This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g).

FORM APPROVED
OMB NO. 0938-0050
EXPIRES 05-31-2019

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 15-1319	Period: From 10/01/2017 To 09/30/2018	Worksheet S Parts I-III Date/Time Prepared: 2/26/2019 10:09 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 2/26/2019 Time: 10:09 am
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by GIBSON GENERAL HOSPITAL (15-1319) 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	-13,239	169,517	0	6,916	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	-44,503	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
7.00	SKILLED NURSING FACILITY	0	0	0		0	7.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
10.00	RURAL HEALTH CLINIC I	0		3,604		0	10.00
200.00	Total	0	-57,742	173,121	0	6,916	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1319 | Period: From 10/01/2017 To 09/30/2018 | Worksheet S-2 Part I Date/Time Prepared: 2/26/2019 10:09 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 1800 SHERMAN DRIVE	PO Box:			1.00
2.00	City: PRINCETON	State: IN	Zip Code: 47670-	County: GIBSON	2.00

		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
	Hospital and Hospital-Based Component Identification:									
3.00	Hospital	GIBSON GENERAL HOSPITAL	151319	99915	1	12/16/2003	N	O	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	GIBSON GENERAL SWING BED	15Z319	99915		12/16/2003	N	O	N	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA	GIBSON HOME HEALTH	157445	99915		10/19/1995	N	P	N	12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC	GIBSON GENERAL FAMILY MEDICINE	158524	99915		09/11/2017	N	O	O	15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	10/01/2017	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

		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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1319 | Period: From 10/01/2017 To 09/30/2018 | Worksheet S-2 Part I Date/Time Prepared: 2/26/2019 10:09 am

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

		Urban/Rural S	Date of Geogr	
		1.00	2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	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.				58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1319 | Period: From 10/01/2017 To 09/30/2018 | Worksheet S-2 Part I | Date/Time Prepared: 2/26/2019 10:09 am

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1319 | Period: From 10/01/2017 To 09/30/2018 | Worksheet S-2 Part I Date/Time Prepared: 2/26/2019 10:09 am

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-1319	Period: From 10/01/2017 To 09/30/2018	Worksheet S-2 Part I Date/Time Prepared: 2/26/2019 10:09 am

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

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

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

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

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

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

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

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	55,602	0	0	118.01

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1319 | Period: From 10/01/2017 To 09/30/2018 | Worksheet S-2 Part I | Date/Time Prepared: 2/26/2019 10:09 am

		1.00	2.00	
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	HB0778	140.00

	1.00	2.00	3.00	
	If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.			
141.00	Name: DEACONESS HEALTH SYSTEM	Contractor's Name: WISCONSIN PHYSICIANS SERVICES	Contractor's Number: 08101	141.00
142.00	Street: 600 MARY STREET	PO Box:		142.00
143.00	City: EVANSVILLE	State: IN	Zip Code: 47710	143.00

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

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

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

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-1319	Period: From 10/01/2017 To 09/30/2018	Worksheet S-2 Part I Date/Time Prepared: 2/26/2019 10:09 am

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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-1319 | Period: From 10/01/2017 To 09/30/2018 | Worksheet S-2 Part II | Date/Time Prepared: 2/26/2019 10:09 am

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

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

		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00

		Y/N	Legal Oper.	
		1.00	2.00	
	Approved Educational Activities			
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00

		Y/N	
		1.00	
	Bad Debts		
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.	N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.	N	14.00
	Bed Complement		
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.	N	15.00

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	Y	11/30/2018	Y	11/30/2018	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-1319 | Period: From 10/01/2017 To 09/30/2018 | Worksheet S-2 Part II | Date/Time Prepared: 2/26/2019 10:09 am

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

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

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

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

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	AUSTIN	FISHER	41.00
42.00	Enter the employer/company name of the cost report preparer.	BLUE & CO.		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317-275-7438	AFISHER@BLUEANDCO.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-1319	Period: From 10/01/2017 To 09/30/2018	Worksheet S-2 Part II Date/Time Prepared: 2/26/2019 10:09 am

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-1319 | Period: From 10/01/2017 To 09/30/2018 | Worksheet S-3 Part I | Date/Time Prepared: 2/26/2019 10:09 am

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	20	7,300	18,192.00	0	1.00
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		20	7,300	18,192.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	5	1,825	2,064.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)		25	9,125	20,256.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	44.00	0	0		0	19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	101.00				0	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	88.00				0	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		25				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00
33.01	LTCH site neutral days and discharges						33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-1319 | Period: From 10/01/2017 To 09/30/2018 | Worksheet S-3 Part I | Date/Time Prepared: 2/26/2019 10:09 am

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	561	2	758			1.00
2.00	HMO and other (see instructions)	136	10				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	578	0	578			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	178			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,139	2	1,514			7.00
8.00	INTENSIVE CARE UNIT	23	0	86			8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	1,162	2	1,600	0.00	223.65	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	0	0	0	0.00	29.20	19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	2,160	0	3,583	0.00	4.56	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	84	0	712	0.00	2.02	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	259.43	27.00
28.00	Observation Bed Days		0	662			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-1319 | Period: From 10/01/2017 To 09/30/2018 | Worksheet S-3 Part I | Date/Time Prepared: 2/26/2019 10:09 am

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	183	1	271	1.00
2.00	HMO and other (see instructions)			37	5		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	183	1	271	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	0.00					19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0.00					22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	0.00					26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01

HOME HEALTH AGENCY STATISTICAL DATA

Provider CCN: 15-1319 | Period: From 10/01/2017 To 09/30/2018 | Worksheet S-4

Component CCN: 15-7445 | Date/Time Prepared: 2/26/2019 10:09 am

Home Health Agency I | PPS

					1.00		
0.00	County						0.00
		Title V	Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	5.00	
	HOME HEALTH AGENCY STATISTICAL DATA						
1.00	Home Health Aide Hours	0	0	0	0	0	1.00
2.00	Unduplicated Census Count (see instructions)	0.00	95.00	0.00	0.00	0.00	2.00
				Number of Employees (Full Time Equivalent)			
		Enter the number of hours in your normal work week		Staff	Contract	Total	
		0		1.00	2.00	3.00	
	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES						
3.00	Administrator and Assistant Administrator(s)		40.00	0.00	0.00	0.00	3.00
4.00	Director(s) and Assistant Director(s)			0.00	0.00	0.00	4.00
5.00	Other Administrative Personnel			0.00	0.00	0.00	5.00
6.00	Direct Nursing Service			2.12	0.00	2.12	6.00
7.00	Nursing Supervisor			0.77	0.00	0.77	7.00
8.00	Physical Therapy Service			0.55	0.00	0.55	8.00
9.00	Physical Therapy Supervisor			0.00	0.00	0.00	9.00
10.00	Occupational Therapy Service			0.07	0.00	0.07	10.00
11.00	Occupational Therapy Supervisor			0.00	0.00	0.00	11.00
12.00	Speech Pathology Service			0.01	0.00	0.01	12.00
13.00	Speech Pathology Supervisor			0.00	0.00	0.00	13.00
14.00	Medical Social Service			0.00	0.00	0.00	14.00
15.00	Medical Social Service Supervisor			0.00	0.00	0.00	15.00
16.00	Home Health Aide			1.04	0.00	1.04	16.00
17.00	Home Health Aide Supervisor			0.00	0.00	0.00	17.00
18.00	Other (specify)			0.00	0.00	0.00	18.00
	HOME HEALTH AGENCY CBSA CODES						
19.00	Enter in column 1 the number of CBSAs where you provided services during the cost reporting period.			1			19.00
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).			99915			20.00
		Full Episodes					
		Without Outliers	With Outliers	LUPA Episodes	PEP Only Episodes	Total (cols. 1-4)	
		1.00	2.00	3.00	4.00	5.00	
	PPS ACTIVITY DATA						
21.00	Skilled Nursing Visits	1,050	18	28	23	1,119	21.00
22.00	Skilled Nursing Visit Charges	167,632	2,880	4,480	3,680	178,672	22.00
23.00	Physical Therapy Visits	743	0	3	14	760	23.00
24.00	Physical Therapy Visit Charges	154,005	0	615	2,870	157,490	24.00
25.00	Occupational Therapy Visits	86	3	1	1	91	25.00
26.00	Occupational Therapy Visit Charges	17,585	615	205	205	18,610	26.00
27.00	Speech Pathology Visits	9	0	0	0	9	27.00
28.00	Speech Pathology Visit Charges	1,845	0	0	0	1,845	28.00
29.00	Medical Social Service Visits	2	0	0	0	2	29.00
30.00	Medical Social Service Visit Charges	526	0	0	0	526	30.00
31.00	Home Health Aide Visits	172	0	0	7	179	31.00
32.00	Home Health Aide Visit Charges	12,900	0	0	525	13,425	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	2,062	21	32	45	2,160	33.00
34.00	Other Charges	0	0	0	0	0	34.00
35.00	Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)	354,493	3,495	5,300	7,280	370,568	35.00
36.00	Total Number of Episodes (standard/non outlier)	120		15	5	140	36.00
37.00	Total Number of Outlier Episodes		1		0	1	37.00
38.00	Total Non-Routine Medical Supply Charges	14,507	0	602	45	15,154	38.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 15-1319 | Component CCN: 15-8524 | Period: From 10/01/2017 To 09/30/2018 | Worksheet S-8 | Date/Time Prepared: 2/26/2019 10:09 am

RHC I | Cost

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

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

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

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

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

			County				
			4.00				
2.00	City, State, ZIP Code, County		GIBSON				2.00
		Tuesday	Wednesday		Thursday		
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)						
11.00	CLINIC	17:00	08:00	17:00	08:00	17:00	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

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

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

Worksheet S-8
Date/Time Prepared:
2/26/2019 10:09 am

RHC I

Cost

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

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 15-1319 | Period: From 10/01/2017 To 09/30/2018 | Worksheet S-10 | Date/Time Prepared: 2/26/2019 10:09 am

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.465225	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	3,250,303	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	7,337,256	6.00
7.00	Medicaid cost (line 1 times line 6)	3,413,475	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)	163,172	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)	163,172	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)	36,475	94,839	131,314	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	16,969	94,839	111,808	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)	16,969	94,839	111,808	23.00

		1.00	
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	2,348,338	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	304,520	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	468,492	27.01
28.00	Non-Medicare bad debt expense (see instructions)	1,879,846	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	1,038,523	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	1,150,331	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	1,313,503	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1319 | Period: From 10/01/2017 To 09/30/2018 | Worksheet A | Date/Time Prepared: 2/26/2019 10:09 am

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		1,461,106	1,461,106	315,168	1,776,274	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		0	0	0	0	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	171,150	752,796	923,946	492,499	1,416,445	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,549,620	3,889,633	5,439,253	72,331	5,511,584	5.00
7.00	00700	OPERATION OF PLANT	258,081	994,252	1,252,333	113,862	1,366,195	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	46,382	44,180	90,562	-2,201	88,361	8.00
9.00	00900	HOUSEKEEPING	270,726	159,162	429,888	-9,122	420,766	9.00
10.00	01000	DIETARY	366,451	383,251	749,702	-380,146	369,556	10.00
11.00	01100	CAFETERIA	0	0	0	369,949	369,949	11.00
13.00	01300	NURSING ADMINISTRATION	203,661	24,015	227,676	-1,067	226,609	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	257,709	132,098	389,807	-6,514	383,293	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,054,045	923,139	1,977,184	-93,299	1,883,885	30.00
31.00	03100	INTENSIVE CARE UNIT	44,469	34,235	78,704	-4,275	74,429	31.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	626,128	782,849	1,408,977	-128,745	1,280,232	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	667,154	669,021	1,336,175	-8,959	1,327,216	54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0	160,592	160,592	0	160,592	54.03
60.00	06000	LABORATORY	705,757	896,978	1,602,735	-10,150	1,592,585	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	38,201	38,201	0	38,201	62.00
65.00	06500	RESPIRATORY THERAPY	401,176	387,595	788,771	-17,995	770,776	65.00
66.00	06600	PHYSICAL THERAPY	681,470	289,194	970,664	-19,527	951,137	66.00
67.00	06700	OCCUPATIONAL THERAPY	238,744	44,052	282,796	-2,081	280,715	67.00
68.00	06800	SPEECH PATHOLOGY	102,363	20,804	123,167	-1,093	122,074	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	170,976	170,976	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	182,757	182,757	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	135,799	1,563,441	1,699,240	-683	1,698,557	73.00
76.00	03480	INFUSION THERAPY	77,322	86,801	164,123	-1,914	162,209	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	76,379	75,414	151,793	38,195	189,988	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	DIABETES	0	-61	-61	0	-61	90.01
90.02	09002	OP PSYCH	0	0	0	0	0	90.02
90.03	09003	PAIN MANAGEMENT	143,342	226,754	370,096	-17,596	352,500	90.03
91.00	09100	EMERGENCY	825,699	1,074,396	1,900,095	-16,662	1,883,433	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	271,587	159,937	431,524	-5,138	426,386	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		318,122	318,122	-318,122	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	9,175,214	15,591,957	24,767,171	710,448	25,477,619	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	MOB	3,365,436	1,921,947	5,287,383	-644,670	4,642,713	194.00
194.01	07951	FOUNDATION	51,632	5,775	57,407	0	57,407	194.01
194.02	07952	ASC	0	0	0	0	0	194.02
194.03	07953	SNF - PERRY CO.	1,259,228	755,709	2,014,937	-65,778	1,949,159	194.03
200.00		TOTAL (SUM OF LINES 118 through 199)	13,851,510	18,275,388	32,126,898	0	32,126,898	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1319 | Period: From 10/01/2017 To 09/30/2018 | Worksheet A | Date/Time Prepared: 2/26/2019 10:09 am

