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: 15-1305	Period: From 10/01/2017 To 09/30/2018	Worksheet S Parts I-III Date/Time Prepared: 7/31/2019 3:12 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 7/31/2019 Time: 3:12 pm
2. [ ] Manually submitted cost report
3. [1] 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 PULASKI MEMORIAL HOSPITAL (15-1305) 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	213,584	189,508	0	15,006	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	42,229	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
9.00	HOME HEALTH AGENCY I	0	0	1		0	9.00
10.00	RURAL HEALTH CLINIC - WINAMAC I	0		170,069		0	10.00
10.01	RURAL HEALTH CLINIC - NORTH JUDSON II	0		59,990		0	10.01
10.02	RURAL HEALTH CLINIC - FRANCESVILLE III	0		21,896		0	10.02
200.00	Total	0	255,813	441,464	0	15,006	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1305 | Period: From 10/01/2017 To 09/30/2018 | Worksheet S-2 Part I Date/Time Prepared: 7/31/2019 3:12 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 616 EAST 13TH	PO Box:			1.00
2.00	City: WINAMAC	State: IN	Zip Code: 46996-	County: PULASKI	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	PULASKI MEMORIAL HOSPITAL	151305	99915	1	10/01/2000	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	PULASKI MEMORIAL HOSPITAL	15Z305	99915		10/01/2000	N	O	P	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	PULASKI MEMORIAL HOSPITAL	157078	99915		10/14/1982	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	PULASKI MEMORIAL RHC - WINAMAC	158512	99915		08/21/2014	N	O	N	15.00
15.01	Hospital-Based Health Clinic - RHC II	PULASKI MEMORIAL RHC - NORTH JUDSON	158527	99915		03/14/2018	N	O	N	15.01
15.02	Hospital-Based Health Clinic - RHC III	PULASKI MEMORIAL RHC - FRANCESVILLE	158528	99915		03/15/2018	N	O	N	15.02
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	10/01/2017	09/30/2018	20.00
21.00	Type of Control (see instructions)	2		21.00

		1.00	2.00	3.00	
	Inpatient PPS Information				
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	N	N		22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	N	N		22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N		22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.	N	N	N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	2	N		23.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1305 | Period: From 10/01/2017 To 09/30/2018 | Worksheet S-2 Part I | Date/Time Prepared: 7/31/2019 3:12 pm

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

		Urban/Rural S	Date of Geogr	
		1.00	2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	2		26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	2		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0		35.00

		Beginning:	Ending:	
		1.00	2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.			36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.	0		37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)			37.01
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.			38.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1305 | Period: From 10/01/2017 To 09/30/2018 | Worksheet S-2 Part I Date/Time Prepared: 7/31/2019 3:12 pm

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

		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)				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: 15-1305 | Period: From 10/01/2017 To 09/30/2018 | Worksheet S-2 Part I Date/Time Prepared: 7/31/2019 3:12 pm

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

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1305 | Period: From 10/01/2017 To 09/30/2018 | Worksheet S-2 Part I Date/Time Prepared: 7/31/2019 3:12 pm

		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:	139,682	0	0	118.01

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-1305	Period: From 10/01/2017 To 09/30/2018	Worksheet S-2 Part I Date/Time Prepared: 7/31/2019 3:12 pm

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

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

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

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

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

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

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

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

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

		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	10/03/2017	12/31/2017	170.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-1305	Period: From 10/01/2017 To 09/30/2018	Worksheet S-2 Part I Date/Time Prepared: 7/31/2019 3:12 pm

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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-1305 | Period: From 10/01/2017 To 09/30/2018 | Worksheet S-2 Part II | Date/Time Prepared: 7/31/2019 3:12 pm

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

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

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

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

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

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	Y	01/17/2019	Y	01/17/2019	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: 15-1305 | Period: From 10/01/2017 To 09/30/2018 | Worksheet S-2 Part II Date/Time Prepared: 7/31/2019 3:12 pm

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

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

		1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)		
	Capital Related Cost		
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions	N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.	N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions	N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.	N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.	N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.	N	27.00
	Interest Expense		
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.	N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions	N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.	N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.	N	31.00
	Purchased Services		
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.	N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.		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.			37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.			38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			40.00

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	MICHAEL	ALESSANDRINI	41.00
42.00	Enter the employer/company name of the cost report preparer.	BLUE AND CO., LLC		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317.713.7959	MALESSANDRINI@BLUEANDCO.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-1305	Period: From 10/01/2017 To 09/30/2018	Worksheet S-2 Part II Date/Time Prepared: 7/31/2019 3:12 pm

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-1305 | Period: From 10/01/2017 To 09/30/2018 | Worksheet S-3 Part I Date/Time Prepared: 7/31/2019 3:12 pm

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	25	9,125	48,360.00	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)		25	9,125	48,360.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	0	0	0.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		25	9,125	48,360.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	101.00				0	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	116.00	0	0			24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC - WINAMAC	88.00				0	26.00
26.01	RURAL HEALTH CLINIC - NORTH JUDSON	88.01				0	26.01
26.02	RURAL HEALTH CLINIC - FRANCESVILLE	88.02				0	26.02
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: 15-1305 | Period: From 10/01/2017 To 09/30/2018 | Worksheet S-3 Part I | Date/Time Prepared: 7/31/2019 3:12 pm

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	1,057	20	2,015			1.00
2.00	HMO and other (see instructions)	200	278				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	897	0	949			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	268			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,954	20	3,232			7.00
8.00	INTENSIVE CARE UNIT	0	0	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		0	147			13.00
14.00	Total (see instructions)	1,954	20	3,379	0.00	175.88	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	2,928	659	3,607	0.00	10.31	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	0	0	0	0.00	0.00	24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC - WINAMAC	6,297	235	22,939	0.00	45.85	26.00
26.01	RURAL HEALTH CLINIC - NORTH JUDSON	903	16	2,114	0.00	4.90	26.01
26.02	RURAL HEALTH CLINIC - FRANCESVILLE	223	12	896	0.00	3.58	26.02
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	240.52	27.00
28.00	Observation Bed Days		0	331			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	39			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: 15-1305 | Period: From 10/01/2017 To 09/30/2018 | Worksheet S-3 Part I | Date/Time Prepared: 7/31/2019 3:12 pm

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	293	6	585	1.00
2.00	HMO and other (see instructions)			24	89		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	293	6	585	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0.00					22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	0.00					24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC - WINAMAC	0.00					26.00
26.01	RURAL HEALTH CLINIC - NORTH JUDSON	0.00					26.01
26.02	RURAL HEALTH CLINIC - FRANCESVILLE	0.00					26.02
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: 15-1305
Component CCN: 15-7078
Period: From 10/01/2017 To 09/30/2018
Worksheet S-4
Date/Time Prepared: 7/31/2019 3:12 pm

Home Health Agency I | PPS

		1.00	
0.00	County		0.00

		Title V	Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	5.00	
	HOME HEALTH AGENCY STATISTICAL DATA						
1.00	Home Health Aide Hours	0	0	0	0	0	1.00
2.00	Unduplicated Census Count (see instructions)	0.00	124.00	0.00	0.00	0.00	2.00

		Enter the number of hours in your normal work week	Number of Employees (Full Time Equivalent)			
			Staff	Contract	Total	
		0	1.00	2.00	3.00	
	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES					
3.00	Administrator and Assistant Administrator(s)	40.00	0.00	0.00	0.00	3.00
4.00	Director(s) and Assistant Director(s)		0.58	0.00	0.58	4.00
5.00	Other Administrative Personnel		0.00	0.00	0.00	5.00
6.00	Direct Nursing Service		4.00	0.00	4.00	6.00
7.00	Nursing Supervisor		0.00	0.00	0.00	7.00
8.00	Physical Therapy Service		0.84	0.00	0.84	8.00
9.00	Physical Therapy Supervisor		0.00	0.00	0.00	9.00
10.00	Occupational Therapy Service		0.29	0.00	0.29	10.00
11.00	Occupational Therapy Supervisor		0.00	0.00	0.00	11.00
12.00	Speech Pathology Service		0.04	0.00	0.04	12.00
13.00	Speech Pathology Supervisor		0.00	0.00	0.00	13.00
14.00	Medical Social Service		0.00	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		2.33	0.00	2.33	16.00
17.00	Home Health Aide Supervisor		0.00	0.00	0.00	17.00
18.00	MEDICAL TECH		0.32	0.00	0.32	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	962	202	28	0	1,192	21.00
22.00	Skilled Nursing Visit Charges	223,783	47,078	6,526	0	277,387	22.00
23.00	Physical Therapy Visits	601	55	7	0	663	23.00
24.00	Physical Therapy Visit Charges	152,671	13,969	1,772	0	168,412	24.00
25.00	Occupational Therapy Visits	201	32	0	0	233	25.00
26.00	Occupational Therapy Visit Charges	51,038	8,136	0	0	59,174	26.00
27.00	Speech Pathology Visits	5	31	0	0	36	27.00
28.00	Speech Pathology Visit Charges	1,271	7,882	0	0	9,153	28.00
29.00	Medical Social Service Visits	0	0	0	0	0	29.00
30.00	Medical Social Service Visit Charges	0	0	0	0	0	30.00
31.00	Home Health Aide Visits	700	102	2	0	804	31.00
32.00	Home Health Aide Visit Charges	75,186	10,972	215	0	86,373	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	2,469	422	37	0	2,928	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)	503,949	88,037	8,513	0	600,499	35.00
36.00	Total Number of Episodes (standard/non outlier)	139		16	0	155	36.00
37.00	Total Number of Outlier Episodes		9		0	9	37.00
38.00	Total Non-Routine Medical Supply Charges	30,891	9,148	2,188	0	42,227	38.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 15-1305 | Component CCN: 15-8512 | Period: From 10/01/2017 To 09/30/2018 | Worksheet S-8 | Date/Time Prepared: 7/31/2019 3:12 pm

