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: 15-1315	Period: From 10/01/2017 To 09/30/2018	Worksheet S Parts I-III Date/Time Prepared: 2/21/2019 3:49 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 2/21/2019 Time: 3:49 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 CAMERON MEMORIAL COMMUNITY HOSPITAL (15-1315) for the cost reporting period beginning 10/01/2017 and ending 09/30/2018 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	68,595	-647,133	0	-87,239	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	-23,057	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
10.00	RURAL HEALTH CLINIC I	0		7,484		0	10.00
11.00	FEDERALLY QUALIFIED HEALTH CENTER I	0		0		0	11.00
200.00	Total	0	45,538	-639,649	0	-87,239	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1315 | Period: From 10/01/2017 To 09/30/2018 | Worksheet S-2 Part I Date/Time Prepared: 2/21/2019 3:49 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 416 E MAUMEE STREET	PO Box:			1.00
2.00	City: ANGOLA	State: IN	Zip Code: 47803-	County: STEUBEN	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	CAMERON MEMORIAL COMMUNITY HOSPITAL	151315	99915	1	02/01/2003	N	O	P	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	CAMERON MEMORIAL COMMUNITY	15Z315	99915		02/01/2003	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	CAMERON HOME HEALTH CARE	157117	99915		04/01/1984	N	P	N	12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice	CAMERON HOSPICE	151561	99915		05/01/1997				14.00
15.00	Hospital-Based Health Clinic - RHC	CAMERON FAMILY MEDICINE	158530	99915		12/31/2016	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)	10/01/2017	09/30/2018	20.00
21.00	Type of Control (see instructions)	2		21.00

		1.00	2.00	3.00	
	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	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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1315 | Period: From 10/01/2017 To 09/30/2018 | Worksheet S-2 Part I | Date/Time Prepared: 2/21/2019 3:49 pm

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
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

		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)			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), (ii), or (iii)? 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), (ii), or (iii)? 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.	N			58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1315 | Period: From 10/01/2017 To 09/30/2018 | Worksheet S-2 Part I Date/Time Prepared: 2/21/2019 3:49 pm

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1315 | Period: From 10/01/2017 To 09/30/2018 | Worksheet S-2 Part I Date/Time Prepared: 2/21/2019 3:49 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
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0	76.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1315 | Period: From 10/01/2017 To 09/30/2018 | Worksheet S-2 Part I Date/Time Prepared: 2/21/2019 3:49 pm

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1315 | Period: From 10/01/2017 To 09/30/2018 | Worksheet S-2 Part I | Date/Time Prepared: 2/21/2019 3:49 pm

		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:	204,776	0	0	118.01

		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N		122.00
	Transplant Center Information			
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y		140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1315 | Period: From 10/01/2017 To 09/30/2018 | Worksheet S-2 Part I | Date/Time Prepared: 2/21/2019 3:49 pm

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

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

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

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

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

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

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

		1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act		
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.	Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)	0	168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)	N	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)	10/01/2017	09/30/2018	170.00

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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-1315 | Period: From 10/01/2017 To 09/30/2018 | Worksheet S-2 Part II | Date/Time Prepared: 2/21/2019 3:49 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)	Y			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	12/17/2018	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	12/04/2018	Y	12/04/2018	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: 15-1315 | Period: From 10/01/2017 To 09/30/2018 | Worksheet S-2 Part II | Date/Time Prepared: 2/21/2019 3:49 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	Y	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.	N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.	N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.	N	27.00
	Interest Expense		
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.	Y	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions	Y	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.	Y	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.	Y	33.00
	Provider-Based Physicians		
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.	Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.	Y	35.00

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

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	KYLE	SMITH	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.	317-713-7957	KCSMITH@BLUEANDCO.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-1315	Period: From 10/01/2017 To 09/30/2018	Worksheet S-2 Part II Date/Time Prepared: 2/21/2019 3:49 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 MANAGER		41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-1315 | Period: From 10/01/2017 To 09/30/2018 | Worksheet S-3 Part I Date/Time Prepared: 2/21/2019 3:49 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	23	8,395	83,592.00	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)		23	8,395	83,592.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	2	730	3,192.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		25	9,125	86,784.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	101.00				0	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	116.00	0	0			24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	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: 15-1315 | Period: From 10/01/2017 To 09/30/2018 | Worksheet S-3 Part I | Date/Time Prepared: 2/21/2019 3:49 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)	1,297	31	3,483			1.00
2.00	HMO and other (see instructions)	442	309				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	263	0	263			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	192			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,560	31	3,938			7.00
8.00	INTENSIVE CARE UNIT	51	23	133			8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY		0	469			13.00
14.00	Total (see instructions)	1,611	54	4,540	0.00	375.12	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						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	753	654	5,668	0.00	8.93	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	0	0	0	0.00	2.34	24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	45	76	8,129	0.00	9.00	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	395.39	27.00
28.00	Observation Bed Days		159	1,186			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	5	15			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: 15-1315 | Period: From 10/01/2017 To 09/30/2018 | Worksheet S-3 Part I | Date/Time Prepared: 2/21/2019 3:49 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	507	13	1,392	1.00
2.00	HMO and other (see instructions)			143	116		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	507	13	1,392	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0.00					22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	0.00					24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	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: 15-1315
Component CCN: 15-7117
Period: From 10/01/2017 To 09/30/2018
Worksheet S-4
Date/Time Prepared: 2/21/2019 3:49 pm

Home Health Agency I | PPS

		1.00	
0.00	County	STEUBEN	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	57.00	0.00	0.00	0.00	2.00

		Enter the number of hours in your normal work week	Number of Employees (Full Time Equivalent)			
			Staff	Contract	Total	
		0	1.00	2.00	3.00	
	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES					
3.00	Administrator and Assistant Administrator(s)	40.00	0.02	0.00	0.02	3.00
4.00	Director(s) and Assistant Director(s)		0.90	0.00	0.90	4.00
5.00	Other Administrative Personnel		0.00	0.00	0.00	5.00
6.00	Direct Nursing Service		3.13	0.00	3.13	6.00
7.00	Nursing Supervisor		0.00	0.00	0.00	7.00
8.00	Physical Therapy Service		2.08	0.00	2.08	8.00
9.00	Physical Therapy Supervisor		0.00	0.00	0.00	9.00
10.00	Occupational Therapy Service		0.43	0.00	0.43	10.00
11.00	Occupational Therapy Supervisor		0.00	0.00	0.00	11.00
12.00	Speech Pathology Service		0.04	0.00	0.04	12.00
13.00	Speech Pathology Supervisor		0.00	0.00	0.00	13.00
14.00	Medical Social Service		0.43	0.00	0.43	14.00
15.00	Medical Social Service Supervisor		0.00	0.00	0.00	15.00
16.00	Home Health Aide		1.35	0.00	1.35	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	242	0	29	5	276	21.00
22.00	Skilled Nursing Visit Charges	43,351	0	5,054	972	49,377	22.00
23.00	Physical Therapy Visits	352	0	9	0	361	23.00
24.00	Physical Therapy Visit Charges	72,262	0	1,848	0	74,110	24.00
25.00	Occupational Therapy Visits	47	0	0	0	47	25.00
26.00	Occupational Therapy Visit Charges	9,333	0	0	0	9,333	26.00
27.00	Speech Pathology Visits	10	0	0	0	10	27.00
28.00	Speech Pathology Visit Charges	1,986	0	0	0	1,986	28.00
29.00	Medical Social Service Visits	3	0	0	0	3	29.00
30.00	Medical Social Service Visit Charges	740	0	0	0	740	30.00
31.00	Home Health Aide Visits	56	0	0	0	56	31.00
32.00	Home Health Aide Visit Charges	2,943	0	0	0	2,943	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	710	0	38	5	753	33.00
34.00	Other Charges	0	0	0	333	333	34.00
35.00	Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)	130,615	0	6,902	1,305	138,822	35.00
36.00	Total Number of Episodes (standard/non outlier)	49		11	1	61	36.00
37.00	Total Number of Outlier Episodes		0		0	0	37.00
38.00	Total Non-Routine Medical Supply Charges	2,732	0	630	0	3,362	38.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 15-1315 | Component CCN: 15-8530 | Period: From 10/01/2017 To 09/30/2018 | Worksheet S-8 | Date/Time Prepared: 2/21/2019 3:49 pm

RHC I | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			1500 W MAUMEE STREET		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	ANGOLOA		IN	46703	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		STEUBEN				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: 15-1315
Component CCN: 15-8530

Period:
From 10/01/2017
To 09/30/2018

Worksheet S-8
Date/Time Prepared:
2/21/2019 3:49 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	12:00				11.00

HOSPITAL-BASED HOSPICE IDENTIFICATION DATA

Provider CCN: 15-1315
Hospice CCN: 15-1561

Period:
From 10/01/2017
To 09/30/2018

Worksheet S-9
PARTS I THROUGH IV
Date/Time Prepared:
2/21/2019 3:49 pm

Hospice I

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

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

		Title XVIII	Title XIX	Other	Total (sum of cols. 1 through 3)	
		1.00	2.00	3.00	4.00	
	PART III - ENROLLMENT DAYS FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2015					
10.00	Hospice Continuous Home Care	0	0	0	0	10.00
11.00	Hospice Routine Home Care	244	180	1,828	2,252	11.00
12.00	Hospice Inpatient Respite Care	3	0	7	10	12.00
13.00	Hospice General Inpatient Care	0	0	460	460	13.00
14.00	Total Hospice Days	247	180	2,295	2,722	14.00
	PART IV - CONTRACTED STATISTICAL DATA FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2015					
15.00	Hospice Inpatient Respite Care	0	0	7	7	15.00
16.00	Hospice General Inpatient Care	0	0	450	450	16.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 15-1315 | Period: From 10/01/2017 To 09/30/2018 | Worksheet S-10 | Date/Time Prepared: 2/21/2019 3:49 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)	0.388427	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	3,834,398	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	15,030,416	6.00
7.00	Medicaid cost (line 1 times line 6)	5,838,219	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)	2,003,821	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)	2,003,821	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)	659,639	20,919	680,558	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	256,222	20,919	277,141	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)	256,222	20,919	277,141	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)	6,689,796	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	593,773	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	913,498	27.01
28.00	Non-Medicare bad debt expense (see instructions)	5,776,298	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	2,563,395	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	2,840,536	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	4,844,357	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1315 | Period: From 10/01/2017 To 09/30/2018 | Worksheet A | Date/Time Prepared: 2/21/2019 3:49 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		6,113,848	6,113,848	-591,761	5,522,087	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		1,866,085	1,866,085	2,293,298	4,159,383	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	7,506,709	7,506,709	0	7,506,709	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	3,779,940	7,223,243	11,003,183	340,487	11,343,670	5.00
7.00	00700	OPERATION OF PLANT	813,455	1,868,167	2,681,622	0	2,681,622	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	33,998	33,998	0	33,998	8.00
9.00	00900	HOUSEKEEPING	667,297	413,487	1,080,784	0	1,080,784	9.00
10.00	01000	DIETARY	390,702	344,631	735,333	-539,736	195,597	10.00
11.00	01100	CAFETERIA	0	0	0	508,188	508,188	11.00
13.00	01300	NURSING ADMINISTRATION	608,952	41,753	650,705	0	650,705	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	174,675	82,909	257,584	0	257,584	14.00
15.00	01500	PHARMACY	484,517	2,484,602	2,969,119	0	2,969,119	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	468,552	188,574	657,126	0	657,126	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,064,714	1,431,571	3,496,285	510,184	4,006,469	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	114,224	114,224	31.00
43.00	04300	NURSERY	0	0	0	43,962	43,962	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,467,922	1,116,876	2,584,798	-619,174	1,965,624	50.00
51.00	05100	RECOVERY ROOM	0	0	0	619,174	619,174	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	910,586	78,969	989,555	-672,605	316,950	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,625,686	926,328	2,552,014	0	2,552,014	54.00
60.00	06000	LABORATORY	990,893	1,743,254	2,734,147	0	2,734,147	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	44,353	919,578	963,931	-176,189	787,742	65.00
65.01	06501	SLEEP LAB	0	0	0	203,614	203,614	65.01
66.00	06600	PHYSICAL THERAPY	895,896	20,747	916,643	0	916,643	66.00
69.00	06900	ELECTROCARDIOLOGY	0	380,815	380,815	-27,425	353,390	69.00
69.01	06901	CARDIAC REHAB	75,848	9,070	84,918	0	84,918	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	1,799,231	1,799,231	-998,267	800,964	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	998,267	998,267	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	CHEMICAL DEPENDENCY	112,033	113,710	225,743	0	225,743	76.00
76.01	03480	ONCOLOGY	0	1,464,011	1,464,011	0	1,464,011	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	783,146	42,471	825,617	0	825,617	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	141,360	32,584	173,944	0	173,944	90.00
90.01	09001	CLINIC- MCDONALD	481,689	1,031,810	1,513,499	0	1,513,499	90.01
91.00	09100	EMERGENCY	1,864,778	283,093	2,147,871	4,235	2,152,106	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	745,307	89,233	834,540	-156,714	677,826	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		1,633,342	1,633,342	-1,633,342	0	113.00
114.00	11400	UTILIZATION REVIEW-SNF	0	0	0	0	0	114.00
116.00	11600	HOSPICE	82,180	27,718	109,898	55,190	165,088	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	19,674,481	41,312,417	60,986,898	275,610	61,262,508	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	DAYCARE-INFANT/TODDLER	0	0	0	0	0	194.00
194.01	07951	MOB	0	0	0	0	0	194.01
194.02	07952	COMMUNITY HEALTH	95,303	7,015	102,318	0	102,318	194.02
194.03	07953	ASSISTED LIVING/CAMERON WOODS	0	0	0	0	0	194.03
194.04	07954	EDUCATION	24,435	95,571	120,006	-70,174	49,832	194.04
194.05	07955	MARKETING	122,363	471,062	593,425	-64,804	528,621	194.05
194.06	07956	GUEST MEALS	0	0	0	31,548	31,548	194.06
194.07	07957	OUTSIDE LAUNDRY	0	0	0	0	0	194.07
194.08	07958	CANCER CENTER	0	0	0	0	0	194.08
194.09	07959	URGENT CARE	1,461,043	181,929	1,642,972	-185,518	1,457,454	194.09
194.10	07960	RHC	0	0	0	0	0	194.10
194.11	07961	OBGYN	896,774	119,075	1,015,849	0	1,015,849	194.11
194.12	07962	TRINE STUDENT HEALTH	79,332	1,279	80,611	0	80,611	194.12
194.13	07963	OCCUPATIONAL HEALTH	220,630	148,037	368,667	0	368,667	194.13
194.14	07964	IMMUNIZATION CLINIC	59,442	1,151	60,593	0	60,593	194.14
194.15	07965	FOUNDATION	54,255	225	54,480	13,338	67,818	194.15
200.00		TOTAL (SUM OF LINES 118 through 199)	22,688,058	42,337,761	65,025,819	0	65,025,819	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1315 | Period: From 10/01/2017 To 09/30/2018 | Worksheet A | Date/Time Prepared: 2/21/2019 3:49 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	-878,373	4,643,714		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-170,156	3,989,227		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-474,091	7,032,618		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-1,971,062	9,372,608		5.00
7.00	00700	OPERATION OF PLANT	-3,300	2,678,322		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	33,998		8.00
9.00	00900	HOUSEKEEPING	0	1,080,784		9.00
10.00	01000	DIETARY	-12,250	183,347		10.00
11.00	01100	CAFETERIA	-255,757	252,431		11.00
13.00	01300	NURSING ADMINISTRATION	0	650,705		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	257,584		14.00
15.00	01500	PHARMACY	-60,897	2,908,222		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-283	656,843		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-1,139,301	2,867,168		30.00
31.00	03100	INTENSIVE CARE UNIT	0	114,224		31.00
43.00	04300	NURSERY	0	43,962		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-556,838	1,408,786		50.00
51.00	05100	RECOVERY ROOM	0	619,174		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	316,950		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,552,014		54.00
60.00	06000	LABORATORY	-7,312	2,726,835		60.00
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	787,742		65.00
65.01	06501	SLEEP LAB	0	203,614		65.01
66.00	06600	PHYSICAL THERAPY	-215	916,428		66.00
69.00	06900	ELECTROCARDIOLOGY	0	353,390		69.00
69.01	06901	CARDIAC REHAB	0	84,918		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	800,964		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	998,267		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
76.00	03020	CHEMICAL DEPENDENCY	0	225,743		76.00
76.01	03480	ONCOLOGY	0	1,464,011		76.01
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	825,617		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0		89.00
90.00	09000	CLINIC	0	173,944		90.00
90.01	09001	CLINIC- MCDONALD	-1,235,391	278,108		90.01
91.00	09100	EMERGENCY	0	2,152,106		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
		OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY	0	677,826		101.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
114.00	11400	UTILIZATION REVIEW-SNF	0	0		114.00
116.00	11600	HOSPICE	0	165,088		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-6,765,226	54,497,282		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
194.00	07950	DAYCARE-INFANT/TODDLER	0	0		194.00
194.01	07951	MOB	0	0		194.01
194.02	07952	COMMUNITY HEALTH	0	102,318		194.02
194.03	07953	ASSISTED LIVING/CAMERON WOODS	0	0		194.03
194.04	07954	EDUCATION	0	49,832		194.04
194.05	07955	MARKETING	0	528,621		194.05
194.06	07956	GUEST MEALS	0	31,548		194.06
194.07	07957	OUTSIDE LAUNDRY	0	0		194.07
194.08	07958	CANCER CENTER	0	0		194.08
194.09	07959	URGENT CARE	0	1,457,454		194.09
194.10	07960	RHC	0	0		194.10
194.11	07961	OBGYN	0	1,015,849		194.11
194.12	07962	TRINE STUDENT HEALTH	0	80,611		194.12
194.13	07963	OCCUPATIONAL HEALTH	0	368,667		194.13
194.14	07964	IMMUNIZATION CLINIC	0	60,593		194.14
194.15	07965	FOUNDATION	0	67,818		194.15
200.00		TOTAL (SUM OF LINES 118 through 199)	-6,765,226	58,260,593		200.00

RECLASSIFICATIONS | Provider CCN: 15-1315 | Period: From 10/01/2017 To 09/30/2018 | Worksheet A-6 | Date/Time Prepared: 2/21/2019 3:49 pm

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - LABOR AND DELIVERY				
1.00	ADULTS & PEDIATRICS	30.00	574,579	49,829	1.00
2.00	NURSERY	43.00	40,454	3,508	2.00
3.00	EMERGENCY	91.00	3,897	338	3.00
	0		618,930	53,675	
	B - PROPERTY INSURANCE				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	88,413	1.00
	0		0	88,413	
	C - CAFETERIA				
1.00	CAFETERIA	11.00	270,014	238,174	1.00
2.00	GUEST MEALS	194.06	16,762	14,786	2.00
	0		286,776	252,960	
	D - INTEREST EXPENSE				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1,586,786	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	16,362	2.00
3.00	ADMINISTRATIVE & GENERAL	5.00	0	30,194	3.00
	0		0	1,633,342	
	E - DEPRECIATION EXPENSE				
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	2,276,936	1.00
	0		0	2,276,936	
	F - ICU				
1.00	INTENSIVE CARE UNIT	31.00	67,454	46,770	1.00
	0		67,454	46,770	
	G - ADVERTISING COST				
1.00	ADMINISTRATIVE & GENERAL	5.00	19,656	61,962	1.00
	0		19,656	61,962	
	H - PROPERTY TAX				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	9,976	1.00
	0		0	9,976	
	I - EDUCATION COSTS				
1.00	ADMINISTRATIVE & GENERAL	5.00	24,435	45,739	1.00
	0		24,435	45,739	
	J - SLEEP LAB				
1.00	SLEEP LAB	65.01	0	203,614	1.00
2.00		0.00	0	0	2.00
	0		0	203,614	
	L - PUBLIC RELATIONS				
1.00	MARKETING	194.05	0	16,814	1.00
	0		0	16,814	
	M - HOME HEALTH SALARY				
1.00	HOME HEALTH AGENCY	101.00	8,130	0	1.00
	0		8,130	0	
	N - RECOVERY ROOM				
1.00	RECOVERY ROOM	51.00	619,174	0	1.00
	0		619,174	0	
	O - IMPLANTABLE DEVICES				
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	998,267	1.00
	0		0	998,267	
	P - HOME HEALTH ADMIN				
1.00	ADMINISTRATIVE & GENERAL	5.00	101,524	0	1.00
	0		101,524	0	
	Q - URGENT CARE				
1.00	ADMINISTRATIVE & GENERAL	5.00	185,518	0	1.00
	0		185,518	0	
	R - HOSPICE RECLASS				
1.00	HOSPICE	116.00	63,320	0	1.00
	0		63,320	0	
	S - FOUNDATION RECLASS				
1.00	FOUNDATION	194.15	13,338	0	1.00
	TOTALS		13,338	0	
500.00	Grand Total: Increases		2,008,255	5,688,468	500.00