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	-35,584	1,740,690		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	0		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,396,308	2,812,753		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,169,580	6,681,164		5.00
7.00	00700	OPERATION OF PLANT	514,815	1,881,010		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	88,361		8.00
9.00	00900	HOUSEKEEPING	0	420,766		9.00
10.00	01000	DIETARY	0	369,556		10.00
11.00	01100	CAFETERIA	-137,997	231,952		11.00
13.00	01300	NURSING ADMINISTRATION	64,101	290,710		13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	106,196	489,489		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-462,942	1,420,943		30.00
31.00	03100	INTENSIVE CARE UNIT	0	74,429		31.00
44.00	04400	SKILLED NURSING FACILITY	0	0		44.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-199,062	1,081,170		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,327,216		54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0	160,592		54.03
60.00	06000	LABORATORY	0	1,592,585		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	38,201		62.00
65.00	06500	RESPIRATORY THERAPY	-65,990	704,786		65.00
66.00	06600	PHYSICAL THERAPY	0	951,137		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	280,715		67.00
68.00	06800	SPEECH PATHOLOGY	0	122,074		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	170,976		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	182,757		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	369,503	2,068,060		73.00
76.00	03480	INFUSION THERAPY	-52,563	109,646		76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	189,988		88.00
90.00	09000	CLINIC	0	0		90.00
90.01	09001	DIABETES	0	-61		90.01
90.02	09002	OP PSYCH	0	0		90.02
90.03	09003	PAIN MANAGEMENT	0	352,500		90.03
91.00	09100	EMERGENCY	0	1,883,433		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
		OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY	0	426,386		101.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,666,365	28,143,984		118.00
		NONREIMBURSABLE COST CENTERS				
194.00	07950	MOB	0	4,642,713		194.00
194.01	07951	FOUNDATION	0	57,407		194.01
194.02	07952	ASC	0	0		194.02
194.03	07953	SNF - PERRY CO.	0	1,949,159		194.03
200.00		TOTAL (SUM OF LINES 118 through 199)	2,666,365	34,793,263		200.00

RECLASSIFICATIONS | Provider CCN: 15-1319 | Period: From 10/01/2017 To 09/30/2018 | Worksheet A-6 | Date/Time Prepared: 2/26/2019 10:09 am

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	C - CAFETERIA				
1.00	CAFETERIA	11.00	180,829	189,120	1.00
	0		180,829	189,120	
	D - MED SUPPLY CHG PTS				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	170,976	1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	182,757	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
	0		0	353,733	
	F - BUSINESS HEALTH SER				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	70,341	43,062	1.00
	0		70,341	43,062	
	G - INTEREST				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	315,168	1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	2,954	2.00
	0		0	318,122	
	I - QUALITY SERVICES				
1.00	ADMINISTRATIVE & GENERAL	5.00	40,016	26,122	1.00
	0		40,016	26,122	
	J - HEALTH INSURANCE				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	241,115	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
22.00		0.00	0	0	22.00
23.00		0.00	0	0	23.00
24.00		0.00	0	0	24.00
	0		0	241,115	
	K - WELLNESS CENTER				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	73,921	64,112	1.00
	0		73,921	64,112	
	M - SNF OPERATION OF PLANT				
1.00	OPERATION OF PLANT	7.00	34,548		1.00
	0		34,548	0	
	N - MALPRACTICE				
1.00	ADMINISTRATIVE & GENERAL	5.00	0	53,991	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
	0		0	53,991	

RECLASSIFICATIONS | Provider CCN: 15-1319 | Period: From 10/01/2017 To 09/30/2018 | Worksheet A-6 | Date/Time Prepared: 2/26/2019 10:09 am

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	O - MOB COLLECTION EXPENSE				
1.00	ADMINISTRATIVE & GENERAL	5.00	0	4,963	1.00
2.00		0.00	0	0	2.00
	0		0	4,963	
	P - RHC RECLASS				
1.00	RURAL HEALTH CLINIC	88.00	50,108	0	1.00
	TOTALS		50,108	0	
	Q - UTILITIES RECLASS				
1.00	OPERATION OF PLANT	7.00	0	83,074	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
	TOTALS		0	83,074	
500.00	Grand Total: Increases		449,763	1,377,414	500.00

RECLASSIFICATIONS | Provider CCN: 15-1319 | Period: From 10/01/2017 To 09/30/2018 | Worksheet A-6 | Date/Time Prepared: 2/26/2019 10:09 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	C - CAFETERIA						
1.00	DIETARY	10.00	180,829	189,120	0		1.00
	0		180,829	189,120			
	D - MED SUPPLY CHG PTS						
1.00	OPERATION OF PLANT	7.00	0	252	0		1.00
2.00	ADULTS & PEDIATRICS	30.00	0	241	0		2.00
3.00	OPERATING ROOM	50.00	0	106,493	0		3.00
4.00	RESPIRATORY THERAPY	65.00	0	11,017	0		4.00
5.00	PHYSICAL THERAPY	66.00	0	1,783	0		5.00
6.00	OCCUPATIONAL THERAPY	67.00	0	114	0		6.00
7.00	DRUGS CHARGED TO PATIENTS	73.00	0	106	0		7.00
8.00	INFUSION THERAPY	76.00	0	882	0		8.00
9.00	RURAL HEALTH CLINIC	88.00	0	9,041	0		9.00
10.00	PAIN MANAGEMENT	90.03	0	13,992	0		10.00
11.00	EMERGENCY	91.00	0	4,501	0		11.00
12.00	HOME HEALTH AGENCY	101.00	0	4	0		12.00
13.00	MOB	194.00	0	205,207	0		13.00
14.00	SNF - PERRY CO.	194.03	0	100	0		14.00
	0		0	353,733			
	F - BUSINESS HEALTH SER						
1.00	MOB	194.00	70,341	43,062	0		1.00
	0		70,341	43,062			
	G - INTEREST						
1.00	INTEREST EXPENSE	113.00	0	318,122	10		1.00
2.00		0.00	0	0	0		2.00
	0		0	318,122			
	I - QUALITY SERVICES						
1.00	ADULTS & PEDIATRICS	30.00	40,016	26,122	0		1.00
	0		40,016	26,122			
	J - HEALTH INSURANCE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	37,413	0		1.00
2.00	OPERATION OF PLANT	7.00	0	3,508	0		2.00
3.00	LAUNDRY & LINEN SERVICE	8.00	0	2,201	0		3.00
4.00	HOUSEKEEPING	9.00	0	9,122	0		4.00
5.00	DIETARY	10.00	0	10,187	0		5.00
6.00	NURSING ADMINISTRATION	13.00	0	841	0		6.00
7.00	MEDICAL RECORDS & LIBRARY	16.00	0	5,862	0		7.00
8.00	ADULTS & PEDIATRICS	30.00	0	26,073	0		8.00
9.00	INTENSIVE CARE UNIT	31.00	0	4,275	0		9.00
10.00	OPERATING ROOM	50.00	0	9,774	0		10.00
11.00	RADIOLOGY-DIAGNOSTIC	54.00	0	8,824	0		11.00
12.00	LABORATORY	60.00	0	10,069	0		12.00
13.00	RESPIRATORY THERAPY	65.00	0	6,897	0		13.00
14.00	PHYSICAL THERAPY	66.00	0	12,601	0		14.00
15.00	OCCUPATIONAL THERAPY	67.00	0	1,967	0		15.00
16.00	SPEECH PATHOLOGY	68.00	0	1,093	0		16.00
17.00	DRUGS CHARGED TO PATIENTS	73.00	0	550	0		17.00
18.00	INFUSION THERAPY	76.00	0	1,008	0		18.00
19.00	RURAL HEALTH CLINIC	88.00	0	526	0		19.00
20.00	PAIN MANAGEMENT	90.03	0	3,504	0		20.00
21.00	EMERGENCY	91.00	0	11,969	0		21.00
22.00	HOME HEALTH AGENCY	101.00	0	5,127	0		22.00
23.00	MOB	194.00	0	40,182	0		23.00
24.00	SNF - PERRY CO.	194.03	0	27,542	0		24.00
	0		0	241,115			
	K - WELLNESS CENTER						
1.00	MOB	194.00	73,921	64,112	0		1.00
	0		73,921	64,112			
	M - SNF OPERATION OF PLANT						
1.00	SNF - PERRY CO.	194.03	34,548	0	0		1.00
	0		34,548	0			
	N - MALPRACTICE						
1.00	ADULTS & PEDIATRICS	30.00	0	753	0		1.00
2.00	OPERATING ROOM	50.00	0	1,570	0		2.00
3.00	RURAL HEALTH CLINIC	88.00	0	1,778	0		3.00
4.00	PAIN MANAGEMENT	90.03	0	100	0		4.00
5.00	MOB	194.00	0	46,302	0		5.00
6.00	SNF - PERRY CO.	194.03	0	3,488	0		6.00
	0		0	53,991			
	O - MOB COLLECTION EXPENSE						
1.00	RURAL HEALTH CLINIC	88.00	0	568	0		1.00
2.00	MOB	194.00	0	4,395	0		2.00
	0		0	4,963			

RECLASSIFICATIONS | Provider CCN: 15-1319 | Period: From 10/01/2017 To 09/30/2018 | Worksheet A-6 | Date/Time Prepared: 2/26/2019 10:09 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	P - RHC RECLASS						
1.00	MOB	194.00	50,108	0	0		1.00
	TOTALS		50,108	0			
	Q - UTILITIES RECLASS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	52	0		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	18,302	0		2.00
3.00	DIETARY	10.00	0	10	0		3.00
4.00	NURSING ADMINISTRATION	13.00	0	226	0		4.00
5.00	MEDICAL RECORDS & LIBRARY	16.00	0	652	0		5.00
6.00	ADULTS & PEDIATRICS	30.00	0	94	0		6.00
7.00	OPERATING ROOM	50.00	0	10,908	0		7.00
8.00	RADIOLOGY-DIAGNOSTIC	54.00	0	135	0		8.00
9.00	LABORATORY	60.00	0	81	0		9.00
10.00	RESPIRATORY THERAPY	65.00	0	81	0		10.00
11.00	PHYSICAL THERAPY	66.00	0	5,143	0		11.00
12.00	DRUGS CHARGED TO PATIENTS	73.00	0	27	0		12.00
13.00	INFUSION THERAPY	76.00	0	24	0		13.00
14.00	EMERGENCY	91.00	0	192	0		14.00
15.00	HOME HEALTH AGENCY	101.00	0	7	0		15.00
16.00	MOB	194.00	0	47,040	0		16.00
17.00	SNF - PERRY CO.	194.03	0	100	0		17.00
	TOTALS		0	83,074			
500.00	Grand Total: Decreases		449,763	1,377,414			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1319 | Period: From 10/01/2017 To 09/30/2018 | Worksheet A-7 Part I | Date/Time Prepared: 2/26/2019 10:09 am

		Beginning Balances	Acquisitions: Purchases	Acquisitions: Donation	Acquisitions: Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	684,802	0	0	0	4,768	1.00
2.00	Land Improvements	0	0	0	0	0	2.00
3.00	Buildings and Fixtures	19,903,822	36,697	0	36,697	232,540	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	14,477,506	928,768	0	928,768	1,767,314	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	35,066,130	965,465	0	965,465	2,004,622	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	35,066,130	965,465	0	965,465	2,004,622	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	680,034	0	1.00
2.00	Land Improvements	0	0	2.00
3.00	Buildings and Fixtures	19,707,979	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	13,638,960	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	34,026,973	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	34,026,973	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1319 | Period: From 10/01/2017 To 09/30/2018 | Worksheet A-7 Part II | Date/Time Prepared: 2/26/2019 10:09 am

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	1,304,781	0	0	144,699	11,626	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	1,304,781	0	0	144,699	11,626	3.00

	Cost Center Description	SUMMARY OF CAPITAL		
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
		14.00	15.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	1,461,106	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	2.00
3.00	Total (sum of lines 1-2)	0	1,461,106	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1319 | Period: From 10/01/2017 To 09/30/2018 | Worksheet A-7 Part III Date/Time Prepared: 2/26/2019 10:09 am

	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	34,026,973	0	34,026,973	1.000000	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0.000000	0	2.00
3.00	Total (sum of lines 1-2)	34,026,973	0	34,026,973	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	1,304,781	279,584	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	1,304,781	279,584	3.00

	Cost Center Description	SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	144,699	11,626	0	1,740,690	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	0	144,699	11,626	0	1,740,690	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1319 | Period: From 10/01/2017 To 09/30/2018 | Worksheet A-8 | Date/Time Prepared: 2/26/2019 10:09 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-35,584	CAP REL COSTS-BLDG & FIXT	1.00	10	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-3,078	OPERATION OF PLANT	7.00	0	7.00
8.00	Television and radio service (chapter 21)	A	-308	OPERATION OF PLANT	7.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-777,580			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	4,821,497			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-137,997	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-8,800	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1319 | Period: From 10/01/2017 To 09/30/2018 | Worksheet A-8 | Date/Time Prepared: 2/26/2019 10:09 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	MISC INCOME	B	-25,980	ADMINISTRATIVE & GENERAL	5.00	0	33.00
33.02	PHYSICIAN RECRUITING	A	-67,524	ADMINISTRATIVE & GENERAL	5.00	0	33.02
33.03	ADVERTISING	A	-112,670	ADMINISTRATIVE & GENERAL	5.00	0	33.03
33.04	ADVERTISING	A	-2,977	OPERATING ROOM	50.00	0	33.04
34.00	HAF FEE	A	-981,811	ADMINISTRATIVE & GENERAL	5.00	0	34.00
35.00	LOBBYING	A	-823	ADMINISTRATIVE & GENERAL	5.00	0	35.00
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		2,666,365				50.00

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1.
(2) Basis for adjustment (see instructions).
A. Costs - if cost, including applicable overhead, can be determined.
B. Amount Received - if cost cannot be determined.
(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.
Note: See instructions for column 5 referencing to Worksheet A-7.