RHC I | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			540 HOSPITAL DRIVE		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	WINIMAC		IN	46996-	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		PULASKI				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	17:30	08:00	19:00	08:00	19:00	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 15-1305
Component CCN: 15-8512

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

Worksheet S-8
Date/Time Prepared:
7/31/2019 3:12 pm

RHC I

Cost

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	CLINIC	08:00	16:30	08:00	12:00		11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 15-1305 | Component CCN: 15-8527 | Period: From 10/01/2017 To 09/30/2018 | Worksheet S-8 | Date/Time Prepared: 7/31/2019 3:12 pm

RHC II | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			NORTH LANE STREET		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	NORTH JUDSON		IN	46366-1226	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?					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		PULASKI				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: 15-1305 Component CCN: 15-8527	Period: From 10/01/2017 To 09/30/2018	Worksheet S-8 Date/Time Prepared: 7/31/2019 3:12 pm
		RHC II	Cost

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

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 15-1305 | Component CCN: 15-8528 | Period: From 10/01/2017 To 09/30/2018 | Worksheet S-8 | Date/Time Prepared: 7/31/2019 3:12 pm

RHC III | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			112 E MONTGOMERY STREET		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	FRANCESVILLE		IN	47946-8087	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	09:00	11.00

			1.00	2.00	
12.00	Have you received an approval for an exception to the productivity standard?				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		PULASKI				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	19:00	08:00	16:00	08:00	16:00	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 15-1305
Component CCN: 15-8528

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

Worksheet S-8
Date/Time Prepared:
7/31/2019 3:12 pm

RHC III

Cost

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

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 15-1305 | Period: From 10/01/2017 To 09/30/2018 | Worksheet S-10 | Date/Time Prepared: 7/31/2019 3:12 pm

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.501715	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	1,435,838	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?	N	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	235,830	5.00
6.00	Medicaid charges	9,945,362	6.00
7.00	Medicaid cost (line 1 times line 6)	4,989,737	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)	3,318,069	8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone CHIP	0	9.00
10.00	Stand-alone CHIP charges	0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	3,318,069	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)	265,522	0	265,522	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	133,216	0	133,216	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)	133,216	0	133,216	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)	1,486,179	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	243,112	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	374,018	27.01
28.00	Non-Medicare bad debt expense (see instructions)	1,112,161	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	688,894	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	822,110	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	4,140,179	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1305 | Period: From 10/01/2017 To 09/30/2018 | Worksheet A | Date/Time Prepared: 7/31/2019 3:12 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		1,692,348	1,692,348	29,336	1,721,684	1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	5,606,397	5,606,397	0	5,606,397	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,135,210	2,427,307	4,562,517	406,633	4,969,150	5.00
7.00	00700	OPERATION OF PLANT	338,260	537,337	875,597	0	875,597	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	19,908	53,571	73,479	0	73,479	8.00
9.00	00900	HOUSEKEEPING	174,367	90,722	265,089	0	265,089	9.00
10.00	01000	DIETARY	164,816	184,389	349,205	0	349,205	10.00
13.00	01300	NURSING ADMINISTRATION	443,514	15,064	458,578	0	458,578	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	42,584	56,148	98,732	0	98,732	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	315,413	51,988	367,401	0	367,401	16.00
17.00	01700	SOCIAL SERVICE	46,636	348	46,984	0	46,984	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,058,241	142,608	2,200,849	17,153	2,218,002	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	17,687	3,962	21,649	30,727	52,376	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	502,220	94,938	597,158	364,224	961,382	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	19,019	5,791	24,810	38,408	63,218	52.00
53.00	05300	ANESTHESIOLOGY	0	574,353	574,353	0	574,353	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	803,769	319,322	1,123,091	0	1,123,091	54.00
60.00	06000	LABORATORY	651,328	827,709	1,479,037	0	1,479,037	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	62,861	62,861	0	62,861	63.00
65.00	06500	RESPIRATORY THERAPY	316,729	31,747	348,476	0	348,476	65.00
66.00	06600	PHYSICAL THERAPY	903,810	37,658	941,468	0	941,468	66.00
67.00	06700	OCCUPATIONAL THERAPY	142,166	1,174	143,340	0	143,340	67.00
68.00	06800	SPEECH PATHOLOGY	61,265	3,548	64,813	0	64,813	68.00
69.00	06900	ELECTROCARDIOLOGY	10,624	14,695	25,319	0	25,319	69.00
69.01	06901	CARDIAC REHABILITATION	53,063	1,443	54,506	0	54,506	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	557,029	557,029	-100,869	456,160	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	100,869	100,869	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,338,836	2,338,836	0	2,338,836	73.00
76.00	03020	ONCOLOGY	103,182	35,175	138,357	0	138,357	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC - WINAMAC	4,606,101	416,155	5,022,256	-769,238	4,253,018	88.00
88.01	08801	RURAL HEALTH CLINIC - NORTH JUDSON	373,047	87,680	460,727	-78,746	381,981	88.01
88.02	08802	RURAL HEALTH CLINIC - FRANCESVILLE	195,045	42,608	237,653	-33,812	203,841	88.02
90.00	09000	CLINIC	84,282	288,587	372,869	0	372,869	90.00
91.00	09100	EMERGENCY	933,406	1,314,784	2,248,190	0	2,248,190	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	608,487	106,341	714,828	-73,950	640,878	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	16,124,179	18,024,623	34,148,802	-69,265	34,079,537	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	HOMECARE	0	0	0	0	0	190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	162,476	40,539	203,015	97,465	300,480	192.00
194.00	07950	MARKETING	68,156	119,847	188,003	-28,200	159,803	194.00
200.00		TOTAL (SUM OF LINES 118 through 199)	16,354,811	18,185,009	34,539,820	0	34,539,820	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1305 | Period: From 10/01/2017 To 09/30/2018 | Worksheet A | Date/Time Prepared: 7/31/2019 3:12 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	-13,105	1,708,579		1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	5,606,397		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-893,388	4,075,762		5.00
7.00	00700	OPERATION OF PLANT	-278	875,319		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	73,479		8.00
9.00	00900	HOUSEKEEPING	0	265,089		9.00
10.00	01000	DIETARY	-67,054	282,151		10.00
13.00	01300	NURSING ADMINISTRATION	0	458,578		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	-10,148	88,584		14.00
15.00	01500	PHARMACY	0	0		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-8,601	358,800		16.00
17.00	01700	SOCIAL SERVICE	0	46,984		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-397,428	1,820,574		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0		31.00
43.00	04300	NURSERY	0	52,376		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-364,224	597,158		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	63,218		52.00
53.00	05300	ANESTHESIOLOGY	-554,438	19,915		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,123,091		54.00
60.00	06000	LABORATORY	-1,824	1,477,213		60.00
60.01	06001	BLOOD LABORATORY	0	0		60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	62,861		63.00
65.00	06500	RESPIRATORY THERAPY	0	348,476		65.00
66.00	06600	PHYSICAL THERAPY	-234	941,234		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	143,340		67.00
68.00	06800	SPEECH PATHOLOGY	0	64,813		68.00
69.00	06900	ELECTROCARDIOLOGY	-5,663	19,656		69.00
69.01	06901	CARDIAC REHABILITATION	0	54,506		69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	456,160		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	100,869		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-81,019	2,257,817		73.00
76.00	03020	ONCOLOGY	0	138,357		76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC - WINAMAC	-13,081	4,239,937		88.00
88.01	08801	RURAL HEALTH CLINIC - NORTH JUDSON	0	381,981		88.01
88.02	08802	RURAL HEALTH CLINIC - FRANCESVILLE	0	203,841		88.02
90.00	09000	CLINIC	0	372,869		90.00
91.00	09100	EMERGENCY	0	2,248,190		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY	0	640,878		101.00
		SPECIAL PURPOSE COST CENTERS				
116.00	11600	HOSPICE	0	0		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-2,410,485	31,669,052		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
190.01	19001	HOMECARE	0	0		190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	300,480		192.00
194.00	07950	MARKETING	0	159,803		194.00
200.00		TOTAL (SUM OF LINES 118 through 199)	-2,410,485	32,129,335		200.00

