319 | Period: From 10/01/2016 To 09/30/2017 | Worksheet G-2 Parts I & II Date/Time Prepared: 2/26/2018 1:23 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	1,815,226		1,815,226	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY	0		0	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)	1,815,226		1,815,226	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	60,812		60,812	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)	60,812		60,812	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	1,876,038		1,876,038	17.00
18.00	Ancillary services	4,328,411	34,441,508	38,769,919	18.00
19.00	Outpatient services	132,985	8,824,053	8,957,038	19.00
20.00	RURAL HEALTH CLINIC	0	15,326	15,326	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		585,171	585,171	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				26.00
27.00	MOB	0	6,073,192	6,073,192	27.00
27.01	SNF PERRY CO	1,733,953	0	1,733,953	27.01
27.02	PRO FEES	0	1,521,890	1,521,890	27.02
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	8,071,387	51,461,140	59,532,527	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		28,623,539		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)		28,623,539		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 15-1319 | Period: From 10/01/2016 To 09/30/2017 | Worksheet G-3 | Date/Time Prepared: 2/26/2018 1:23 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	59,532,527	1.00
2.00	Less contractual allowances and discounts on patients' accounts	29,575,145	2.00
3.00	Net patient revenues (line 1 minus line 2)	29,957,382	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	28,623,539	4.00
5.00	Net income from service to patients (line 3 minus line 4)	1,333,843	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	223,700	6.00
7.00	Income from investments	14,946	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	137,150	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	59,192	22.00
23.00	Governmental appropriations	0	23.00
24.00	MISCELLANEOUS INCOME	64,484	24.00
25.00	Total other income (sum of lines 6-24)	499,472	25.00
26.00	Total (line 5 plus line 25)	1,833,315	26.00
27.00	OTHER EXPENSE	120,107	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	120,107	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	1,713,208	29.00

ANALYSIS OF HOSPITAL-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 15-1319 | HHA CCN: 15-7445 | Period: From 10/01/2016 To 09/30/2017 | Worksheet H | Date/Time Prepared: 2/26/2018 1:23 pm

Home Health Agency I | PPS

		Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased Services	Other Costs	Total (sum of cols. 1 thru 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures			0		0	0	1.00
2.00	Capital Related - Movable Equipment			0		0	0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0	0	0	3.00
4.00	Transportation	0	0	0	0	0	0	4.00
5.00	Administrative and General	69,562	17,496	29,130	0	36,718	152,906	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	165,737	41,687	0	0	0	207,424	6.00
7.00	Physical Therapy	28,026	7,049	0	0	0	35,075	7.00
8.00	Occupational Therapy	6,087	1,531	0	0	0	7,618	8.00
9.00	Speech Pathology	1,496	376	0	0	0	1,872	9.00
10.00	Medical Social Services	0	0	0	0	0	0	10.00
11.00	Home Health Aide	26,977	6,785	0	0	0	33,762	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0	308	308	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)	297,885	74,924	29,130	0	37,026	438,965	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	-7,419	145,487	0	145,487			5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	207,424	0	207,424			6.00
7.00	Physical Therapy	0	35,075	0	35,075			7.00
8.00	Occupational Therapy	0	7,618	0	7,618			8.00
9.00	Speech Pathology	0	1,872	0	1,872			9.00
10.00	Medical Social Services	0	0	0	0			10.00
11.00	Home Health Aide	0	33,762	0	33,762			11.00
12.00	Supplies (see instructions)	0	0	0	0			12.00
13.00	Drugs	-308	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)	-7,727	431,238	0	431,238			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: 15-1319 | HHA CCN: 15-7445 | Period: From 10/01/2016 To 09/30/2017 | Worksheet H-1 Part I | Date/Time Prepared: 2/26/2018 1:23 pm

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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	145,487	0	0	0	0	145,487	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	207,424	0	0	0	0	207,424	6.00
7.00	Physical Therapy	35,075	0	0	0	0	35,075	7.00
8.00	Occupational Therapy	7,618	0	0	0	0	7,618	8.00
9.00	Speech Pathology	1,872	0	0	0	0	1,872	9.00
10.00	Medical Social Services	0	0	0	0	0	0	10.00
11.00	Home Health Aide	33,762	0	0	0	0	33,762	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)	431,238	0	0	0	0	431,238	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	145,487			5.00
	HHA REIMBURSABLE SERVICES				
6.00	Skilled Nursing Care	105,607	313,031		6.00
7.00	Physical Therapy	17,858	52,933		7.00
8.00	Occupational Therapy	3,879	11,497		8.00
9.00	Speech Pathology	953	2,825		9.00
10.00	Medical Social Services	0	0		10.00
11.00	Home Health Aide	17,190	50,952		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)		431,238		24.00