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 15-1319 | Period: From 10/01/2017 To 09/30/2018 | Worksheet A-8-1 | Date/Time Prepared: 2/26/2019 10:09 am

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	HOME OFFICE	1,396,308	0	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE	2,467,359	0	2.00
3.00	7.00	OPERATION OF PLANT	HOME OFFICE	518,201	0	3.00
4.00	13.00	NURSING ADMINISTRATION	HOME OFFICE	64,101	0	4.00
4.01	73.00	DRUGS CHARGED TO PATIENTS	HOME OFFICE	369,503	0	4.01
4.02	16.00	MEDICAL RECORDS & LIBRARY	HOME OFFICE	114,996	0	4.02
4.03	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE	172,188	0	4.03
4.04	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE	403,926	685,085	4.04
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			5,506,582	685,085	5.00

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

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

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

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

6.00	G		0.00	DEACONESS HOSP	100.00	6.00
7.00			0.00		0.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:	HOME OFFICE				100.00

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	Provider CCN: 15-1319	Period: From 10/01/2017 To 09/30/2018	Worksheet A-8-1 Date/Time Prepared: 2/26/2019 10:09 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	1,396,308	0		1.00
2.00	2,467,359	0		2.00
3.00	518,201	0		3.00
4.00	64,101	0		4.00
4.01	369,503	0		4.01
4.02	114,996	0		4.02
4.03	172,188	0		4.03
4.04	-281,159	0		4.04
5.00	4,821,497			5.00

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

	Related Organization(s) and/or Home Office		
	Type of Business		
	6.00		
	B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:		

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

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

6.00	HOME OFFICE		6.00
7.00			7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 15-1319 | Period: From 10/01/2017 To 09/30/2018 | Worksheet A-8-2 | Date/Time Prepared: 2/26/2019 10:09 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	ADULTS & PEDIATRICS	462,942	462,942	0	0	0	1.00
2.00	50.00	OPERATING ROOM	196,085	196,085	0	0	0	2.00
3.00	60.00	LABORATORY	40,000	0	40,000	0	0	3.00
4.00	65.00	RESPIRATORY THERAPY	65,990	65,990	0	0	0	4.00
5.00	91.00	EMERGENCY	755,884	0	755,884	0	0	5.00
6.00	76.00	INFUSION THERAPY	52,563	52,563	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			1,573,464	777,580	795,884		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	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	50.00	OPERATING ROOM	0	0	0	0	0	2.00
3.00	60.00	LABORATORY	0	0	0	0	0	3.00
4.00	65.00	RESPIRATORY THERAPY	0	0	0	0	0	4.00
5.00	91.00	EMERGENCY	0	0	0	0	0	5.00
6.00	76.00	INFUSION THERAPY	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	30.00	ADULTS & PEDIATRICS	0	0	0	462,942		1.00
2.00	50.00	OPERATING ROOM	0	0	0	196,085		2.00
3.00	60.00	LABORATORY	0	0	0	0		3.00
4.00	65.00	RESPIRATORY THERAPY	0	0	0	65,990		4.00
5.00	91.00	EMERGENCY	0	0	0	0		5.00
6.00	76.00	INFUSION THERAPY	0	0	0	52,563		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	777,580		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1319 | Period: From 10/01/2017 To 09/30/2018 | Worksheet B Part I Date/Time Prepared: 2/26/2019 10:09 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	1,740,690	1,740,690				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0		0			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,812,753	14,027	0	2,826,780		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	6,681,164	83,917	0	331,968	7,097,049	5.00
7.00	00700	OPERATION OF PLANT	1,881,010	325,790	0	61,111	2,267,911	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	88,361	30,608	0	9,686	128,655	8.00
9.00	00900	HOUSEKEEPING	420,766	17,275	0	56,537	494,578	9.00
10.00	01000	DIETARY	369,556	39,809	0	38,764	448,129	10.00
11.00	01100	CAFETERIA	231,952	38,776	0	37,763	308,491	11.00
13.00	01300	NURSING ADMINISTRATION	290,710	5,183	0	42,531	338,424	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	489,489	25,031	0	53,818	568,338	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,420,943	153,639	0	211,763	1,786,345	30.00
31.00	03100	INTENSIVE CARE UNIT	74,429	36,354	0	9,287	120,070	31.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,081,170	95,841	0	130,756	1,307,767	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,327,216	65,647	0	139,324	1,532,187	54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	160,592	7,887	0	0	168,479	54.03
60.00	06000	LABORATORY	1,592,585	28,730	0	147,385	1,768,700	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	38,201	0	0	0	38,201	62.00
65.00	06500	RESPIRATORY THERAPY	704,786	30,270	0	83,779	818,835	65.00
66.00	06600	PHYSICAL THERAPY	951,137	52,784	0	142,313	1,146,234	66.00
67.00	06700	OCCUPATIONAL THERAPY	280,715	15,360	0	49,858	345,933	67.00
68.00	06800	SPEECH PATHOLOGY	122,074	1,164	0	21,377	144,615	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	170,976	67,393	0	0	238,369	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	182,757	0	0	0	182,757	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,068,060	19,003	0	28,359	2,115,422	73.00
76.00	03480	INFUSION THERAPY	109,646	20,036	0	16,147	145,829	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	189,988	0	0	26,415	216,403	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	DIABETES	-61	26,251	0	0	26,190	90.01
90.02	09002	OP PSYCH	0	0	0	0	0	90.02
90.03	09003	PAIN MANAGEMENT	352,500	0	0	29,935	382,435	90.03
91.00	09100	EMERGENCY	1,883,433	166,164	0	172,433	2,222,030	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	426,386	9,483	0	56,716	492,585	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	28,143,984	1,376,422	0	1,898,025	26,850,961	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	MOB	4,642,713	160,624	0	662,219	5,465,556	194.00
194.01	07951	FOUNDATION	57,407	24,580	0	10,782	92,769	194.01
194.02	07952	ASC	0	0	0	0	0	194.02
194.03	07953	SNF - PERRY CO.	1,949,159	179,064	0	255,754	2,383,977	194.03
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	34,793,263	1,740,690	0	2,826,780	34,793,263	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1319 | Period: From 10/01/2017 To 09/30/2018 | Worksheet B Part I | Date/Time Prepared: 2/26/2019 10:09 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	7,097,049					5.00
7.00	00700	OPERATION OF PLANT	581,143	2,849,054				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	32,967	66,216	227,838			8.00
9.00	00900	HOUSEKEEPING	126,734	37,373	0	658,685		9.00
10.00	01000	DIETARY	114,831	86,121	0	20,662	669,743	10.00
11.00	01100	CAFETERIA	79,050	83,887	0	20,126	0	11.00
13.00	01300	NURSING ADMINISTRATION	86,720	11,212	0	2,690	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	145,634	54,150	0	12,992	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	457,744	332,377	23,665	79,743	69,566	30.00
31.00	03100	INTENSIVE CARE UNIT	30,767	78,646	1,344	18,869	3,952	31.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	335,110	207,340	0	49,744	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	392,617	142,018	0	34,073	0	54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	43,172	17,062	0	4,093	0	54.03
60.00	06000	LABORATORY	453,222	62,153	0	14,912	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	9,789	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	209,823	65,484	0	15,711	0	65.00
66.00	06600	PHYSICAL THERAPY	293,718	114,191	0	27,396	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	88,644	33,230	0	7,972	0	67.00
68.00	06800	SPEECH PATHOLOGY	37,057	2,519	0	604	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	61,081	145,796	0	34,979	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	46,831	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	542,068	41,110	0	9,863	0	73.00
76.00	03480	INFUSION THERAPY	37,368	43,345	0	10,399	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	55,452	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	DIABETES	6,711	56,791	0	13,625	0	90.01
90.02	09002	OP PSYCH	0	0	0	0	0	90.02
90.03	09003	PAIN MANAGEMENT	97,997	0	0	0	0	90.03
91.00	09100	EMERGENCY	569,386	359,473	0	86,244	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	126,223	20,515	0	4,922	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	5,061,859	2,061,009	25,009	469,619	73,518	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	MOB	1,400,533	347,489	0	83,369	0	194.00
194.01	07951	FOUNDATION	23,772	53,176	0	12,758	0	194.01
194.02	07952	ASC	0	0	0	0	0	194.02
194.03	07953	SNF - PERRY CO.	610,885	387,380	202,829	92,939	596,225	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	7,097,049	2,849,054	227,838	658,685	669,743	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1319 | Period: From 10/01/2017 To 09/30/2018 | Worksheet B Part I | Date/Time Prepared: 2/26/2019 10:09 am

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			11.00	13.00	16.00	24.00	25.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	491,554					11.00
13.00	01300	NURSING ADMINISTRATION	11,991	451,037				13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	15,173	0	796,287			16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	59,701	105,896	17,752	2,932,789	0	30.00
31.00	03100	INTENSIVE CARE UNIT	2,618	6,161	829	263,256	0	31.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	36,863	24,696	49,050	2,010,570	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	39,279	0	131,990	2,272,164	0	54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0	0	5,302	238,108	0	54.03
60.00	06000	LABORATORY	41,551	0	111,902	2,452,440	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	813	48,803	0	62.00
65.00	06500	RESPIRATORY THERAPY	23,619	0	41,202	1,174,674	0	65.00
66.00	06600	PHYSICAL THERAPY	40,122	0	72,620	1,694,281	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	14,056	0	23,717	513,552	0	67.00
68.00	06800	SPEECH PATHOLOGY	6,027	0	8,350	199,172	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	4,722	484,947	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	5,292	234,880	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	7,995	4,361	78,522	2,799,341	0	73.00
76.00	03480	INFUSION THERAPY	4,552	10,461	4,521	256,475	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	1,203	273,058	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	DIABETES	0	0	235	103,552	0	90.01
90.02	09002	OP PSYCH	0	0	0	0	0	90.02
90.03	09003	PAIN MANAGEMENT	5,894	14,591	24,118	525,035	0	90.03
91.00	09100	EMERGENCY	48,613	98,999	99,019	3,483,764	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	15,990	21,586	7,815	689,636	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	374,044	286,751	688,974	22,650,497	0	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	MOB	42,369	32,950	83,438	7,455,704	0	194.00
194.01	07951	FOUNDATION	3,040	0	0	185,515	0	194.01
194.02	07952	ASC	0	0	0	0	0	194.02
194.03	07953	SNF - PERRY CO.	72,101	131,336	23,875	4,501,547	0	194.03
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	491,554	451,037	796,287	34,793,263	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1319 | Period: From 10/01/2017 To 09/30/2018 | Worksheet B Part I | Date/Time Prepared: 2/26/2019 10:09 am