RECLASSIFICATIONS | Provider CCN: 15-1305 | Period: From 10/01/2017 To 09/30/2018 | Worksheet A-6 | Date/Time Prepared: 7/31/2019 3:12 pm

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - PROPERTY INSURANCE					
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	29,336		1.00
	0		0	29,336		
	B - MARKETING RECLASS					
1.00	ADMINISTRATIVE & GENERAL	5.00	10,223	17,977		1.00
	0		10,223	17,977		
	C - IMPLANTABLE DEVICES					
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	100,869		1.00
	0		0	100,869		
	D - PHYSICIAN SALARIES					
1.00	ADULTS & PEDIATRICS	30.00	86,288	0		1.00
2.00	OPERATING ROOM	50.00	364,224	0		2.00
3.00	RURAL HEALTH CLINIC - WINAMAC	88.00	147,495	0		3.00
4.00	RURAL HEALTH CLINIC - NORTH JUDSON	88.01	13,606	0		4.00
5.00	RURAL HEALTH CLINIC - FRANCESVILLE	88.02	9,562	0		5.00
6.00	PHYSICIANS' PRIVATE OFFICES	192.00	97,465	0		6.00
	0		718,640	0		
	E - RHC PHYSICIAN COSTS					
1.00	RURAL HEALTH CLINIC - WINAMAC	88.00	0	19,665		1.00
	0		0	19,665		
	F - BILLER RECLASS					
1.00	ADMINISTRATIVE & GENERAL	5.00	73,950	0		1.00
	0		73,950	0		
	G - PATIENT ACCOUNTS RECLASS					
1.00	ADMINISTRATIVE & GENERAL	5.00	353,484	0		1.00
	0		353,484	0		
	H - RHC DEPT 175 RECLASS					
1.00	RURAL HEALTH CLINIC - NORTH JUDSON	88.01	0	18,023		1.00
2.00	RURAL HEALTH CLINIC - FRANCESVILLE	88.02	0	7,639		2.00
	0		0	25,662		
	I - RN SALARIES					
1.00	NURSERY	43.00	30,727	0		1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	38,408	0		2.00
	0		69,135	0		
500.00	Grand Total: Increases		1,225,432	193,509		500.00

RECLASSIFICATIONS | Provider CCN: 15-1305 | Period: From 10/01/2017 To 09/30/2018 | Worksheet A-6 | Date/Time Prepared: 7/31/2019 3:12 pm

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - PROPERTY INSURANCE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	29,336	12		1.00
	0		0	29,336			
	B - MARKETING RECLASS						
1.00	MARKETING	194.00	10,223	17,977	0		1.00
	0		10,223	17,977			
	C - IMPLANTABLE DEVICES						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	100,869	0		1.00
	0		0	100,869			
	D - PHYSICIAN SALARIES						
1.00	RURAL HEALTH CLINIC - WINAMAC	88.00	557,252	0	0		1.00
2.00	RURAL HEALTH CLINIC - NORTH JUDSON	88.01	110,375	0	0		2.00
3.00	RURAL HEALTH CLINIC - FRANCESVILLE	88.02	51,013	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
	0		718,640	0			
	E - RHC PHYSICIAN COSTS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	19,665	0		1.00
	0		0	19,665			
	F - BILLER RECLASS						
1.00	HOME HEALTH AGENCY	101.00	73,950	0	0		1.00
	0		73,950	0			
	G - PATIENT ACCOUNTS RECLASS						
1.00	RURAL HEALTH CLINIC - WINAMAC	88.00	353,484	0	0		1.00
	0		353,484	0			
	H - RHC DEPT 175 RECLASS						
1.00	RURAL HEALTH CLINIC - WINAMAC	88.00	0	25,662	0		1.00
2.00		0.00	0	0	0		2.00
	0		0	25,662			
	I - RN SALARIES						
1.00	ADULTS & PEDIATRICS	30.00	69,135	0	0		1.00
2.00		0.00	0	0	0		2.00
	0		69,135	0			
500.00	Grand Total: Decreases		1,225,432	193,509			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1305 | Period: From 10/01/2017 To 09/30/2018 | Worksheet A-7 Part I | Date/Time Prepared: 7/31/2019 3:12 pm

		Beginning Balances	Acquisitions: Purchases	Acquisitions: Donation	Acquisitions: Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	12,288,972	943,937	0	943,937	0	1.00
2.00	Land Improvements	432,594	0	0	0	0	2.00
3.00	Buildings and Fixtures	195,525	152,777	0	152,777	0	3.00
4.00	Building Improvements	187,055	0	0	0	0	4.00
5.00	Fixed Equipment	8,514,633	183,037	0	183,037	0	5.00
6.00	Movable Equipment	7,874,656	150,661	0	150,661	588,637	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	29,493,435	1,430,412	0	1,430,412	588,637	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	29,493,435	1,430,412	0	1,430,412	588,637	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	13,232,909	0	1.00
2.00	Land Improvements	432,594	0	2.00
3.00	Buildings and Fixtures	348,302	0	3.00
4.00	Building Improvements	187,055	0	4.00
5.00	Fixed Equipment	8,697,670	0	5.00
6.00	Movable Equipment	7,436,680	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	30,335,210	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	30,335,210	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1305 | Period: From 10/01/2017 To 09/30/2018 | Worksheet A-7 Part II | Date/Time Prepared: 7/31/2019 3:12 pm

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1,424,822	0	267,526	0	0	1.00
3.00	Total (sum of lines 1-2)	1,424,822	0	267,526	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL			
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)		
		14.00	15.00		
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2				
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	1,692,348		1.00
3.00	Total (sum of lines 1-2)	0	1,692,348		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1305 | Period: From 10/01/2017 To 09/30/2018 | Worksheet A-7 Part III Date/Time Prepared: 7/31/2019 3:12 pm

	Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	30,335,333	0	30,335,333	1.000000	0	1.00
3.00	Total (sum of lines 1-2)	30,335,333	0	30,335,333	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	1,415,164	0	1.00
3.00	Total (sum of lines 1-2)	0	0	0	1,415,164	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	264,079	29,336	0	0	1,708,579	1.00
3.00	Total (sum of lines 1-2)	264,079	29,336	0	0	1,708,579	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1305 | Period: From 10/01/2017 To 09/30/2018 | Worksheet A-8 | Date/Time Prepared: 7/31/2019 3:12 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	*** Cost Center Deleted ***	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)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-767,033			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	0			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests		0		0.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts		0		0.00	0	18.00
19.00	Nursing 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 - NEW CAP REL COSTS-BLDG & FIXT		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	*** Cost Center Deleted ***	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: 15-1305 | Period: From 10/01/2017 To 09/30/2018 | Worksheet A-8 | Date/Time Prepared: 7/31/2019 3:12 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	A	-9,658	NEW CAP REL COSTS-BLDG & FIXT	1.00	9	32.00
33.00	INVEST INC/UNRESTRIC- INT EXP	B	-3,447	NEW CAP REL COSTS-BLDG & FIXT	1.00	11	33.00
34.00	OTHER NONOPER REV	B	122	ADMINISTRATIVE & GENERAL	5.00	0	34.00
35.00	OTHER SERVICES -OTHER REV	B	-13,937	ADMINISTRATIVE & GENERAL	5.00	0	35.00
36.00	POB/RENT INCOME	B	-30,612	ADMINISTRATIVE & GENERAL	5.00	0	36.00
37.00	CAFETERIA VENDING - OTHER REV	B	-67,054	DIETARY	10.00	0	37.00
38.00	SALE OF SCRAP -OTHER REV	B	-356	CENTRAL SERVICES & SUPPLY	14.00	0	38.00
40.00	REBATES & REFUNDS - OTHER REV	B	-9,792	CENTRAL SERVICES & SUPPLY	14.00	0	40.00
43.00	MEDICAL RECORDS FEES -OTHER REV	B	-8,601	MEDICAL RECORDS & LIBRARY	16.00	0	43.00
44.00	ICG - OTHER REV	B	-2,106	ADULTS & PEDIATRICS	30.00	0	44.00
45.00	ATHLETIC TRAIN SUPP -OTHER REV	B	-234	PHYSICAL THERAPY	66.00	0	45.00
45.01	EMPLOYEE RX PROGRAM -OTHER REV	B	-81,019	DRUGS CHARGED TO PATIENTS	73.00	0	45.01
45.02	OTHER REVENUE RHC- OTHER REV	B	-13,081	RURAL HEALTH CLINIC - WINAMAC	88.00	0	45.02
45.03	TELEVISION	A	-278	OPERATION OF PLANT	7.00	0	45.03
45.04	PHYSICIAN RECRUITMENT- ADMIN	A	-1,920	ADMINISTRATIVE & GENERAL	5.00	0	45.04
45.05	LOBBYING EXPENSE	A	-3,149	ADMINISTRATIVE & GENERAL	5.00	0	45.05
45.06	CRNA	A	-554,438	ANESTHESIOLOGY	53.00	0	45.06
45.07	HAF EXPENSE	A	-843,892	ADMINISTRATIVE & GENERAL	5.00	0	45.07
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-2,410,485				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.