RECLASSIFICATIONS | Provider CCN: 15-1315 | Period: From 10/01/2017 To 09/30/2018 | Worksheet A-6 | Date/Time Prepared: 2/21/2019 3:49 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - LABOR AND DELIVERY						
1.00	DELIVERY ROOM & LABOR ROOM	52.00	618,930	53,675	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
	0		618,930	53,675			
	B - PROPERTY INSURANCE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	88,413	12		1.00
	0		0	88,413			
	C - CAFETERIA						
1.00	DIETARY	10.00	286,776	252,960	0		1.00
2.00		0.00	0	0	0		2.00
	0		286,776	252,960			
	D - INTEREST EXPENSE						
1.00	INTEREST EXPENSE	113.00	0	1,633,342	9		1.00
2.00		0.00	0	0	10		2.00
3.00		0.00	0	0	0		3.00
	0		0	1,633,342			
	E - DEPRECIATION EXPENSE						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	2,276,936	9		1.00
	0		0	2,276,936			
	F - ICU						
1.00	ADULTS & PEDIATRICS	30.00	67,454	46,770	0		1.00
	0		67,454	46,770			
	G - ADVERTISING COST						
1.00	MARKETING	194.05	19,656	61,962	0		1.00
	0		19,656	61,962			
	H - PROPERTY TAX						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	9,976	13		1.00
	0		0	9,976			
	I - EDUCATION COSTS						
1.00	EDUCATION	194.04	24,435	45,739	0		1.00
	0		24,435	45,739			
	J - SLEEP LAB						
1.00	RESPIRATORY THERAPY	65.00	0	176,189	0		1.00
2.00	ELECTROCARDIOLOGY	69.00	0	27,425	0		2.00
	0		0	203,614			
	L - PUBLIC RELATIONS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	16,814	0		1.00
	0		0	16,814			
	M - HOME HEALTH SALARY						
1.00	HOSPICE	116.00	8,130	0	0		1.00
	0		8,130	0			
	N - RECOVERY ROOM						
1.00	OPERATING ROOM	50.00	619,174	0	0		1.00
	0		619,174	0			
	O - IMPLANTABLE DEVICES						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	998,267	0		1.00
	0		0	998,267			
	P - HOME HEALTH ADMIN						
1.00	HOME HEALTH AGENCY	101.00	101,524	0	0		1.00
	0		101,524	0			
	Q - URGENT CARE						
1.00	URGENT CARE	194.09	185,518	0	0		1.00
	0		185,518	0			
	R - HOSPICE RECLASS						
1.00	HOME HEALTH AGENCY	101.00	63,320	0	0		1.00
	0		63,320	0			
	S - FOUNDATION RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00	13,338	0	0		1.00
	TOTALS		13,338	0			
500.00	Grand Total: Decreases		2,008,255	5,688,468			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1315 | Period: From 10/01/2017 To 09/30/2018 | Worksheet A-7 Part I | Date/Time Prepared: 2/21/2019 3:49 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	1,317,868	145,000	0	145,000	0	1.00
2.00	Land Improvements	0	0	0	0	0	2.00
3.00	Buildings and Fixtures	56,766,732	206,078	0	206,078	0	3.00
4.00	Building Improvements	20,000	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	18,884,224	811,320	0	811,320	374,854	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	76,988,824	1,162,398	0	1,162,398	374,854	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	76,988,824	1,162,398	0	1,162,398	374,854	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	1,462,868	0	1.00
2.00	Land Improvements	0	0	2.00
3.00	Buildings and Fixtures	56,972,810	0	3.00
4.00	Building Improvements	20,000	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	19,320,690	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	77,776,368	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	77,776,368	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1315 | Period: From 10/01/2017 To 09/30/2018 | Worksheet A-7 Part II Date/Time Prepared: 2/21/2019 3:49 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	6,113,848	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	1,866,085	0	0	0	2.00
3.00	Total (sum of lines 1-2)	6,113,848	1,866,085	0	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL		
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
		14.00	15.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	6,113,848	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	1,866,085	2.00
3.00	Total (sum of lines 1-2)	0	7,979,933	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1315 | Period: From 10/01/2017 To 09/30/2018 | Worksheet A-7 Part III Date/Time Prepared: 2/21/2019 3:49 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	58,435,678	0	58,435,678	0.751329	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	19,340,691	0	19,340,691	0.248671	0	2.00
3.00	Total (sum of lines 1-2)	77,776,369	0	77,776,369	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	5,392,006	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	2,115,511	1,882,447	2.00
3.00	Total (sum of lines 1-2)	0	0	0	7,507,517	1,882,447	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	-846,681	88,413	9,976	0	4,643,714	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	-8,731	0	0	0	3,989,227	2.00
3.00	Total (sum of lines 1-2)	-855,412	88,413	9,976	0	8,632,941	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1315 | Period: From 10/01/2017 To 09/30/2018 | Worksheet A-8 | Date/Time Prepared: 2/21/2019 3:49 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)	A	-846,681	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)	A	-8,731	CAP REL COSTS-MVBLE EQUIP	2.00	11	2.00
3.00	Investment income - other (chapter 2)	A	-16,111	ADMINISTRATIVE & GENERAL	5.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)	B	-11,614	CAP REL COSTS-MVBLE EQUIP	2.00	9	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-2,709,166			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	-637,638			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-236,941	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients	B	-60,897	PHARMACY	15.00	0	17.00
18.00	Sale of medical records and abstracts	B	-283	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	B	-16,256	CAFETERIA	11.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	UTILIZATION REVIEW-SNF	114.00		25.00
26.00	Depreciation - 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	A	-229,676	CLINIC- MCDONALD	90.01	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	A	-18,814	CAP REL COSTS-MVBLE EQUIP	2.00	9	32.00
33.00	LOBBYING EXPENSES	A	-4,638	ADMINISTRATIVE & GENERAL	5.00	0	33.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1315 | Period: From 10/01/2017 To 09/30/2018 | Worksheet A-8 | Date/Time Prepared: 2/21/2019 3:49 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	
33.01	EMPLOYEE CHRISTMAS PARTY	A	-11,447	ADMINISTRATIVE & GENERAL	5.00	0	33.01
33.02	PHYSICIAN RECRUITMENT	A	-127,445	ADMINISTRATIVE & GENERAL	5.00	0	33.02
33.03	MEALS ON WHEELS	B	-12,250	DIETARY	10.00	0	33.03
33.04	RENTAL INCOME OFFSET - CANCER CENTER	B	-31,692	CAP REL COSTS-BLDG & FIXT	1.00	9	33.04
33.05	ATM SURCHARGE REVENUE	B	-455	ADMINISTRATIVE & GENERAL	5.00	0	33.05
33.06	OP EDUCATION	B	-1,050	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.06
33.07	DIETICIAN CONSULTATIONS	B	-2,560	CAFETERIA	11.00	0	33.07
33.08	PHYSICIAN INCOME GUARANTEE	A	9,194	ADMINISTRATIVE & GENERAL	5.00	0	33.08
33.09	HAF EXPENSE	B	-1,789,860	ADMINISTRATIVE & GENERAL	5.00	0	33.09
33.10	CLIMB PROGRAM REVENUE	B	-215	PHYSICAL THERAPY	66.00	0	33.10
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-6,765,226				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: 15-1315 | Period: From 10/01/2017 To 09/30/2018 | Worksheet A-8-1 | Date/Time Prepared: 2/21/2019 3:49 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	CMO OVERHEAD - BENEFITS	0	473,041	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	CMO OVERHEAD - A&G	0	30,300	2.00
3.00	7.00	OPERATION OF PLANT	CMO OVERHEAD - PLANT OPS	0	3,300	3.00
4.00	2.00	CAP REL COSTS-MVBLE EQUIP	RENT PAID TO CMO	467,743	598,740	4.00
5.00	0		0	467,743	1,105,381	5.00

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

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

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

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

6.00	C	CAMERON MEDICAL	100.00		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:					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: 15-1315 | Period: From 10/01/2017 To 09/30/2018 | Worksheet A-8-1 | Date/Time Prepared: 2/21/2019 3:49 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	-473,041	0		1.00
2.00	-30,300	0		2.00
3.00	-3,300	0		3.00
4.00	-130,997	9		4.00
5.00	-637,638			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			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: 15-1315 | Period: From 10/01/2017 To 09/30/2018 | Worksheet A-8-2 | Date/Time Prepared: 2/21/2019 3:49 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	60.00	LABORATORY	13,521	7,312	6,209	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	996,485	951,961	44,524	0	0	2.00
3.00	50.00	OPERATING ROOM	556,838	556,838	0	0	0	3.00
4.00	30.00	ADULTS & PEDIATRICS	187,340	187,340	0	0	0	4.00
5.00	90.01	CLINIC- MCDONALD	1,005,715	1,005,715	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			2,759,899	2,709,166	50,733		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	60.00	LABORATORY	0	0	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	2.00
3.00	50.00	OPERATING ROOM	0	0	0	0	0	3.00
4.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	4.00
5.00	90.01	CLINIC- MCDONALD	0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	60.00	LABORATORY	0	0	0	7,312		1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	951,961		2.00
3.00	50.00	OPERATING ROOM	0	0	0	556,838		3.00
4.00	30.00	ADULTS & PEDIATRICS	0	0	0	187,340		4.00
5.00	90.01	CLINIC- MCDONALD	0	0	0	1,005,715		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	2,709,166		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 15-1315 | Period: From 10/01/2017 To 09/30/2018 | Worksheet A-8-3 Parts I-VI Date/Time Prepared: 2/21/2019 3:49 pm

		Respiratory Therapy	Cost	
			1.00	
	PART I - GENERAL INFORMATION			
1.00	Total number of weeks worked (excluding aides) (see instructions)		52	1.00
2.00	Line 1 multiplied by 15 hours per week		780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)		365	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)		0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)		0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)		0	6.00
7.00	Standard travel expense rate		3.25	7.00
8.00	Optional travel expense rate per mile		0.00	8.00

		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	2,505.80	21,597.25	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	64.62	64.62	0.00	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	32.31	32.31	0.00			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)						12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)						13.01

			1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION			
14.00	Supervisors (column 1, line 9 times column 1, line 10)		161,925	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)		1,395,614	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)		0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)		1,557,539	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)		0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)		0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)		1,557,539	20.00
	If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.			
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)		0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)		0	22.00
23.00	Total salary equivalency (see instructions)		1,557,539	23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE			
	Standard Travel Allowance			
24.00	Therapists (line 3 times column 2, line 11)		11,793	24.00
25.00	Assistants (line 4 times column 3, line 11)		0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)		11,793	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)		1,186	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)		12,979	28.00
	Optional Travel Allowance and Optional Travel Expense			
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)		0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)		0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)		0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)		0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)		0	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)		0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)		0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE			
	Standard Travel Expense			
36.00	Therapists (line 5 times column 2, line 11)		0	36.00
37.00	Assistants (line 6 times column 3, line 11)		0	37.00
38.00	Subtotal (sum of lines 36 and 37)		0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)		0	39.00
	Optional Travel Allowance and Optional Travel Expense			
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)		0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)		0	41.00
42.00	Subtotal (sum of lines 40 and 41)		0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)		0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.			
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)		0	44.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS	Provider CCN: 15-1315	Period: From 10/01/2017 To 09/30/2018	Worksheet A-8-3 Parts I-VI Date/Time Prepared: 2/21/2019 3:49 pm

		Respiratory Therapy	Cost	
			1.00	
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)		0	45.00
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)		0	46.00

		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	1,114.50	0.00	0.00	0.00	1,114.50	47.00
48.00	Overtime rate (see instructions)	96.93	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	108,028.49	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	100.00	0.00	0.00	0.00	100.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	2,080.00	0.00	0.00	0.00	2,080.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	64.62	0.00	0.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	134,410	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	108,028	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	72,019	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	36,009	0	0	0	36,009	56.00

			1.00	
	Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT			
57.00	Salary equivalency amount (from line 23)		1,557,539	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))		0	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)		0	59.00
60.00	Overtime allowance (from column 5, line 56)		36,009	60.00
61.00	Equipment cost (see instructions)		0	61.00
62.00	Supplies (see instructions)		0	62.00
63.00	Total allowance (sum of lines 57-62)		1,593,548	63.00
64.00	Total cost of outside supplier services (from your records)		680,819	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)		0	65.00
	LINE 33 CALCULATION			
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others		11,793	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others		1,186	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27		12,979	100.02
	LINE 34 CALCULATION			
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others		1,186	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others		0	101.01
101.02	Line 34 = sum of lines 27 and 31		1,186	101.02
	LINE 35 CALCULATION			
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others		0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others		0	102.01
102.02	Line 35 = sum of lines 31 and 32		0	102.02

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1315 | Period: From 10/01/2017 To 09/30/2018 | Worksheet B Part I | Date/Time Prepared: 2/21/2019 3:49 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	4,643,714	4,643,714				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	3,989,227		3,989,227			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	7,032,618	23,961	16,626	7,073,205		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	9,372,608	410,829	381,702	1,277,506	11,442,645	5.00
7.00	00700	OPERATION OF PLANT	2,678,322	417,408	359,524	253,602	3,708,856	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	33,998	43,130	29,927	0	107,055	8.00
9.00	00900	HOUSEKEEPING	1,080,784	19,250	13,357	208,036	1,321,427	9.00
10.00	01000	DIETARY	183,347	159,279	110,523	32,400	485,549	10.00
11.00	01100	CAFETERIA	252,431	80,614	55,938	84,179	473,162	11.00
13.00	01300	NURSING ADMINISTRATION	650,705	33,139	22,995	189,846	896,685	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	257,584	126,546	87,810	54,457	526,397	14.00
15.00	01500	PHARMACY	2,908,222	46,907	32,548	151,053	3,138,730	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	656,843	0	31,196	146,075	834,114	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,867,168	656,084	455,251	801,794	4,780,297	30.00
31.00	03100	INTENSIVE CARE UNIT	114,224	47,922	33,253	21,029	216,428	31.00
43.00	04300	NURSERY	43,962	17,057	11,836	12,612	85,467	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,408,786	441,450	306,320	264,605	2,421,161	50.00
51.00	05100	RECOVERY ROOM	619,174	288,628	200,277	193,033	1,301,112	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	316,950	137,390	95,334	90,926	640,600	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,552,014	335,250	232,628	506,822	3,626,714	54.00
60.00	06000	LABORATORY	2,726,835	112,657	78,172	308,920	3,226,584	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	787,742	54,623	37,902	13,827	894,094	65.00
65.01	06501	SLEEP LAB	203,614	0	73,269	0	276,883	65.01
66.00	06600	PHYSICAL THERAPY	916,428	244,889	169,927	279,304	1,610,548	66.00
69.00	06900	ELECTROCARDIOLOGY	353,390	5,807	4,030	0	363,227	69.00
69.01	06901	CARDIAC REHAB	84,918	31,352	21,755	23,646	161,671	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	800,964	0	0	0	800,964	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	998,267	0	0	0	998,267	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	CHEMICAL DEPENDENCY	225,743	0	0	34,927	260,670	76.00
76.01	03480	ONCOLOGY	1,464,011	450,791	312,801	0	2,227,603	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	825,617	0	123,683	244,153	1,193,453	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	173,944	19,981	13,865	44,070	251,860	90.00
90.01	09001	CLINIC- MCDONALD	278,108	0	117,991	150,171	546,270	90.01
91.00	09100	EMERGENCY	2,152,106	387,599	268,952	582,576	3,391,233	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	677,826	0	41,397	183,499	902,722	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	165,088	0	8,482	42,826	216,396	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	54,497,282	4,592,543	3,749,271	6,195,894	53,328,844	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	23,555	16,345	0	39,900	190.00
194.00	07950	DAYCARE-INFANT/TODDLER	0	0	0	0	0	194.00
194.01	07951	MOB	0	0	0	0	0	194.01
194.02	07952	COMMUNITY HEALTH	102,318	0	0	29,712	132,030	194.02
194.03	07953	ASSISTED LIVING/CAMERON WOODS	0	0	0	0	0	194.03
194.04	07954	EDUCATION	49,832	0	0	0	49,832	194.04
194.05	07955	MARKETING	528,621	27,616	19,163	32,020	607,420	194.05
194.06	07956	GUEST MEALS	31,548	0	0	5,226	36,774	194.06
194.07	07957	OUTSIDE LAUNDRY	0	0	0	0	0	194.07
194.08	07958	CANCER CENTER	0	0	0	0	0	194.08
194.09	07959	URGENT CARE	1,457,454	0	177,169	397,656	2,032,279	194.09
194.10	07960	RHC	0	0	0	0	0	194.10
194.11	07961	OBGYN	1,015,849	0	0	279,577	1,295,426	194.11
194.12	07962	TRINE STUDENT HEALTH	80,611	0	0	24,732	105,343	194.12
194.13	07963	OCCUPATIONAL HEALTH	368,667	0	23,869	68,783	461,319	194.13
194.14	07964	IMMUNIZATION CLINIC	60,593	0	3,410	18,532	82,535	194.14
194.15	07965	FOUNDATION	67,818	0	0	21,073	88,891	194.15
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1315 | Period: From 10/01/2017 To 09/30/2018 | Worksheet B Part I Date/Time Prepared: 2/21/2019 3:49 pm

	Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			BLDG & FIXT	MVBLE EQUIP			
		0	1.00	2.00	4.00	4A	
202.00	TOTAL (sum lines 118 through 201)	58,260,593	4,643,714	3,989,227	7,073,205	58,260,593	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1315 | Period: From 10/01/2017 To 09/30/2018 | Worksheet B Part I | Date/Time Prepared: 2/21/2019 3:49 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	11,442,645					5.00
7.00	00700	OPERATION OF PLANT	906,470	4,615,326				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	26,165	42,745	175,965			8.00
9.00	00900	HOUSEKEEPING	322,966	19,078	46,322	1,709,793		9.00
10.00	01000	DIETARY	118,672	157,858	411	16,800	779,290	10.00
11.00	01100	CAFETERIA	115,644	79,895	1,131	46,073	0	11.00
13.00	01300	NURSING ADMINISTRATION	219,156	32,844	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	128,655	125,417	0	12,473	0	14.00
15.00	01500	PHARMACY	767,128	46,488	0	16,291	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	203,863	44,556	0	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,168,347	650,230	34,857	481,605	750,643	30.00
31.00	03100	INTENSIVE CARE UNIT	52,897	47,494	1,853	9,927	28,647	31.00
43.00	04300	NURSERY	20,889	16,905	8,065	102,328	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	591,749	437,512	25,509	125,237	0	50.00
51.00	05100	RECOVERY ROOM	318,001	286,053	0	81,964	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	156,567	136,164	2,490	25,200	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	886,394	332,259	14,927	128,801	0	54.00
60.00	06000	LABORATORY	788,600	111,652	577	78,146	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	218,523	54,136	76	16,800	0	65.00
65.01	06501	SLEEP LAB	67,672	104,649	1,958	22,909	0	65.01
66.00	06600	PHYSICAL THERAPY	393,629	242,704	3,816	66,182	0	66.00
69.00	06900	ELECTROCARDIOLOGY	88,775	5,756	0	0	0	69.00
69.01	06901	CARDIAC REHAB	39,514	31,073	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	195,761	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	243,983	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	CHEMICAL DEPENDENCY	63,710	0	0	0	0	76.00
76.01	03480	ONCOLOGY	544,442	446,769	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	291,688	176,655	1,719	53,709	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	61,556	19,803	0	0	0	90.00
90.01	09001	CLINIC- MCDONALD	133,512	168,525	2,141	144,074	0	90.01
91.00	09100	EMERGENCY	828,841	384,141	30,062	239,529	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	220,632	59,126	51	13,236	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	52,889	12,115	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	10,237,290	4,272,602	175,965	1,681,284	779,290	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	9,752	23,345	0	0	0	190.00
194.00	07950	DAYCARE-INFANT/TODDLER	0	0	0	0	0	194.00
194.01	07951	MOB	0	0	0	0	0	194.01
194.02	07952	COMMUNITY HEALTH	32,269	0	0	0	0	194.02
194.03	07953	ASSISTED LIVING/CAMERON WOODS	0	0	0	0	0	194.03
194.04	07954	EDUCATION	12,179	0	0	0	0	194.04
194.05	07955	MARKETING	148,458	27,370	0	0	0	194.05
194.06	07956	GUEST MEALS	8,988	0	0	0	0	194.06
194.07	07957	OUTSIDE LAUNDRY	0	0	0	0	0	194.07
194.08	07958	CANCER CENTER	0	0	0	0	0	194.08
194.09	07959	URGENT CARE	496,703	253,048	0	28,509	0	194.09
194.10	07960	RHC	0	0	0	0	0	194.10
194.11	07961	OBGYN	316,611	0	0	0	0	194.11
194.12	07962	TRINE STUDENT HEALTH	25,747	0	0	0	0	194.12
194.13	07963	OCCUPATIONAL HEALTH	112,750	34,091	0	0	0	194.13
194.14	07964	IMMUNIZATION CLINIC	20,172	4,870	0	0	0	194.14
194.15	07965	FOUNDATION	21,726	0	0	0	0	194.15
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)	11,442,645	4,615,326	175,965	1,709,793	779,290	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1315 | Period: From 10/01/2017 To 09/30/2018 | Worksheet B Part I | Date/Time Prepared: 2/21/2019 3:49 pm