COST ALLOCATION - HHA STATISTICAL BASIS | Provider CCN: 15-1319 | HHA CCN: 15-7445 | Period: From 10/01/2016 To 09/30/2017 | Worksheet H-1 Part II | Date/Time Prepared: 2/26/2018 1:23 pm

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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	-145,487	285,751	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	0	207,424	6.00
7.00	Physical Therapy	0	0	0	0	0	35,075	7.00
8.00	Occupational Therapy	0	0	0	0	0	7,618	8.00
9.00	Speech Pathology	0	0	0	0	0	1,872	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	33,762	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	-145,487	285,751	24.00
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0	0		145,487	25.00
26.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000		0.509139	26.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 15-1319 HHA CCN: 15-7445

Period: From 10/01/2016 To 09/30/2017

Worksheet H-2 Part I Date/Time Prepared: 2/26/2018 1:23 pm

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	Cost Center Description	HHA Trial Balance (1)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	
		0	1.00	2.00	4.00	4A	5.00	
1.00	Administrative and General	0	9,555	0	38,156	47,711	13,964	1.00
2.00	Skilled Nursing Care	313,031	0	0	0	313,031	91,618	2.00
3.00	Physical Therapy	52,933	0	0	0	52,933	15,493	3.00
4.00	Occupational Therapy	11,497	0	0	0	11,497	3,365	4.00
5.00	Speech Pathology	2,825	0	0	0	2,825	827	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	50,952	0	0	0	50,952	14,913	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)	431,238	9,555	0	38,156	478,949	140,180	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	13,245	0	4,586	0	16,234	19,231	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)	13,245	0	4,586	0	16,234	19,231	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: 15-1319 HHA CCN: 15-7445

Period: From 10/01/2016 To 09/30/2017

Worksheet H-2 Part I Date/Time Prepared: 2/26/2018 1:23 pm

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	Cost Center Description	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	Allocated HHA A&G (see Part II)	Total HHA Costs	
		16.00	24.00	25.00	26.00	27.00	28.00	
1.00	Administrative and General	7,029	122,000	0	122,000			1.00
2.00	Skilled Nursing Care	0	404,649	0	404,649	88,558	493,207	2.00
3.00	Physical Therapy	0	68,426	0	68,426	14,975	83,401	3.00
4.00	Occupational Therapy	0	14,862	0	14,862	3,253	18,115	4.00
5.00	Speech Pathology	0	3,652	0	3,652	799	4,451	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	65,865	0	65,865	14,415	80,280	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)	7,029	679,454	0	679,454	122,000	679,454	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.					0.218852		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: 15-1319
HHA CCN: 15-7445

Period: From 10/01/2016 To 09/30/2017

Worksheet H-2 Part II
Date/Time Prepared: 2/26/2018 1:23 pm

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	Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
		1.00	2.00	4.00	5A	5.00	7.00	
1.00	Administrative and General	505	505	297,885	0	47,711	505	1.00
2.00	Skilled Nursing Care	0	0	0	0	313,031	0	2.00
3.00	Physical Therapy	0	0	0	0	52,933	0	3.00
4.00	Occupational Therapy	0	0	0	0	11,497	0	4.00
5.00	Speech Pathology	0	0	0	0	2,825	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	50,952	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)	505	505	297,885		478,949	505	20.00
21.00	Total cost to be allocated	9,555	0	38,156		140,180	13,245	21.00
22.00	Unit cost multiplier	18.920792	0.000000	0.128090		0.292683	26.227723	22.00

	Cost Center Description	LAUNDRY & LINEN SERVICE (PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (PATIENT DAYS)	CAFETERIA (GROSS SALARIES)	NURSING ADMINISTRATION (NURSE SALARIES)	MEDICAL RECORDS & LIBRARY (GROSS PATIENT REVENUE)	
		8.00	9.00	10.00	11.00	13.00	16.00	
1.00	Administrative and General	0	505	0	297,885	186,939	585,171	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	505	0	297,885	186,939	585,171	20.00
21.00	Total cost to be allocated	0	4,586	0	16,234	19,231	7,029	21.00
22.00	Unit cost multiplier	0.000000	9.081188	0.000000	0.054498	0.102873	0.012012	22.00