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 15-1305 | Period: From 10/01/2017 To 09/30/2018 | Worksheet A-8-2 | Date/Time Prepared: 7/31/2019 3:12 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	91.00	EMERGENCY	1,233,116	0	1,233,116	0	0	1.00
2.00	60.00	LABORATORY	24,000	1,824	22,176	0	0	2.00
3.00	90.00	CLINIC	35,400	0	35,400	0	0	3.00
4.00	30.00	ADULTS & PEDIATRICS	309,034	309,034	0	0	0	4.00
5.00	69.00	ELECTROCARDIOLOGY	656	656	0	0	0	5.00
6.00	69.00	ELECTROCARDIOLOGY	5,007	5,007	0	0	0	6.00
7.00	30.00	ADULTS & PEDIATRICS	86,288	86,288	0	0	0	7.00
8.00	50.00	OPERATING ROOM	364,224	364,224	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			2,057,725	767,033	1,290,692		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	91.00	EMERGENCY	0	0	0	0	0	1.00
2.00	60.00	LABORATORY	0	0	0	0	0	2.00
3.00	90.00	CLINIC	0	0	0	0	0	3.00
4.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	4.00
5.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	5.00
6.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	6.00
7.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	7.00
8.00	50.00	OPERATING ROOM	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	91.00	EMERGENCY	0	0	0	0		1.00
2.00	60.00	LABORATORY	0	0	0	1,824		2.00
3.00	90.00	CLINIC	0	0	0	0		3.00
4.00	30.00	ADULTS & PEDIATRICS	0	0	0	309,034		4.00
5.00	69.00	ELECTROCARDIOLOGY	0	0	0	656		5.00
6.00	69.00	ELECTROCARDIOLOGY	0	0	0	5,007		6.00
7.00	30.00	ADULTS & PEDIATRICS	0	0	0	86,288		7.00
8.00	50.00	OPERATING ROOM	0	0	0	364,224		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	767,033		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1305 | Period: From 10/01/2017 To 09/30/2018 | Worksheet B Part I | Date/Time Prepared: 7/31/2019 3:12 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS NEW BLDG & FIXT	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	
			0	1.00	4.00	4A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	1,708,579	1,708,579				1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	5,606,397	25,396	5,631,793			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	4,075,762	240,113	885,969	5,201,844	5,201,844	5.00
7.00	00700	OPERATION OF PLANT	875,319	176,041	116,480	1,167,840	225,603	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	73,479	14,275	6,855	94,609	18,277	8.00
9.00	00900	HOUSEKEEPING	265,089	8,750	60,043	333,882	64,499	9.00
10.00	01000	DIETARY	282,151	70,782	56,755	409,688	79,144	10.00
13.00	01300	NURSING ADMINISTRATION	458,578	16,741	152,724	628,043	121,325	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	88,584	24,566	14,664	127,814	24,691	14.00
15.00	01500	PHARMACY	0	18,377	0	18,377	3,550	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	358,800	34,762	108,613	502,175	97,010	16.00
17.00	01700	SOCIAL SERVICE	46,984	0	16,059	63,043	12,179	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,820,574	204,900	714,664	2,740,138	529,340	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	52,376	3,818	16,671	72,865	14,076	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	597,158	125,771	298,361	1,021,290	197,293	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	63,218	13,279	19,775	96,272	18,598	52.00
53.00	05300	ANESTHESIOLOGY	19,915	735	0	20,650	3,989	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,123,091	114,128	276,779	1,513,998	292,474	54.00
60.00	06000	LABORATORY	1,477,213	32,960	224,285	1,734,458	335,063	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	62,861	996	0	63,857	12,336	63.00
65.00	06500	RESPIRATORY THERAPY	348,476	18,567	109,066	476,109	91,975	65.00
66.00	06600	PHYSICAL THERAPY	941,234	56,056	311,228	1,308,518	252,780	66.00
67.00	06700	OCCUPATIONAL THERAPY	143,340	0	48,955	192,295	37,148	67.00
68.00	06800	SPEECH PATHOLOGY	64,813	0	21,097	85,910	16,596	68.00
69.00	06900	ELECTROCARDIOLOGY	19,656	0	3,658	23,314	4,504	69.00
69.01	06901	CARDIAC REHABILITATION	54,506	10,623	18,272	83,401	16,111	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	456,160	0	0	456,160	88,121	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	100,869	0	0	100,869	19,486	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,257,817	0	0	2,257,817	436,165	73.00
76.00	03020	ONCOLOGY	138,357	13,374	35,531	187,262	36,175	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC - WINAMAC	4,239,937	265,462	1,323,292	5,828,691	1,125,976	88.00
88.01	08801	RURAL HEALTH CLINIC - NORTH JUDSON	381,981	0	95,137	477,118	92,170	88.01
88.02	08802	RURAL HEALTH CLINIC - FRANCESVILLE	203,841	0	52,890	256,731	49,595	88.02
90.00	09000	CLINIC	372,869	43,038	29,023	444,930	85,952	90.00
91.00	09100	EMERGENCY	2,248,190	146,069	321,419	2,715,678	524,615	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	640,878	15,461	184,068	840,407	162,350	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	31,669,052	1,695,040	5,522,333	31,546,053	5,089,166	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	10,694	0	10,694	2,066	190.00
190.01	19001	HOMECARE	0	2,845	0	2,845	550	190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	300,480	0	89,511	389,991	75,338	192.00
194.00	07950	MARKETING	159,803	0	19,949	179,752	34,724	194.00
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	32,129,335	1,708,579	5,631,793	32,129,335	5,201,844	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1305 | Period: From 10/01/2017 To 09/30/2018 | Worksheet B Part I | Date/Time Prepared: 7/31/2019 3:12 pm

		Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	NURSING ADMINISTRATION	
			7.00	8.00	9.00	10.00	13.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	1,393,443					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	13,382	126,268				8.00
9.00	00900	HOUSEKEEPING	8,202	0	406,583			9.00
10.00	01000	DIETARY	66,352	0	19,665	574,849		10.00
13.00	01300	NURSING ADMINISTRATION	15,693	0	4,651	0	769,712	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	23,029	0	6,825	0	0	14.00
15.00	01500	PHARMACY	17,227	0	5,106	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	32,587	0	9,658	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	192,077	46,930	56,927	574,849	408,630	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	3,579	2,266	1,061	0	22,306	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	117,900	20,051	34,943	0	92,132	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	12,448	0	3,689	0	32,422	52.00
53.00	05300	ANESTHESIOLOGY	689	0	204	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	106,986	13,863	31,708	0	19,339	54.00
60.00	06000	LABORATORY	30,898	264	9,157	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	934	0	277	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	17,405	0	5,158	0	18,317	65.00
66.00	06600	PHYSICAL THERAPY	52,548	14,656	15,574	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
69.01	06901	CARDIAC REHABILITATION	9,958	0	2,951	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	ONCOLOGY	12,537	40	3,716	0	43,588	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC - WINAMAC	253,963	1,597	75,266	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC - NORTH JUDSON	35,255	0	10,449	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC - FRANCESVILLE	19,761	32	5,857	0	0	88.02
90.00	09000	CLINIC	40,345	0	11,957	0	16,048	90.00
91.00	09100	EMERGENCY	136,928	26,252	40,582	0	116,930	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	14,493	0	4,295	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,235,176	125,951	359,676	574,849	769,712	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	10,025	0	2,971	0	0	190.00
190.01	19001	HOMECARE	2,667	0	791	0	0	190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	145,575	317	43,145	0	0	192.00
194.00	07950	MARKETING	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,393,443	126,268	406,583	574,849	769,712	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1305 | Period: From 10/01/2017 To 09/30/2018 | Worksheet B Part I | Date/Time Prepared: 7/31/2019 3:12 pm