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
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	715,905					11.00
13.00	01300	NURSING ADMINISTRATION	24,392	1,173,077				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	15,106	0	808,048			14.00
15.00	01500	PHARMACY	17,460	0	4,745	3,990,842		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	37,177	0	60	0	1,119,770	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	151,061	504,898	27,672	0	9,480	30.00
31.00	03100	INTENSIVE CARE UNIT	4,293	14,297	935	0	684	31.00
43.00	04300	NURSERY	1,717	5,738	0	0	1,966	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	46,718	156,148	83,693	0	21,918	50.00
51.00	05100	RECOVERY ROOM	29,513	98,616	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	12,371	41,385	10,246	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	77,216	0	8,018	0	205,377	54.00
60.00	06000	LABORATORY	64,305	0	216,781	0	337,056	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	1,208	0	6,478	0	29,341	65.00
65.01	06501	SLEEP LAB	0	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	46,781	0	2,244	0	101,617	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	705	0	50,942	69.00
69.01	06901	CARDIAC REHAB	3,880	0	421	0	26,958	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	170,835	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	212,917	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	3,990,842	0	73.00
76.00	03020	CHEMICAL DEPENDENCY	6,774	0	83	0	1,374	76.00
76.01	03480	ONCOLOGY	0	0	15	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	1,541	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	8,237	27,532	4,538	0	35,946	90.00
90.01	09001	CLINIC- MCDONALD	22,580	0	2,620	0	35,464	90.01
91.00	09100	EMERGENCY	97,093	324,463	36,310	0	128,416	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	28,400	0	1,757	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	7,442	0	107	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	703,724	1,173,077	792,721	3,990,842	986,539	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	DAYCARE-INFANT/TODDLER	0	0	0	0	0	194.00
194.01	07951	MOB	0	0	0	0	101,800	194.01
194.02	07952	COMMUNITY HEALTH	4,071	0	306	0	0	194.02
194.03	07953	ASSISTED LIVING/CAMERON WOODS	0	0	0	0	0	194.03
194.04	07954	EDUCATION	0	0	0	0	0	194.04
194.05	07955	MARKETING	6,329	0	120	0	0	194.05
194.06	07956	GUEST MEALS	1,781	0	0	0	0	194.06
194.07	07957	OUTSIDE LAUNDRY	0	0	0	0	0	194.07
194.08	07958	CANCER CENTER	0	0	0	0	0	194.08
194.09	07959	URGENT CARE	0	0	10,920	0	0	194.09
194.10	07960	RHC	0	0	0	0	0	194.10
194.11	07961	OBGYN	0	0	2,774	0	31,431	194.11
194.12	07962	TRINE STUDENT HEALTH	0	0	252	0	0	194.12
194.13	07963	OCCUPATIONAL HEALTH	0	0	751	0	0	194.13
194.14	07964	IMMUNIZATION CLINIC	0	0	204	0	0	194.14
194.15	07965	FOUNDATION	0	0	0	0	0	194.15
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)	715,905	1,173,077	808,048	3,990,842	1,119,770	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1315 | Period: From 10/01/2017 To 09/30/2018 | Worksheet B Part I | Date/Time Prepared: 2/21/2019 3:49 pm

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	8,559,090	0	8,559,090		30.00
31.00	03100	INTENSIVE CARE UNIT	377,455	0	377,455		31.00
43.00	04300	NURSERY	243,075	0	243,075		43.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	3,909,645	0	3,909,645		50.00
51.00	05100	RECOVERY ROOM	2,115,259	0	2,115,259		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,025,023	0	1,025,023		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,279,706	0	5,279,706		54.00
60.00	06000	LABORATORY	4,823,701	0	4,823,701		60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	1,220,656	0	1,220,656		65.00
65.01	06501	SLEEP LAB	474,071	0	474,071		65.01
66.00	06600	PHYSICAL THERAPY	2,467,521	0	2,467,521		66.00
69.00	06900	ELECTROCARDIOLOGY	509,405	0	509,405		69.00
69.01	06901	CARDIAC REHAB	263,517	0	263,517		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,167,560	0	1,167,560		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,455,167	0	1,455,167		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,990,842	0	3,990,842		73.00
76.00	03020	CHEMICAL DEPENDENCY	332,611	0	332,611		76.00
76.01	03480	ONCOLOGY	3,218,829	0	3,218,829		76.01
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	1,718,765	0	1,718,765		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		89.00
90.00	09000	CLINIC	409,472	0	409,472		90.00
90.01	09001	CLINIC- MCDONALD	1,055,186	0	1,055,186		90.01
91.00	09100	EMERGENCY	5,460,088	0	5,460,088		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0			92.00
		OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY	1,225,924	0	1,225,924		101.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
114.00	11400	UTILIZATION REVIEW-SNF					114.00
116.00	11600	HOSPICE	288,949	0	288,949		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	51,591,517	0	51,591,517		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	72,997	0	72,997		190.00
194.00	07950	DAYCARE-INFANT/TODDLER	0	0	0		194.00
194.01	07951	MOB	101,800	0	101,800		194.01
194.02	07952	COMMUNITY HEALTH	168,676	0	168,676		194.02
194.03	07953	ASSISTED LIVING/CAMERON WOODS	0	0	0		194.03
194.04	07954	EDUCATION	62,011	0	62,011		194.04
194.05	07955	MARKETING	789,697	0	789,697		194.05
194.06	07956	GUEST MEALS	47,543	0	47,543		194.06
194.07	07957	OUTSIDE LAUNDRY	0	0	0		194.07
194.08	07958	CANCER CENTER	0	0	0		194.08
194.09	07959	URGENT CARE	2,821,459	0	2,821,459		194.09
194.10	07960	RHC	0	0	0		194.10
194.11	07961	OBGYN	1,646,242	0	1,646,242		194.11
194.12	07962	TRINE STUDENT HEALTH	131,342	0	131,342		194.12
194.13	07963	OCCUPATIONAL HEALTH	608,911	0	608,911		194.13
194.14	07964	IMMUNIZATION CLINIC	107,781	0	107,781		194.14
194.15	07965	FOUNDATION	110,617	0	110,617		194.15
200.00		Cross Foot Adjustments	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	58,260,593	0	58,260,593		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1315 | Period: From 10/01/2017 To 09/30/2018 | Worksheet B Part II | Date/Time Prepared: 2/21/2019 3:49 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	23,961	16,626	40,587	40,587	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	410,829	381,702	792,531	7,330	5.00
7.00	00700	OPERATION OF PLANT	0	417,408	359,524	776,932	1,455	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	43,130	29,927	73,057	0	8.00
9.00	00900	HOUSEKEEPING	0	19,250	13,357	32,607	1,194	9.00
10.00	01000	DIETARY	0	159,279	110,523	269,802	186	10.00
11.00	01100	CAFETERIA	0	80,614	55,938	136,552	483	11.00
13.00	01300	NURSING ADMINISTRATION	0	33,139	22,995	56,134	1,089	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	126,546	87,810	214,356	312	14.00
15.00	01500	PHARMACY	0	46,907	32,548	79,455	867	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	31,196	31,196	838	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	656,084	455,251	1,111,335	4,601	30.00
31.00	03100	INTENSIVE CARE UNIT	0	47,922	33,253	81,175	121	31.00
43.00	04300	NURSERY	0	17,057	11,836	28,893	72	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	441,450	306,320	747,770	1,518	50.00
51.00	05100	RECOVERY ROOM	0	288,628	200,277	488,905	1,108	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	137,390	95,334	232,724	522	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	335,250	232,628	567,878	2,908	54.00
60.00	06000	LABORATORY	0	112,657	78,172	190,829	1,773	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	54,623	37,902	92,525	79	65.00
65.01	06501	SLEEP LAB	0	0	73,269	73,269	0	65.01
66.00	06600	PHYSICAL THERAPY	0	244,889	169,927	414,816	1,603	66.00
69.00	06900	ELECTROCARDIOLOGY	0	5,807	4,030	9,837	0	69.00
69.01	06901	CARDIAC REHAB	0	31,352	21,755	53,107	136	69.01
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
76.00	03020	CHEMICAL DEPENDENCY	0	0	0	0	200	76.00
76.01	03480	ONCOLOGY	0	450,791	312,801	763,592	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	123,683	123,683	1,401	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	19,981	13,865	33,846	253	90.00
90.01	09001	CLINIC- MCDONALD	0	0	117,991	117,991	862	90.01
91.00	09100	EMERGENCY	0	387,599	268,952	656,551	3,343	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	41,397	41,397	1,053	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	0	0	8,482	8,482	246	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	4,592,543	3,749,271	8,341,814	35,553	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	23,555	16,345	39,900	0	190.00
194.00	07950	DAYCARE-INFANT/TODDLER	0	0	0	0	0	194.00
194.01	07951	MOB	0	0	0	0	0	194.01
194.02	07952	COMMUNITY HEALTH	0	0	0	0	170	194.02
194.03	07953	ASSISTED LIVING/CAMERON WOODS	0	0	0	0	0	194.03
194.04	07954	EDUCATION	0	0	0	0	0	194.04
194.05	07955	MARKETING	0	27,616	19,163	46,779	184	194.05
194.06	07956	GUEST MEALS	0	0	0	0	30	194.06
194.07	07957	OUTSIDE LAUNDRY	0	0	0	0	0	194.07
194.08	07958	CANCER CENTER	0	0	0	0	0	194.08
194.09	07959	URGENT CARE	0	0	177,169	177,169	2,282	194.09
194.10	07960	RHC	0	0	0	0	0	194.10
194.11	07961	OBGYN	0	0	0	0	1,604	194.11
194.12	07962	TRINE STUDENT HEALTH	0	0	0	0	142	194.12
194.13	07963	OCCUPATIONAL HEALTH	0	0	23,869	23,869	395	194.13
194.14	07964	IMMUNIZATION CLINIC	0	0	3,410	3,410	106	194.14
194.15	07965	FOUNDATION	0	0	0	0	121	194.15
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	4,643,714	3,989,227	8,632,941	40,587	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1315 | Period: From 10/01/2017 To 09/30/2018 | Worksheet B Part II | Date/Time Prepared: 2/21/2019 3:49 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	799,861					5.00
7.00	00700	OPERATION OF PLANT	63,362	841,749				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,829	7,796	82,682			8.00
9.00	00900	HOUSEKEEPING	22,575	3,480	21,766	81,622		9.00
10.00	01000	DIETARY	8,295	28,790	193	802	308,068	10.00
11.00	01100	CAFETERIA	8,083	14,571	531	2,199	0	11.00
13.00	01300	NURSING ADMINISTRATION	15,319	5,990	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	8,993	22,874	0	595	0	14.00
15.00	01500	PHARMACY	53,622	8,479	0	778	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	14,250	8,126	0	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	81,692	118,587	16,378	22,989	296,743	30.00
31.00	03100	INTENSIVE CARE UNIT	3,697	8,662	871	474	11,325	31.00
43.00	04300	NURSERY	1,460	3,083	3,789	4,885	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	41,363	79,794	11,986	5,979	0	50.00
51.00	05100	RECOVERY ROOM	22,228	52,171	0	3,913	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	10,944	24,834	1,170	1,203	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	61,959	60,598	7,014	6,149	0	54.00
60.00	06000	LABORATORY	55,123	20,363	271	3,731	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	15,275	9,873	36	802	0	65.00
65.01	06501	SLEEP LAB	4,730	19,086	920	1,094	0	65.01
66.00	06600	PHYSICAL THERAPY	27,515	44,265	1,793	3,159	0	66.00
69.00	06900	ELECTROCARDIOLOGY	6,205	1,050	0	0	0	69.00
69.01	06901	CARDIAC REHAB	2,762	5,667	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	13,684	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	17,054	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	CHEMICAL DEPENDENCY	4,453	0	0	0	0	76.00
76.01	03480	ONCOLOGY	38,056	81,482	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	20,389	32,219	808	2,564	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	4,303	3,612	0	0	0	90.00
90.01	09001	CLINIC- MCDONALD	9,332	30,736	1,006	6,878	0	90.01
91.00	09100	EMERGENCY	57,936	70,060	14,126	11,435	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	15,422	10,784	24	632	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	3,697	2,210	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	715,607	779,242	82,682	80,261	308,068	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	682	4,258	0	0	0	190.00
194.00	07950	DAYCARE-INFANT/TODDLER	0	0	0	0	0	194.00
194.01	07951	MOB	0	0	0	0	0	194.01
194.02	07952	COMMUNITY HEALTH	2,256	0	0	0	0	194.02
194.03	07953	ASSISTED LIVING/CAMERON WOODS	0	0	0	0	0	194.03
194.04	07954	EDUCATION	851	0	0	0	0	194.04
194.05	07955	MARKETING	10,377	4,992	0	0	0	194.05
194.06	07956	GUEST MEALS	628	0	0	0	0	194.06
194.07	07957	OUTSIDE LAUNDRY	0	0	0	0	0	194.07
194.08	07958	CANCER CENTER	0	0	0	0	0	194.08
194.09	07959	URGENT CARE	34,719	46,151	0	1,361	0	194.09
194.10	07960	RHC	0	0	0	0	0	194.10
194.11	07961	OBGYN	22,131	0	0	0	0	194.11
194.12	07962	TRINE STUDENT HEALTH	1,800	0	0	0	0	194.12
194.13	07963	OCCUPATIONAL HEALTH	7,881	6,218	0	0	0	194.13
194.14	07964	IMMUNIZATION CLINIC	1,410	888	0	0	0	194.14
194.15	07965	FOUNDATION	1,519	0	0	0	0	194.15
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)	799,861	841,749	82,682	81,622	308,068	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1315 | Period: From 10/01/2017 To 09/30/2018 | Worksheet B Part II | Date/Time Prepared: 2/21/2019 3:49 pm

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
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	162,419					11.00
13.00	01300	NURSING ADMINISTRATION	5,534	84,066				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3,427	0	250,557			14.00
15.00	01500	PHARMACY	3,961	0	1,471	148,633		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	8,434	0	19	0	62,863	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	34,271	36,182	8,581	0	532	30.00
31.00	03100	INTENSIVE CARE UNIT	974	1,025	290	0	38	31.00
43.00	04300	NURSERY	390	411	0	0	110	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	10,599	11,190	25,951	0	1,230	50.00
51.00	05100	RECOVERY ROOM	6,696	7,067	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,807	2,966	3,177	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	17,518	0	2,486	0	11,530	54.00
60.00	06000	LABORATORY	14,589	0	67,217	0	18,923	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	274	0	2,009	0	1,647	65.00
65.01	06501	SLEEP LAB	0	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	10,613	0	696	0	5,705	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	219	0	2,860	69.00
69.01	06901	CARDIAC REHAB	880	0	131	0	1,513	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	52,973	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	66,021	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	148,633	0	73.00
76.00	03020	CHEMICAL DEPENDENCY	1,537	0	26	0	77	76.00
76.01	03480	ONCOLOGY	0	0	4	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	478	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	1,869	1,973	1,407	0	2,018	90.00
90.01	09001	CLINIC- MCDONALD	5,123	0	812	0	1,991	90.01
91.00	09100	EMERGENCY	22,028	23,252	11,259	0	7,209	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	6,443	0	545	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	1,688	0	33	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	159,655	84,066	245,805	148,633	55,383	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	DAYCARE-INFANT/TODDLER	0	0	0	0	0	194.00
194.01	07951	MOB	0	0	0	0	5,715	194.01
194.02	07952	COMMUNITY HEALTH	924	0	95	0	0	194.02
194.03	07953	ASSISTED LIVING/CAMERON WOODS	0	0	0	0	0	194.03
194.04	07954	EDUCATION	0	0	0	0	0	194.04
194.05	07955	MARKETING	1,436	0	37	0	0	194.05
194.06	07956	GUEST MEALS	404	0	0	0	0	194.06
194.07	07957	OUTSIDE LAUNDRY	0	0	0	0	0	194.07
194.08	07958	CANCER CENTER	0	0	0	0	0	194.08
194.09	07959	URGENT CARE	0	0	3,386	0	0	194.09
194.10	07960	RHC	0	0	0	0	0	194.10
194.11	07961	OBGYN	0	0	860	0	1,765	194.11
194.12	07962	TRINE STUDENT HEALTH	0	0	78	0	0	194.12
194.13	07963	OCCUPATIONAL HEALTH	0	0	233	0	0	194.13
194.14	07964	IMMUNIZATION CLINIC	0	0	63	0	0	194.14
194.15	07965	FOUNDATION	0	0	0	0	0	194.15
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)	162,419	84,066	250,557	148,633	62,863	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1315 | Period: From 10/01/2017 To 09/30/2018 | Worksheet B Part II | Date/Time Prepared: 2/21/2019 3:49 pm

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	1,731,891	0	1,731,891		30.00
31.00	03100	INTENSIVE CARE UNIT	108,652	0	108,652		31.00
43.00	04300	NURSERY	43,093	0	43,093		43.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	937,380	0	937,380		50.00
51.00	05100	RECOVERY ROOM	582,088	0	582,088		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	280,347	0	280,347		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	738,040	0	738,040		54.00
60.00	06000	LABORATORY	372,819	0	372,819		60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	122,520	0	122,520		65.00
65.01	06501	SLEEP LAB	99,099	0	99,099		65.01
66.00	06600	PHYSICAL THERAPY	510,165	0	510,165		66.00
69.00	06900	ELECTROCARDIOLOGY	20,171	0	20,171		69.00
69.01	06901	CARDIAC REHAB	64,196	0	64,196		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	66,657	0	66,657		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	83,075	0	83,075		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	148,633	0	148,633		73.00
76.00	03020	CHEMICAL DEPENDENCY	6,293	0	6,293		76.00
76.01	03480	ONCOLOGY	883,134	0	883,134		76.01
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	181,542	0	181,542		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		89.00
90.00	09000	CLINIC	49,281	0	49,281		90.00
90.01	09001	CLINIC- MCDONALD	174,731	0	174,731		90.01
91.00	09100	EMERGENCY	877,199	0	877,199		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0			92.00
		OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY	76,300	0	76,300		101.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
114.00	11400	UTILIZATION REVIEW-SNF					114.00
116.00	11600	HOSPICE	16,356	0	16,356		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	8,173,662	0	8,173,662		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	44,840	0	44,840		190.00
194.00	07950	DAYCARE-INFANT/TODDLER	0	0	0		194.00
194.01	07951	MOB	5,715	0	5,715		194.01
194.02	07952	COMMUNITY HEALTH	3,445	0	3,445		194.02
194.03	07953	ASSISTED LIVING/CAMERON WOODS	0	0	0		194.03
194.04	07954	EDUCATION	851	0	851		194.04
194.05	07955	MARKETING	63,805	0	63,805		194.05
194.06	07956	GUEST MEALS	1,062	0	1,062		194.06
194.07	07957	OUTSIDE LAUNDRY	0	0	0		194.07
194.08	07958	CANCER CENTER	0	0	0		194.08
194.09	07959	URGENT CARE	265,068	0	265,068		194.09
194.10	07960	RHC	0	0	0		194.10
194.11	07961	OBGYN	26,360	0	26,360		194.11
194.12	07962	TRINE STUDENT HEALTH	2,020	0	2,020		194.12
194.13	07963	OCCUPATIONAL HEALTH	38,596	0	38,596		194.13
194.14	07964	IMMUNIZATION CLINIC	5,877	0	5,877		194.14
194.15	07965	FOUNDATION	1,640	0	1,640		194.15
200.00		Cross Foot Adjustments	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	8,632,941	0	8,632,941		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1315 | Period: From 10/01/2017 To 09/30/2018 | Worksheet B-1 | Date/Time Prepared: 2/21/2019 3:49 pm

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	114,344					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		141,561				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	590	590	22,688,058			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	10,116	13,545	4,097,735	-11,442,645	46,817,948	5.00
7.00	00700	OPERATION OF PLANT	10,278	12,758	813,455	0	3,708,856	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,062	1,062	0	0	107,055	8.00
9.00	00900	HOUSEKEEPING	474	474	667,297	0	1,321,427	9.00
10.00	01000	DIETARY	3,922	3,922	103,926	0	485,549	10.00
11.00	01100	CAFETERIA	1,985	1,985	270,014	0	473,162	11.00
13.00	01300	NURSING ADMINISTRATION	816	816	608,952	0	896,685	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3,116	3,116	174,675	0	526,397	14.00
15.00	01500	PHARMACY	1,155	1,155	484,517	0	3,138,730	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,107	468,552	0	834,114	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	16,155	16,155	2,571,839	0	4,780,297	30.00
31.00	03100	INTENSIVE CARE UNIT	1,180	1,180	67,454	0	216,428	31.00
43.00	04300	NURSERY	420	420	40,454	0	85,467	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	10,870	10,870	848,748	0	2,421,161	50.00
51.00	05100	RECOVERY ROOM	7,107	7,107	619,174	0	1,301,112	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,383	3,383	291,656	0	640,600	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,255	8,255	1,625,686	0	3,626,714	54.00
60.00	06000	LABORATORY	2,774	2,774	990,893	0	3,226,584	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	1,345	1,345	44,353	0	894,094	65.00
65.01	06501	SLEEP LAB	0	2,600	0	0	276,883	65.01
66.00	06600	PHYSICAL THERAPY	6,030	6,030	895,896	0	1,610,548	66.00
69.00	06900	ELECTROCARDIOLOGY	143	143	0	0	363,227	69.00
69.01	06901	CARDIAC REHAB	772	772	75,848	0	161,671	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	800,964	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	998,267	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	CHEMICAL DEPENDENCY	0	0	112,033	0	260,670	76.00
76.01	03480	ONCOLOGY	11,100	11,100	0	0	2,227,603	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	4,389	783,146	0	1,193,453	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	492	492	141,360	0	251,860	90.00
90.01	09001	CLINIC- MCDONALD	0	4,187	481,689	0	546,270	90.01
91.00	09100	EMERGENCY	9,544	9,544	1,868,675	0	3,391,233	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	1,469	588,593	0	902,722	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	0	301	137,370	0	216,396	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	113,084	133,046	19,873,990	-11,442,645	41,886,199	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	580	580	0	0	39,900	190.00
194.00	07950	DAYCARE-INFANT/TODDLER	0	0	0	0	0	194.00
194.01	07951	MOB	0	0	0	0	0	194.01
194.02	07952	COMMUNITY HEALTH	0	0	95,303	0	132,030	194.02
194.03	07953	ASSISTED LIVING/CAMERON WOODS	0	0	0	0	0	194.03
194.04	07954	EDUCATION	0	0	0	0	49,832	194.04
194.05	07955	MARKETING	680	680	102,707	0	607,420	194.05
194.06	07956	GUEST MEALS	0	0	16,762	0	36,774	194.06
194.07	07957	OUTSIDE LAUNDRY	0	0	0	0	0	194.07
194.08	07958	CANCER CENTER	0	0	0	0	0	194.08
194.09	07959	URGENT CARE	0	6,287	1,275,525	0	2,032,279	194.09
194.10	07960	RHC	0	0	0	0	0	194.10
194.11	07961	OBGYN	0	0	896,774	0	1,295,426	194.11
194.12	07962	TRINE STUDENT HEALTH	0	0	79,332	0	105,343	194.12
194.13	07963	OCCUPATIONAL HEALTH	0	847	220,630	0	461,319	194.13
194.14	07964	IMMUNIZATION CLINIC	0	121	59,442	0	82,535	194.14
194.15	07965	FOUNDATION	0	0	67,593	0	88,891	194.15
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1315 | Period: From 10/01/2017 To 09/30/2018 | Worksheet B-1 | Date/Time Prepared: 2/21/2019 3:49 pm