APPORTIONMENT OF PATIENT SERVICE COSTS | Provider CCN: 15-1319 | HHA CCN: 15-7445 | Period: From 10/01/2016 To 09/30/2017 | Worksheet H-3 Part I | Date/Time Prepared: 2/26/2018 1:23 pm

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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	493,207		493,207	1,930	255.55	1.00
2.00	Physical Therapy	3.00	83,401	0	83,401	1,105	75.48	2.00
3.00	Occupational Therapy	4.00	18,115	0	18,115	240	75.48	3.00
4.00	Speech Pathology	5.00	4,451	0	4,451	59	75.44	4.00
5.00	Medical Social Services	6.00	0		0	15	0.00	5.00
6.00	Home Health Aide	7.00	80,280		80,280	396	202.73	6.00
7.00	Total (sum of lines 1-6)		679,454	0	679,454	3,745		7.00

	Cost Center Description	Cost Limits	CBSA No. (1)	Program Visits: Part A	Program Visits: Part B Not Subject to Deductibles & Coinsurance	Program Visits: Part B Subject to Deductibles		
		0	1.00	2.00	3.00	4.00	5.00	
	Limitation Cost Computation							
8.00	Skilled Nursing Care		99915	0	1,170			8.00
9.00	Physical Therapy		99915	0	725			9.00
10.00	Occupational Therapy		99915	0	101			10.00
11.00	Speech Pathology		99915	0	27			11.00
12.00	Medical Social Services		99915	0	0			12.00
13.00	Home Health Aide		99915	0	287			13.00
14.00	Total (sum of lines 8-13)			0	2,310			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	1,170		0	298,994		1.00
2.00	Physical Therapy	0	725		0	54,723		2.00
3.00	Occupational Therapy	0	101		0	7,623		3.00
4.00	Speech Pathology	0	27		0	2,037		4.00
5.00	Medical Social Services	0	0		0	0		5.00
6.00	Home Health Aide	0	287		0	58,184		6.00
7.00	Total (sum of lines 1-6)	0	2,310		0	421,561		7.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 15-1319 HHA CCN: 15-7445 | Period: From 10/01/2016 To 09/30/2017 | Worksheet H-3 Part I Date/Time Prepared: 2/26/2018 1:23 pm

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

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

	Cost Center Description	Total Program Cost (sum of cols. 9-10)		
		12.00		
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION			
	Cost Per Visit Computation			
1.00	Skilled Nursing Care	298,994		1.00
2.00	Physical Therapy	54,723		2.00
3.00	Occupational Therapy	7,623		3.00
4.00	Speech Pathology	2,037		4.00
5.00	Medical Social Services	0		5.00
6.00	Home Health Aide	58,184		6.00
7.00	Total (sum of lines 1-6)	421,561		7.00

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

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 15-1319 | HHA CCN: 15-7445 | Period: From 10/01/2016 To 09/30/2017 | Worksheet H-3 Part II | Date/Time Prepared: 2/26/2018 1:23 pm

Title XVIII | Home Health Agency I | PPS

	Cost Center Description	From Wkst. C, Part I, col. 9, line	Cost to Charge Ratio	Total HHA Charge (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)	Transfer to Part I as Indicated		
		0	1.00	2.00	3.00	4.00		
	PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS							
1.00	Physical Therapy	66.00	0.323569	0	0	col. 2, line 2.00		1.00
2.00	Occupational Therapy	67.00	0.292047	0	0	col. 2, line 3.00		2.00
3.00	Speech Pathology	68.00	0.342278	0	0	col. 2, line 4.00		3.00
4.00	Cost of Medical Supplies	71.00	1.048870	0	0	col. 2, line 15.00		4.00
5.00	Cost of Drugs	73.00	0.557388	0	0	col. 2, line 16.00		5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT | Provider CCN: 15-1319 HHA CCN: 15-7445 | Period: From 10/01/2016 To 09/30/2017 | Worksheet H-4 Part I-II Date/Time Prepared: 2/26/2018 1:23 pm