		Cost Center Description	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	
			14.00	15.00	16.00	17.00	24.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
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
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	182,359					14.00
15.00	01500	PHARMACY	0	44,260				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	641,430			16.00
17.00	01700	SOCIAL SERVICE	0	0	0	75,222		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	24,813	70,201	4,643,905	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	0	0	979	0	117,132	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	55,555	5,021	1,544,185	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	3,353	0	166,782	52.00
53.00	05300	ANESTHESIOLOGY	0	0	8,711	0	34,243	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	132,050	0	2,110,418	54.00
60.00	06000	LABORATORY	0	0	121,745	0	2,231,585	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	2,547	0	79,951	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	13,790	0	622,754	65.00
66.00	06600	PHYSICAL THERAPY	0	0	32,593	0	1,676,669	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	5,039	0	234,482	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	1,241	0	103,747	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	5,202	0	33,020	69.00
69.01	06901	CARDIAC REHABILITATION	0	0	939	0	113,360	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	168,701	0	23,277	0	736,259	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	13,658	0	1,885	0	135,898	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	44,260	95,498	0	2,833,740	73.00
76.00	03020	ONCOLOGY	0	0	2,066	0	285,384	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC - WINAMAC	0	0	47,929	0	7,333,422	88.00
88.01	08801	RURAL HEALTH CLINIC - NORTH JUDSON	0	0	4,148	0	619,140	88.01
88.02	08802	RURAL HEALTH CLINIC - FRANCESVILLE	0	0	2,208	0	334,184	88.02
90.00	09000	CLINIC	0	0	3,520	0	602,752	90.00
91.00	09100	EMERGENCY	0	0	44,055	0	3,605,040	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	8,287	0	1,029,832	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	182,359	44,260	641,430	75,222	31,227,884	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	25,756	190.00
190.01	19001	HOMECARE	0	0	0	0	6,853	190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	654,366	192.00
194.00	07950	MARKETING	0	0	0	0	214,476	194.00
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	182,359	44,260	641,430	75,222	32,129,335	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1305 | Period: From 10/01/2017 To 09/30/2018 | Worksheet B Part I | Date/Time Prepared: 7/31/2019 3:12 pm

		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			25.00	26.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT				1.00
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
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
17.00	01700	SOCIAL SERVICE				17.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	4,643,905		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0		31.00
43.00	04300	NURSERY	0	117,132		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	1,544,185		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	166,782		52.00
53.00	05300	ANESTHESIOLOGY	0	34,243		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,110,418		54.00
60.00	06000	LABORATORY	0	2,231,585		60.00
60.01	06001	BLOOD LABORATORY	0	0		60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	79,951		63.00
65.00	06500	RESPIRATORY THERAPY	0	622,754		65.00
66.00	06600	PHYSICAL THERAPY	0	1,676,669		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	234,482		67.00
68.00	06800	SPEECH PATHOLOGY	0	103,747		68.00
69.00	06900	ELECTROCARDIOLOGY	0	33,020		69.00
69.01	06901	CARDIAC REHABILITATION	0	113,360		69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	736,259		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	135,898		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,833,740		73.00
76.00	03020	ONCOLOGY	0	285,384		76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC - WINAMAC	0	7,333,422		88.00
88.01	08801	RURAL HEALTH CLINIC - NORTH JUDSON	0	619,140		88.01
88.02	08802	RURAL HEALTH CLINIC - FRANCESVILLE	0	334,184		88.02
90.00	09000	CLINIC	0	602,752		90.00
91.00	09100	EMERGENCY	0	3,605,040		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0			92.00
		OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY	0	1,029,832		101.00
		SPECIAL PURPOSE COST CENTERS				
116.00	11600	HOSPICE	0	0		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	31,227,884		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	25,756		190.00
190.01	19001	HOMECARE	0	6,853		190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	654,366		192.00
194.00	07950	MARKETING	0	214,476		194.00
200.00		Cross Foot Adjustments	0	0		200.00
201.00		Negative Cost Centers	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	0	32,129,335		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1305 | Period: From 10/01/2017 To 09/30/2018 | Worksheet B Part II Date/Time Prepared: 7/31/2019 3:12 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS NEW BLDG & FIXT	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	
			0	1.00	2A	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	25,396	25,396	25,396		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	240,113	240,113	3,996	244,109	5.00
7.00	00700	OPERATION OF PLANT	0	176,041	176,041	525	10,586	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	14,275	14,275	31	858	8.00
9.00	00900	HOUSEKEEPING	0	8,750	8,750	271	3,027	9.00
10.00	01000	DIETARY	0	70,782	70,782	256	3,714	10.00
13.00	01300	NURSING ADMINISTRATION	0	16,741	16,741	689	5,693	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	24,566	24,566	66	1,159	14.00
15.00	01500	PHARMACY	0	18,377	18,377	0	167	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	34,762	34,762	490	4,552	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	72	571	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	204,900	204,900	3,223	24,839	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	0	3,818	3,818	75	661	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	125,771	125,771	1,346	9,258	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	13,279	13,279	89	873	52.00
53.00	05300	ANESTHESIOLOGY	0	735	735	0	187	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	114,128	114,128	1,248	13,724	54.00
60.00	06000	LABORATORY	0	32,960	32,960	1,012	15,723	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	996	996	0	579	63.00
65.00	06500	RESPIRATORY THERAPY	0	18,567	18,567	492	4,316	65.00
66.00	06600	PHYSICAL THERAPY	0	56,056	56,056	1,404	11,862	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	221	1,743	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	95	779	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	16	211	69.00
69.01	06901	CARDIAC REHABILITATION	0	10,623	10,623	82	756	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	4,135	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	914	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	20,467	73.00
76.00	03020	ONCOLOGY	0	13,374	13,374	160	1,698	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC - WINAMAC	0	265,462	265,462	5,964	52,849	88.00
88.01	08801	RURAL HEALTH CLINIC - NORTH JUDSON	0	0	0	429	4,325	88.01
88.02	08802	RURAL HEALTH CLINIC - FRANCESVILLE	0	0	0	239	2,327	88.02
90.00	09000	CLINIC	0	43,038	43,038	131	4,033	90.00
91.00	09100	EMERGENCY	0	146,069	146,069	1,450	24,618	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0			92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	15,461	15,461	830	7,618	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	1,695,040	1,695,040	24,902	238,822	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	10,694	10,694	0	97	190.00
190.01	19001	HOMECARE	0	2,845	2,845	0	26	190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	404	3,535	192.00
194.00	07950	MARKETING	0	0	0	90	1,629	194.00
200.00		Cross Foot Adjustments			0			200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	1,708,579	1,708,579	25,396	244,109	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1305 | Period: From 10/01/2017 To 09/30/2018 | Worksheet B Part II Date/Time Prepared: 7/31/2019 3:12 pm

		Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	NURSING ADMINISTRATION	
			7.00	8.00	9.00	10.00	13.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	187,152					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,797	16,961				8.00
9.00	00900	HOUSEKEEPING	1,102	0	13,150			9.00
10.00	01000	DIETARY	8,912	0	636	84,300		10.00
13.00	01300	NURSING ADMINISTRATION	2,108	0	150	0	25,381	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3,093	0	221	0	0	14.00
15.00	01500	PHARMACY	2,314	0	165	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,377	0	312	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	25,798	6,305	1,841	84,300	13,474	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	481	304	34	0	736	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	15,835	2,693	1,130	0	3,038	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,672	0	119	0	1,069	52.00
53.00	05300	ANESTHESIOLOGY	93	0	7	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	14,369	1,862	1,026	0	638	54.00
60.00	06000	LABORATORY	4,150	35	296	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	125	0	9	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	2,338	0	167	0	604	65.00
66.00	06600	PHYSICAL THERAPY	7,058	1,969	504	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
69.01	06901	CARDIAC REHABILITATION	1,338	0	95	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	ONCOLOGY	1,684	5	120	0	1,437	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC - WINAMAC	34,106	215	2,435	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC - NORTH JUDSON	4,735	0	338	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC - FRANCESVILLE	2,654	4	189	0	0	88.02
90.00	09000	CLINIC	5,419	0	387	0	529	90.00
91.00	09100	EMERGENCY	18,391	3,526	1,313	0	3,856	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	1,947	0	139	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	165,896	16,918	11,633	84,300	25,381	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,346	0	96	0	0	190.00
190.01	19001	HOMECARE	358	0	26	0	0	190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	19,552	43	1,395	0	0	192.00
194.00	07950	MARKETING	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	187,152	16,961	13,150	84,300	25,381	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1305 | Period: From 10/01/2017 To 09/30/2018 | Worksheet B Part II Date/Time Prepared: 7/31/2019 3:12 pm

		Cost Center Description	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	
			14.00	15.00	16.00	17.00	24.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
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
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	29,105					14.00
15.00	01500	PHARMACY	0	21,023				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	44,493			16.00
17.00	01700	SOCIAL SERVICE	0	0	0	643		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	1,722	600	367,002	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	0	0	68	0	6,177	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	3,855	43	162,969	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	233	0	17,334	52.00
53.00	05300	ANESTHESIOLOGY	0	0	604	0	1,626	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	9,149	0	156,144	54.00
60.00	06000	LABORATORY	0	0	8,447	0	62,623	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	177	0	1,886	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	957	0	27,441	65.00
66.00	06600	PHYSICAL THERAPY	0	0	2,261	0	81,114	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	350	0	2,314	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	86	0	960	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	361	0	588	69.00
69.01	06901	CARDIAC REHABILITATION	0	0	65	0	12,959	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	26,925	0	1,615	0	32,675	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,180	0	131	0	3,225	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	21,023	6,626	0	48,116	73.00
76.00	03020	ONCOLOGY	0	0	143	0	18,621	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC - WINAMAC	0	0	3,326	0	364,357	88.00
88.01	08801	RURAL HEALTH CLINIC - NORTH JUDSON	0	0	288	0	10,115	88.01
88.02	08802	RURAL HEALTH CLINIC - FRANCESVILLE	0	0	153	0	5,566	88.02
90.00	09000	CLINIC	0	0	244	0	53,781	90.00
91.00	09100	EMERGENCY	0	0	3,057	0	202,280	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	575	0	26,570	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	29,105	21,023	44,493	643	1,666,443	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	12,233	190.00
190.01	19001	HOMECARE	0	0	0	0	3,255	190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	24,929	192.00
194.00	07950	MARKETING	0	0	0	0	1,719	194.00
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	29,105	21,023	44,493	643	1,708,579	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1305 | Period: From 10/01/2017 To 09/30/2018 | Worksheet B Part II | Date/Time Prepared: 7/31/2019 3:12 pm