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
202.00		Cost to be allocated (per Wkst. B, Part I)	4,643,714	3,989,227	7,073,205		11,442,645	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	40.611785	28.180269	0.311759		0.244407	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			40,587		799,861	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.001789		0.017084	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1315 | Period: From 10/01/2017 To 09/30/2018 | Worksheet B-1 | Date/Time Prepared: 2/21/2019 3:49 pm

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDR)	HOUSEKEEPING (HOURS OF SERVIC)	DIETARY (MEALS SERVED)	CAFETERIA (FTES)	
			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	114,668					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,062	78,722				8.00
9.00	00900	HOUSEKEEPING	474	20,723	6,717			9.00
10.00	01000	DIETARY	3,922	184	66	14,989		10.00
11.00	01100	CAFETERIA	1,985	506	181	0	22,511	11.00
13.00	01300	NURSING ADMINISTRATION	816	0	0	0	767	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3,116	0	49	0	475	14.00
15.00	01500	PHARMACY	1,155	0	64	0	549	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,107	0	0	0	1,169	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	16,155	15,594	1,892	14,438	4,750	30.00
31.00	03100	INTENSIVE CARE UNIT	1,180	829	39	551	135	31.00
43.00	04300	NURSERY	420	3,608	402	0	54	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	10,870	11,412	492	0	1,469	50.00
51.00	05100	RECOVERY ROOM	7,107	0	322	0	928	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,383	1,114	99	0	389	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,255	6,678	506	0	2,428	54.00
60.00	06000	LABORATORY	2,774	258	307	0	2,022	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	1,345	34	66	0	38	65.00
65.01	06501	SLEEP LAB	2,600	876	90	0	0	65.01
66.00	06600	PHYSICAL THERAPY	6,030	1,707	260	0	1,471	66.00
69.00	06900	ELECTROCARDIOLOGY	143	0	0	0	0	69.00
69.01	06901	CARDIAC REHAB	772	0	0	0	122	69.01
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
76.00	03020	CHEMICAL DEPENDENCY	0	0	0	0	213	76.00
76.01	03480	ONCOLOGY	11,100	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	4,389	769	211	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	492	0	0	0	259	90.00
90.01	09001	CLINIC- MCDONALD	4,187	958	566	0	710	90.01
91.00	09100	EMERGENCY	9,544	13,449	941	0	3,053	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	1,469	23	52	0	893	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	301	0	0	0	234	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	106,153	78,722	6,605	14,989	22,128	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	580	0	0	0	0	190.00
194.00	07950	DAYCARE-INFANT/TODDLER	0	0	0	0	0	194.00
194.01	07951	MOB	0	0	0	0	0	194.01
194.02	07952	COMMUNITY HEALTH	0	0	0	0	128	194.02
194.03	07953	ASSISTED LIVING/CAMERON WOODS	0	0	0	0	0	194.03
194.04	07954	EDUCATION	0	0	0	0	0	194.04
194.05	07955	MARKETING	680	0	0	0	199	194.05
194.06	07956	GUEST MEALS	0	0	0	0	56	194.06
194.07	07957	OUTSIDE LAUNDRY	0	0	0	0	0	194.07
194.08	07958	CANCER CENTER	0	0	0	0	0	194.08
194.09	07959	URGENT CARE	6,287	0	112	0	0	194.09
194.10	07960	RHC	0	0	0	0	0	194.10
194.11	07961	OBGYN	0	0	0	0	0	194.11
194.12	07962	TRINE STUDENT HEALTH	0	0	0	0	0	194.12
194.13	07963	OCCUPATIONAL HEALTH	847	0	0	0	0	194.13
194.14	07964	IMMUNIZATION CLINIC	121	0	0	0	0	194.14
194.15	07965	FOUNDATION	0	0	0	0	0	194.15
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	4,615,326	175,965	1,709,793	779,290	715,905	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	40.249468	2.235271	254.547119	51.990793	31.802452	203.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1315 | Period: From 10/01/2017 To 09/30/2018 | Worksheet B-1 | Date/Time Prepared: 2/21/2019 3:49 pm

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDR)	HOUSEKEEPING (HOURS OF SERVIC)	DIETARY (MEALS SERVED)	CAFETERIA (FTES)	
			7.00	8.00	9.00	10.00	11.00	
204.00		Cost to be allocated (per Wkst. B, Part II)	841,749	82,682	81,622	308,068	162,419	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	7.340749	1.050304	12.151556	20.552939	7.215095	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1315 | Period: From 10/01/2017 To 09/30/2018 | Worksheet B-1 | Date/Time Prepared: 2/21/2019 3:49 pm

		Cost Center Description	NURSING ADMINISTRATION (DIRECT NRSING HR)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)		
			13.00	14.00	15.00	16.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	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	229,570					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	3,788,540				14.00
15.00	01500	PHARMACY	0	22,245	100			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	280	0	664,777		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	98,808	129,741	0	5,628		30.00
31.00	03100	INTENSIVE CARE UNIT	2,798	4,386	0	406		31.00
43.00	04300	NURSERY	1,123	0	0	1,167		43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	30,558	392,394	0	13,012		50.00
51.00	05100	RECOVERY ROOM	19,299	0	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	8,099	48,040	0	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	37,591	0	121,927		54.00
60.00	06000	LABORATORY	0	1,016,375	0	200,101		60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	30,374	0	17,419		65.00
65.01	06501	SLEEP LAB	0	0	0	0		65.01
66.00	06600	PHYSICAL THERAPY	0	10,522	0	60,327		66.00
69.00	06900	ELECTROCARDIOLOGY	0	3,306	0	30,243		69.00
69.01	06901	CARDIAC REHAB	0	1,976	0	16,004		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	800,964	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	998,267	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	100	0		73.00
76.00	03020	CHEMICAL DEPENDENCY	0	388	0	816		76.00
76.01	03480	ONCOLOGY	0	68	0	0		76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	7,223	0	0		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0		89.00
90.00	09000	CLINIC	5,388	21,278	0	21,340		90.00
90.01	09001	CLINIC- MCDONALD	0	12,283	0	21,054		90.01
91.00	09100	EMERGENCY	63,497	170,239	0	76,237		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	8,239	0	0		101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	0	501	0	0		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	229,570	3,716,680	100	585,681		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
194.00	07950	DAYCARE-INFANT/TODDLER	0	0	0	0		194.00
194.01	07951	MOB	0	0	0	60,436		194.01
194.02	07952	COMMUNITY HEALTH	0	1,435	0	0		194.02
194.03	07953	ASSISTED LIVING/CAMERON WOODS	0	0	0	0		194.03
194.04	07954	EDUCATION	0	0	0	0		194.04
194.05	07955	MARKETING	0	564	0	0		194.05
194.06	07956	GUEST MEALS	0	0	0	0		194.06
194.07	07957	OUTSIDE LAUNDRY	0	0	0	0		194.07
194.08	07958	CANCER CENTER	0	0	0	0		194.08
194.09	07959	URGENT CARE	0	51,197	0	0		194.09
194.10	07960	RHC	0	0	0	0		194.10
194.11	07961	OBGYN	0	13,008	0	18,660		194.11
194.12	07962	TRINE STUDENT HEALTH	0	1,180	0	0		194.12
194.13	07963	OCCUPATIONAL HEALTH	0	3,521	0	0		194.13
194.14	07964	IMMUNIZATION CLINIC	0	955	0	0		194.14
194.15	07965	FOUNDATION	0	0	0	0		194.15
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)	1,173,077	808,048	3,990,842	1,119,770		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1315 | Period: From 10/01/2017 To 09/30/2018 | Worksheet B-1 | Date/Time Prepared: 2/21/2019 3:49 pm

		Cost Center Description	NURSING ADMINISTRATION (DIRECT NRSING HR)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)		
			13.00	14.00	15.00	16.00		
203.00		Unit cost multiplier (Wkst. B, Part I)	5.109888	0.213287	39,908.420000	1.684430		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	84,066	250,557	148,633	62,863		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.366189	0.066136	1,486.330000	0.094563		205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1315 | Period: From 10/01/2017 To 09/30/2018 | Worksheet C Part I Date/Time Prepared: 2/21/2019 3:49 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	8,559,090		8,559,090	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	377,455		377,455	0	0	31.00
43.00	04300	NURSERY	243,075		243,075	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,909,645		3,909,645	0	0	50.00
51.00	05100	RECOVERY ROOM	2,115,259		2,115,259	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,025,023		1,025,023	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,279,706		5,279,706	0	0	54.00
60.00	06000	LABORATORY	4,823,701		4,823,701	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0		0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	1,220,656	0	1,220,656	0	0	65.00
65.01	06501	SLEEP LAB	474,071	0	474,071	0	0	65.01
66.00	06600	PHYSICAL THERAPY	2,467,521	0	2,467,521	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	509,405		509,405	0	0	69.00
69.01	06901	CARDIAC REHAB	263,517		263,517	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,167,560		1,167,560	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,455,167		1,455,167	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,990,842		3,990,842	0	0	73.00
76.00	03020	CHEMICAL DEPENDENCY	332,611		332,611	0	0	76.00
76.01	03480	ONCOLOGY	3,218,829		3,218,829	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,718,765		1,718,765	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0	89.00
90.00	09000	CLINIC	409,472		409,472	0	0	90.00
90.01	09001	CLINIC- MCDONALD	1,055,186		1,055,186	0	0	90.01
91.00	09100	EMERGENCY	5,460,088		5,460,088	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,051,057		2,051,057		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	1,225,924		1,225,924		0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	288,949		288,949		0	116.00
200.00		Subtotal (see instructions)	53,642,574	0	53,642,574	0	0	200.00
201.00		Less Observation Beds	2,051,057		2,051,057		0	201.00
202.00		Total (see instructions)	51,591,517	0	51,591,517	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1315 | Period: From 10/01/2017 To 09/30/2018 | Worksheet C Part I Date/Time Prepared: 2/21/2019 3:49 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	8,078,369		8,078,369			30.00
31.00	03100	INTENSIVE CARE UNIT	279,300		279,300			31.00
43.00	04300	NURSERY	473,000		473,000			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,850,047	13,148,567	15,998,614	0.244374	0.000000	50.00
51.00	05100	RECOVERY ROOM	653,580	2,675,623	3,329,203	0.635365	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	931,107	306,145	1,237,252	0.828467	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,801,282	29,383,058	31,184,340	0.169306	0.000000	54.00
60.00	06000	LABORATORY	1,858,196	13,282,176	15,140,372	0.318599	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0.000000	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	1,762,316	945,954	2,708,270	0.450714	0.000000	65.00
65.01	06501	SLEEP LAB	0	1,212,570	1,212,570	0.390964	0.000000	65.01
66.00	06600	PHYSICAL THERAPY	758,912	4,017,987	4,776,899	0.516553	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	282,853	1,870,658	2,153,511	0.236546	0.000000	69.00
69.01	06901	CARDIAC REHAB	11,396	465,258	476,654	0.552848	0.000000	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	614,224	1,945,381	2,559,605	0.456149	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	963,397	899,198	1,862,595	0.781258	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,763,017	8,751,921	10,514,938	0.379540	0.000000	73.00
76.00	03020	CHEMICAL DEPENDENCY	0	113,133	113,133	2.940000	0.000000	76.00
76.01	03480	ONCOLOGY	0	9,193,010	9,193,010	0.350139	0.000000	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	1,091,982	1,091,982			88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0			89.00
90.00	09000	CLINIC	40	622,038	622,078	0.658233	0.000000	90.00
90.01	09001	CLINIC- MCDONALD	0	156,084	156,084	6.760373	0.000000	90.01
91.00	09100	EMERGENCY	559,498	15,995,023	16,554,521	0.329825	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	61,426	1,649,837	1,711,263	1.198563	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	1,079,725	1,079,725			101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	0	314,449	314,449			116.00
200.00		Subtotal (see instructions)	23,701,960	109,119,777	132,821,737			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	23,701,960	109,119,777	132,821,737			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1315 | Period: From 10/01/2017 To 09/30/2018 | Worksheet C Part I Date/Time Prepared: 2/21/2019 3:49 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
43.00	04300	NURSERY			43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
51.00	05100	RECOVERY ROOM	0.000000		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	06000	LABORATORY	0.000000		60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000		64.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
65.01	06501	SLEEP LAB	0.000000		65.01
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
69.01	06901	CARDIAC REHAB	0.000000		69.01
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
76.00	03020	CHEMICAL DEPENDENCY	0.000000		76.00
76.01	03480	ONCOLOGY	0.000000		76.01
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC			88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER			89.00
90.00	09000	CLINIC	0.000000		90.00
90.01	09001	CLINIC- MCDONALD	0.000000		90.01
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
		OTHER REIMBURSABLE COST CENTERS			
101.00	10100	HOME HEALTH AGENCY			101.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
114.00	11400	UTILIZATION REVIEW-SNF			114.00
116.00	11600	HOSPICE			116.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1315 | Period: From 10/01/2017 To 09/30/2018 | Worksheet C Part I Date/Time Prepared: 2/21/2019 3:49 pm

Title XIX | Hospital | PPS

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	Costs RCE Disallowance	Costs Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	8,559,090		8,559,090	0	8,559,090	30.00
31.00	03100	INTENSIVE CARE UNIT	377,455		377,455	0	377,455	31.00
43.00	04300	NURSERY	243,075		243,075	0	243,075	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,909,645		3,909,645	0	3,909,645	50.00
51.00	05100	RECOVERY ROOM	2,115,259		2,115,259	0	2,115,259	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,025,023		1,025,023	0	1,025,023	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,279,706		5,279,706	0	5,279,706	54.00
60.00	06000	LABORATORY	4,823,701		4,823,701	0	4,823,701	60.00
64.00	06400	INTRAVENOUS THERAPY	0		0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	1,220,656	0	1,220,656	0	1,220,656	65.00
65.01	06501	SLEEP LAB	474,071	0	474,071	0	474,071	65.01
66.00	06600	PHYSICAL THERAPY	2,467,521	0	2,467,521	0	2,467,521	66.00
69.00	06900	ELECTROCARDIOLOGY	509,405		509,405	0	509,405	69.00
69.01	06901	CARDIAC REHAB	263,517		263,517	0	263,517	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,167,560		1,167,560	0	1,167,560	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,455,167		1,455,167	0	1,455,167	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,990,842		3,990,842	0	3,990,842	73.00
76.00	03020	CHEMICAL DEPENDENCY	332,611		332,611	0	332,611	76.00
76.01	03480	ONCOLOGY	3,218,829		3,218,829	0	3,218,829	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,718,765		1,718,765	0	1,718,765	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0	89.00
90.00	09000	CLINIC	409,472		409,472	0	409,472	90.00
90.01	09001	CLINIC- MCDONALD	1,055,186		1,055,186	0	1,055,186	90.01
91.00	09100	EMERGENCY	5,460,088		5,460,088	0	5,460,088	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,051,057		2,051,057		2,051,057	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	1,225,924		1,225,924		1,225,924	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	288,949		288,949		288,949	116.00
200.00		Subtotal (see instructions)	53,642,574	0	53,642,574	0	53,642,574	200.00
201.00		Less Observation Beds	2,051,057		2,051,057		2,051,057	201.00
202.00		Total (see instructions)	51,591,517	0	51,591,517	0	51,591,517	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1315 | Period: From 10/01/2017 To 09/30/2018 | Worksheet C Part I Date/Time Prepared: 2/21/2019 3:49 pm

Title XIX | Hospital | PPS

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	8,078,369		8,078,369			30.00
31.00	03100	INTENSIVE CARE UNIT	279,300		279,300			31.00
43.00	04300	NURSERY	473,000		473,000			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,850,047	13,148,567	15,998,614	0.244374	0.000000	50.00
51.00	05100	RECOVERY ROOM	653,580	2,675,623	3,329,203	0.635365	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	931,107	306,145	1,237,252	0.828467	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,801,282	29,383,058	31,184,340	0.169306	0.000000	54.00
60.00	06000	LABORATORY	1,858,196	13,282,176	15,140,372	0.318599	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0.000000	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	1,762,316	945,954	2,708,270	0.450714	0.000000	65.00
65.01	06501	SLEEP LAB	0	1,212,570	1,212,570	0.390964	0.000000	65.01
66.00	06600	PHYSICAL THERAPY	758,912	4,017,987	4,776,899	0.516553	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	282,853	1,870,658	2,153,511	0.236546	0.000000	69.00
69.01	06901	CARDIAC REHAB	11,396	465,258	476,654	0.552848	0.000000	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	614,224	1,945,381	2,559,605	0.456149	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	963,397	899,198	1,862,595	0.781258	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,763,017	8,751,921	10,514,938	0.379540	0.000000	73.00
76.00	03020	CHEMICAL DEPENDENCY	0	113,133	113,133	2.940000	0.000000	76.00
76.01	03480	ONCOLOGY	0	9,193,010	9,193,010	0.350139	0.000000	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	1,091,982	1,091,982	1.573987	0.000000	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.000000	0.000000	89.00
90.00	09000	CLINIC	40	622,038	622,078	0.658233	0.000000	90.00
90.01	09001	CLINIC- MCDONALD	0	156,084	156,084	6.760373	0.000000	90.01
91.00	09100	EMERGENCY	559,498	15,995,023	16,554,521	0.329825	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	61,426	1,649,837	1,711,263	1.198563	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	1,079,725	1,079,725			101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	0	314,449	314,449			116.00
200.00		Subtotal (see instructions)	23,701,960	109,119,777	132,821,737			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	23,701,960	109,119,777	132,821,737			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1315 | Period: From 10/01/2017 To 09/30/2018 | Worksheet C Part I Date/Time Prepared: 2/21/2019 3:49 pm

Title XIX | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
43.00	04300	NURSERY		43.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.244374	50.00
51.00	05100	RECOVERY ROOM	0.635365	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.828467	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.169306	54.00
60.00	06000	LABORATORY	0.318599	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0.450714	65.00
65.01	06501	SLEEP LAB	0.390964	65.01
66.00	06600	PHYSICAL THERAPY	0.516553	66.00
69.00	06900	ELECTROCARDIOLOGY	0.236546	69.00
69.01	06901	CARDIAC REHAB	0.552848	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.456149	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.781258	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.379540	73.00
76.00	03020	CHEMICAL DEPENDENCY	2.940000	76.00
76.01	03480	ONCOLOGY	0.350139	76.01
		OUTPATIENT SERVICE COST CENTERS		
88.00	08800	RURAL HEALTH CLINIC	1.573987	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	89.00
90.00	09000	CLINIC	0.658233	90.00
90.01	09001	CLINIC- MCDONALD	6.760373	90.01
91.00	09100	EMERGENCY	0.329825	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.198563	92.00
		OTHER REIMBURSABLE COST CENTERS		
101.00	10100	HOME HEALTH AGENCY		101.00
		SPECIAL PURPOSE COST CENTERS		
113.00	11300	INTEREST EXPENSE		113.00
114.00	11400	UTILIZATION REVIEW-SNF		114.00
116.00	11600	HOSPICE		116.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

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

Provider CCN: 15-1315 | Period: From 10/01/2017 To 09/30/2018 | Worksheet C Part II Date/Time Prepared: 2/21/2019 3:49 pm

Title XIX | Hospital | PPS

		Cost Center Description	Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,909,645	937,380	2,972,265	0	0	50.00
51.00	05100	RECOVERY ROOM	2,115,259	582,088	1,533,171	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,025,023	280,347	744,676	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,279,706	738,040	4,541,666	0	0	54.00
60.00	06000	LABORATORY	4,823,701	372,819	4,450,882	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	1,220,656	122,520	1,098,136	0	0	65.00
65.01	06501	SLEEP LAB	474,071	99,099	374,972	0	0	65.01
66.00	06600	PHYSICAL THERAPY	2,467,521	510,165	1,957,356	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	509,405	20,171	489,234	0	0	69.00
69.01	06901	CARDIAC REHAB	263,517	64,196	199,321	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,167,560	66,657	1,100,903	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,455,167	83,075	1,372,092	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,990,842	148,633	3,842,209	0	0	73.00
76.00	03020	CHEMICAL DEPENDENCY	332,611	6,293	326,318	0	0	76.00
76.01	03480	ONCOLOGY	3,218,829	883,134	2,335,695	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,718,765	181,542	1,537,223	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	409,472	49,281	360,191	0	0	90.00
90.01	09001	CLINIC- MCDONALD	1,055,186	174,731	880,455	0	0	90.01
91.00	09100	EMERGENCY	5,460,088	877,199	4,582,889	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,051,057	415,021	1,636,036	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	1,225,924	76,300	1,149,624	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	288,949	16,356	272,593	0	0	116.00
200.00		Subtotal (sum of lines 50 thru 199)	44,462,954	6,705,047	37,757,907	0	0	200.00
201.00		Less Observation Beds	2,051,057	415,021	1,636,036	0	0	201.00
202.00		Total (line 200 minus line 201)	42,411,897	6,290,026	36,121,871	0	0	202.00