Title XVIII | Home Health Agency I | PPS

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

		Part A Services	Part B Services	
		1.00	2.00	
	PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT			
10.00	Total reasonable cost (see instructions)	0	0	10.00
11.00	Total PPS Reimbursement - Full Episodes without Outliers	0	281,850	11.00
12.00	Total PPS Reimbursement - Full Episodes with Outliers	0	6,467	12.00
13.00	Total PPS Reimbursement - LUPA Episodes	0	7,240	13.00
14.00	Total PPS Reimbursement - PEP Episodes	0	2,029	14.00
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers	0	2,070	15.00
16.00	Total PPS Outlier Reimbursement - PEP Episodes	0	953	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	300,609	22.00
23.00	Excess reasonable cost (from line 8)	0	0	23.00
24.00	Subtotal (line 22 minus line 23)	0	300,609	24.00
25.00	Coinsurance billed to program patients (from your records)		875	25.00
26.00	Net cost (line 24 minus line 25)	0	299,734	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	299,734	29.00
30.00	OTHER ADJUSTMENT	0	0	30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	0	30.50
30.99	Demonstration payment adjustment amount before sequestration	0	0	30.99
31.00	Subtotal (see instructions)	0	299,734	31.00
31.01	Sequestration adjustment (see instructions)	0	5,995	31.01
31.02	Demonstration payment adjustment amount after sequestration	0	0	31.02
32.00	Interim payments (see instructions)	0	293,739	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: 15-1319 HHA CCN: 15-7445 | Period: From 10/01/2016 To 09/30/2017 | Worksheet H-5 Date/Time Prepared: 2/26/2018 1:23 pm

Home Health Agency I | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		0		293,739	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		293,739	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01			0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50			0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		0		293,739	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 RHC/FQHC COSTS

Provider CCN: 15-1319
Component CCN: 15-8524

Period: From 10/01/2016 To 09/30/2017

Worksheet M-1
Date/Time Prepared: 2/26/2018 1:23 pm

RHC I | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	0	0	0	-2,621	-2,621	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	0	0	0	4,911	4,911	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	0	0	0	2,370	2,370	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	0	0	0	4,660	4,660	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	0	0	0	0	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	0	0	0	0	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	0	0	4,660	4,660	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	0	0	356	356	29.00
30.00	Administrative Costs	0	0	0	7,138	7,138	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	0	0	7,494	7,494	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	0	0	12,154	12,154	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1319 | Component CCN: 15-8524 | Period: From 10/01/2016 To 09/30/2017 | Worksheet M-1 | Date/Time Prepared: 2/26/2018 1:23 pm

RHC I | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	-2,621		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	4,911		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	2,370		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	0		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	4,660		10.00
11.00	Physician Services Under Agreement	0	0		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	0		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0		14.00
15.00	Medical Supplies	0	0		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	0		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	4,660		22.00
	COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
25.01	Telehealth	0	0		25.01
25.02	Chronic Care Management	0	0		25.02
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs				27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	356		29.00
30.00	Administrative Costs	0	7,138		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	7,494		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	12,154		32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES | Provider CCN: 15-1319 | Component CCN: 15-8524 | Period: From 10/01/2016 To 09/30/2017 | Worksheet M-2 | Date/Time Prepared: 2/26/2018 1:23 pm

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	RHC I Minimum Visits (col. 1 x col. 3)	Cost Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	0.00	0	4,200	0		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	0.05	34	2,100	105		3.00
4.00	Subtotal (sum of lines 1 through 3)	0.05	34		105	105	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	0.05	34			105	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)					4,660	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)					4,660	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)					7,494	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					4,854	15.00
16.00	Total overhead (sum of lines 14 and 15)					12,348	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					12,348	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					12,348	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					17,008	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 15-1319 Component CCN: 15-8524	Period: From 10/01/2016 To 09/30/2017	Worksheet M-3 Date/Time Prepared: 2/26/2018 1:23 pm
	Title XVIII	RHC I	Cost

				1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES				
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			17,008	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			0	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			17,008	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			105	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)			105	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			161.98	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)	161.98	161.98		9.00
	CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	0	0		10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	0		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	0		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.)		0		16.04
16.05	Total program cost (see instructions)	0	0		16.05
17.00	Primary payer amounts		0		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		0		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		0		19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		0		20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		0		21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		0		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)		0		26.00
26.01	Sequestration adjustment (see instructions)		0		26.01
26.02	Demonstration payment adjustment amount after sequestration		0		26.02
27.00	Interim payments		0		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)		0		29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0		30.00