		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			25.00	26.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT				1.00
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
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
17.00	01700	SOCIAL SERVICE				17.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	367,002		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0		31.00
43.00	04300	NURSERY	0	6,177		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	162,969		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	17,334		52.00
53.00	05300	ANESTHESIOLOGY	0	1,626		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	156,144		54.00
60.00	06000	LABORATORY	0	62,623		60.00
60.01	06001	BLOOD LABORATORY	0	0		60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	1,886		63.00
65.00	06500	RESPIRATORY THERAPY	0	27,441		65.00
66.00	06600	PHYSICAL THERAPY	0	81,114		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	2,314		67.00
68.00	06800	SPEECH PATHOLOGY	0	960		68.00
69.00	06900	ELECTROCARDIOLOGY	0	588		69.00
69.01	06901	CARDIAC REHABILITATION	0	12,959		69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	32,675		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	3,225		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	48,116		73.00
76.00	03020	ONCOLOGY	0	18,621		76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC - WINAMAC	0	364,357		88.00
88.01	08801	RURAL HEALTH CLINIC - NORTH JUDSON	0	10,115		88.01
88.02	08802	RURAL HEALTH CLINIC - FRANCESVILLE	0	5,566		88.02
90.00	09000	CLINIC	0	53,781		90.00
91.00	09100	EMERGENCY	0	202,280		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0			92.00
		OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY	0	26,570		101.00
		SPECIAL PURPOSE COST CENTERS				
116.00	11600	HOSPICE	0	0		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	1,666,443		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	12,233		190.00
190.01	19001	HOMECARE	0	3,255		190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	24,929		192.00
194.00	07950	MARKETING	0	1,719		194.00
200.00		Cross Foot Adjustments	0	0		200.00
201.00		Negative Cost Centers	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	0	1,708,579		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1305 | Period: From 10/01/2017 To 09/30/2018 | Worksheet B-1 | Date/Time Prepared: 7/31/2019 3:12 pm

		Cost Center Description	CAPITAL RELATED COSTS NEW BLDG & FIXT (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
			1.00	4.00	5A	5.00	7.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	72,054					1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,071	16,354,811				4.00
5.00	00500	ADMINISTRATIVE & GENERAL	10,126	2,572,867	-5,201,844	26,927,491		5.00
7.00	00700	OPERATION OF PLANT	7,424	338,260	0	1,167,840	62,687	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	602	19,908	0	94,609	602	8.00
9.00	00900	HOUSEKEEPING	369	174,367	0	333,882	369	9.00
10.00	01000	DIETARY	2,985	164,816	0	409,688	2,985	10.00
13.00	01300	NURSING ADMINISTRATION	706	443,514	0	628,043	706	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,036	42,584	0	127,814	1,036	14.00
15.00	01500	PHARMACY	775	0	0	18,377	775	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,466	315,413	0	502,175	1,466	16.00
17.00	01700	SOCIAL SERVICE	0	46,636	0	63,043	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	8,641	2,075,394	0	2,740,138	8,641	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	161	48,414	0	72,865	161	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,304	866,444	0	1,021,290	5,304	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	560	57,427	0	96,272	560	52.00
53.00	05300	ANESTHESIOLOGY	31	0	0	20,650	31	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,813	803,769	0	1,513,998	4,813	54.00
60.00	06000	LABORATORY	1,390	651,328	0	1,734,458	1,390	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	42	0	0	63,857	42	63.00
65.00	06500	RESPIRATORY THERAPY	783	316,729	0	476,109	783	65.00
66.00	06600	PHYSICAL THERAPY	2,364	903,810	0	1,308,518	2,364	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	142,166	0	192,295	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	61,265	0	85,910	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	10,624	0	23,314	0	69.00
69.01	06901	CARDIAC REHABILITATION	448	53,063	0	83,401	448	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	456,160	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	100,869	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	2,257,817	0	73.00
76.00	03020	ONCOLOGY	564	103,182	0	187,262	564	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC - WINAMAC	11,195	3,842,860	0	5,828,691	11,425	88.00
88.01	08801	RURAL HEALTH CLINIC - NORTH JUDSON	0	276,278	0	477,118	1,586	88.01
88.02	08802	RURAL HEALTH CLINIC - FRANCESVILLE	0	153,594	0	256,731	889	88.02
90.00	09000	CLINIC	1,815	84,282	0	444,930	1,815	90.00
91.00	09100	EMERGENCY	6,160	933,406	0	2,715,678	6,160	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	652	534,537	0	840,407	652	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	71,483	16,036,937	-5,201,844	26,344,209	55,567	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	451	0	0	10,694	451	190.00
190.01	19001	HOMECARE	120	0	0	2,845	120	190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	259,941	0	389,991	6,549	192.00
194.00	07950	MARKETING	0	57,933	0	179,752	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,708,579	5,631,793		5,201,844	1,393,443	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	23.712480	0.344351		0.193180	22.228580	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)		25,396		244,109	187,152	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)		0.001553		0.009065	2.985499	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: 15-1305 | Period: From 10/01/2017 To 09/30/2018 | Worksheet B-1 | Date/Time Prepared: 7/31/2019 3:12 pm

		Cost Center Description	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (100%)	
			8.00	9.00	10.00	13.00	14.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
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	163,809					8.00
9.00	00900	HOUSEKEEPING	0	61,716				9.00
10.00	01000	DIETARY	0	2,985	100			10.00
13.00	01300	NURSING ADMINISTRATION	0	706	0	82,784		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,036	0	0	2,441,656	14.00
15.00	01500	PHARMACY	0	775	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,466	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	60,882	8,641	100	43,949	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	2,940	161	0	2,399	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	26,013	5,304	0	9,909	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	560	0	3,487	0	52.00
53.00	05300	ANESTHESIOLOGY	0	31	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	17,985	4,813	0	2,080	0	54.00
60.00	06000	LABORATORY	342	1,390	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	42	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	783	0	1,970	0	65.00
66.00	06600	PHYSICAL THERAPY	19,014	2,364	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
69.01	06901	CARDIAC REHABILITATION	0	448	0	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	2,258,783	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	182,873	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	ONCOLOGY	52	564	0	4,688	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC - WINAMAC	2,072	11,425	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC - NORTH JUDSON	0	1,586	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC - FRANCESVILLE	41	889	0	0	0	88.02
90.00	09000	CLINIC	0	1,815	0	1,726	0	90.00
91.00	09100	EMERGENCY	34,057	6,160	0	12,576	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	652	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	163,398	54,596	100	82,784	2,441,656	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	451	0	0	0	190.00
190.01	19001	HOMECARE	0	120	0	0	0	190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	411	6,549	0	0	0	192.00
194.00	07950	MARKETING	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	126,268	406,583	574,849	769,712	182,359	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.770825	6.587967	5,748.490000	9.297835	0.074687	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	16,961	13,150	84,300	25,381	29,105	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.103541	0.213073	843.000000	0.306593	0.011920	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: 15-1305 | Period: From 10/01/2017 To 09/30/2018 | Worksheet B-1 | Date/Time Prepared: 7/31/2019 3:12 pm