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

Provider CCN: 15-1315 | Period: From 10/01/2017 To 09/30/2018 | Worksheet C Part II Date/Time Prepared: 2/21/2019 3:49 pm

Title XIX | Hospital | PPS

		Cost Center Description	Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)		
			6.00	7.00	8.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	3,909,645	15,998,614	0.244374		50.00
51.00	05100	RECOVERY ROOM	2,115,259	3,329,203	0.635365		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,025,023	1,237,252	0.828467		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,279,706	31,184,340	0.169306		54.00
60.00	06000	LABORATORY	4,823,701	15,140,372	0.318599		60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0.000000		64.00
65.00	06500	RESPIRATORY THERAPY	1,220,656	2,708,270	0.450714		65.00
65.01	06501	SLEEP LAB	474,071	1,212,570	0.390964		65.01
66.00	06600	PHYSICAL THERAPY	2,467,521	4,776,899	0.516553		66.00
69.00	06900	ELECTROCARDIOLOGY	509,405	2,153,511	0.236546		69.00
69.01	06901	CARDIAC REHAB	263,517	476,654	0.552848		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,167,560	2,559,605	0.456149		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,455,167	1,862,595	0.781258		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,990,842	10,514,938	0.379540		73.00
76.00	03020	CHEMICAL DEPENDENCY	332,611	113,133	2.940000		76.00
76.01	03480	ONCOLOGY	3,218,829	9,193,010	0.350139		76.01
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	1,718,765	1,091,982	1.573987		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000		89.00
90.00	09000	CLINIC	409,472	622,078	0.658233		90.00
90.01	09001	CLINIC- MCDONALD	1,055,186	156,084	6.760373		90.01
91.00	09100	EMERGENCY	5,460,088	16,554,521	0.329825		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,051,057	1,711,263	1.198563		92.00
		OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY	1,225,924	1,079,725	1.135404		101.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
114.00	11400	UTILIZATION REVIEW-SNF					114.00
116.00	11600	HOSPICE	288,949	314,449	0.918906		116.00
200.00		Subtotal (sum of lines 50 thru 199)	44,462,954	123,991,068			200.00
201.00		Less Observation Beds	2,051,057	0			201.00
202.00		Total (line 200 minus line 201)	42,411,897	123,991,068			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-1315 | Period: From 10/01/2017 To 09/30/2018 | Worksheet D Part II Date/Time Prepared: 2/21/2019 3:49 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	937,380	15,998,614	0.058591	900,640	52,769	50.00
51.00	05100	RECOVERY ROOM	582,088	3,329,203	0.174843	167,912	29,358	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	280,347	1,237,252	0.226588	4,260	965	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	738,040	31,184,340	0.023667	612,029	14,485	54.00
60.00	06000	LABORATORY	372,819	15,140,372	0.024624	631,696	15,555	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0.000000	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	122,520	2,708,270	0.045239	664,471	30,060	65.00
65.01	06501	SLEEP LAB	99,099	1,212,570	0.081726	0	0	65.01
66.00	06600	PHYSICAL THERAPY	510,165	4,776,899	0.106798	196,607	20,997	66.00
69.00	06900	ELECTROCARDIOLOGY	20,171	2,153,511	0.009367	233,531	2,187	69.00
69.01	06901	CARDIAC REHAB	64,196	476,654	0.134681	989	133	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	66,657	2,559,605	0.026042	447,350	11,650	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	83,075	1,862,595	0.044602	353,031	15,746	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	148,633	10,514,938	0.014135	593,116	8,384	73.00
76.00	03020	CHEMICAL DEPENDENCY	6,293	113,133	0.055625	0	0	76.00
76.01	03480	ONCOLOGY	883,134	9,193,010	0.096066	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	181,542	1,091,982	0.166250	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00
90.00	09000	CLINIC	49,281	622,078	0.079220	39	3	90.00
90.01	09001	CLINIC- MCDONALD	174,731	156,084	1.119468	0	0	90.01
91.00	09100	EMERGENCY	877,199	16,554,521	0.052988	16,536	876	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	415,021	1,711,263	0.242523	47,468	11,512	92.00
200.00		Total (lines 50 through 199)	6,612,391	122,596,894		4,869,675	214,680	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1315 | Period: From 10/01/2017 To 09/30/2018 | Worksheet D Part IV | Date/Time Prepared: 2/21/2019 3:49 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
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
65.01	06501	SLEEP LAB	0	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901	CARDIAC REHAB	0	0	0	0	0	69.01
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
76.00	03020	CHEMICAL DEPENDENCY	0	0	0	0	0	76.00
76.01	03480	ONCOLOGY	0	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	CLINIC- MCDONALD	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1315 | Period: From 10/01/2017 To 09/30/2018 | Worksheet D Part IV | Date/Time Prepared: 2/21/2019 3:49 pm

Title XVIII | Hospital | Cost

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 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	15,998,614	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	3,329,203	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	1,237,252	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	31,184,340	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	15,140,372	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	2,708,270	0.000000	65.00
65.01	06501	SLEEP LAB	0	0	0	1,212,570	0.000000	65.01
66.00	06600	PHYSICAL THERAPY	0	0	0	4,776,899	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	2,153,511	0.000000	69.00
69.01	06901	CARDIAC REHAB	0	0	0	476,654	0.000000	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	2,559,605	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1,862,595	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	10,514,938	0.000000	73.00
76.00	03020	CHEMICAL DEPENDENCY	0	0	0	113,133	0.000000	76.00
76.01	03480	ONCOLOGY	0	0	0	9,193,010	0.000000	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	1,091,982	0.000000	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0.000000	89.00
90.00	09000	CLINIC	0	0	0	622,078	0.000000	90.00
90.01	09001	CLINIC- MCDONALD	0	0	0	156,084	0.000000	90.01
91.00	09100	EMERGENCY	0	0	0	16,554,521	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	1,711,263	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	122,596,894		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1315 | Period: From 10/01/2017 To 09/30/2018 | Worksheet D Part IV | Date/Time Prepared: 2/21/2019 3:49 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	900,640	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	167,912	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	4,260	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	612,029	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	631,696	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	664,471	0	0	0	65.00
65.01	06501	SLEEP LAB	0.000000	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0.000000	196,607	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	233,531	0	0	0	69.00
69.01	06901	CARDIAC REHAB	0.000000	989	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	447,350	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	353,031	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	593,116	0	0	0	73.00
76.00	03020	CHEMICAL DEPENDENCY	0.000000	0	0	0	0	76.00
76.01	03480	ONCOLOGY	0.000000	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	0	0	0	89.00
90.00	09000	CLINIC	0.000000	39	0	0	0	90.00
90.01	09001	CLINIC- MCDONALD	0.000000	0	0	0	0	90.01
91.00	09100	EMERGENCY	0.000000	16,536	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	47,468	0	0	0	92.00
200.00		Total (lines 50 through 199)		4,869,675	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1315 | Period: From 10/01/2017 To 09/30/2018 | Worksheet D Part V Date/Time Prepared: 2/21/2019 3:49 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	0.244374	0	3,305,692	0	0	50.00
51.00	05100	RECOVERY ROOM	0.635365	0	498,221	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.828467	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.169306	0	7,253,509	0	0	54.00
60.00	06000	LABORATORY	0.318599	0	3,478,510	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.450714	0	532,241	0	0	65.00
65.01	06501	SLEEP LAB	0.390964	0	16,340	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0.516553	0	1,217,638	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.236546	0	594,930	0	0	69.00
69.01	06901	CARDIAC REHAB	0.552848	0	146,957	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.456149	0	360,410	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.781258	0	274,155	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.379540	0	3,255,392	10,814	0	73.00
76.00	03020	CHEMICAL DEPENDENCY	2.940000	0	67,328	0	0	76.00
76.01	03480	ONCOLOGY	0.350139	0	3,726,665	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000				0	89.00
90.00	09000	CLINIC	0.658233	0	292,365	0	0	90.00
90.01	09001	CLINIC- MCDONALD	6.760373	0	88,068	4	0	90.01
91.00	09100	EMERGENCY	0.329825	0	3,414,600	2,008	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.198563	0	975,153	788	0	92.00
200.00		Subtotal (see instructions)		0	29,498,174	13,614	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	29,498,174	13,614	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1315 | Period: From 10/01/2017 To 09/30/2018 | Worksheet D Part V Date/Time Prepared: 2/21/2019 3:49 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	807,825	0		50.00
51.00	05100	RECOVERY ROOM	316,552	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,228,063	0		54.00
60.00	06000	LABORATORY	1,108,250	0		60.00
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	239,888	0		65.00
65.01	06501	SLEEP LAB	6,388	0		65.01
66.00	06600	PHYSICAL THERAPY	628,975	0		66.00
69.00	06900	ELECTROCARDIOLOGY	140,728	0		69.00
69.01	06901	CARDIAC REHAB	81,245	0		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	164,401	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	214,186	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,235,551	4,104		73.00
76.00	03020	CHEMICAL DEPENDENCY	197,944	0		76.00
76.01	03480	ONCOLOGY	1,304,851	0		76.01
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0		89.00
90.00	09000	CLINIC	192,444	0		90.00
90.01	09001	CLINIC- MCDONALD	595,373	27		90.01
91.00	09100	EMERGENCY	1,126,220	662		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,168,782	944		92.00
200.00		Subtotal (see instructions)	10,757,666	5,737		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	10,757,666	5,737		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-1315 | Component CCN: 15-Z315 | Period: From 10/01/2017 To 09/30/2018 | Worksheet D Part V | Date/Time Prepared: 2/21/2019 3:49 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	0.244374	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.635365	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.828467	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.169306	0	0	0	0	54.00
60.00	06000	LABORATORY	0.318599	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.450714	0	0	0	0	65.00
65.01	06501	SLEEP LAB	0.390964	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0.516553	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.236546	0	0	0	0	69.00
69.01	06901	CARDIAC REHAB	0.552848	0	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.456149	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.781258	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.379540	0	0	0	0	73.00
76.00	03020	CHEMICAL DEPENDENCY	2.940000	0	0	0	0	76.00
76.01	03480	ONCOLOGY	0.350139	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000				0	89.00
90.00	09000	CLINIC	0.658233	0	0	0	0	90.00
90.01	09001	CLINIC- MCDONALD	6.760373	0	0	0	0	90.01
91.00	09100	EMERGENCY	0.329825	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.198563	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: 15-1315 | Component CCN: 15-Z315 | Period: From 10/01/2017 To 09/30/2018 | Worksheet D Part V | Date/Time Prepared: 2/21/2019 3:49 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
51.00	05100	RECOVERY ROOM	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
60.00	06000	LABORATORY	0	0		60.00
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
65.01	06501	SLEEP LAB	0	0		65.01
66.00	06600	PHYSICAL THERAPY	0	0		66.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
69.01	06901	CARDIAC REHAB	0	0		69.01
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
76.00	03020	CHEMICAL DEPENDENCY	0	0		76.00
76.01	03480	ONCOLOGY	0	0		76.01
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0		89.00
90.00	09000	CLINIC	0	0		90.00
90.01	09001	CLINIC- MCDONALD	0	0		90.01
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
200.00		Subtotal (see instructions)	0	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	0		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 15-1315 | Period: From 10/01/2017 To 09/30/2018 | Worksheet D Part I Date/Time Prepared: 2/21/2019 3:49 pm

Title XIX | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	1,731,891	98,054	1,633,837	4,669	349.93	30.00
31.00	INTENSIVE CARE UNIT	108,652		108,652	133	816.93	31.00
43.00	NURSERY	43,093		43,093	469	91.88	43.00
200.00	Total (lines 30 through 199)	1,883,636		1,785,582	5,271		200.00

	Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
		6.00	7.00				
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	31	10,848				30.00
31.00	INTENSIVE CARE UNIT	23	18,789				31.00
43.00	NURSERY	0	0				43.00
200.00	Total (lines 30 through 199)	54	29,637				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-1315 | Period: From 10/01/2017 To 09/30/2018 | Worksheet D Part II Date/Time Prepared: 2/21/2019 3:49 pm

Title XIX | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	937,380	15,998,614	0.058591	22,836	1,338	50.00
51.00	05100	RECOVERY ROOM	582,088	3,329,203	0.174843	5,237	916	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	280,347	1,237,252	0.226588	7,461	1,691	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	738,040	31,184,340	0.023667	14,433	342	54.00
60.00	06000	LABORATORY	372,819	15,140,372	0.024624	14,889	367	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0.000000	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	122,520	2,708,270	0.045239	14,121	639	65.00
65.01	06501	SLEEP LAB	99,099	1,212,570	0.081726	0	0	65.01
66.00	06600	PHYSICAL THERAPY	510,165	4,776,899	0.106798	6,081	649	66.00
69.00	06900	ELECTROCARDIOLOGY	20,171	2,153,511	0.009367	1,064	10	69.00
69.01	06901	CARDIAC REHAB	64,196	476,654	0.134681	91	12	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	66,657	2,559,605	0.026042	12,641	329	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	83,075	1,862,595	0.044602	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	148,633	10,514,938	0.014135	14,126	200	73.00
76.00	03020	CHEMICAL DEPENDENCY	6,293	113,133	0.055625	0	0	76.00
76.01	03480	ONCOLOGY	883,134	9,193,010	0.096066	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	181,542	1,091,982	0.166250	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00
90.00	09000	CLINIC	49,281	622,078	0.079220	0	0	90.00
90.01	09001	CLINIC- MCDONALD	174,731	156,084	1.119468	0	0	90.01
91.00	09100	EMERGENCY	877,199	16,554,521	0.052988	4,483	238	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	415,021	1,711,263	0.242523	7,397	1,794	92.00
200.00		Total (lines 50 through 199)	6,612,391	122,596,894		124,860	8,525	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-1315 | Period: From 10/01/2017 To 09/30/2018 | Worksheet D Part III Date/Time Prepared: 2/21/2019 3:49 pm

Title XIX | Hospital | PPS

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

		Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
			4.00	5.00	6.00	7.00	8.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	4,669	0.00	31	30.00
31.00	03100	INTENSIVE CARE UNIT		0	133	0.00	23	31.00
43.00	04300	NURSERY		0	469	0.00	0	43.00
200.00		Total (lines 30 through 199)		0	5,271		54	200.00

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

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1315 | Period: From 10/01/2017 To 09/30/2018 | Worksheet D Part IV Date/Time Prepared: 2/21/2019 3:49 pm

Title XIX | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
65.01	06501	SLEEP LAB	0	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901	CARDIAC REHAB	0	0	0	0	0	69.01
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
76.00	03020	CHEMICAL DEPENDENCY	0	0	0	0	0	76.00
76.01	03480	ONCOLOGY	0	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	CLINIC- MCDONALD	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1315 | Period: From 10/01/2017 To 09/30/2018 | Worksheet D Part IV Date/Time Prepared: 2/21/2019 3:49 pm

Title XIX | Hospital | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 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	15,998,614	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	3,329,203	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	1,237,252	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	31,184,340	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	15,140,372	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	2,708,270	0.000000	65.00
65.01	06501	SLEEP LAB	0	0	0	1,212,570	0.000000	65.01
66.00	06600	PHYSICAL THERAPY	0	0	0	4,776,899	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	2,153,511	0.000000	69.00
69.01	06901	CARDIAC REHAB	0	0	0	476,654	0.000000	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	2,559,605	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1,862,595	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	10,514,938	0.000000	73.00
76.00	03020	CHEMICAL DEPENDENCY	0	0	0	113,133	0.000000	76.00
76.01	03480	ONCOLOGY	0	0	0	9,193,010	0.000000	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	1,091,982	0.000000	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0.000000	89.00
90.00	09000	CLINIC	0	0	0	622,078	0.000000	90.00
90.01	09001	CLINIC- MCDONALD	0	0	0	156,084	0.000000	90.01
91.00	09100	EMERGENCY	0	0	0	16,554,521	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	1,711,263	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	122,596,894		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1315 | Period: From 10/01/2017 To 09/30/2018 | Worksheet D Part IV | Date/Time Prepared: 2/21/2019 3:49 pm

Title XIX | Hospital | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	22,836	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	5,237	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	7,461	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	14,433	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	14,889	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	14,121	0	0	0	65.00
65.01	06501	SLEEP LAB	0.000000	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0.000000	6,081	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	1,064	0	0	0	69.00
69.01	06901	CARDIAC REHAB	0.000000	91	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	12,641	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	14,126	0	0	0	73.00
76.00	03020	CHEMICAL DEPENDENCY	0.000000	0	0	0	0	76.00
76.01	03480	ONCOLOGY	0.000000	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	0	0	0	89.00
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	CLINIC- MCDONALD	0.000000	0	0	0	0	90.01
91.00	09100	EMERGENCY	0.000000	4,483	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	7,397	0	0	0	92.00
200.00		Total (lines 50 through 199)		124,860	0	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1315 | Period: From 10/01/2017 To 09/30/2018 | Worksheet D-1 | Date/Time Prepared: 2/21/2019 3:49 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)	5,124	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	4,669	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	3,483	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)	263	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	192	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	1,297	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)	263	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	155.02	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)	8,559,090	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)	29,764	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)	484,591	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	8,074,499	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)	8,074,499	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)	1,729.38	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	2,243,006	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	2,243,006	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1315 | Period: From 10/01/2017 To 09/30/2018 | Worksheet D-1 | Date/Time Prepared: 2/21/2019 3:49 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)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	377,455	133	2,838.01	51	144,739	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)	1,859,367	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	4,247,112	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)	454,827	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	454,827	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)	1,186	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,729.39	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	2,051,057	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1315 | Period: From 10/01/2017 To 09/30/2018 | Worksheet D-1 | Date/Time Prepared: 2/21/2019 3:49 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	1,731,891	8,559,090	0.202345	2,051,057	415,021	90.00
91.00	Nursing School cost	0	8,559,090	0.000000	2,051,057	0	91.00
92.00	Allied health cost	0	8,559,090	0.000000	2,051,057	0	92.00
93.00	All other Medical Education	0	8,559,090	0.000000	2,051,057	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1315 | Period: From 10/01/2017 To 09/30/2018 | Worksheet D-1 | Date/Time Prepared: 2/21/2019 3:49 pm

Title XIX | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	5,124	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	4,669	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	3,483	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)	263	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	192	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	31	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)	469	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	155.02	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)	8,559,090	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)	29,764	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)	484,591	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	8,074,499	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)	8,074,499	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)	1,729.39	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	53,611	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)	53,611	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1315 | Period: From 10/01/2017 To 09/30/2018 | Worksheet D-1 | Date/Time Prepared: 2/21/2019 3:49 pm

Title XIX | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	243,075	469	518.28	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	377,455	133	2,838.01	23	65,274	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)	53,557	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	172,442	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)	29,637	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	8,525	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	38,162	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	134,280	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)	1,186	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,729.39	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	2,051,057	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1315 | Period: From 10/01/2017 To 09/30/2018 | Worksheet D-1 | Date/Time Prepared: 2/21/2019 3:49 pm

Title XIX | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	1,731,891	8,559,090	0.202345	2,051,057	415,021	90.00
91.00	Nursing School cost	0	8,559,090	0.000000	2,051,057	0	91.00
92.00	Allied health cost	0	8,559,090	0.000000	2,051,057	0	92.00
93.00	All other Medical Education	0	8,559,090	0.000000	2,051,057	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1315 | Period: From 10/01/2017 To 09/30/2018 | Worksheet D-3 | Date/Time Prepared: 2/21/2019 3:49 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		1,937,104		30.00
31.00	03100	INTENSIVE CARE UNIT		107,100		31.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.244374	900,640	220,093	50.00
51.00	05100	RECOVERY ROOM	0.635365	167,912	106,685	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.828467	4,260	3,529	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.169306	612,029	103,620	54.00
60.00	06000	LABORATORY	0.318599	631,696	201,258	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.450714	664,471	299,486	65.00
65.01	06501	SLEEP LAB	0.390964	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0.516553	196,607	101,558	66.00
69.00	06900	ELECTROCARDIOLOGY	0.236546	233,531	55,241	69.00
69.01	06901	CARDIAC REHAB	0.552848	989	547	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.456149	447,350	204,058	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.781258	353,031	275,808	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.379540	593,116	225,111	73.00
76.00	03020	CHEMICAL DEPENDENCY	2.940000	0	0	76.00
76.01	03480	ONCOLOGY	0.350139	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0	89.00
90.00	09000	CLINIC	0.658233	39	26	90.00
90.01	09001	CLINIC- MCDONALD	6.760373	0	0	90.01
91.00	09100	EMERGENCY	0.329825	16,536	5,454	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.198563	47,468	56,893	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		4,869,675	1,859,367	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)		4,869,675		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1315 | Component CCN: 15-Z315 | Period: From 10/01/2017 To 09/30/2018 | Worksheet D-3 | Date/Time Prepared: 2/21/2019 3:49 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
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.244374	0	0	50.00
51.00	05100	RECOVERY ROOM	0.635365	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.828467	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.169306	15,100	2,557	54.00
60.00	06000	LABORATORY	0.318599	19,302	6,150	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.450714	34,680	15,631	65.00
65.01	06501	SLEEP LAB	0.390964	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0.516553	182,381	94,209	66.00
69.00	06900	ELECTROCARDIOLOGY	0.236546	1,213	287	69.00
69.01	06901	CARDIAC REHAB	0.552848	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.456149	10,528	4,802	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.781258	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.379540	33,829	12,839	73.00
76.00	03020	CHEMICAL DEPENDENCY	2.940000	0	0	76.00
76.01	03480	ONCOLOGY	0.350139	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0	89.00
90.00	09000	CLINIC	0.658233	0	0	90.00
90.01	09001	CLINIC- MCDONALD	6.760373	0	0	90.01
91.00	09100	EMERGENCY	0.329825	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.198563	3,117	3,736	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		300,150	140,211	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)		300,150		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1315 | Period: From 10/01/2017 To 09/30/2018 | Worksheet D-3 | Date/Time Prepared: 2/21/2019 3:49 pm