		Cost Center Description	Total		
			26.00		
		GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.00	00500	ADMINISTRATIVE & GENERAL			5.00
7.00	00700	OPERATION OF PLANT			7.00
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
13.00	01300	NURSING ADMINISTRATION			13.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	2,932,789		30.00
31.00	03100	INTENSIVE CARE UNIT	263,256		31.00
44.00	04400	SKILLED NURSING FACILITY	0		44.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	2,010,570		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,272,164		54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	238,108		54.03
60.00	06000	LABORATORY	2,452,440		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	48,803		62.00
65.00	06500	RESPIRATORY THERAPY	1,174,674		65.00
66.00	06600	PHYSICAL THERAPY	1,694,281		66.00
67.00	06700	OCCUPATIONAL THERAPY	513,552		67.00
68.00	06800	SPEECH PATHOLOGY	199,172		68.00
69.00	06900	ELECTROCARDIOLOGY	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	484,947		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	234,880		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,799,341		73.00
76.00	03480	INFUSION THERAPY	256,475		76.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	273,058		88.00
90.00	09000	CLINIC	0		90.00
90.01	09001	DIABETES	103,552		90.01
90.02	09002	OP PSYCH	0		90.02
90.03	09003	PAIN MANAGEMENT	525,035		90.03
91.00	09100	EMERGENCY	3,483,764		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
		OTHER REIMBURSABLE COST CENTERS			
101.00	10100	HOME HEALTH AGENCY	689,636		101.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	22,650,497		118.00
		NONREIMBURSABLE COST CENTERS			
194.00	07950	MOB	7,455,704		194.00
194.01	07951	FOUNDATION	185,515		194.01
194.02	07952	ASC	0		194.02
194.03	07953	SNF - PERRY CO.	4,501,547		194.03
200.00		Cross Foot Adjustments	0		200.00
201.00		Negative Cost Centers	0		201.00
202.00		TOTAL (sum lines 118 through 201)	34,793,263		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1319 | Period: From 10/01/2017 To 09/30/2018 | Worksheet B Part II Date/Time Prepared: 2/26/2019 10:09 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	14,027	0	14,027	14,027	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	83,917	0	83,917	1,647	5.00
7.00	00700	OPERATION OF PLANT	0	325,790	0	325,790	303	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	30,608	0	30,608	48	8.00
9.00	00900	HOUSEKEEPING	0	17,275	0	17,275	280	9.00
10.00	01000	DIETARY	0	39,809	0	39,809	192	10.00
11.00	01100	CAFETERIA	0	38,776	0	38,776	187	11.00
13.00	01300	NURSING ADMINISTRATION	0	5,183	0	5,183	211	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	25,031	0	25,031	267	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	153,639	0	153,639	1,051	30.00
31.00	03100	INTENSIVE CARE UNIT	0	36,354	0	36,354	46	31.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	95,841	0	95,841	649	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	65,647	0	65,647	691	54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0	7,887	0	7,887	0	54.03
60.00	06000	LABORATORY	0	28,730	0	28,730	731	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	30,270	0	30,270	416	65.00
66.00	06600	PHYSICAL THERAPY	0	52,784	0	52,784	706	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	15,360	0	15,360	247	67.00
68.00	06800	SPEECH PATHOLOGY	0	1,164	0	1,164	106	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	67,393	0	67,393	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	19,003	0	19,003	141	73.00
76.00	03480	INFUSION THERAPY	0	20,036	0	20,036	80	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	131	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	DIABETES	0	26,251	0	26,251	0	90.01
90.02	09002	OP PSYCH	0	0	0	0	0	90.02
90.03	09003	PAIN MANAGEMENT	0	0	0	0	149	90.03
91.00	09100	EMERGENCY	0	166,164	0	166,164	855	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	9,483	0	9,483	281	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	1,376,422	0	1,376,422	9,415	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	MOB	0	160,624	0	160,624	3,290	194.00
194.01	07951	FOUNDATION	0	24,580	0	24,580	53	194.01
194.02	07952	ASC	0	0	0	0	0	194.02
194.03	07953	SNF - PERRY CO.	0	179,064	0	179,064	1,269	194.03
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	1,740,690	0	1,740,690	14,027	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1319 | Period: From 10/01/2017 To 09/30/2018 | Worksheet B Part II | Date/Time Prepared: 2/26/2019 10:09 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	85,564					5.00
7.00	00700	OPERATION OF PLANT	7,006	333,099				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	397	7,742	38,795			8.00
9.00	00900	HOUSEKEEPING	1,528	4,370	0	23,453		9.00
10.00	01000	DIETARY	1,384	10,069	0	736	52,190	10.00
11.00	01100	CAFETERIA	953	9,808	0	717	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,045	1,311	0	96	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,756	6,331	0	463	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,518	38,860	4,030	2,839	5,421	30.00
31.00	03100	INTENSIVE CARE UNIT	371	9,195	229	672	308	31.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,040	24,241	0	1,771	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,733	16,604	0	1,213	0	54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	520	1,995	0	146	0	54.03
60.00	06000	LABORATORY	5,464	7,267	0	531	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	118	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	2,529	7,656	0	559	0	65.00
66.00	06600	PHYSICAL THERAPY	3,541	13,351	0	975	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,069	3,885	0	284	0	67.00
68.00	06800	SPEECH PATHOLOGY	447	294	0	22	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	736	17,046	0	1,245	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	565	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,535	4,806	0	351	0	73.00
76.00	03480	INFUSION THERAPY	450	5,068	0	370	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	668	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	DIABETES	81	6,640	0	485	0	90.01
90.02	09002	OP PSYCH	0	0	0	0	0	90.02
90.03	09003	PAIN MANAGEMENT	1,181	0	0	0	0	90.03
91.00	09100	EMERGENCY	6,864	42,028	0	3,071	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	1,522	2,398	0	175	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	61,021	240,965	4,259	16,721	5,729	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	MOB	16,892	40,627	0	2,968	0	194.00
194.01	07951	FOUNDATION	287	6,217	0	454	0	194.01
194.02	07952	ASC	0	0	0	0	0	194.02
194.03	07953	SNF - PERRY CO.	7,364	45,290	34,536	3,310	46,461	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	85,564	333,099	38,795	23,453	52,190	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1319 | Period: From 10/01/2017 To 09/30/2018 | Worksheet B Part II | Date/Time Prepared: 2/26/2019 10:09 am

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			11.00	13.00	16.00	24.00	25.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	50,441					11.00
13.00	01300	NURSING ADMINISTRATION	1,230	9,076				13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,557	0	35,405			16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,126	2,131	789	220,404	0	30.00
31.00	03100	INTENSIVE CARE UNIT	269	124	37	47,605	0	31.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,782	497	2,181	133,002	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,030	0	5,867	98,785	0	54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0	0	236	10,784	0	54.03
60.00	06000	LABORATORY	4,263	0	4,976	51,962	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	36	154	0	62.00
65.00	06500	RESPIRATORY THERAPY	2,424	0	1,832	45,686	0	65.00
66.00	06600	PHYSICAL THERAPY	4,117	0	3,229	78,703	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,442	0	1,055	23,342	0	67.00
68.00	06800	SPEECH PATHOLOGY	618	0	371	3,022	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	210	86,630	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	235	800	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	820	88	3,492	35,236	0	73.00
76.00	03480	INFUSION THERAPY	467	211	201	26,883	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	53	852	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	DIABETES	0	0	10	33,467	0	90.01
90.02	09002	OP PSYCH	0	0	0	0	0	90.02
90.03	09003	PAIN MANAGEMENT	605	294	1,072	3,301	0	90.03
91.00	09100	EMERGENCY	4,988	1,992	4,403	230,365	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	1,641	434	348	16,282	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	38,379	5,771	30,633	1,147,265	0	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	MOB	4,347	663	3,710	233,121	0	194.00
194.01	07951	FOUNDATION	312	0	0	31,903	0	194.01
194.02	07952	ASC	0	0	0	0	0	194.02
194.03	07953	SNF - PERRY CO.	7,403	2,642	1,062	328,401	0	194.03
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	50,441	9,076	35,405	1,740,690	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1319 | Period: From 10/01/2017 To 09/30/2018 | Worksheet B Part II | Date/Time Prepared: 2/26/2019 10:09 am

		Cost Center Description	Total		
			26.00		
		GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.00	00500	ADMINISTRATIVE & GENERAL			5.00
7.00	00700	OPERATION OF PLANT			7.00
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
13.00	01300	NURSING ADMINISTRATION			13.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	220,404		30.00
31.00	03100	INTENSIVE CARE UNIT	47,605		31.00
44.00	04400	SKILLED NURSING FACILITY	0		44.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	133,002		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	98,785		54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	10,784		54.03
60.00	06000	LABORATORY	51,962		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	154		62.00
65.00	06500	RESPIRATORY THERAPY	45,686		65.00
66.00	06600	PHYSICAL THERAPY	78,703		66.00
67.00	06700	OCCUPATIONAL THERAPY	23,342		67.00
68.00	06800	SPEECH PATHOLOGY	3,022		68.00
69.00	06900	ELECTROCARDIOLOGY	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	86,630		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	800		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	35,236		73.00
76.00	03480	INFUSION THERAPY	26,883		76.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	852		88.00
90.00	09000	CLINIC	0		90.00
90.01	09001	DIABETES	33,467		90.01
90.02	09002	OP PSYCH	0		90.02
90.03	09003	PAIN MANAGEMENT	3,301		90.03
91.00	09100	EMERGENCY	230,365		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
		OTHER REIMBURSABLE COST CENTERS			
101.00	10100	HOME HEALTH AGENCY	16,282		101.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,147,265		118.00
		NONREIMBURSABLE COST CENTERS			
194.00	07950	MOB	233,121		194.00
194.01	07951	FOUNDATION	31,903		194.01
194.02	07952	ASC	0		194.02
194.03	07953	SNF - PERRY CO.	328,401		194.03
200.00		Cross Foot Adjustments	0		200.00
201.00		Negative Cost Centers	0		201.00
202.00		TOTAL (sum lines 118 through 201)	1,740,690		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1319 | Period: From 10/01/2017 To 09/30/2018 | Worksheet B-1 | Date/Time Prepared: 2/26/2019 10:09 am

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	92,700					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		92,700				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	747	747	13,536,098			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	4,469	4,469	1,589,636	-7,097,049	27,696,214	5.00
7.00	00700	OPERATION OF PLANT	17,350	17,350	292,629	0	2,267,911	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,630	1,630	46,382	0	128,655	8.00
9.00	00900	HOUSEKEEPING	920	920	270,726	0	494,578	9.00
10.00	01000	DIETARY	2,120	2,120	185,622	0	448,129	10.00
11.00	01100	CAFETERIA	2,065	2,065	180,829	0	308,491	11.00
13.00	01300	NURSING ADMINISTRATION	276	276	203,661	0	338,424	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,333	1,333	257,709	0	568,338	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	8,182	8,182	1,014,029	0	1,786,345	30.00
31.00	03100	INTENSIVE CARE UNIT	1,936	1,936	44,469	0	120,070	31.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,104	5,104	626,128	0	1,307,767	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,496	3,496	667,154	0	1,532,187	54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	420	420	0	0	168,479	54.03
60.00	06000	LABORATORY	1,530	1,530	705,757	0	1,768,700	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	38,201	62.00
65.00	06500	RESPIRATORY THERAPY	1,612	1,612	401,176	0	818,835	65.00
66.00	06600	PHYSICAL THERAPY	2,811	2,811	681,470	0	1,146,234	66.00
67.00	06700	OCCUPATIONAL THERAPY	818	818	238,744	0	345,933	67.00
68.00	06800	SPEECH PATHOLOGY	62	62	102,363	0	144,615	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,589	3,589	0	0	238,369	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	182,757	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,012	1,012	135,799	0	2,115,422	73.00
76.00	03480	INFUSION THERAPY	1,067	1,067	77,322	0	145,829	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	126,487	0	216,403	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	DIABETES	1,398	1,398	0	0	26,190	90.01
90.02	09002	OP PSYCH	0	0	0	0	0	90.02
90.03	09003	PAIN MANAGEMENT	0	0	143,342	0	382,435	90.03
91.00	09100	EMERGENCY	8,849	8,849	825,699	0	2,222,030	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	505	505	271,587	0	492,585	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	73,301	73,301	9,088,720	-7,097,049	19,753,912	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	MOB	8,554	8,554	3,171,066	0	5,465,556	194.00
194.01	07951	FOUNDATION	1,309	1,309	51,632	0	92,769	194.01
194.02	07952	ASC	0	0	0	0	0	194.02
194.03	07953	SNF - PERRY CO.	9,536	9,536	1,224,680	0	2,383,977	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,740,690	0	2,826,780		7,097,049	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	18.777670	0.000000	0.208833		0.256246	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			14,027		85,564	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.001036		0.003089	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: 15-1319 | Period: From 10/01/2017 To 09/30/2018 | Worksheet B-1 | Date/Time Prepared: 2/26/2019 10:09 am