		Cost Center Description	PHARMACY (100%)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (ALLOCATION OF TIME)		
			15.00	16.00	17.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
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
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY	100				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	62,242,330			16.00
17.00	01700	SOCIAL SERVICE	0	0	9,888		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	0	2,407,849	9,228		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0		31.00
43.00	04300	NURSERY	0	95,027	0		43.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	5,391,079	660		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	325,418	0		52.00
53.00	05300	ANESTHESIOLOGY	0	845,273	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	12,811,828	0		54.00
60.00	06000	LABORATORY	0	11,814,129	0		60.00
60.01	06001	BLOOD LABORATORY	0	0	0		60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	247,206	0		63.00
65.00	06500	RESPIRATORY THERAPY	0	1,338,190	0		65.00
66.00	06600	PHYSICAL THERAPY	0	3,162,876	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	488,962	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	120,399	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	504,852	0		69.00
69.01	06901	CARDIAC REHABILITATION	0	91,154	0		69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2,258,783	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	182,873	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	100	9,267,200	0		73.00
76.00	03020	ONCOLOGY	0	200,507	0		76.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC - WINAMAC	0	4,651,066	0		88.00
88.01	08801	RURAL HEALTH CLINIC - NORTH JUDSON	0	402,519	0		88.01
88.02	08802	RURAL HEALTH CLINIC - FRANCESVILLE	0	214,284	0		88.02
90.00	09000	CLINIC	0	341,592	0		90.00
91.00	09100	EMERGENCY	0	4,275,087	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
		OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY	0	804,177	0		101.00
		SPECIAL PURPOSE COST CENTERS					
116.00	11600	HOSPICE	0	0	0		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	100	62,242,330	9,888		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0		190.00
190.01	19001	HOMECARE	0	0	0		190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0		192.00
194.00	07950	MARKETING	0	0	0		194.00
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	44,260	641,430	75,222		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	442.600000	0.010305	7.607403		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	21,023	44,493	643		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	210.230000	0.000715	0.065028		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: 15-1305 | Period: From 10/01/2017 To 09/30/2018 | Worksheet C Part I Date/Time Prepared: 7/31/2019 3:12 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,643,905		4,643,905	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0		0	0	0	31.00
43.00	04300	NURSERY	117,132		117,132	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,544,185		1,544,185	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	166,782		166,782	0	0	52.00
53.00	05300	ANESTHESIOLOGY	34,243		34,243	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,110,418		2,110,418	0	0	54.00
60.00	06000	LABORATORY	2,231,585		2,231,585	0	0	60.00
60.01	06001	BLOOD LABORATORY	0		0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	79,951		79,951	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	622,754	0	622,754	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,676,669	0	1,676,669	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	234,482	0	234,482	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	103,747	0	103,747	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	33,020		33,020	0	0	69.00
69.01	06901	CARDIAC REHABILITATION	113,360		113,360	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0		0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	736,259		736,259	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	135,898		135,898	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,833,740		2,833,740	0	0	73.00
76.00	03020	ONCOLOGY	285,384		285,384	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC - WINAMAC	7,333,422		7,333,422	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC - NORTH JUDSON	619,140		619,140	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC - FRANCESVILLE	334,184		334,184	0	0	88.02
90.00	09000	CLINIC	602,752		602,752	0	0	90.00
91.00	09100	EMERGENCY	3,605,040		3,605,040	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	462,331		462,331		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	1,029,832		1,029,832		0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0		0		0	116.00
200.00		Subtotal (see instructions)	31,690,215	0	31,690,215	0	0	200.00
201.00		Less Observation Beds	462,331		462,331		0	201.00
202.00		Total (see instructions)	31,227,884	0	31,227,884	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1305 | Period: From 10/01/2017 To 09/30/2018 | Worksheet C Part I Date/Time Prepared: 7/31/2019 3:12 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,164,044		2,164,044			30.00
31.00	03100	INTENSIVE CARE UNIT	0		0			31.00
43.00	04300	NURSERY	95,027		95,027			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	871,352	4,519,727	5,391,079	0.286433	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	208,133	117,285	325,418	0.512516	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	119,669	725,604	845,273	0.040511	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,375,366	11,436,462	12,811,828	0.164724	0.000000	54.00
60.00	06000	LABORATORY	2,259,971	9,554,158	11,814,129	0.188891	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	0.000000	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	117,194	130,012	247,206	0.323419	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	987,286	350,904	1,338,190	0.465370	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	549,083	2,613,793	3,162,876	0.530109	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	221,709	267,253	488,962	0.479551	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	39,813	80,586	120,399	0.861693	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	39,665	465,187	504,852	0.065405	0.000000	69.00
69.01	06901	CARDIAC REHABILITATION	0	91,154	91,154	1.243610	0.000000	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	766,210	1,492,573	2,258,783	0.325954	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	63,291	119,582	182,873	0.743128	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,765,298	4,501,902	9,267,200	0.305782	0.000000	73.00
76.00	03020	ONCOLOGY	1,921	198,586	200,507	1.423312	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC - WINAMAC	0	4,651,066	4,651,066			88.00
88.01	08801	RURAL HEALTH CLINIC - NORTH JUDSON	0	402,519	402,519			88.01
88.02	08802	RURAL HEALTH CLINIC - FRANCESVILLE	0	214,284	214,284			88.02
90.00	09000	CLINIC	0	341,592	341,592	1.764538	0.000000	90.00
91.00	09100	EMERGENCY	294,864	3,980,223	4,275,087	0.843267	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	243,805	243,805	1.896315	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	804,177	804,177			101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0			116.00
200.00		Subtotal (see instructions)	14,939,896	47,302,434	62,242,330			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	14,939,896	47,302,434	62,242,330			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1305 | Period: From 10/01/2017 To 09/30/2018 | Worksheet C Part I Date/Time Prepared: 7/31/2019 3:12 pm

Title XVIII | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
43.00	04300	NURSERY			43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	06000	LABORATORY	0.000000		60.00
60.01	06001	BLOOD LABORATORY	0.000000		60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000		63.00
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
69.01	06901	CARDIAC REHABILITATION	0.000000		69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
76.00	03020	ONCOLOGY	0.000000		76.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC - WINAMAC			88.00
88.01	08801	RURAL HEALTH CLINIC - NORTH JUDSON			88.01
88.02	08802	RURAL HEALTH CLINIC - FRANCESVILLE			88.02
90.00	09000	CLINIC	0.000000		90.00
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
		OTHER REIMBURSABLE COST CENTERS			
101.00	10100	HOME HEALTH AGENCY			101.00
		SPECIAL PURPOSE COST CENTERS			
116.00	11600	HOSPICE			116.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1305 | Period: From 10/01/2017 To 09/30/2018 | Worksheet C Part I Date/Time Prepared: 7/31/2019 3:12 pm

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,643,905		4,643,905	0	4,643,905	30.00
31.00	03100	INTENSIVE CARE UNIT	0		0	0	0	31.00
43.00	04300	NURSERY	117,132		117,132	0	117,132	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,544,185		1,544,185	0	1,544,185	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	166,782		166,782	0	166,782	52.00
53.00	05300	ANESTHESIOLOGY	34,243		34,243	0	34,243	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,110,418		2,110,418	0	2,110,418	54.00
60.00	06000	LABORATORY	2,231,585		2,231,585	0	2,231,585	60.00
60.01	06001	BLOOD LABORATORY	0		0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	79,951		79,951	0	79,951	63.00
65.00	06500	RESPIRATORY THERAPY	622,754	0	622,754	0	622,754	65.00
66.00	06600	PHYSICAL THERAPY	1,676,669	0	1,676,669	0	1,676,669	66.00
67.00	06700	OCCUPATIONAL THERAPY	234,482	0	234,482	0	234,482	67.00
68.00	06800	SPEECH PATHOLOGY	103,747	0	103,747	0	103,747	68.00
69.00	06900	ELECTROCARDIOLOGY	33,020		33,020	0	33,020	69.00
69.01	06901	CARDIAC REHABILITATION	113,360		113,360	0	113,360	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0		0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	736,259		736,259	0	736,259	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	135,898		135,898	0	135,898	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,833,740		2,833,740	0	2,833,740	73.00
76.00	03020	ONCOLOGY	285,384		285,384	0	285,384	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC - WINAMAC	7,333,422		7,333,422	0	7,333,422	88.00
88.01	08801	RURAL HEALTH CLINIC - NORTH JUDSON	619,140		619,140	0	619,140	88.01
88.02	08802	RURAL HEALTH CLINIC - FRANCESVILLE	334,184		334,184	0	334,184	88.02
90.00	09000	CLINIC	602,752		602,752	0	602,752	90.00
91.00	09100	EMERGENCY	3,605,040		3,605,040	0	3,605,040	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	462,331		462,331		462,331	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	1,029,832		1,029,832		1,029,832	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0		0		0	116.00
200.00		Subtotal (see instructions)	31,690,215	0	31,690,215	0	31,690,215	200.00
201.00		Less Observation Beds	462,331		462,331		462,331	201.00
202.00		Total (see instructions)	31,227,884	0	31,227,884	0	31,227,884	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1305 | Period: From 10/01/2017 To 09/30/2018 | Worksheet C Part I Date/Time Prepared: 7/31/2019 3:12 pm