Title XIX | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		45,016		30.00
31.00	03100	INTENSIVE CARE UNIT		2,238		31.00
43.00	04300	NURSERY		3,790		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.244374	22,836	5,581	50.00
51.00	05100	RECOVERY ROOM	0.635365	5,237	3,327	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.828467	7,461	6,181	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.169306	14,433	2,444	54.00
60.00	06000	LABORATORY	0.318599	14,889	4,744	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.450714	14,121	6,365	65.00
65.01	06501	SLEEP LAB	0.390964	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0.516553	6,081	3,141	66.00
69.00	06900	ELECTROCARDIOLOGY	0.236546	1,064	252	69.00
69.01	06901	CARDIAC REHAB	0.552848	91	50	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.456149	12,641	5,766	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.781258	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.379540	14,126	5,361	73.00
76.00	03020	CHEMICAL DEPENDENCY	2.940000	0	0	76.00
76.01	03480	ONCOLOGY	0.350139	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	1.573987	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	0	89.00
90.00	09000	CLINIC	0.658233	0	0	90.00
90.01	09001	CLINIC- MCDONALD	6.760373	0	0	90.01
91.00	09100	EMERGENCY	0.329825	4,483	1,479	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.198563	7,397	8,866	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		124,860	53,557	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)		124,860		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1315	Period: From 10/01/2017 To 09/30/2018	Worksheet E Part B Date/Time Prepared: 2/21/2019 3:49 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	10,763,403	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)	10,763,403	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	0	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (see instructions)	10,871,037	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 amounts (for CAH, see instructions)	65,443	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	5,190,769	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	5,614,825	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	5,614,825	30.00
31.00	Primary payer payments	4,616	31.00
32.00	Subtotal (line 30 minus line 31)	5,610,209	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)	853,402	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	554,711	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	632,211	36.00
37.00	Subtotal (see instructions)	6,164,920	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		39.50
39.97	Demonstration payment adjustment amount before sequestration	0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	6,164,920	40.00
40.01	Sequestration adjustment (see instructions)	123,298	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
41.00	Interim payments	6,688,755	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	-647,133	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: 15-1315 | Period: From 10/01/2017 To 09/30/2018 | Worksheet E-1 Part I Date/Time Prepared: 2/21/2019 3:49 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		3,680,800		6,552,555	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	04/20/2018	136,200	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		136,200	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)		3,680,800		6,688,755	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		68,595		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		647,133	6.02
7.00	Total Medicare program liability (see instructions)		3,749,395		6,041,622	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: 15-1315 | Component CCN: 15-Z315 | Period: From 10/01/2017 To 09/30/2018 | Worksheet E-1 Part I | Date/Time Prepared: 2/21/2019 3:49 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		611,380		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)		611,380		0	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		23,057		0	6.02
7.00	Total Medicare program liability (see instructions)		588,323		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: 15-1315	Period: From 10/01/2017 To 09/30/2018	Worksheet E-1 Part II Date/Time Prepared: 2/21/2019 3:49 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: 15-1315 | Component CCN: 15-Z315 | Period: From 10/01/2017 To 09/30/2018 | Worksheet E-2 | Date/Time Prepared: 2/21/2019 3:49 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)	459,375	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)	141,613	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	263	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)	600,988	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	600,988	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)	600,988	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	658	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)	600,330	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)			16.50
16.55	Rural community hospital demonstration project (§410A Demonstration) payment adjustment (see instructions)	0		16.55
16.99	Demonstration payment adjustment amount before sequestration	0	0	16.99
17.00	Allowable bad debts (see instructions)	0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (see instructions)	600,330	0	19.00
19.01	Sequestration adjustment (see instructions)	12,007	0	19.01
19.02	Demonstration payment adjustment amount after sequestration)	0	0	19.02
20.00	Interim payments	611,380	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)	-23,057	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: 15-1315	Period: From 10/01/2017 To 09/30/2018	Worksheet E-3 Part V Date/Time Prepared: 2/21/2019 3:49 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	4,247,112	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)	4,247,112	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	4,289,583	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)	4,289,583	19.00
20.00	Deductibles (exclude professional component)	502,732	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	3,786,851	22.00
23.00	Coinsurance	0	23.00
24.00	Subtotal (line 22 minus line 23)	3,786,851	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	60,096	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	39,062	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	29,315	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	3,825,913	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)	3,825,913	30.00
30.01	Sequestration adjustment (see instructions)	76,518	30.01
30.02	Demonstration payment adjustment amount after sequestration	0	30.02
31.00	Interim payments	3,680,800	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)	68,595	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: 15-1315 | Period: From 10/01/2017 To 09/30/2018 | Worksheet E-3 Part VII Date/Time Prepared: 2/21/2019 3:49 pm

Title XIX | Hospital | PPS

		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	0		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)	0	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)	0	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	51,044		8.00
9.00	Ancillary service charges	124,860	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)	175,904	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)	175,904	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	175,904	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)	0	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)	0	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)	0	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)	0	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	0	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)	0	0	40.00
41.00	Interim payments	87,239	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	-87,239	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: 15-1315 | Period: From 10/01/2017 To 09/30/2018 | Worksheet G | Date/Time Prepared: 2/21/2019 3:49 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	2,857,852	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	9,809,507	0	0	0	4.00
5.00	Other receivable	510,372	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	1,745,446	0	0	0	7.00
8.00	Prepaid expenses	911,631	0	0	0	8.00
9.00	Other current assets	66,635	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)	15,901,443	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	1,462,868	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	56,959,487	0	0	0	15.00
16.00	Accumulated depreciation	-17,089,344	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	0	0	0	0	19.00
20.00	Accumulated depreciation	0	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	19,354,015	0	0	0	23.00
24.00	Accumulated depreciation	-13,345,940	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	47,341,086	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	23,745,888	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	982,036	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	24,727,924	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	87,970,453	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	1,733,527	0	0	0	37.00
38.00	Salaries, wages, and fees payable	2,087,779	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	1,063,107	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	600,127	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	5,484,540	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	43,936,093	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	43,936,093	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	49,420,633	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	38,549,820				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	38,549,820	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	87,970,453	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-1315 | Period: From 10/01/2017 To 09/30/2018 | Worksheet G-1 | Date/Time Prepared: 2/21/2019 3:49 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		39,714,106		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-1,164,286				2.00
3.00	Total (sum of line 1 and line 2)		38,549,820		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)		38,549,820		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)		38,549,820		0		19.00

		Endowment Fund	Plant Fund		
		6.00	7.00	8.00	
1.00	Fund balances at beginning of period	0		0	1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)				2.00
3.00	Total (sum of line 1 and line 2)	0		0	3.00
4.00	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: 15-1315 | Period: From 10/01/2017 To 09/30/2018 | Worksheet G-2 Parts I & II Date/Time Prepared: 2/21/2019 3:49 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	8,551,369		8,551,369	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	8,551,369		8,551,369	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	279,300		279,300	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)	279,300		279,300	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	8,830,669		8,830,669	17.00
18.00	Ancillary services	14,100,326	88,360,639	102,460,965	18.00
19.00	Outpatient services	620,923	18,423,021	19,043,944	19.00
20.00	RURAL HEALTH CLINIC	0	1,091,982	1,091,982	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		1,079,725	1,079,725	22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE	0	314,449	314,449	26.00
27.00	PROFESSIONAL FEES	1,919,809	2,243,442	4,163,251	27.00
27.01	OTHER REVENUE	319,916	5,094,371	5,414,287	27.01
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	25,791,643	116,607,629	142,399,272	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		65,025,819		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)		65,025,819		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 15-1315 | Period: From 10/01/2017 To 09/30/2018 | Worksheet G-3 | Date/Time Prepared: 2/21/2019 3:49 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	142,399,272	1.00
2.00	Less contractual allowances and discounts on patients' accounts	80,744,360	2.00
3.00	Net patient revenues (line 1 minus line 2)	61,654,912	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	65,025,819	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-3,370,907	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER INCOME	1,292,242	24.00
24.01	CONTRIBUTIONS	165,020	24.01
24.02	LOSS ON DISPOSAL OF PROPERTY	-47,499	24.02
24.03	CONTRIBUTION TO FOUNDATION	0	24.03
24.04	CHANGE IN ASSETS FOUNDATION	0	24.04
24.05	INVESTMENT INCOME	784,129	24.05
24.06	OP REVENUE, GROUPED TO OTHER	12,729	24.06
25.00	Total other income (sum of lines 6-24)	2,206,621	25.00
26.00	Total (line 5 plus line 25)	-1,164,286	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-1,164,286	29.00

ANALYSIS OF HOSPITAL-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 15-1315 HHA CCN: 15-7117 | Period: From 10/01/2017 To 09/30/2018 | Worksheet H | Date/Time Prepared: 2/21/2019 3:49 pm

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		Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased Services	Other Costs	Total (sum of cols. 1 thru 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures			0		0	0	1.00
2.00	Capital Related - Movable Equipment			0		0	0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0	0	0	3.00
4.00	Transportation	0	0	0	0	0	0	4.00
5.00	Administrative and General	193,504	0	0	36,691	30,168	260,363	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	272,945	0	22,375	0	0	295,320	6.00
7.00	Physical Therapy	166,427	0	0	0	0	166,427	7.00
8.00	Occupational Therapy	36,819	0	0	0	0	36,819	8.00
9.00	Speech Pathology	3,157	0	0	0	0	3,157	9.00
10.00	Medical Social Services	24,651	0	0	0	0	24,651	10.00
11.00	Home Health Aide	47,803	0	0	0	0	47,803	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	745,306	0	22,375	36,691	30,168	834,540	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	-108,137	152,226	0	152,226			5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	-39,315	256,005	0	256,005			6.00
7.00	Physical Therapy	-129	166,298	0	166,298			7.00
8.00	Occupational Therapy	-42	36,777	0	36,777			8.00
9.00	Speech Pathology	0	3,157	0	3,157			9.00
10.00	Medical Social Services	-2,796	21,855	0	21,855			10.00
11.00	Home Health Aide	-6,295	41,508	0	41,508			11.00
12.00	Supplies (see instructions)	0	0	0	0			12.00
13.00	Drugs	0	0	0	0			13.00
14.00	DME	0	0	0	0			14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0			15.00
16.00	Respiratory Therapy	0	0	0	0			16.00
17.00	Private Duty Nursing	0	0	0	0			17.00
18.00	Clinic	0	0	0	0			18.00
19.00	Health Promotion Activities	0	0	0	0			19.00
20.00	Day Care Program	0	0	0	0			20.00
21.00	Home Delivered Meals Program	0	0	0	0			21.00
22.00	Homemaker Service	0	0	0	0			22.00
23.00	All Others (specify)	0	0	0	0			23.00
23.50	Telemedicine	0	0	0	0			23.50
24.00	Total (sum of lines 1-23)	-156,714	677,826	0	677,826			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: 15-1315 HHA CCN: 15-7117 | Period: From 10/01/2017 To 09/30/2018 | Worksheet H-1 Part I Date/Time Prepared: 2/21/2019 3:49 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	152,226	0	0	0	0	152,226	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	256,005	0	0	0	0	256,005	6.00
7.00	Physical Therapy	166,298	0	0	0	0	166,298	7.00
8.00	Occupational Therapy	36,777	0	0	0	0	36,777	8.00
9.00	Speech Pathology	3,157	0	0	0	0	3,157	9.00
10.00	Medical Social Services	21,855	0	0	0	0	21,855	10.00
11.00	Home Health Aide	41,508	0	0	0	0	41,508	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)	677,826	0	0	0	0	677,826	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	152,226		5.00
	HHA REIMBURSABLE SERVICES			
6.00	Skilled Nursing Care	74,145	330,150	6.00
7.00	Physical Therapy	48,164	214,462	7.00
8.00	Occupational Therapy	10,651	47,428	8.00
9.00	Speech Pathology	914	4,071	9.00
10.00	Medical Social Services	6,330	28,185	10.00
11.00	Home Health Aide	12,022	53,530	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)		677,826	24.00

COST ALLOCATION - HHA STATISTICAL BASIS | Provider CCN: 15-1315 HHA CCN: 15-7117 | Period: From 10/01/2017 To 09/30/2018 | Worksheet H-1 Part II Date/Time Prepared: 2/21/2019 3:49 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	-152,226	525,600	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	0	256,005	6.00
7.00	Physical Therapy	0	0	0	0	0	166,298	7.00
8.00	Occupational Therapy	0	0	0	0	0	36,777	8.00
9.00	Speech Pathology	0	0	0	0	0	3,157	9.00
10.00	Medical Social Services	0	0	0	0	0	21,855	10.00
11.00	Home Health Aide	0	0	0	0	0	41,508	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	-152,226	525,600	24.00
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0	0		152,226	25.00
26.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000		0.289623	26.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 15-1315 HHA CCN: 15-7117

Period: From 10/01/2017 To 09/30/2018

Worksheet H-2 Part I Date/Time Prepared: 2/21/2019 3:49 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	0	41,397	183,499	224,896	54,966	1.00
2.00	Skilled Nursing Care	330,150	0	0	0	330,150	80,691	2.00
3.00	Physical Therapy	214,462	0	0	0	214,462	52,416	3.00
4.00	Occupational Therapy	47,428	0	0	0	47,428	11,592	4.00
5.00	Speech Pathology	4,071	0	0	0	4,071	995	5.00
6.00	Medical Social Services	28,185	0	0	0	28,185	6,889	6.00
7.00	Home Health Aide	53,530	0	0	0	53,530	13,083	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)	677,826	0	41,397	183,499	902,722	220,632	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	59,126	51	13,236	0	28,400	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	59,126	51	13,236	0	28,400	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 15-1315 HHA CCN: 15-7117 | Period: From 10/01/2017 To 09/30/2018 | Worksheet H-2 Part I Date/Time Prepared: 2/21/2019 3:49 pm

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	Cost Center Description	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	
		14.00	15.00	16.00	24.00	25.00	26.00	
1.00	Administrative and General	1,757	0	0	382,432	0	382,432	1.00
2.00	Skilled Nursing Care	0	0	0	410,841	0	410,841	2.00
3.00	Physical Therapy	0	0	0	266,878	0	266,878	3.00
4.00	Occupational Therapy	0	0	0	59,020	0	59,020	4.00
5.00	Speech Pathology	0	0	0	5,066	0	5,066	5.00
6.00	Medical Social Services	0	0	0	35,074	0	35,074	6.00
7.00	Home Health Aide	0	0	0	66,613	0	66,613	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	1,757	0	0	1,225,924	0	1,225,924	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

	Cost Center Description	Allocated HHA A&G (see Part II)	Total HHA Costs					
		27.00	28.00					
1.00	Administrative and General							1.00
2.00	Skilled Nursing Care	186,272	597,113					2.00
3.00	Physical Therapy	121,000	387,878					3.00
4.00	Occupational Therapy	26,759	85,779					4.00
5.00	Speech Pathology	2,297	7,363					5.00
6.00	Medical Social Services	15,902	50,976					6.00
7.00	Home Health Aide	30,202	96,815					7.00
8.00	Supplies (see instructions)	0	0					8.00
9.00	Drugs	0	0					9.00
10.00	DME	0	0					10.00
11.00	Home Dialysis Aide Services	0	0					11.00
12.00	Respiratory Therapy	0	0					12.00
13.00	Private Duty Nursing	0	0					13.00
14.00	Clinic	0	0					14.00
15.00	Health Promotion Activities	0	0					15.00
16.00	Day Care Program	0	0					16.00
17.00	Home Delivered Meals Program	0	0					17.00
18.00	Homemaker Service	0	0					18.00
19.00	All Others (specify)	0	0					19.00
19.50	Telemedicine	0	0					19.50
20.00	Total (sum of lines 1-19) (2)	382,432	1,225,924					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.	0.453391						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: 15-1315 HHA CCN: 15-7117

Period: From 10/01/2017 To 09/30/2018

Worksheet H-2 Part II Date/Time Prepared: 2/21/2019 3:49 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	0	1,469	588,593	0	224,896	1,469	1.00
2.00	Skilled Nursing Care	0	0	0	0	330,150	0	2.00
3.00	Physical Therapy	0	0	0	0	214,462	0	3.00
4.00	Occupational Therapy	0	0	0	0	47,428	0	4.00
5.00	Speech Pathology	0	0	0	0	4,071	0	5.00
6.00	Medical Social Services	0	0	0	0	28,185	0	6.00
7.00	Home Health Aide	0	0	0	0	53,530	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	1,469	588,593		902,722	1,469	20.00
21.00	Total cost to be allocated	0	41,397	183,499		220,632	59,126	21.00
22.00	Unit cost multiplier	0.000000	28.180395	0.311759		0.244407	40.249149	22.00

	Cost Center Description	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDR)	HOUSEKEEPING (HOURS OF SERVIC)	DIETARY (MEALS SERVED)	CAFETERIA (FTES)	NURSING ADMINISTRATION (DIRECT NRSING HR)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	
		8.00	9.00	10.00	11.00	13.00	14.00	
1.00	Administrative and General	23	52	0	893	0	8,239	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)	23	52	0	893	0	8,239	20.00
21.00	Total cost to be allocated	51	13,236	0	28,400	0	1,757	21.00
22.00	Unit cost multiplier	2.217391	254.538462	0.000000	31.802912	0.000000	0.213254	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 15-1315
HHA CCN: 15-7117

Period:
From 10/01/2017
To 09/30/2018

Worksheet H-2
Part II
Date/Time Prepared:
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	Cost Center Description	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)			
		15.00	16.00			
1.00	Administrative and General	0	0			1.00
2.00	Skilled Nursing Care	0	0			2.00
3.00	Physical Therapy	0	0			3.00
4.00	Occupational Therapy	0	0			4.00
5.00	Speech Pathology	0	0			5.00
6.00	Medical Social Services	0	0			6.00
7.00	Home Health Aide	0	0			7.00
8.00	Supplies (see instructions)	0	0			8.00
9.00	Drugs	0	0			9.00
10.00	DME	0	0			10.00
11.00	Home Dialysis Aide Services	0	0			11.00
12.00	Respiratory Therapy	0	0			12.00
13.00	Private Duty Nursing	0	0			13.00
14.00	Clinic	0	0			14.00
15.00	Health Promotion Activities	0	0			15.00
16.00	Day Care Program	0	0			16.00
17.00	Home Delivered Meals Program	0	0			17.00
18.00	Homemaker Service	0	0			18.00
19.00	All Others (specify)	0	0			19.00
19.50	Telemedicine	0	0			19.50
20.00	Total (sum of lines 1-19)	0	0			20.00
21.00	Total cost to be allocated	0	0			21.00
22.00	Unit cost multiplier	0.000000	0.000000			22.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 15-1315 | HHA CCN: 15-7117 | Period: From 10/01/2017 To 09/30/2018 | Worksheet H-3 Part I | Date/Time Prepared: 2/21/2019 3:49 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	597,113		597,113	2,040	292.70	1.00
2.00	Physical Therapy	3.00	387,878	0	387,878	2,259	171.70	2.00
3.00	Occupational Therapy	4.00	85,779	0	85,779	349	245.79	3.00
4.00	Speech Pathology	5.00	7,363	0	7,363	53	138.92	4.00
5.00	Medical Social Services	6.00	50,976		50,976	46	1,108.17	5.00
6.00	Home Health Aide	7.00	96,815		96,815	921	105.12	6.00
7.00	Total (sum of lines 1-6)		1,225,924	0	1,225,924	5,668		7.00

	Cost Center Description	Cost Limits	CBSA No. (1)	Part A	Program Visits Part B Not Subject to Deductibles & Coinsurance	Part B Subject to Deductibles		
		0	1.00	2.00	3.00	4.00	5.00	
	Limitation Cost Computation							
8.00	Skilled Nursing Care		99915	0	276			8.00
9.00	Physical Therapy		99915	0	361			9.00
10.00	Occupational Therapy		99915	0	47			10.00
11.00	Speech Pathology		99915	0	10			11.00
12.00	Medical Social Services		99915	0	3			12.00
13.00	Home Health Aide		99915	0	56			13.00
14.00	Total (sum of lines 8-13)			0	753			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	Part B Not Subject to Deductibles & Coinsurance	Part B Subject to Deductibles & Coinsurance	
		6.00	7.00	8.00	9.00	10.00	11.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	0	276		0	80,785		1.00
2.00	Physical Therapy	0	361		0	61,984		2.00
3.00	Occupational Therapy	0	47		0	11,552		3.00
4.00	Speech Pathology	0	10		0	1,389		4.00
5.00	Medical Social Services	0	3		0	3,325		5.00
6.00	Home Health Aide	0	56		0	5,887		6.00
7.00	Total (sum of lines 1-6)	0	753		0	164,922		7.00

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

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 15-1315 | HHA CCN: 15-7117 | Period: From 10/01/2017 To 09/30/2018 | Worksheet H-3 Part I | Date/Time Prepared: 2/21/2019 3:49 pm