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (PATIENT DAYS)	CAFETERIA (GROSS SALARIES)	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	70,134					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,630	14,576				8.00
9.00	00900	HOUSEKEEPING	920	0	67,584			9.00
10.00	01000	DIETARY	2,120	0	2,120	14,576		10.00
11.00	01100	CAFETERIA	2,065	0	2,065	0	8,349,144	11.00
13.00	01300	NURSING ADMINISTRATION	276	0	276	0	203,661	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,333	0	1,333	0	257,709	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	8,182	1,514	8,182	1,514	1,014,029	30.00
31.00	03100	INTENSIVE CARE UNIT	1,936	86	1,936	86	44,469	31.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,104	0	5,104	0	626,128	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,496	0	3,496	0	667,154	54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	420	0	420	0	0	54.03
60.00	06000	LABORATORY	1,530	0	1,530	0	705,757	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	1,612	0	1,612	0	401,176	65.00
66.00	06600	PHYSICAL THERAPY	2,811	0	2,811	0	681,470	66.00
67.00	06700	OCCUPATIONAL THERAPY	818	0	818	0	238,744	67.00
68.00	06800	SPEECH PATHOLOGY	62	0	62	0	102,363	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,589	0	3,589	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,012	0	1,012	0	135,799	73.00
76.00	03480	INFUSION THERAPY	1,067	0	1,067	0	77,322	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	DIABETES	1,398	0	1,398	0	0	90.01
90.02	09002	OP PSYCH	0	0	0	0	0	90.02
90.03	09003	PAIN MANAGEMENT	0	0	0	0	100,115	90.03
91.00	09100	EMERGENCY	8,849	0	8,849	0	825,699	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	505	0	505	0	271,587	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	50,735	1,600	48,185	1,600	6,353,182	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	MOB	8,554	0	8,554	0	719,650	194.00
194.01	07951	FOUNDATION	1,309	0	1,309	0	51,632	194.01
194.02	07952	ASC	0	0	0	0	0	194.02
194.03	07953	SNF - PERRY CO.	9,536	12,976	9,536	12,976	1,224,680	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	2,849,054	227,838	658,685	669,743	491,554	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	40.623007	15.631037	9.746168	45.948340	0.058875	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	333,099	38,795	23,453	52,190	50,441	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	4.749465	2.661567	0.347020	3.580543	0.006041	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: 15-1319 | Period: From 10/01/2017 To 09/30/2018 | Worksheet B-1 | Date/Time Prepared: 2/26/2019 10:09 am

		Cost Center Description	NURSING ADMINISTRATION (NURSE SALARIES)	MEDICAL RECORDS & LIBRARY (GROSS PATIENT REVENUE)		
			13.00	16.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION	3,444,842			13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	55,414,756		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	808,792	1,235,320		30.00
31.00	03100	INTENSIVE CARE UNIT	47,058	57,680		31.00
44.00	04400	SKILLED NURSING FACILITY	0	0		44.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	188,621	3,413,336		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	9,186,754		54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0	368,979		54.03
60.00	06000	LABORATORY	0	7,787,226		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	56,581		62.00
65.00	06500	RESPIRATORY THERAPY	0	2,867,209		65.00
66.00	06600	PHYSICAL THERAPY	0	5,053,571		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,650,437		67.00
68.00	06800	SPEECH PATHOLOGY	0	581,049		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	328,624		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	368,249		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	33,308	5,464,311		73.00
76.00	03480	INFUSION THERAPY	79,899	314,606		76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	83,709		88.00
90.00	09000	CLINIC	0	0		90.00
90.01	09001	DIABETES	0	16,377		90.01
90.02	09002	OP PSYCH	0	0		90.02
90.03	09003	PAIN MANAGEMENT	111,438	1,678,370		90.03
91.00	09100	EMERGENCY	756,113	6,890,686		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
		OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY	164,864	543,822		101.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE				113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,190,093	47,946,896		118.00
		NONREIMBURSABLE COST CENTERS				
194.00	07950	MOB	251,657	5,806,406		194.00
194.01	07951	FOUNDATION	0	0		194.01
194.02	07952	ASC	0	0		194.02
194.03	07953	SNF - PERRY CO.	1,003,092	1,661,454		194.03
200.00		Cross Foot Adjustments				200.00
201.00		Negative Cost Centers				201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	451,037	796,287		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.130931	0.014370		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	9,076	35,405		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.002635	0.000639		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: 15-1319 | Period: From 10/01/2017 To 09/30/2018 | Worksheet C Part I Date/Time Prepared: 2/26/2019 10:09 am

Title XVIII | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,932,789		2,932,789	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	263,256		263,256	0	0	31.00
44.00	04400	SKILLED NURSING FACILITY	0		0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,010,570		2,010,570	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,272,164		2,272,164	0	0	54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	238,108		238,108	0	0	54.03
60.00	06000	LABORATORY	2,452,440		2,452,440	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	48,803		48,803	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	1,174,674	0	1,174,674	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,694,281	0	1,694,281	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	513,552	0	513,552	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	199,172	0	199,172	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0		0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	484,947		484,947	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	234,880		234,880	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,799,341		2,799,341	0	0	73.00
76.00	03480	INFUSION THERAPY	256,475		256,475	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	273,058		273,058	0	0	88.00
90.00	09000	CLINIC	0		0	0	0	90.00
90.01	09001	DIABETES	103,552		103,552	0	0	90.01
90.02	09002	OP PSYCH	0		0	0	0	90.02
90.03	09003	PAIN MANAGEMENT	525,035		525,035	0	0	90.03
91.00	09100	EMERGENCY	3,483,764		3,483,764	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	962,581		962,581		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	689,636		689,636		0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	23,613,078	0	23,613,078	0	0	200.00
201.00		Less Observation Beds	962,581		962,581		0	201.00
202.00		Total (see instructions)	22,650,497	0	22,650,497	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1319 | Period: From 10/01/2017 To 09/30/2018 | Worksheet C Part I Date/Time Prepared: 2/26/2019 10:09 am

Title XVIII | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,235,320		1,235,320			30.00
31.00	03100	INTENSIVE CARE UNIT	57,680		57,680			31.00
44.00	04400	SKILLED NURSING FACILITY	0		0			44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	75,821	3,337,515	3,413,336	0.589034	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	178,123	9,008,631	9,186,754	0.247330	0.000000	54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	17,055	351,924	368,979	0.645316	0.000000	54.03
60.00	06000	LABORATORY	816,226	6,971,000	7,787,226	0.314931	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	23,602	32,979	56,581	0.862533	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	457,850	2,409,359	2,867,209	0.409692	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	857,039	4,196,532	5,053,571	0.335264	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	318,275	1,332,162	1,650,437	0.311161	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	33,296	547,753	581,049	0.342780	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	219,709	108,915	328,624	1.475690	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	66,165	302,084	368,249	0.637829	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	572,168	4,892,143	5,464,311	0.512295	0.000000	73.00
76.00	03480	INFUSION THERAPY	101	314,505	314,606	0.815226	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	83,709	83,709			88.00
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
90.01	09001	DIABETES	0	16,377	16,377	6.323014	0.000000	90.01
90.02	09002	OP PSYCH	0	0	0	0.000000	0.000000	90.02
90.03	09003	PAIN MANAGEMENT	0	1,678,370	1,678,370	0.312824	0.000000	90.03
91.00	09100	EMERGENCY	122,941	6,767,745	6,890,686	0.505576	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	24,131	716,141	740,272	1.300307	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	543,822	543,822			101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	5,075,502	43,611,666	48,687,168			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	5,075,502	43,611,666	48,687,168			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1319 | Period: From 10/01/2017 To 09/30/2018 | Worksheet C Part I Date/Time Prepared: 2/26/2019 10:09 am

Title XVIII | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
44.00	04400	SKILLED NURSING FACILITY			44.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0.000000		54.03
60.00	06000	LABORATORY	0.000000		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000		62.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
76.00	03480	INFUSION THERAPY	0.000000		76.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC			88.00
90.00	09000	CLINIC	0.000000		90.00
90.01	09001	DIABETES	0.000000		90.01
90.02	09002	OP PSYCH	0.000000		90.02
90.03	09003	PAIN MANAGEMENT	0.000000		90.03
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
		OTHER REIMBURSABLE COST CENTERS			
101.00	10100	HOME HEALTH AGENCY			101.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1319 | Period: From 10/01/2017 To 09/30/2018 | Worksheet C Part I Date/Time Prepared: 2/26/2019 10:09 am

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,932,789		2,932,789	0	2,932,789	30.00
31.00	03100	INTENSIVE CARE UNIT	263,256		263,256	0	263,256	31.00
44.00	04400	SKILLED NURSING FACILITY	0		0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,010,570		2,010,570	0	2,010,570	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,272,164		2,272,164	0	2,272,164	54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	238,108		238,108	0	238,108	54.03
60.00	06000	LABORATORY	2,452,440		2,452,440	0	2,452,440	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	48,803		48,803	0	48,803	62.00
65.00	06500	RESPIRATORY THERAPY	1,174,674	0	1,174,674	0	1,174,674	65.00
66.00	06600	PHYSICAL THERAPY	1,694,281	0	1,694,281	0	1,694,281	66.00
67.00	06700	OCCUPATIONAL THERAPY	513,552	0	513,552	0	513,552	67.00
68.00	06800	SPEECH PATHOLOGY	199,172	0	199,172	0	199,172	68.00
69.00	06900	ELECTROCARDIOLOGY	0		0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	484,947		484,947	0	484,947	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	234,880		234,880	0	234,880	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,799,341		2,799,341	0	2,799,341	73.00
76.00	03480	INFUSION THERAPY	256,475		256,475	0	256,475	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	273,058		273,058	0	273,058	88.00
90.00	09000	CLINIC	0		0	0	0	90.00
90.01	09001	DIABETES	103,552		103,552	0	103,552	90.01
90.02	09002	OP PSYCH	0		0	0	0	90.02
90.03	09003	PAIN MANAGEMENT	525,035		525,035	0	525,035	90.03
91.00	09100	EMERGENCY	3,483,764		3,483,764	0	3,483,764	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	962,581		962,581		962,581	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	689,636		689,636		689,636	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	23,613,078	0	23,613,078	0	23,613,078	200.00
201.00		Less Observation Beds	962,581		962,581		962,581	201.00
202.00		Total (see instructions)	22,650,497	0	22,650,497	0	22,650,497	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1319 | Period: From 10/01/2017 To 09/30/2018 | Worksheet C Part I Date/Time Prepared: 2/26/2019 10:09 am

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,235,320		1,235,320			30.00
31.00	03100	INTENSIVE CARE UNIT	57,680		57,680			31.00
44.00	04400	SKILLED NURSING FACILITY	0		0			44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	75,821	3,337,515	3,413,336	0.589034	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	178,123	9,008,631	9,186,754	0.247330	0.000000	54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	17,055	351,924	368,979	0.645316	0.000000	54.03
60.00	06000	LABORATORY	816,226	6,971,000	7,787,226	0.314931	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	23,602	32,979	56,581	0.862533	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	457,850	2,409,359	2,867,209	0.409692	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	857,039	4,196,532	5,053,571	0.335264	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	318,275	1,332,162	1,650,437	0.311161	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	33,296	547,753	581,049	0.342780	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	219,709	108,915	328,624	1.475690	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	66,165	302,084	368,249	0.637829	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	572,168	4,892,143	5,464,311	0.512295	0.000000	73.00
76.00	03480	INFUSION THERAPY	101	314,505	314,606	0.815226	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	83,709	83,709	3.261991	0.000000	88.00
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
90.01	09001	DIABETES	0	16,377	16,377	6.323014	0.000000	90.01
90.02	09002	OP PSYCH	0	0	0	0.000000	0.000000	90.02
90.03	09003	PAIN MANAGEMENT	0	1,678,370	1,678,370	0.312824	0.000000	90.03
91.00	09100	EMERGENCY	122,941	6,767,745	6,890,686	0.505576	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	24,131	716,141	740,272	1.300307	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	543,822	543,822			101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	5,075,502	43,611,666	48,687,168			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	5,075,502	43,611,666	48,687,168			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1319 | Period: From 10/01/2017 To 09/30/2018 | Worksheet C Part I Date/Time Prepared: 2/26/2019 10:09 am

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
44.00	04400	SKILLED NURSING FACILITY			44.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0.000000		54.03
60.00	06000	LABORATORY	0.000000		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000		62.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
76.00	03480	INFUSION THERAPY	0.000000		76.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	0.000000		88.00
90.00	09000	CLINIC	0.000000		90.00
90.01	09001	DIABETES	0.000000		90.01
90.02	09002	OP PSYCH	0.000000		90.02
90.03	09003	PAIN MANAGEMENT	0.000000		90.03
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
		OTHER REIMBURSABLE COST CENTERS			
101.00	10100	HOME HEALTH AGENCY			101.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-1319 | Period: From 10/01/2017 To 09/30/2018 | Worksheet D Part II Date/Time Prepared: 2/26/2019 10:09 am

Title XVIII | Hospital | Cost

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	133,002	3,413,336	0.038965	38,805	1,512	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	98,785	9,186,754	0.010753	87,927	945	54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	10,784	368,979	0.029227	16,055	469	54.03
60.00	06000	LABORATORY	51,962	7,787,226	0.006673	303,384	2,024	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	154	56,581	0.002722	3,241	9	62.00
65.00	06500	RESPIRATORY THERAPY	45,686	2,867,209	0.015934	192,888	3,073	65.00
66.00	06600	PHYSICAL THERAPY	78,703	5,053,571	0.015574	74,819	1,165	66.00
67.00	06700	OCCUPATIONAL THERAPY	23,342	1,650,437	0.014143	18,509	262	67.00
68.00	06800	SPEECH PATHOLOGY	3,022	581,049	0.005201	5,076	26	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	86,630	328,624	0.263614	82,990	21,877	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	800	368,249	0.002172	33,378	72	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	35,236	5,464,311	0.006448	168,117	1,084	73.00
76.00	03480	INFUSION THERAPY	26,883	314,606	0.085450	101	9	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	852	83,709	0.010178	0	0	88.00
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
90.01	09001	DIABETES	33,467	16,377	2.043537	0	0	90.01
90.02	09002	OP PSYCH	0	0	0.000000	0	0	90.02
90.03	09003	PAIN MANAGEMENT	3,301	1,678,370	0.001967	0	0	90.03
91.00	09100	EMERGENCY	230,365	6,890,686	0.033431	1,369	46	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	72,340	740,272	0.097721	0	0	92.00
200.00		Total (lines 50 through 199)	935,314	46,850,346		1,026,659	32,573	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1319 | Period: From 10/01/2017 To 09/30/2018 | Worksheet D Part IV | Date/Time Prepared: 2/26/2019 10:09 am