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	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		240	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	80,785	1.00
2.00	Physical Therapy	61,984	2.00
3.00	Occupational Therapy	11,552	3.00
4.00	Speech Pathology	1,389	4.00
5.00	Medical Social Services	3,325	5.00
6.00	Home Health Aide	5,887	6.00
7.00	Total (sum of lines 1-6)	164,922	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: 15-1315 HHA CCN: 15-7117 | Period: From 10/01/2017 To 09/30/2018 | Worksheet H-3 Part II Date/Time Prepared: 2/21/2019 3:49 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	0.516553	0	0	col. 2, line 2.00		1.00
2.00	Occupational Therapy							2.00
3.00	Speech Pathology							3.00
4.00	Cost of Medical Supplies	71.00	0.456149	0	0	col. 2, line 15.00		4.00
5.00	Cost of Drugs	73.00	0.379540	0	0	col. 2, line 16.00		5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT

Provider CCN: 15-1315 | HHA CCN: 15-7117 | Period: From 10/01/2017 To 09/30/2018 | Worksheet H-4 Part I-II | Date/Time Prepared: 2/21/2019 3:49 pm

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		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	240	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	240	0	6.00
7.00	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)	0	240	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	131,380	11.00
12.00	Total PPS Reimbursement - Full Episodes with Outliers	0	0	12.00
13.00	Total PPS Reimbursement - LUPA Episodes	0	5,294	13.00
14.00	Total PPS Reimbursement - PEP Episodes	0	360	14.00
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers	0	0	15.00
16.00	Total PPS Outlier Reimbursement - PEP Episodes	0	0	16.00
17.00	Total Other Payments	0	0	17.00
18.00	DME Payments	0	0	18.00
19.00	Oxygen Payments	0	0	19.00
20.00	Prosthetic and Orthotic Payments	0	0	20.00
21.00	Part B deductibles billed to Medicare patients (exclude coinsurance)		0	21.00
22.00	Subtotal (sum of lines 10 thru 20 minus line 21)	0	137,034	22.00
23.00	Excess reasonable cost (from line 8)	0	0	23.00
24.00	Subtotal (line 22 minus line 23)	0	137,034	24.00
25.00	Coinsurance billed to program patients (from your records)		0	25.00
26.00	Net cost (line 24 minus line 25)	0	137,034	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	137,034	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	0	30.50
30.99	Demonstration payment adjustment amount before sequestration	0	0	30.99
31.00	Subtotal (see instructions)	0	137,034	31.00
31.01	Sequestration adjustment (see instructions)	0	2,742	31.01
31.02	Demonstration payment adjustment amount after sequestration	0	0	31.02
32.00	Interim payments (see instructions)	0	134,292	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: 15-1315 HHA CCN: 15-7117 | Period: From 10/01/2017 To 09/30/2018 | Worksheet H-5 | Date/Time Prepared: 2/21/2019 3:49 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		134,292	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		134,292	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		134,292	7.00

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

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS

Provider CCN: 15-1315 | Hospice CCN: 15-1561 | Period: From 10/01/2017 To 09/30/2018 | Worksheet O | Date/Time Prepared: 2/21/2019 3:49 pm

Hospice I

		SALARIES	OTHER	SUBTOTAL (col. 1 plus col. 2)	RECLASSIFI-CATIONS	SUBTOTAL	
		1.00	2.00	3.00	4.00	5.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT*		0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP*		0	0	0	0	2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT*	0	0	0	0	0	3.00
4.00	ADMINISTRATIVE & GENERAL*	14,744	3,201	17,945	0	17,945	4.00
5.00	PLANT OPERATION & MAINTENANCE*	0	0	0	0	0	5.00
6.00	LAUNDRY & LINEN SERVICE*	0	0	0	0	0	6.00
7.00	HOUSEKEEPING*	0	0	0	0	0	7.00
8.00	DIETARY*	0	0	0	0	0	8.00
9.00	NURSING ADMINISTRATION*	0	0	0	0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES*	0	0	0	0	0	10.00
11.00	MEDICAL RECORDS*	0	0	0	0	0	11.00
12.00	STAFF TRANSPORTATION*	0	21,794	21,794	0	21,794	12.00
13.00	VOLUNTEER SERVICE COORDINATION*	1,589	0	1,589	0	1,589	13.00
14.00	PHARMACY*	0	0	0	0	0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES*	0	0	0	0	0	15.00
16.00	OTHER GENERAL SERVICE*	0	0	0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES						17.00
	DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED**		2,723	2,723	0	2,723	25.00
26.00	PHYSICIAN SERVICES**	0	0	0	0	0	26.00
27.00	NURSE PRACTITIONER**	0	0	0	0	0	27.00
28.00	REGISTERED NURSE**	95,376	0	95,376	0	95,376	28.00
29.00	LPN/LVN**	0	0	0	0	0	29.00
30.00	PHYSICAL THERAPY**	129	0	129	0	129	30.00
31.00	OCCUPATIONAL THERAPY**	42	0	42	0	42	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY**	0	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES**	17,512	0	17,512	0	17,512	33.00
34.00	SPIRITUAL COUNSELING**	1,683	0	1,683	0	1,683	34.00
35.00	DIETARY COUNSELING**	0	0	0	0	0	35.00
36.00	COUNSELING - OTHER**	0	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES**	6,295	0	6,295	0	6,295	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN**	0	0	0	0	0	38.00
39.00	PATIENT TRANSPORTATION**	0	0	0	0	0	39.00
40.00	IMAGING SERVICES**	0	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS**	0	0	0	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE**	0	0	0	0	0	42.00
42.50	DRUGS CHARGED TO PATIENTS**	0	0	0	0	0	42.50
43.00	OUTPATIENT SERVICES**	0	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY**	0	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY**	0	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)**	0	0	0	0	0	46.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM *	0	0	0	0	0	60.00
61.00	VOLUNTEER PROGRAM *	0	0	0	0	0	61.00
62.00	FUNDRAISING*	0	0	0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS*	0	0	0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM*	0	0	0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES*	0	0	0	0	0	65.00
66.00	RESIDENTIAL CARE*	0	0	0	0	0	66.00
67.00	ADVERTISING*	0	0	0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING*	0	0	0	0	0	68.00
69.00	THRIFT STORE*	0	0	0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD*	0	0	0	0	0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)*	0	0	0	0	0	71.00
100.00	TOTAL	137,370	27,718	165,088	0	165,088	100.00

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

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS

Provider CCN: 15-1315 | Hospice CCN: 15-1561 | Period: From 10/01/2017 To 09/30/2018 | Worksheet O | Date/Time Prepared: 2/21/2019 3:49 pm

Hospice I

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)		
		6.00	7.00		
	GENERAL SERVICE COST CENTERS				
1.00	CAP REL COSTS-BLDG & FIXT*	0	0		1.00
2.00	CAP REL COSTS-MVBLE EQUIP*	0	0		2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT*	0	0		3.00
4.00	ADMINISTRATIVE & GENERAL*	0	17,945		4.00
5.00	PLANT OPERATION & MAINTENANCE*	0	0		5.00
6.00	LAUNDRY & LINEN SERVICE*	0	0		6.00
7.00	HOUSEKEEPING*	0	0		7.00
8.00	DIETARY*	0	0		8.00
9.00	NURSING ADMINISTRATION*	0	0		9.00
10.00	ROUTINE MEDICAL SUPPLIES*	0	0		10.00
11.00	MEDICAL RECORDS*	0	0		11.00
12.00	STAFF TRANSPORTATION*	0	21,794		12.00
13.00	VOLUNTEER SERVICE COORDINATION*	0	1,589		13.00
14.00	PHARMACY*	0	0		14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES*	0	0		15.00
16.00	OTHER GENERAL SERVICE*	0	0		16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES				17.00
	DIRECT PATIENT CARE SERVICE COST CENTERS				
25.00	INPATIENT CARE-CONTRACTED**	0	2,723		25.00
26.00	PHYSICIAN SERVICES**	0	0		26.00
27.00	NURSE PRACTITIONER**	0	0		27.00
28.00	REGISTERED NURSE**	0	95,376		28.00
29.00	LPN/LVN**	0	0		29.00
30.00	PHYSICAL THERAPY**	0	129		30.00
31.00	OCCUPATIONAL THERAPY**	0	42		31.00
32.00	SPEECH/LANGUAGE PATHOLOGY**	0	0		32.00
33.00	MEDICAL SOCIAL SERVICES**	0	17,512		33.00
34.00	SPIRITUAL COUNSELING**	0	1,683		34.00
35.00	DIETARY COUNSELING**	0	0		35.00
36.00	COUNSELING - OTHER**	0	0		36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES**	0	6,295		37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN**	0	0		38.00
39.00	PATIENT TRANSPORTATION**	0	0		39.00
40.00	IMAGING SERVICES**	0	0		40.00
41.00	LABS & DIAGNOSTICS**	0	0		41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE**	0	0		42.00
42.50	DRUGS CHARGED TO PATIENTS**	0	0		42.50
43.00	OUTPATIENT SERVICES**	0	0		43.00
44.00	PALLIATIVE RADIATION THERAPY**	0	0		44.00
45.00	PALLIATIVE CHEMOTHERAPY**	0	0		45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)**	0	0		46.00
	NONREIMBURSABLE COST CENTERS				
60.00	BEREAVEMENT PROGRAM *	0	0		60.00
61.00	VOLUNTEER PROGRAM *	0	0		61.00
62.00	FUNDRAISING*	0	0		62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS*	0	0		63.00
64.00	PALLIATIVE CARE PROGRAM*	0	0		64.00
65.00	OTHER PHYSICIAN SERVICES*	0	0		65.00
66.00	RESIDENTIAL CARE*	0	0		66.00
67.00	ADVERTISING*	0	0		67.00
68.00	TELEHEALTH/TELEMONITORING*	0	0		68.00
69.00	THRIFT STORE*	0	0		69.00
70.00	NURSING FACILITY ROOM & BOARD*	0	0		70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)*	0	0		71.00
100.00	TOTAL	0	165,088		100.00

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

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

Provider CCN: 15-1315 Hospice CCN: 15-1561 | Period: From 10/01/2017 To 09/30/2018 | Worksheet O-2 Date/Time Prepared: 2/21/2019 3:49 pm

Hospice I

		SALARIES	OTHER	SUBTOTAL (col. 1 + col. 2)	RECLASSIFI-CATIONS	SUBTOTAL	
		1.00	2.00	3.00	4.00	5.00	
	DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED						25.00
26.00	PHYSICIAN SERVICES	0	0	0	0	0	26.00
27.00	NURSE PRACTITIONER	0	0	0	0	0	27.00
28.00	REGISTERED NURSE	78,908	0	78,908	0	78,908	28.00
29.00	LPN/LVN	0	0	0	0	0	29.00
30.00	PHYSICAL THERAPY	107	0	107	0	107	30.00
31.00	OCCUPATIONAL THERAPY	35	0	35	0	35	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	14,489	0	14,489	0	14,489	33.00
34.00	SPIRITUAL COUNSELING	1,393	0	1,393	0	1,393	34.00
35.00	DIETARY COUNSELING	0	0	0	0	0	35.00
36.00	COUNSELING - OTHER	0	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	5,208	0	5,208	0	5,208	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	0	0	0	38.00
39.00	PATIENT TRANSPORTATION	0	0	0	0	0	39.00
40.00	IMAGING SERVICES	0	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	0	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	0	0	0	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	42.50
43.00	OUTPATIENT SERVICES	0	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	0	0	0	46.00
100.00	TOTAL *	100,140	0	100,140	0	100,140	100.00

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

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)		
		6.00	7.00		
	DIRECT PATIENT CARE SERVICE COST CENTERS				
25.00	INPATIENT CARE-CONTRACTED				25.00
26.00	PHYSICIAN SERVICES	0	0		26.00
27.00	NURSE PRACTITIONER	0	0		27.00
28.00	REGISTERED NURSE	0	78,908		28.00
29.00	LPN/LVN	0	0		29.00
30.00	PHYSICAL THERAPY	0	107		30.00
31.00	OCCUPATIONAL THERAPY	0	35		31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0		32.00
33.00	MEDICAL SOCIAL SERVICES	0	14,489		33.00
34.00	SPIRITUAL COUNSELING	0	1,393		34.00
35.00	DIETARY COUNSELING	0	0		35.00
36.00	COUNSELING - OTHER	0	0		36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	5,208		37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0		38.00
39.00	PATIENT TRANSPORTATION	0	0		39.00
40.00	IMAGING SERVICES	0	0		40.00
41.00	LABS & DIAGNOSTICS	0	0		41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0		42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0		42.50
43.00	OUTPATIENT SERVICES	0	0		43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0		44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0		45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0		46.00
100.00	TOTAL *	0	100,140		100.00

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

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

Provider CCN: 15-1315 | Hospice CCN: 15-1561 | Period: From 10/01/2017 To 09/30/2018 | Worksheet O-3 | Date/Time Prepared: 2/21/2019 3:49 pm

Hospice I

		SALARIES	OTHER	SUBTOTAL (col. 1 + col. 2)	RECLASSIFI-CATIONS	SUBTOTAL	
		1.00	2.00	3.00	4.00	5.00	
	DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED		58	58	0	58	25.00
26.00	PHYSICIAN SERVICES	0	0	0	0	0	26.00
27.00	NURSE PRACTITIONER	0	0	0	0	0	27.00
28.00	REGISTERED NURSE	350	0	350	0	350	28.00
29.00	LPN/LVN	0	0	0	0	0	29.00
30.00	PHYSICAL THERAPY	0	0	0	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	64	0	64	0	64	33.00
34.00	SPIRITUAL COUNSELING	6	0	6	0	6	34.00
35.00	DIETARY COUNSELING	0	0	0	0	0	35.00
36.00	COUNSELING - OTHER	0	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	23	0	23	0	23	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	0	0	0	38.00
39.00	PATIENT TRANSPORTATION	0	0	0	0	0	39.00
40.00	IMAGING SERVICES	0	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	0	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	0	0	0	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	42.50
43.00	OUTPATIENT SERVICES	0	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	0	0	0	46.00
100.00	TOTAL *	443	58	501	0	501	100.00

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

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)		
		6.00	7.00		
	DIRECT PATIENT CARE SERVICE COST CENTERS				
25.00	INPATIENT CARE-CONTRACTED	0	58		25.00
26.00	PHYSICIAN SERVICES	0	0		26.00
27.00	NURSE PRACTITIONER	0	0		27.00
28.00	REGISTERED NURSE	0	350		28.00
29.00	LPN/LVN	0	0		29.00
30.00	PHYSICAL THERAPY	0	0		30.00
31.00	OCCUPATIONAL THERAPY	0	0		31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0		32.00
33.00	MEDICAL SOCIAL SERVICES	0	64		33.00
34.00	SPIRITUAL COUNSELING	0	6		34.00
35.00	DIETARY COUNSELING	0	0		35.00
36.00	COUNSELING - OTHER	0	0		36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	23		37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0		38.00
39.00	PATIENT TRANSPORTATION	0	0		39.00
40.00	IMAGING SERVICES	0	0		40.00
41.00	LABS & DIAGNOSTICS	0	0		41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0		42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0		42.50
43.00	OUTPATIENT SERVICES	0	0		43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0		44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0		45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0		46.00
100.00	TOTAL *	0	501		100.00

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

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

Provider CCN: 15-1315 | Hospice CCN: 15-1561 | Period: From 10/01/2017 To 09/30/2018 | Worksheet O-4 | Date/Time Prepared: 2/21/2019 3:49 pm

Hospice I

		SALARIES	OTHER	SUBTOTAL (col. 1 + col. 2)	RECLASSIFI-CATIONS	SUBTOTAL	
		1.00	2.00	3.00	4.00	5.00	
	DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED		2,665	2,665	0	2,665	25.00
26.00	PHYSICIAN SERVICES	0	0	0	0	0	26.00
27.00	NURSE PRACTITIONER	0	0	0	0	0	27.00
28.00	REGISTERED NURSE	16,118	0	16,118	0	16,118	28.00
29.00	LPN/LVN	0	0	0	0	0	29.00
30.00	PHYSICAL THERAPY	22	0	22	0	22	30.00
31.00	OCCUPATIONAL THERAPY	7	0	7	0	7	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	2,959	0	2,959	0	2,959	33.00
34.00	SPIRITUAL COUNSELING	284	0	284	0	284	34.00
35.00	DIETARY COUNSELING	0	0	0	0	0	35.00
36.00	COUNSELING - OTHER	0	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	1,064	0	1,064	0	1,064	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	0	0	0	38.00
39.00	PATIENT TRANSPORTATION	0	0	0	0	0	39.00
40.00	IMAGING SERVICES	0	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	0	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	0	0	0	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	42.50
43.00	OUTPATIENT SERVICES	0	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	0	0	0	46.00
100.00	TOTAL *	20,454	2,665	23,119	0	23,119	100.00

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

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)		
		6.00	7.00		
	DIRECT PATIENT CARE SERVICE COST CENTERS				
25.00	INPATIENT CARE-CONTRACTED	0	2,665		25.00
26.00	PHYSICIAN SERVICES	0	0		26.00
27.00	NURSE PRACTITIONER	0	0		27.00
28.00	REGISTERED NURSE	0	16,118		28.00
29.00	LPN/LVN	0	0		29.00
30.00	PHYSICAL THERAPY	0	22		30.00
31.00	OCCUPATIONAL THERAPY	0	7		31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0		32.00
33.00	MEDICAL SOCIAL SERVICES	0	2,959		33.00
34.00	SPIRITUAL COUNSELING	0	284		34.00
35.00	DIETARY COUNSELING	0	0		35.00
36.00	COUNSELING - OTHER	0	0		36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	1,064		37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0		38.00
39.00	PATIENT TRANSPORTATION	0	0		39.00
40.00	IMAGING SERVICES	0	0		40.00
41.00	LABS & DIAGNOSTICS	0	0		41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0		42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0		42.50
43.00	OUTPATIENT SERVICES	0	0		43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0		44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0		45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0		46.00
100.00	TOTAL *	0	23,119		100.00

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

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

Provider CCN: 15-1315 Hospice CCN: 15-1561

Period: From 10/01/2017 To 09/30/2018

Worksheet O-5

Date/Time Prepared: 2/21/2019 3:49 pm

Hospice I

	Descriptions	HOSPICE DIRECT EXPENSES (see instructions)	GENERAL SERVICE EXPENSES FROM WKST B PART I (see instructions)	TOTAL EXPENSES (sum of cols. 1 + 2)	
		1.00	2.00	3.00	
	GENERAL SERVICE COST CENTERS				
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	8,482	8,482	2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	0	42,826	42,826	3.00
4.00	ADMINISTRATIVE & GENERAL	17,945	60,331	78,276	4.00
5.00	PLANT OPERATION & MAINTENANCE	0	12,115	12,115	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0	6.00
7.00	HOUSEKEEPING	0	0	0	7.00
8.00	DIETARY	0	0	0	8.00
9.00	NURSING ADMINISTRATION	0	0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	107	107	10.00
11.00	MEDICAL RECORDS	0	0	0	11.00
12.00	STAFF TRANSPORTATION	21,794		21,794	12.00
13.00	VOLUNTEER SERVICE COORDINATION	1,589		1,589	13.00
14.00	PHARMACY	0	0	0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0		0	15.00
16.00	OTHER GENERAL SERVICE	0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES		0	0	17.00
	LEVEL OF CARE				
50.00	HOSPICE CONTINUOUS HOME CARE	0		0	50.00
51.00	HOSPICE ROUTINE HOME CARE	100,140		100,140	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	501		501	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	23,119		23,119	53.00
	NONREIMBURSABLE COST CENTERS				
60.00	BEREAVEMENT PROGRAM	0		0	60.00
61.00	VOLUNTEER PROGRAM	0		0	61.00
62.00	FUNDRAISING	0		0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0		0	63.00
64.00	PALLIATIVE CARE PROGRAM	0		0	64.00
65.00	OTHER PHYSICIAN SERVICES	0		0	65.00
66.00	RESIDENTIAL CARE	0		0	66.00
67.00	ADVERTISING	0		0	67.00
68.00	TELEHEALTH/TELEMONITORING	0		0	68.00
69.00	THRIFT STORE	0		0	69.00
70.00	NURSING FACILITY ROOM & BOARD	0		0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0		0	71.00
99.00	NEGATIVE COST CENTER	0		0	99.00
100.00	TOTAL	165,088	123,861	288,949	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN: 15-1315
Hospice CCN: 15-1561

Period: From 10/01/2017 To 09/30/2018

Worksheet O-6 Part I
Date/Time Prepared: 2/21/2019 3:49 pm

Hospice I

	Descriptions	TOTAL EXPENSES	CAP REL BLDG & FIX	CAP REL MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	SUBTOTAL	
		0	1.00	2.00	3.00	3A	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	8,482		8,482			2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	42,826	0	0	42,826		3.00
4.00	ADMINISTRATIVE & GENERAL	78,276	0	0	0	78,276	4.00
5.00	PLANT OPERATION & MAINTENANCE	12,115	0	0	0	12,115	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0	0	0	6.00
7.00	HOUSEKEEPING	0	0	0	0	0	7.00
8.00	DIETARY	0	0	0	0	0	8.00
9.00	NURSING ADMINISTRATION	0	0	0	0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES	107	0	0	0	107	10.00
11.00	MEDICAL RECORDS	0	0	0	0	0	11.00
12.00	STAFF TRANSPORTATION	21,794	0	0	0	21,794	12.00
13.00	VOLUNTEER SERVICE COORDINATION	1,589	0	0	0	1,589	13.00
14.00	PHARMACY	0	0	0	0	0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0	0	0	0	15.00
16.00	OTHER GENERAL SERVICE	0	0	0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES		0	0		0	17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0			0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	100,140			35,432	135,572	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	501	0	180	157	838	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	23,119	0	8,302	7,237	38,658	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0	0	0	0	0	60.00
61.00	VOLUNTEER PROGRAM	0	0	0	0	0	61.00
62.00	FUNDRAISING	0	0	0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0	0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0	0	0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES	0	0	0	0	0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0	0	0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING	0	0	0	0	0	68.00
69.00	THRIFT STORE	0	0	0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD	0				0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER	0	0	0	0		99.00
100.00	TOTAL	288,949	0	8,482	42,826	288,949	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN: 15-1315
Hospice CCN: 15-1561

Period: From 10/01/2017 To 09/30/2018

Worksheet O-6 Part I
Date/Time Prepared: 2/21/2019 3:49 pm

Hospice I

	Descriptions	ADMINISTRATIVE & GENERAL	PLANT OPERATION & MAINTENANCE	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		4.00	5.00	6.00	7.00	8.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL	78,276					4.00
5.00	PLANT OPERATION & MAINTENANCE	4,501	16,616				5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0			6.00
7.00	HOUSEKEEPING	0	0		0		7.00
8.00	DIETARY	0	0		0	0	8.00
9.00	NURSING ADMINISTRATION	0	0		0		9.00
10.00	ROUTINE MEDICAL SUPPLIES	40	0		0		10.00
11.00	MEDICAL RECORDS	0	0		0		11.00
12.00	STAFF TRANSPORTATION	8,098	0		0		12.00
13.00	VOLUNTEER SERVICE COORDINATION	590	0		0		13.00
14.00	PHARMACY	0	0		0		14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0		0		15.00
16.00	OTHER GENERAL SERVICE	0	0		0		16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0	0		0		17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0					50.00
51.00	HOSPICE ROUTINE HOME CARE	50,373					51.00
52.00	HOSPICE INPATIENT RESPITE CARE	311	354	0	0	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	14,363	16,262	0	0	0	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0	0		0		60.00
61.00	VOLUNTEER PROGRAM	0	0		0		61.00
62.00	FUNDRAISING	0	0		0		62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0		0		63.00
64.00	PALLIATIVE CARE PROGRAM	0	0		0		64.00
65.00	OTHER PHYSICIAN SERVICES	0	0		0		65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0	0		0		67.00
68.00	TELEHEALTH/TELEMONITORING	0	0		0		68.00
69.00	THRIFT STORE	0	0		0		69.00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER	0	0	0	0	0	99.00
100.00	TOTAL	78,276	16,616	0	0	0	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN: 15-1315
Hospice CCN: 15-1561

Period: From 10/01/2017 To 09/30/2018

Worksheet O-6 Part I
Date/Time Prepared: 2/21/2019 3:49 pm

Hospice I

	Descriptions	NURSING ADMINISTRATION	ROUTINE MEDICAL SUPPLIES	MEDICAL RECORDS	STAFF TRANSPORTATION	VOLUNTEER SERVICE COORDINATION	
		9.00	10.00	11.00	12.00	13.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5.00
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPING						7.00
8.00	DIETARY						8.00
9.00	NURSING ADMINISTRATION	0					9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	147				10.00
11.00	MEDICAL RECORDS	0		0			11.00
12.00	STAFF TRANSPORTATION	0			29,892		12.00
13.00	VOLUNTEER SERVICE COORDINATION	0			0	2,179	13.00
14.00	PHARMACY	0			0	0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0			0	0	15.00
16.00	OTHER GENERAL SERVICE	0			0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES						17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0	0	0	0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	0	121	0	24,731	1,803	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	1	0	110	8	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	25	0	5,051	368	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0			0	0	60.00
61.00	VOLUNTEER PROGRAM	0			0	0	61.00
62.00	FUNDRAISING	0			0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0			0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0			0	0	64.00
65.00	OTHER PHYSICIAN SERVICES	0			0	0	65.00
66.00	RESIDENTIAL CARE	0			0	0	66.00
67.00	ADVERTISING	0			0	0	67.00
68.00	TELEHEALTH/TELEMONITORING	0			0	0	68.00
69.00	THRIFT STORE	0			0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0			0	0	71.00
99.00	NEGATIVE COST CENTER	0	0	0	0	0	99.00
100.00	TOTAL	0	147	0	29,892	2,179	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN: 15-1315
Hospice CCN: 15-1561

Period: From 10/01/2017 To 09/30/2018

Worksheet O-6 Part I
Date/Time Prepared: 2/21/2019 3:49 pm

Hospice I

	Descriptions	PHARMACY	PHYSICIAN ADMINISTRATIVE SERVICES	OTHER GENERAL SERVICE	PATIENT/ RESIDENTIAL CARE SERVICES	TOTAL	
		14.00	15.00	16.00	17.00	18.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5.00
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPING						7.00
8.00	DIETARY						8.00
9.00	NURSING ADMINISTRATION						9.00
10.00	ROUTINE MEDICAL SUPPLIES						10.00
11.00	MEDICAL RECORDS						11.00
12.00	STAFF TRANSPORTATION						12.00
13.00	VOLUNTEER SERVICE COORDINATION						13.00
14.00	PHARMACY	0					14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0				15.00
16.00	OTHER GENERAL SERVICE	0		0			16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES				0		17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0	0	0		0	50.00
51.00	HOSPICE ROUTINE HOME CARE	0	0	0		212,600	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0	0	0	1,622	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	0	0	74,727	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0		0		0	60.00
61.00	VOLUNTEER PROGRAM	0		0		0	61.00
62.00	FUNDRAISING	0		0		0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0		0		0	63.00
64.00	PALLIATIVE CARE PROGRAM	0		0		0	64.00
65.00	OTHER PHYSICIAN SERVICES	0		0		0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0		0		0	67.00
68.00	TELEHEALTH/TELEMONITORING	0		0		0	68.00
69.00	THRIFT STORE	0		0		0	69.00
70.00	NURSING FACILITY ROOM & BOARD					0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER	0	0	0	0	0	99.00
100.00	TOTAL	0	0	0	0	288,949	100.00

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

Provider CCN: 15-1315
Hospice CCN: 15-1561

Period:
From 10/01/2017
To 09/30/2018

Worksheet O-6
Part II
Date/Time Prepared:
2/21/2019 3:49 pm

Hospice I

	Cost Center Descriptions	CAP REL BLDG & FIX (SQUARE FEET)	CAP REL MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	RECONCILIATION	ADMINISTRATIVE & GENERAL (ACCUMULATED COSTS)	
		1.00	2.00	3.00	4A	4.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0					1.00
2.00	CAP REL COSTS-MVBLE EQUIP		7,812				2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	0	0	42,825			3.00
4.00	ADMINISTRATIVE & GENERAL	0	0	0	-78,276	210,673	4.00
5.00	PLANT OPERATION & MAINTENANCE	0	0	0	0	12,115	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0	0	0	6.00
7.00	HOUSEKEEPING	0	0	0	0	0	7.00
8.00	DIETARY	0	0	0	0	0	8.00
9.00	NURSING ADMINISTRATION	0	0	0	0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	0	0	0	107	10.00
11.00	MEDICAL RECORDS	0	0	0	0	0	11.00
12.00	STAFF TRANSPORTATION	0	0	0	0	21,794	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0	0	0	0	1,589	13.00
14.00	PHARMACY	0	0	0	0	0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0	0	0	0	15.00
16.00	OTHER GENERAL SERVICE	0	0	0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0	0		0	0	17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE			0	0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE			35,431	0	135,572	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	166	157	0	838	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	7,646	7,237	0	38,658	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0	0	0	0	0	60.00
61.00	VOLUNTEER PROGRAM	0	0	0	0	0	61.00
62.00	FUNDRAISING	0	0	0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0	0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0	0	0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES	0	0	0	0	0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0	0	0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING	0	0	0	0	0	68.00
69.00	THRIFT STORE	0	0	0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD				0		70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER						99.00
100.00	COST TO BE ALLOCATED (per Wkst. O-6, Part I)	0	8,482	42,826		78,276	100.00
101.00	UNIT COST MULTIPLIER	0.000000	1.085765	1.000023		0.371552	101.00

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

Provider CCN: 15-1315
Hospice CCN: 15-1561

Period:
From 10/01/2017
To 09/30/2018

Worksheet O-6
Part II
Date/Time Prepared:
2/21/2019 3:49 pm

Hospice I

	Cost Center Descriptions	PLANT OPERATION & MAINTENANCE (SQUARE FEET)	LAUNDRY & LINEN SERVICE (IN-FACILITY DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (IN-FACILITY DAYS)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	
		5.00	6.00	7.00	8.00	9.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE	17,794					5.00
6.00	LAUNDRY & LINEN SERVICE	0	0				6.00
7.00	HOUSEKEEPING	0		0			7.00
8.00	DIETARY	0		0	0		8.00
9.00	NURSING ADMINISTRATION	0		0		0	9.00
10.00	ROUTINE MEDICAL SUPPLIES	0		0		0	10.00
11.00	MEDICAL RECORDS	0		0		0	11.00
12.00	STAFF TRANSPORTATION	0		0		0	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0		0		0	13.00
14.00	PHARMACY	0		0		0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0		0		0	15.00
16.00	OTHER GENERAL SERVICE	0		0		0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0		0			17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE					0	50.00
51.00	HOSPICE ROUTINE HOME CARE					0	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	379	0	0	0	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	17,415	0	0	0	0	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0		0		0	60.00
61.00	VOLUNTEER PROGRAM	0		0		0	61.00
62.00	FUNDRAISING	0		0		0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0		0		0	63.00
64.00	PALLIATIVE CARE PROGRAM	0		0		0	64.00
65.00	OTHER PHYSICIAN SERVICES	0		0		0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0		0		0	67.00
68.00	TELEHEALTH/TELEMONITORING	0		0		0	68.00
69.00	THRIFT STORE	0		0		0	69.00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER						99.00
100.00	COST TO BE ALLOCATED (per Wkst. O-6, Part I)	16,616	0	0	0	0	100.00
101.00	UNIT COST MULTIPLIER	0.933798	0.000000	0.000000	0.000000	0.000000	101.00

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

Provider CCN: 15-1315
Hospice CCN: 15-1561

Period:
From 10/01/2017
To 09/30/2018

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

	Cost Center Descriptions	ROUTINE MEDICAL SUPPLIES (PATIENT DAYS)	MEDICAL RECORDS (PATIENT DAYS)	STAFF TRANSPORTATION (MILEAGE)	VOLUNTEER SERVICE COORDINATION (HOURS OF SERVICE)	PHARMACY (CHARGES)	
		10.00	11.00	12.00	13.00	14.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5.00
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPING						7.00
8.00	DIETARY						8.00
9.00	NURSING ADMINISTRATION						9.00
10.00	ROUTINE MEDICAL SUPPLIES	2,722					10.00
11.00	MEDICAL RECORDS		0				11.00
12.00	STAFF TRANSPORTATION			32,008			12.00
13.00	VOLUNTEER SERVICE COORDINATION			0	2,334		13.00
14.00	PHARMACY			0	0	0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES			0	0	0	15.00
16.00	OTHER GENERAL SERVICE			0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES						17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0	0	0	0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	2,252	0	26,481	1,931	0	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	10	0	118	9	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	460	0	5,409	394	0	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM			0	0	0	60.00
61.00	VOLUNTEER PROGRAM			0	0	0	61.00
62.00	FUNDRAISING			0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS			0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM			0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES			0	0	0	65.00
66.00	RESIDENTIAL CARE			0	0	0	66.00
67.00	ADVERTISING			0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING			0	0	0	68.00
69.00	THRIFT STORE			0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)			0	0	0	71.00
99.00	NEGATIVE COST CENTER						99.00
100.00	COST TO BE ALLOCATED (per Wkst. O-6, Part I)	147	0	29,892	2,179	0	100.00
101.00	UNIT COST MULTIPLIER	0.054004	0.000000	0.933892	0.933590	0.000000	101.00

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

Provider CCN: 15-1315
Hospice CCN: 15-1561

Period:
From 10/01/2017
To 09/30/2018

Worksheet O-6
Part II
Date/Time Prepared:
2/21/2019 3:49 pm

Hospice I

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

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

Provider CCN: 15-1315 Hospice CCN: 15-1561

Period: From 10/01/2017 To 09/30/2018

Worksheet O-7

Date/Time Prepared: 2/21/2019 3:49 pm

Hospice I

	Cost Center Descriptions	From Wkst. C, Part I, Col. 9 line	Cost to Charge Ratio	Charges by LOC (from Provider Records) HCHC	HRHC	HIRC	
		0	1.00	2.00	3.00	4.00	
	ANCILLARY SERVICE COST CENTERS						
1.00	PHYSICAL THERAPY	66.00	0.516553	0	0	0	1.00
2.00	OCCUPATIONAL THERAPY	67.00					2.00
3.00	SPEECH PATHOLOGY	68.00					3.00
4.00	DRUGS CHARGED TO PATIENTS	73.00	0.379540	0	0	0	4.00
5.00	DURABLE MEDICAL EQUIP-RENTED	96.00					5.00
6.00	LABORATORY	60.00	0.318599	0	0	0	6.00
7.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0.456149	0	0	0	7.00
8.00	OTHER OUTPATIENT SERVICE COST CENTER	93.00					8.00
9.00	RADIOLOGY-THERAPEUTIC	55.00					9.00
10.00	CHEMICAL DEPENDENCY	76.00	2.940000	0	0	0	10.00
10.01	ONCOLOGY	76.01	0.350139	0	0	0	10.01
11.00	Totals (sum of lines 1-11)						11.00

	Cost Center Descriptions	Charges by LOC (from Provider Records) HGIP	Shared Service Costs by LOC HCHC (col. 1 x col. 2)	HRHC (col. 1 x col. 3)	HIRC (col. 1 x col. 4)	HGIP (col. 1 x col. 5)	
		5.00	6.00	7.00	8.00	9.00	
	ANCILLARY SERVICE COST CENTERS						
1.00	PHYSICAL THERAPY	0	0	0	0	0	1.00
2.00	OCCUPATIONAL THERAPY						2.00
3.00	SPEECH PATHOLOGY						3.00
4.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	4.00
5.00	DURABLE MEDICAL EQUIP-RENTED						5.00
6.00	LABORATORY	0	0	0	0	0	6.00
7.00	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	7.00
8.00	OTHER OUTPATIENT SERVICE COST CENTER						8.00
9.00	RADIOLOGY-THERAPEUTIC						9.00
10.00	CHEMICAL DEPENDENCY	0	0	0	0	0	10.00
10.01	ONCOLOGY	0	0	0	0	0	10.01
11.00	Totals (sum of lines 1-11)		0	0	0	0	11.00

CALCULATION OF HOSPITAL-BASED HOSPICE PER DIEM COST

Provider CCN: 15-1315 | Hospice CCN: 15-1561 | Period: From 10/01/2017 To 09/30/2018 | Worksheet O-8 | Date/Time Prepared: 2/21/2019 3:49 pm

Hospice I

		TITLE XVIII MEDICARE	TITLE XIX MEDICAID	TOTAL	
		1.00	2.00	3.00	
	HOSPICE CONTINUOUS HOME CARE				
1.00	Total cost (Wkst. O-6, Part I, col. 18, line 50 plus Wkst. O-7, col. 6, line 11)			0	1.00
2.00	Total unduplicated days (Wkst. S-9, col. 4, line 10)			0	2.00
3.00	Total average cost per diem (line 1 divided by line 2)			0.00	3.00
4.00	Unduplicated program days (Wkst. S-9 col. as appropriate, line 10)	0	0		4.00
5.00	Program cost (line 3 times line 4)	0	0		5.00
	HOSPICE ROUTINE HOME CARE				
6.00	Total cost (Wkst. O-6, Part I, col. 18, line 51 plus Wkst. O-7, col. 7, line 11)			212,600	6.00
7.00	Total unduplicated days (Wkst. S-9, col. 4, line 11)			2,252	7.00
8.00	Total average cost per diem (line 6 divided by line 7)			94.40	8.00
9.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 11)	244	180		9.00
10.00	Program cost (line 8 times line 9)	23,034	16,992		10.00
	HOSPICE INPATIENT RESPITE CARE				
11.00	Total cost (Wkst. O-6, Part I, col. 18, line 52 plus Wkst. O-7, col. 8, line 11)			1,622	11.00
12.00	Total unduplicated days (Wkst. S-9, col. 4, line 12)			10	12.00
13.00	Total average cost per diem (line 11 divided by line 12)			162.20	13.00
14.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 12)	3	0		14.00
15.00	Program cost (line 13 times line 14)	487	0		15.00
	HOSPICE GENERAL INPATIENT CARE				
16.00	Total cost (Wkst. O-6, Part I, col. 18, line 53 plus Wkst. O-7, col. 9, line 11)			74,727	16.00
17.00	Total unduplicated days (Wkst. S-9, col. 4, line 13)			460	17.00
18.00	Total average cost per diem (line 16 divided by line 17)			162.45	18.00
19.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 13)	0	0		19.00
20.00	Program cost (line 18 times line 19)	0	0		20.00
	TOTAL HOSPICE CARE				
21.00	Total cost (sum of line 1 + line 6 + line 11 + line 16)			288,949	21.00
22.00	Total unduplicated days (Wkst. S-9, col. 4, line 14)			2,722	22.00
23.00	Average cost per diem (line 21 divided by line 22)			106.15	23.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1315 | Component CCN: 15-8530 | Period: From 10/01/2017 To 09/30/2018 | Worksheet M-1 | Date/Time Prepared: 2/21/2019 3:49 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	421,596	5,234	426,830	0	426,830	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	117,595	0	117,595	0	117,595	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	90,679	0	90,679	0	90,679	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)	629,870	5,234	635,104	0	635,104	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	4,356	4,356	0	4,356	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	4,356	4,356	0	4,356	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	629,870	9,590	639,460	0	639,460	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	908	908	0	908	29.00
30.00	Administrative Costs	153,275	31,974	185,249	0	185,249	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	153,275	32,882	186,157	0	186,157	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	783,145	42,472	825,617	0	825,617	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1315 | Component CCN: 15-8530 | Period: From 10/01/2017 To 09/30/2018 | Worksheet M-1 | Date/Time Prepared: 2/21/2019 3:49 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	426,830		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	117,595		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	90,679		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	635,104		10.00
11.00	Physician Services Under Agreement	0	0		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	0		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0		14.00
15.00	Medical Supplies	0	4,356		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	4,356		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	639,460		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	908		29.00
30.00	Administrative Costs	0	185,249		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	186,157		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	825,617		32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 15-1315 | Component CCN: 15-8530 | Period: From 10/01/2017 To 09/30/2018 | Worksheet M-2 | Date/Time Prepared: 2/21/2019 3:49 pm

RHC I | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	0.73	4,204	4,200	3,066		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	0.85	3,925	2,100	1,785		3.00
4.00	Subtotal (sum of lines 1 through 3)	1.58	8,129		4,851	8,129	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	1.58	8,129			8,129	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)					639,460	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)					639,460	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)					186,157	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					893,148	15.00
16.00	Total overhead (sum of lines 14 and 15)					1,079,305	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					1,079,305	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					1,079,305	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					1,718,765	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 15-1315 Component CCN: 15-8530	Period: From 10/01/2017 To 09/30/2018	Worksheet M-3 Date/Time Prepared: 2/21/2019 3:49 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)			1,718,765	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			10,608	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			1,708,157	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			8,129	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)			8,129	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			210.13	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)	82.30	83.45		8.00
9.00	Rate for Program covered visits (see instructions)	210.13	210.13		9.00
	CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	0	45		10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	9,456		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	9,456		16.00
16.01	Total program charges (see instructions)(from contractor's records)		5,667		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.)		7,424		16.04
16.05	Total program cost (see instructions)	0	7,424		16.05
17.00	Primary payer amounts		0		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		176		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		1,098		19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		7,424		20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		6,228		21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		13,652		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)		13,652		26.00
26.01	Sequestration adjustment (see instructions)		273		26.01
26.02	Demonstration payment adjustment amount after sequestration		0		26.02
27.00	Interim payments		5,895		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)		7,484		29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0		30.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA VACCINE COST

Provider CCN: 15-1315 | Component CCN: 15-8530 | Period: From 10/01/2017 To 09/30/2018 | Worksheet M-4 | Date/Time Prepared: 2/21/2019 3:49 pm

Title XVIII | RHC I | Cost

		Pneumococcal	Influenza	
		1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	635,104	635,104	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000000	0.003739	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	0	2,375	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	0	1,572	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	0	3,947	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	639,460	639,460	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	1,079,305	1,079,305	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.000000	0.006172	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	0	6,661	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	0	10,608	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	0	109	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	0.00	97.32	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	0	64	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	0	6,228	14.00
15.00	Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2)		10,608	15.00
16.00	Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3, line 21)		6,228	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 15-1315 Component CCN: 15-8530	Period: From 10/01/2017 To 09/30/2018	Worksheet M-5 Date/Time Prepared: 2/21/2019 3:49 pm
		RHC I	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		5,895	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00
	Program to Provider			
3.01			0	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
	Provider to Program			
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		5,895	4.00
	TO BE COMPLETED BY CONTRACTOR			
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			5.00
	Program to Provider			
5.01			0	5.01
5.02			0	5.02
5.03			0	5.03
	Provider to Program			
5.50			0	5.50
5.51			0	5.51
5.52			0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00
6.01	SETTLEMENT TO PROVIDER		7,484	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		13,379	7.00

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