Title XVIII | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0	0	0	0	0	54.03
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03480	INFUSION THERAPY	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	DIABETES	0	0	0	0	0	90.01
90.02	09002	OP PSYCH	0	0	0	0	0	90.02
90.03	09003	PAIN MANAGEMENT	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-1319 | Period: From 10/01/2017 To 09/30/2018 | Worksheet D Part IV Date/Time Prepared: 2/26/2019 10:09 am

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	3,413,336	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	9,186,754	0.000000	54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0	0	0	368,979	0.000000	54.03
60.00	06000	LABORATORY	0	0	0	7,787,226	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	56,581	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	2,867,209	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	5,053,571	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,650,437	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	581,049	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	328,624	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	368,249	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	5,464,311	0.000000	73.00
76.00	03480	INFUSION THERAPY	0	0	0	314,606	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	83,709	0.000000	88.00
90.00	09000	CLINIC	0	0	0	0	0.000000	90.00
90.01	09001	DIABETES	0	0	0	16,377	0.000000	90.01
90.02	09002	OP PSYCH	0	0	0	0	0.000000	90.02
90.03	09003	PAIN MANAGEMENT	0	0	0	1,678,370	0.000000	90.03
91.00	09100	EMERGENCY	0	0	0	6,890,686	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	740,272	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	46,850,346		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1319 | Period: From 10/01/2017 To 09/30/2018 | Worksheet D Part IV | Date/Time Prepared: 2/26/2019 10:09 am

Title XVIII | Hospital | Cost

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	38,805	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	87,927	0	0	0	54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0.000000	16,055	0	0	0	54.03
60.00	06000	LABORATORY	0.000000	303,384	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	3,241	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.000000	192,888	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	74,819	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	18,509	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	5,076	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	82,990	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	33,378	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	168,117	0	0	0	73.00
76.00	03480	INFUSION THERAPY	0.000000	101	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	DIABETES	0.000000	0	0	0	0	90.01
90.02	09002	OP PSYCH	0.000000	0	0	0	0	90.02
90.03	09003	PAIN MANAGEMENT	0.000000	0	0	0	0	90.03
91.00	09100	EMERGENCY	0.000000	1,369	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		1,026,659	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1319 | Period: From 10/01/2017 To 09/30/2018 | Worksheet D Part V Date/Time Prepared: 2/26/2019 10:09 am

Title XVIII | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.589034	0	1,578,862	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.247330	0	2,491,762	0	0	54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0.645316	0	124,280	0	0	54.03
60.00	06000	LABORATORY	0.314931	0	2,368,873	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.862533	0	19,168	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.409692	0	783,304	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.335264	0	1,476,078	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.311161	0	223,654	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.342780	0	27,579	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1.475690	0	85,348	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.637829	0	163,731	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.512295	0	2,965,928	5,864	0	73.00
76.00	03480	INFUSION THERAPY	0.815226	0	131,723	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	DIABETES	6.323014	0	1,696	0	0	90.01
90.02	09002	OP PSYCH	0.000000	0	0	0	0	90.02
90.03	09003	PAIN MANAGEMENT	0.312824	0	612,643	0	0	90.03
91.00	09100	EMERGENCY	0.505576	0	1,484,988	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.300307	0	319,607	0	0	92.00
200.00		Subtotal (see instructions)		0	14,859,224	5,864	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	14,859,224	5,864	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1319 | Period: From 10/01/2017 To 09/30/2018 | Worksheet D Part V Date/Time Prepared: 2/26/2019 10:09 am

Title XVIII | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	930,003	0		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	616,287	0		54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	80,200	0		54.03
60.00	06000	LABORATORY	746,032	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	16,533	0		62.00
65.00	06500	RESPIRATORY THERAPY	320,913	0		65.00
66.00	06600	PHYSICAL THERAPY	494,876	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	69,592	0		67.00
68.00	06800	SPEECH PATHOLOGY	9,454	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	125,947	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	104,432	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,519,430	3,004		73.00
76.00	03480	INFUSION THERAPY	107,384	0		76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
90.00	09000	CLINIC	0	0		90.00
90.01	09001	DIABETES	10,724	0		90.01
90.02	09002	OP PSYCH	0	0		90.02
90.03	09003	PAIN MANAGEMENT	191,649	0		90.03
91.00	09100	EMERGENCY	750,774	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	415,587	0		92.00
200.00		Subtotal (see instructions)	6,509,817	3,004		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	6,509,817	3,004		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-1319 | Component CCN: 15-Z319 | Period: From 10/01/2017 To 09/30/2018 | Worksheet D Part V Date/Time Prepared: 2/26/2019 10:09 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.589034	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.247330	0	0	0	0	54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0.645316	0	0	0	0	54.03
60.00	06000	LABORATORY	0.314931	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.862533	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.409692	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.335264	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.311161	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.342780	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1.475690	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.637829	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.512295	0	0	0	0	73.00
76.00	03480	INFUSION THERAPY	0.815226	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	DIABETES	6.323014	0	0	0	0	90.01
90.02	09002	OP PSYCH	0.000000	0	0	0	0	90.02
90.03	09003	PAIN MANAGEMENT	0.312824	0	0	0	0	90.03
91.00	09100	EMERGENCY	0.505576	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.300307	0	0	0	0	92.00
200.00		Subtotal (see instructions)		0	0	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-1319 | Component CCN: 15-Z319 | Period: From 10/01/2017 To 09/30/2018 | Worksheet D Part V | Date/Time Prepared: 2/26/2019 10:09 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0	0		54.03
60.00	06000	LABORATORY	0	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		62.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
76.00	03480	INFUSION THERAPY	0	0		76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
90.00	09000	CLINIC	0	0		90.00
90.01	09001	DIABETES	0	0		90.01
90.02	09002	OP PSYCH	0	0		90.02
90.03	09003	PAIN MANAGEMENT	0	0		90.03
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
200.00		Subtotal (see instructions)	0	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	0		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1319 | Period: From 10/01/2017 To 09/30/2018 | Worksheet D-1 | Date/Time Prepared: 2/26/2019 10:09 am

Title XVIII | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	2,176	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,420	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)	758	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)	578	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	178	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	561	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)	578	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)	2,932,789	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	27,594	25.00
26.00	Total swing-bed cost (see instructions)	868,035	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	2,064,754	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	2,064,754	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)	1,454.05	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	815,722	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)	815,722	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1319 | Period: From 10/01/2017 To 09/30/2018 | Worksheet D-1 | Date/Time Prepared: 2/26/2019 10:09 am

Title XVIII | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	263,256	86	3,061.12	23	70,406	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)	495,569	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	1,381,697	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)	840,441	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	840,441	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)	662	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,454.05	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	962,581	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1319 | Period: From 10/01/2017 To 09/30/2018 | Worksheet D-1 | Date/Time Prepared: 2/26/2019 10:09 am

Title XVIII | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	220,404	2,932,789	0.075152	962,581	72,340	90.00
91.00	Nursing School cost	0	2,932,789	0.000000	962,581	0	91.00
92.00	Allied health cost	0	2,932,789	0.000000	962,581	0	92.00
93.00	All other Medical Education	0	2,932,789	0.000000	962,581	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1319 | Period: From 10/01/2017 To 09/30/2018 | Worksheet D-1 | Date/Time Prepared: 2/26/2019 10:09 am

Title XIX | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	2,176	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,420	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)	758	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)	578	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	178	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	2	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	2,932,789	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	848,423	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	2,084,366	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	2,084,366	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)	1,467.86	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	2,936	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)	2,936	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1319 | Period: From 10/01/2017 To 09/30/2018 | Worksheet D-1 | Date/Time Prepared: 2/26/2019 10:09 am

Title XIX | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	263,256	86	3,061.12	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	4,179	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	7,115	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	662	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,467.86	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	971,723	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1319 | Period: From 10/01/2017 To 09/30/2018 | Worksheet D-1 | Date/Time Prepared: 2/26/2019 10:09 am

Title XIX | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	220,404	2,932,789	0.075152	971,723	73,027	90.00
91.00	Nursing School cost	0	2,932,789	0.000000	971,723	0	91.00
92.00	Allied health cost	0	2,932,789	0.000000	971,723	0	92.00
93.00	All other Medical Education	0	2,932,789	0.000000	971,723	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1319 | Period: From 10/01/2017 To 09/30/2018 | Worksheet D-3 | Date/Time Prepared: 2/26/2019 10:09 am

Title XVIII | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		487,395		30.00
31.00	03100	INTENSIVE CARE UNIT		43,240		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.589034	38,805	22,857	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.247330	87,927	21,747	54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0.645316	16,055	10,361	54.03
60.00	06000	LABORATORY	0.314931	303,384	95,545	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.862533	3,241	2,795	62.00
65.00	06500	RESPIRATORY THERAPY	0.409692	192,888	79,025	65.00
66.00	06600	PHYSICAL THERAPY	0.335264	74,819	25,084	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.311161	18,509	5,759	67.00
68.00	06800	SPEECH PATHOLOGY	0.342780	5,076	1,740	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1.475690	82,990	122,468	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.637829	33,378	21,289	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.512295	168,117	86,125	73.00
76.00	03480	INFUSION THERAPY	0.815226	101	82	76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000	CLINIC	0.000000	0	0	90.00
90.01	09001	DIABETES	6.323014	0	0	90.01
90.02	09002	OP PSYCH	0.000000	0	0	90.02
90.03	09003	PAIN MANAGEMENT	0.312824	0	0	90.03
91.00	09100	EMERGENCY	0.505576	1,369	692	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.300307	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		1,026,659	495,569	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		1,026,659		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-1319 | Period: From 10/01/2017 To 09/30/2018 | Worksheet D-3

Component CCN: 15-Z319 | Date/Time Prepared: 2/26/2019 10:09 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.589034	2,156	1,270	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.247330	18,055	4,466	54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0.645316	0	0	54.03
60.00	06000	LABORATORY	0.314931	158,991	50,071	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.862533	2,778	2,396	62.00
65.00	06500	RESPIRATORY THERAPY	0.409692	63,670	26,085	65.00
66.00	06600	PHYSICAL THERAPY	0.335264	197,455	66,200	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.311161	69,118	21,507	67.00
68.00	06800	SPEECH PATHOLOGY	0.342780	2,785	955	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1.475690	44,400	65,521	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.637829	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.512295	126,306	64,706	73.00
76.00	03480	INFUSION THERAPY	0.815226	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000	CLINIC	0.000000	0	0	90.00
90.01	09001	DIABETES	6.323014	0	0	90.01
90.02	09002	OP PSYCH	0.000000	0	0	90.02
90.03	09003	PAIN MANAGEMENT	0.312824	0	0	90.03
91.00	09100	EMERGENCY	0.505576	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.300307	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		685,714	303,177	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)		685,714		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1319 | Period: From 10/01/2017 To 09/30/2018 | Worksheet D-3 | Date/Time Prepared: 2/26/2019 10:09 am

Title XIX | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		3,256		30.00
31.00	03100	INTENSIVE CARE UNIT		412		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.589034	1,422	838	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.247330	1,758	435	54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0.645316	134	86	54.03
60.00	06000	LABORATORY	0.314931	3,932	1,238	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.862533	75	65	62.00
65.00	06500	RESPIRATORY THERAPY	0.409692	1,750	717	65.00
66.00	06600	PHYSICAL THERAPY	0.335264	116	39	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.311161	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.342780	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1.475690	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.637829	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.512295	0	0	73.00
76.00	03480	INFUSION THERAPY	0.815226	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	3.261991	0	0	88.00
90.00	09000	CLINIC	0.000000	0	0	90.00
90.01	09001	DIABETES	6.323014	0	0	90.01
90.02	09002	OP PSYCH	0.000000	0	0	90.02
90.03	09003	PAIN MANAGEMENT	0.312824	0	0	90.03
91.00	09100	EMERGENCY	0.505576	1,506	761	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.300307	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		10,693	4,179	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)		10,693		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-1319 | Period: From 10/01/2017 To 09/30/2018 | Worksheet E Part B Date/Time Prepared: 2/26/2019 10:09 am

Title XVIII | Hospital | Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	6,512,821	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	OPPS payments	0	3.00
4.00	Outlier payment (see instructions)	0	4.00
4.01	Outlier reconciliation amount (see instructions)	0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	6,512,821	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	0	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (see instructions)	6,577,949	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)	51,970	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	2,470,939	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)	4,055,040	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)	4,055,040	30.00
31.00	Primary payer payments	1,093	31.00
32.00	Subtotal (line 30 minus line 31)	4,053,947	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)	439,838	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	285,895	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	417,411	36.00
37.00	Subtotal (see instructions)	4,339,842	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)	4,339,842	40.00
40.01	Sequestration adjustment (see instructions)	86,797	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
41.00	Interim payments	4,083,528	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	169,517	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED | Provider CCN: 15-1319 | Period: From 10/01/2017 To 09/30/2018 | Worksheet E-1 Part I Date/Time Prepared: 2/26/2019 10:09 am

Title XVIII | Hospital | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,225,215		3,603,828	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	05/22/2018	50,200	3.01
3.02			0	05/22/2018	429,500	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		479,700	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,225,215		4,083,528	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		169,517	6.01
6.02	SETTLEMENT TO PROGRAM		13,239		0	6.02
7.00	Total Medicare program liability (see instructions)		1,211,976		4,253,045	7.00

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 15-1319 | Component CCN: 15-Z319 | Period: From 10/01/2017 To 09/30/2018 | Worksheet E-1 Part I | Date/Time Prepared: 2/26/2019 10:09 am

Title XVIII | Swing Beds - SNF | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,072,940		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	05/23/2018	91,600		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)		91,600		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,164,540		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		44,503		0	6.02
7.00	Total Medicare program liability (see instructions)		1,120,037		0	7.00

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

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-1319	Period: From 10/01/2017 To 09/30/2018	Worksheet E-1 Part II Date/Time Prepared: 2/26/2019 10:09 am
	Title XVIII	Hospital	Cost

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

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS | Provider CCN: 15-1319 | Component CCN: 15-Z319 | Period: From 10/01/2017 To 09/30/2018 | Worksheet E-2 | Date/Time Prepared: 2/26/2019 10:09 am

Title XVIII | Swing Beds - SNF | Cost

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	848,845	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)	306,209	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	578	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)		0	6.00
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	1,155,054	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	1,155,054	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0	0	11.00
12.00	Subtotal (line 10 minus line 11)	1,155,054	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	12,159	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)	1,142,895	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)	1,142,895	0	19.00
19.01	Sequestration adjustment (see instructions)	22,858	0	19.01
19.02	Demonstration payment adjustment amount after sequestration)	0	0	19.02
20.00	Interim payments	1,164,540	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)	-44,503	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	23.00
	Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment			
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
	Cost Reimbursement			
201.00	Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital))			201.00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))			202.00
203.00	Total (sum of lines 201 and 202)			203.00
204.00	Medicare swing-bed SNF discharges (see instructions)			204.00
	Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)			
205.00	Medicare swing-bed SNF target amount			205.00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)			206.00
	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement			
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)			208.00
209.00	Adjustment to Medicare swing-bed SNF PPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
	Comparision of PPS versus Cost Reimbursement			
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see instructions)			215.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1319	Period: From 10/01/2017 To 09/30/2018	Worksheet E-3 Part V Date/Time Prepared: 2/26/2019 10:09 am
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	1,381,697	1.00
2.00	Nursing and Allied Health Managed Care payment (see instructions)	0	2.00
3.00	Organ acquisition	0	3.00
4.00	Subtotal (sum of lines 1 through 3)	1,381,697	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	1,395,514	6.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
7.00	Routine service charges	0	7.00
8.00	Ancillary service charges	0	8.00
9.00	Organ acquisition charges, net of revenue	0	9.00
10.00	Total reasonable charges	0	10.00
	Customary charges		
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)	0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)	0.000000	13.00
14.00	Total customary charges (see instructions)	0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)	0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)	0	16.00
17.00	Cost of physicians' services in a teaching hospital (see instructions)	0	17.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)	0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)	1,395,514	19.00
20.00	Deductibles (exclude professional component)	176,771	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	1,218,743	22.00
23.00	Coinsurance	658	23.00
24.00	Subtotal (line 22 minus line 23)	1,218,085	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	28,654	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	18,625	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	26,182	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	1,236,710	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	29.50
29.99	Demonstration payment adjustment amount before sequestration	0	29.99
30.00	Subtotal (see instructions)	1,236,710	30.00
30.01	Sequestration adjustment (see instructions)	24,734	30.01
30.02	Demonstration payment adjustment amount after sequestration	0	30.02
31.00	Interim payments	1,225,215	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)	-13,239	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-1319 | Period: From 10/01/2017 To 09/30/2018 | Worksheet E-3 Part VII | Date/Time Prepared: 2/26/2019 10:09 am

Title XIX | Hospital | Cost

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	7,115		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)	7,115	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)	7,115	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	3,668		8.00
9.00	Ancillary service charges	10,693	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)	14,361	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)	14,361	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	7,246	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)	7,115	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)	7,115	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)	7,115	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)	7,115	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	7,115	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)	7,115	0	40.00
41.00	Interim payments	199	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	6,916	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 15-1319 | Period: From 10/01/2017 To 09/30/2018 | Worksheet G | Date/Time Prepared: 2/26/2019 10:09 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	4,616,767	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	4,897,089	0	0	0	4.00
5.00	Other receivable	219,593	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-1,391,492	0	0	0	6.00
7.00	Inventory	711,314	0	0	0	7.00
8.00	Prepaid expenses	261,380	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	9,314,651	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	421,244	0	0	0	12.00
13.00	Land improvements	258,790	0	0	0	13.00
14.00	Accumulated depreciation	-179,538	0	0	0	14.00
15.00	Buildings	19,717,525	0	0	0	15.00
16.00	Accumulated depreciation	-12,121,393	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	3,819,414	0	0	0	19.00
20.00	Accumulated depreciation	-3,314,754	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	9,066,939	0	0	0	23.00
24.00	Accumulated depreciation	-7,945,935	0	0	0	24.00
25.00	Minor equipment depreciable	743,061	0	0	0	25.00
26.00	Accumulated depreciation	-516,021	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)	9,949,332	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	1,630,641	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	0	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	1,630,641	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	20,894,624	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	612,119	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,646,774	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	171,015	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	249,232	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	2,679,140	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	7,705,296	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	7,705,296	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	10,384,436	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	10,510,188				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)	10,510,188	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	20,894,624	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-1319 | Period: From 10/01/2017 To 09/30/2018 | Worksheet G-1 | Date/Time Prepared: 2/26/2019 10:09 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		11,341,639		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-831,451				2.00
3.00	Total (sum of line 1 and line 2)		10,510,188		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)		10,510,188		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)		10,510,188		0		19.00

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

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 15-1319 | Period: From 10/01/2017 To 09/30/2018 | Worksheet G-2 Parts I & II Date/Time Prepared: 2/26/2019 10:09 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	1,235,320		1,235,320	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY	0		0	7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	1,235,320		1,235,320	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	57,680		57,680	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)	57,680		57,680	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	1,293,000		1,293,000	17.00
18.00	Ancillary services	3,635,430	33,805,501	37,440,931	18.00
19.00	Outpatient services	147,072	9,178,633	9,325,705	19.00
20.00	RURAL HEALTH CLINIC	0	83,709	83,709	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		543,822	543,822	22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	MOB	0	5,806,406	5,806,406	27.00
27.01	SNF PERRY CO	1,661,454	0	1,661,454	27.01
27.02	PRO FEES	0	950,650	950,650	27.02
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	6,736,956	50,368,721	57,105,677	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		32,126,898		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)		32,126,898		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 15-1319 | Period: From 10/01/2017 To 09/30/2018 | Worksheet G-3 | Date/Time Prepared: 2/26/2019 10:09 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	57,105,677	1.00
2.00	Less contractual allowances and discounts on patients' accounts	26,485,818	2.00
3.00	Net patient revenues (line 1 minus line 2)	30,619,859	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	32,126,898	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-1,507,039	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	357,554	6.00
7.00	Income from investments	35,584	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	137,997	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	69,182	22.00
23.00	Governmental appropriations	0	23.00
24.00	MISCELLANEOUS INCOME	75,271	24.00
25.00	Total other income (sum of lines 6-24)	675,588	25.00
26.00	Total (line 5 plus line 25)	-831,451	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)	-831,451	29.00

ANALYSIS OF HOSPITAL-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 15-1319 HHA CCN: 15-7445 | Period: From 10/01/2017 To 09/30/2018 | Worksheet H | Date/Time Prepared: 2/26/2019 10:09 am

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		Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased Services	Other Costs	Total (sum of cols. 1 thru 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures			0		0	0	1.00
2.00	Capital Related - Movable Equipment			0		0	0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0	0	0	3.00
4.00	Transportation	0	0	0	0	0	0	4.00
5.00	Administrative and General	65,683	20,546	21,303	0	53,677	161,209	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	138,390	43,289	0	0	0	181,679	6.00
7.00	Physical Therapy	32,731	10,238	0	0	0	42,969	7.00
8.00	Occupational Therapy	3,953	1,236	0	0	0	5,189	8.00
9.00	Speech Pathology	379	119	0	0	0	498	9.00
10.00	Medical Social Services	0	0	0	0	0	0	10.00
11.00	Home Health Aide	30,451	9,525	0	0	0	39,976	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0	4	4	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)	271,587	84,953	21,303	0	53,681	431,524	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	-5,138	156,071	0	156,071			5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	181,679	0	181,679			6.00
7.00	Physical Therapy	0	42,969	0	42,969			7.00
8.00	Occupational Therapy	0	5,189	0	5,189			8.00
9.00	Speech Pathology	0	498	0	498			9.00
10.00	Medical Social Services	0	0	0	0			10.00
11.00	Home Health Aide	0	39,976	0	39,976			11.00
12.00	Supplies (see instructions)	0	0	0	0			12.00
13.00	Drugs	0	4	0	4			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)	-5,138	426,386	0	426,386			24.00

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

COST ALLOCATION - HHA GENERAL SERVICE COST | Provider CCN: 15-1319 | HHA CCN: 15-7445 | Period: From 10/01/2017 To 09/30/2018 | Worksheet H-1 Part I | Date/Time Prepared: 2/26/2019 10:09 am

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		Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Capital Related Costs: Bldgs & Fixtures	Capital Related Costs: Movable Equipment	Plant Operation & Maintenance	Transportation	Subtotal (cols. 0-4)	
		0	1.00	2.00	3.00	4.00	4A.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0				0	1.00
2.00	Capital Related - Movable Equipment	0		0			0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0		0	3.00
4.00	Transportation	0	0	0	0	0		4.00
5.00	Administrative and General	156,071	0	0	0	0	156,071	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	181,679	0	0	0	0	181,679	6.00
7.00	Physical Therapy	42,969	0	0	0	0	42,969	7.00
8.00	Occupational Therapy	5,189	0	0	0	0	5,189	8.00
9.00	Speech Pathology	498	0	0	0	0	498	9.00
10.00	Medical Social Services	0	0	0	0	0	0	10.00
11.00	Home Health Aide	39,976	0	0	0	0	39,976	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	0	12.00
13.00	Drugs	4	0	0	0		4	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)	426,386	0	0	0	0	426,386	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	156,071		5.00
	HHA REIMBURSABLE SERVICES			
6.00	Skilled Nursing Care	104,895	286,574	6.00
7.00	Physical Therapy	24,809	67,778	7.00
8.00	Occupational Therapy	2,996	8,185	8.00
9.00	Speech Pathology	288	786	9.00
10.00	Medical Social Services	0	0	10.00
11.00	Home Health Aide	23,081	63,057	11.00
12.00	Supplies (see instructions)	0	0	12.00
13.00	Drugs	2	6	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)		426,386	24.00

COST ALLOCATION - HHA STATISTICAL BASIS | Provider CCN: 15-1319 | HHA CCN: 15-7445 | Period: From 10/01/2017 To 09/30/2018 | Worksheet H-1 Part II | Date/Time Prepared: 2/26/2019 10:09 am

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		Capital Related Costs						
		Bldgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)	Plant Operation & Maintenance (SQUARE FEET)	Transportation (MILEAGE)	Reconciliation	Administrative & General (ACCUM. COST)	
		1.00	2.00	3.00	4.00	5A.00	5.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0				0		1.00
2.00	Capital Related - Movable Equipment		0			0		2.00
3.00	Plant Operation & Maintenance	0	0	0		0		3.00
4.00	Transportation (see instructions)	0	0	0	0			4.00
5.00	Administrative and General	0	0	0	0	-156,071	270,315	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	0	181,679	6.00
7.00	Physical Therapy	0	0	0	0	0	42,969	7.00
8.00	Occupational Therapy	0	0	0	0	0	5,189	8.00
9.00	Speech Pathology	0	0	0	0	0	498	9.00
10.00	Medical Social Services	0	0	0	0	0	0	10.00
11.00	Home Health Aide	0	0	0	0	0	39,976	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	0	12.00
13.00	Drugs	0	0	0		0	4	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	-156,071	270,315	24.00
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0	0		156,071	25.00
26.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000		0.577367	26.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

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

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

Worksheet H-2 Part I Date/Time Prepared: 2/26/2019 10:09 am

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	Cost Center Description	HHA Trial Balance (1)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	
		0	1.00	2.00	4.00	4A	5.00	
1.00	Administrative and General	0	9,483	0	56,716	66,199	16,963	1.00
2.00	Skilled Nursing Care	286,574	0	0	0	286,574	73,434	2.00
3.00	Physical Therapy	67,778	0	0	0	67,778	17,368	3.00
4.00	Occupational Therapy	8,185	0	0	0	8,185	2,097	4.00
5.00	Speech Pathology	786	0	0	0	786	201	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	63,057	0	0	0	63,057	16,158	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	6	0	0	0	6	2	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)	426,386	9,483	0	56,716	492,585	126,223	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	20,515	0	4,922	0	15,990	21,586	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)	20,515	0	4,922	0	15,990	21,586	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

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

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

Worksheet H-2 Part I Date/Time Prepared: 2/26/2019 10:09 am

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	Cost Center Description	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	Allocated HHA A&G (see Part II)	Total HHA Costs	
		16.00	24.00	25.00	26.00	27.00	28.00	
1.00	Administrative and General	7,815	153,990	0	153,990			1.00
2.00	Skilled Nursing Care	0	360,008	0	360,008	103,497	463,505	2.00
3.00	Physical Therapy	0	85,146	0	85,146	24,478	109,624	3.00
4.00	Occupational Therapy	0	10,282	0	10,282	2,956	13,238	4.00
5.00	Speech Pathology	0	987	0	987	284	1,271	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	79,215	0	79,215	22,773	101,988	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	8	0	8	2	10	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	7,815	689,636	0	689,636	153,990	689,636	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.					0.287485		21.00

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

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

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

Worksheet H-2 Part II Date/Time Prepared: 2/26/2019 10:09 am

Home Health Agency I

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	Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
		1.00	2.00	4.00	5A	5.00	7.00	
1.00	Administrative and General	505	505	271,587	0	66,199	505	1.00
2.00	Skilled Nursing Care	0	0	0	0	286,574	0	2.00
3.00	Physical Therapy	0	0	0	0	67,778	0	3.00
4.00	Occupational Therapy	0	0	0	0	8,185	0	4.00
5.00	Speech Pathology	0	0	0	0	786	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	63,057	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	6	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	505	505	271,587		492,585	505	20.00
21.00	Total cost to be allocated	9,483	0	56,716		126,223	20,515	21.00
22.00	Unit cost multiplier	18.778218	0.000000	0.208832		0.256246	40.623762	22.00

	Cost Center Description	LAUNDRY & LINEN SERVICE (PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (PATIENT DAYS)	CAFETERIA (GROSS SALARIES)	NURSING ADMINISTRATION (NURSE SALARIES)	MEDICAL RECORDS & LIBRARY (GROSS PATIENT REVENUE)	
		8.00	9.00	10.00	11.00	13.00	16.00	
1.00	Administrative and General	0	505	0	271,587	164,864	543,822	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	0	505	0	271,587	164,864	543,822	20.00
21.00	Total cost to be allocated	0	4,922	0	15,990	21,586	7,815	21.00
22.00	Unit cost multiplier	0.000000	9.746535	0.000000	0.058876	0.130932	0.014371	22.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 15-1319 | HHA CCN: 15-7445 | Period: From 10/01/2017 To 09/30/2018 | Worksheet H-3 Part I | Date/Time Prepared: 2/26/2019 10:09 am

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	Cost Center Description	From, Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Visits	Average Cost Per Visit (col. 3 ÷ col. 4)	
		0	1.00	2.00	3.00	4.00	5.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	2.00	463,505		463,505	1,902	243.69	1.00
2.00	Physical Therapy	3.00	109,624	0	109,624	1,209	90.67	2.00
3.00	Occupational Therapy	4.00	13,238	0	13,238	146	90.67	3.00
4.00	Speech Pathology	5.00	1,271	0	1,271	14	90.79	4.00
5.00	Medical Social Services	6.00	0		0	2	0.00	5.00
6.00	Home Health Aide	7.00	101,988		101,988	310	328.99	6.00
7.00	Total (sum of lines 1-6)		689,626	0	689,626	3,583		7.00

	Cost Center Description	Cost Limits	CBSA No. (1)	Program Visits: Part A	Program Visits: Part B Not Subject to Deductibles & Coinsurance	Program Visits: Part B Subject to Deductibles		
		0	1.00	2.00	3.00	4.00	5.00	
	Limitation Cost Computation							
8.00	Skilled Nursing Care		99915	0	1,119			8.00
9.00	Physical Therapy		99915	0	760			9.00
10.00	Occupational Therapy		99915	0	91			10.00
11.00	Speech Pathology		99915	0	9			11.00
12.00	Medical Social Services		99915	0	2			12.00
13.00	Home Health Aide		99915	0	179			13.00
14.00	Total (sum of lines 8-13)			0	2,160			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	10	0	10	0	0.000000	16.00

	Cost Center Description	Program Visits: Part A	Program Visits: Part B Not Subject to Deductibles & Coinsurance	Program Visits: Part B Subject to Deductibles & Coinsurance	Cost of Services: Part A	Cost of Services: Part B Not Subject to Deductibles & Coinsurance	Cost of Services: Part B Subject to Deductibles & Coinsurance	
		6.00	7.00	8.00	9.00	10.00	11.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	0	1,119		0	272,689		1.00
2.00	Physical Therapy	0	760		0	68,909		2.00
3.00	Occupational Therapy	0	91		0	8,251		3.00
4.00	Speech Pathology	0	9		0	817		4.00
5.00	Medical Social Services	0	2		0	0		5.00
6.00	Home Health Aide	0	179		0	58,889		6.00
7.00	Total (sum of lines 1-6)	0	2,160		0	409,555		7.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 15-1319 | HHA CCN: 15-7445 | Period: From 10/01/2017 To 09/30/2018 | Worksheet H-3 Part I | Date/Time Prepared: 2/26/2019 10:09 am

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

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

	Cost Center Description	Total Program Cost (sum of cols. 9-10)		
		12.00		
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION			
	Cost Per Visit Computation			
1.00	Skilled Nursing Care	272,689		1.00
2.00	Physical Therapy	68,909		2.00
3.00	Occupational Therapy	8,251		3.00
4.00	Speech Pathology	817		4.00
5.00	Medical Social Services	0		5.00
6.00	Home Health Aide	58,889		6.00
7.00	Total (sum of lines 1-6)	409,555		7.00

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

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 15-1319 | HHA CCN: 15-7445 | Period: From 10/01/2017 To 09/30/2018 | Worksheet H-3 Part II | Date/Time Prepared: 2/26/2019 10:09 am

Title XVIII | Home Health Agency I | PPS

	Cost Center Description	From Wkst. C, Part I, col. 9, line	Cost to Charge Ratio	Total HHA Charge (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)	Transfer to Part I as Indicated		
		0	1.00	2.00	3.00	4.00		
	PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS							
1.00	Physical Therapy	66.00	0.335264	0	0	col. 2, line 2.00		1.00
2.00	Occupational Therapy	67.00	0.311161	0	0	col. 2, line 3.00		2.00
3.00	Speech Pathology	68.00	0.342780	0	0	col. 2, line 4.00		3.00
4.00	Cost of Medical Supplies	71.00	1.475690	0	0	col. 2, line 15.00		4.00
5.00	Cost of Drugs	73.00	0.512295	0	0	col. 2, line 16.00		5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT

Provider CCN: 15-1319 | HHA CCN: 15-7445 | Period: From 10/01/2017 To 09/30/2018 | Worksheet H-4 Part I-II | Date/Time Prepared: 2/26/2019 10:09 am

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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	0	0	2.00
	Customary Charges				
3.00	Amount actually collected from patients liable for payment for services on a charge basis (from your records)	0	0	0	3.00
4.00	Amount that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(b)	0	0	0	4.00
5.00	Ratio of line 3 to line 4 (not to exceed 1.000000)	0.000000	0.000000	0.000000	5.00
6.00	Total customary charges (see instructions)	0	0	0	6.00
7.00	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)	0	0	0	7.00
8.00	Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6)	0	0	0	8.00
9.00	Primary payer amounts	0	0	0	9.00

		Part A Services	Part B Services	
		1.00	2.00	
	PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT			
10.00	Total reasonable cost (see instructions)	0	0	10.00
11.00	Total PPS Reimbursement - Full Episodes without Outliers	0	303,214	11.00
12.00	Total PPS Reimbursement - Full Episodes with Outliers	0	1,329	12.00
13.00	Total PPS Reimbursement - LUPA Episodes	0	4,799	13.00
14.00	Total PPS Reimbursement - PEP Episodes	0	3,480	14.00
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers	0	79	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	312,901	22.00
23.00	Excess reasonable cost (from line 8)	0	0	23.00
24.00	Subtotal (line 22 minus line 23)	0	312,901	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	312,901	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	312,901	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	312,901	31.00
31.01	Sequestration adjustment (see instructions)	0	6,258	31.01
31.02	Demonstration payment adjustment amount after sequestration	0	0	31.02
32.00	Interim payments (see instructions)	0	306,643	32.00
33.00	Tentative settlement (for contractor use only)	0	0	33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 32, and 33)	0	0	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	35.00

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

Provider CCN: 15-1319 HHA CCN: 15-7445 | Period: From 10/01/2017 To 09/30/2018 | Worksheet H-5 Date/Time Prepared: 2/26/2019 10:09 am

Home Health Agency I | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		0		306,643	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		306,643	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		306,643	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1319 | Component CCN: 15-8524 | Period: From 10/01/2017 To 09/30/2018 | Worksheet M-1 | Date/Time Prepared: 2/26/2019 10:09 am

RHC I | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	-32,788	7	-32,781	50,108	17,327	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	34,084	0	34,084	0	34,084	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	38,950	0	38,950	0	38,950	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)	40,246	7	40,253	50,108	90,361	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	0	0	0	0	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	0	0	0	0	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	40,246	7	40,253	50,108	90,361	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	6,441	6,441	0	6,441	29.00
30.00	Administrative Costs	36,133	59,925	96,058	-2,872	93,186	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	36,133	66,366	102,499	-2,872	99,627	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	76,379	66,373	142,752	47,236	189,988	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1319 | Component CCN: 15-8524 | Period: From 10/01/2017 To 09/30/2018 | Worksheet M-1 | Date/Time Prepared: 2/26/2019 10:09 am

RHC I | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	17,327		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	34,084		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	38,950		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	90,361		10.00
11.00	Physician Services Under Agreement	0	0		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	0		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0		14.00
15.00	Medical Supplies	0	0		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	0		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	90,361		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	6,441		29.00
30.00	Administrative Costs	0	93,186		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	99,627		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	189,988		32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 15-1319 | Component CCN: 15-8524 | Period: From 10/01/2017 To 09/30/2018 | Worksheet M-2 | Date/Time Prepared: 2/26/2019 10:09 am

RHC I | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	0.10	293	4,200	420		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	0.40	419	2,100	840		3.00
4.00	Subtotal (sum of lines 1 through 3)	0.50	712		1,260	1,260	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	0.50	712			1,260	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)					90,361	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)					90,361	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)					99,627	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					83,070	15.00
16.00	Total overhead (sum of lines 14 and 15)					182,697	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					182,697	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					182,697	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					273,058	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 15-1319 Component CCN: 15-8524	Period: From 10/01/2017 To 09/30/2018	Worksheet M-3 Date/Time Prepared: 2/26/2019 10:09 am
	Title XVIII	RHC I	Cost

				1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES				
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			273,058	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			11,069	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			261,989	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			1,260	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)			0	5.00
6.00	Total adjusted visits (line 4 plus line 5)			1,260	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			207.93	7.00
		Calculation of Limit (1)			
		Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)		
		1.00	2.00		
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	0.00	0.00		8.00
9.00	Rate for Program covered visits (see instructions)	207.93	207.93		9.00
	CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	0	84		10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	17,466		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	17,466		16.00
16.01	Total program charges (see instructions)(from contractor's records)		18,490		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		825		16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		779		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.)		12,682		16.04
16.05	Total program cost (see instructions)	0	13,461		16.05
17.00	Primary payer amounts		0		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		834		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		3,366		19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		13,461		20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		283		21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		13,744		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)		13,744		26.00
26.01	Sequestration adjustment (see instructions)		275		26.01
26.02	Demonstration payment adjustment amount after sequestration		0		26.02
27.00	Interim payments		9,865		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)		3,604		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: 15-1319 Component CCN: 15-8524	Period: From 10/01/2017 To 09/30/2018	Worksheet M-4 Date/Time Prepared: 2/26/2019 10:09 am
	Title XVIII	RHC I	Cost

		Pneumococcal	Influenza	
		1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	90,361	90,361	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.003476	0.006083	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	314	550	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	1,710	1,089	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	2,024	1,639	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	90,361	90,361	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	182,697	182,697	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.022399	0.018138	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	4,092	3,314	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	6,116	4,953	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	22	35	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	278.00	141.51	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	0	2	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	0	283	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)		11,069	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)		283	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 15-1319 Component CCN: 15-8524	Period: From 10/01/2017 To 09/30/2018	Worksheet M-5 Date/Time Prepared: 2/26/2019 10:09 am
		RHC I	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		9,865	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)		9,865	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		3,604	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		13,469	7.00

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