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,164,044		2,164,044			30.00
31.00	03100	INTENSIVE CARE UNIT	0		0			31.00
43.00	04300	NURSERY	95,027		95,027			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	871,352	4,519,727	5,391,079	0.286433	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	208,133	117,285	325,418	0.512516	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	119,669	725,604	845,273	0.040511	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,375,366	11,436,462	12,811,828	0.164724	0.000000	54.00
60.00	06000	LABORATORY	2,259,971	9,554,158	11,814,129	0.188891	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	0.000000	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	117,194	130,012	247,206	0.323419	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	987,286	350,904	1,338,190	0.465370	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	549,083	2,613,793	3,162,876	0.530109	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	221,709	267,253	488,962	0.479551	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	39,813	80,586	120,399	0.861693	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	39,665	465,187	504,852	0.065405	0.000000	69.00
69.01	06901	CARDIAC REHABILITATION	0	91,154	91,154	1.243610	0.000000	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	766,210	1,492,573	2,258,783	0.325954	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	63,291	119,582	182,873	0.743128	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,765,298	4,501,902	9,267,200	0.305782	0.000000	73.00
76.00	03020	ONCOLOGY	1,921	198,586	200,507	1.423312	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC - WINAMAC	0	4,651,066	4,651,066	1.576719	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC - NORTH JUDSON	0	402,519	402,519	1.538163	0.000000	88.01
88.02	08802	RURAL HEALTH CLINIC - FRANCESVILLE	0	214,284	214,284	1.559538	0.000000	88.02
90.00	09000	CLINIC	0	341,592	341,592	1.764538	0.000000	90.00
91.00	09100	EMERGENCY	294,864	3,980,223	4,275,087	0.843267	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	243,805	243,805	1.896315	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	804,177	804,177			101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0			116.00
200.00		Subtotal (see instructions)	14,939,896	47,302,434	62,242,330			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	14,939,896	47,302,434	62,242,330			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1305 | Period: From 10/01/2017 To 09/30/2018 | Worksheet C Part I Date/Time Prepared: 7/31/2019 3:12 pm

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
43.00	04300	NURSERY			43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	06000	LABORATORY	0.000000		60.00
60.01	06001	BLOOD LABORATORY	0.000000		60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000		63.00
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
69.01	06901	CARDIAC REHABILITATION	0.000000		69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
76.00	03020	ONCOLOGY	0.000000		76.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC - WINAMAC	0.000000		88.00
88.01	08801	RURAL HEALTH CLINIC - NORTH JUDSON	0.000000		88.01
88.02	08802	RURAL HEALTH CLINIC - FRANCESVILLE	0.000000		88.02
90.00	09000	CLINIC	0.000000		90.00
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
		OTHER REIMBURSABLE COST CENTERS			
101.00	10100	HOME HEALTH AGENCY			101.00
		SPECIAL PURPOSE COST CENTERS			
116.00	11600	HOSPICE			116.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-1305 | Period: From 10/01/2017 To 09/30/2018 | Worksheet D Part II Date/Time Prepared: 7/31/2019 3:12 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	162,969	5,391,079	0.030229	287,862	8,702	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	17,334	325,418	0.053267	0	0	52.00
53.00	05300	ANESTHESIOLOGY	1,626	845,273	0.001924	34,427	66	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	156,144	12,811,828	0.012187	574,493	7,001	54.00
60.00	06000	LABORATORY	62,623	11,814,129	0.005301	657,617	3,486	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	1,886	247,206	0.007629	37,777	288	63.00
65.00	06500	RESPIRATORY THERAPY	27,441	1,338,190	0.020506	437,139	8,964	65.00
66.00	06600	PHYSICAL THERAPY	81,114	3,162,876	0.025646	107,389	2,754	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,314	488,962	0.004732	42,184	200	67.00
68.00	06800	SPEECH PATHOLOGY	960	120,399	0.007973	6,658	53	68.00
69.00	06900	ELECTROCARDIOLOGY	588	504,852	0.001165	25,333	30	69.00
69.01	06901	CARDIAC REHABILITATION	12,959	91,154	0.142166	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	32,675	2,258,783	0.014466	224,419	3,246	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,225	182,873	0.017635	30,977	546	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	48,116	9,267,200	0.005192	1,701,900	8,836	73.00
76.00	03020	ONCOLOGY	18,621	200,507	0.092870	1,066	99	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC - WINAMAC	364,357	4,651,066	0.078338	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC - NORTH JUDSON	10,115	402,519	0.025129	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC - FRANCESVILLE	5,566	214,284	0.025975	0	0	88.02
90.00	09000	CLINIC	53,781	341,592	0.157442	0	0	90.00
91.00	09100	EMERGENCY	202,280	4,275,087	0.047316	44,795	2,120	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	36,538	243,805	0.149866	0	0	92.00
200.00		Total (lines 50 through 199)	1,303,232	59,179,082		4,214,036	46,391	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1305 | Period: From 10/01/2017 To 09/30/2018 | Worksheet D Part IV | Date/Time Prepared: 7/31/2019 3:12 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
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
69.01	06901	CARDIAC REHABILITATION	0	0	0	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	ONCOLOGY	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC - WINAMAC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC - NORTH JUDSON	0	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC - FRANCESVILLE	0	0	0	0	0	88.02
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0		0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1305 | Period: From 10/01/2017 To 09/30/2018 | Worksheet D Part IV | Date/Time Prepared: 7/31/2019 3:12 pm

Title XVIII | Hospital | Cost

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	5,391,079	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	325,418	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	845,273	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	12,811,828	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	11,814,129	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0.000000	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	247,206	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	1,338,190	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	3,162,876	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	488,962	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	120,399	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	504,852	0.000000	69.00
69.01	06901	CARDIAC REHABILITATION	0	0	0	91,154	0.000000	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	2,258,783	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	182,873	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	9,267,200	0.000000	73.00
76.00	03020	ONCOLOGY	0	0	0	200,507	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC - WINAMAC	0	0	0	4,651,066	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC - NORTH JUDSON	0	0	0	402,519	0.000000	88.01
88.02	08802	RURAL HEALTH CLINIC - FRANCESVILLE	0	0	0	214,284	0.000000	88.02
90.00	09000	CLINIC	0	0	0	341,592	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	4,275,087	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	243,805	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	59,179,082		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-1305 | Period: From 10/01/2017 To 09/30/2018 | Worksheet D Part IV Date/Time Prepared: 7/31/2019 3:12 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	287,862	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	34,427	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	574,493	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	657,617	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	37,777	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.000000	437,139	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	107,389	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	42,184	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	6,658	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	25,333	0	0	0	69.00
69.01	06901	CARDIAC REHABILITATION	0.000000	0	0	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	224,419	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	30,977	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	1,701,900	0	0	0	73.00
76.00	03020	ONCOLOGY	0.000000	1,066	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC - WINAMAC	0.000000	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC - NORTH JUDSON	0.000000	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC - FRANCESVILLE	0.000000	0	0	0	0	88.02
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.000000	44,795	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)		4,214,036	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1305 | Period: From 10/01/2017 To 09/30/2018 | Worksheet D Part V Date/Time Prepared: 7/31/2019 3:12 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.286433	0	1,505,365	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.512516	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.040511	0	224,215	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.164724	0	4,217,169	0	0	54.00
60.00	06000	LABORATORY	0.188891	0	3,995,525	0	0	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.323419	0	47,106	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.465370	0	242,469	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.530109	0	936,929	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.479551	0	65,497	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.861693	0	7,071	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.065405	0	186,413	0	0	69.00
69.01	06901	CARDIAC REHABILITATION	1.243610	0	40,768	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.325954	0	379,780	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.743128	0	40,748	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.305782	0	1,961,295	276	0	73.00
76.00	03020	ONCOLOGY	1.423312	0	83,857	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC - WINAMAC	0.000000				0	88.00
88.01	08801	RURAL HEALTH CLINIC - NORTH JUDSON	0.000000				0	88.01
88.02	08802	RURAL HEALTH CLINIC - FRANCESVILLE	0.000000				0	88.02
90.00	09000	CLINIC	1.764538	0	305,536	0	0	90.00
91.00	09100	EMERGENCY	0.843267	0	1,212,796	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.896315	0	74,523	0	0	92.00
200.00		Subtotal (see instructions)		0	15,527,062	276	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	15,527,062	276	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1305 | Period: From 10/01/2017 To 09/30/2018 | Worksheet D Part V Date/Time Prepared: 7/31/2019 3:12 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	431,186	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	9,083	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	694,669	0		54.00
60.00	06000	LABORATORY	754,719	0		60.00
60.01	06001	BLOOD LABORATORY	0	0		60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	15,235	0		63.00
65.00	06500	RESPIRATORY THERAPY	112,838	0		65.00
66.00	06600	PHYSICAL THERAPY	496,674	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	31,409	0		67.00
68.00	06800	SPEECH PATHOLOGY	6,093	0		68.00
69.00	06900	ELECTROCARDIOLOGY	12,192	0		69.00
69.01	06901	CARDIAC REHABILITATION	50,699	0		69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	123,791	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	30,281	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	599,729	84		73.00
76.00	03020	ONCOLOGY	119,355	0		76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC - WINAMAC	0	0		88.00
88.01	08801	RURAL HEALTH CLINIC - NORTH JUDSON	0	0		88.01
88.02	08802	RURAL HEALTH CLINIC - FRANCESVILLE	0	0		88.02
90.00	09000	CLINIC	539,130	0		90.00
91.00	09100	EMERGENCY	1,022,711	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	141,319	0		92.00
200.00		Subtotal (see instructions)	5,191,113	84		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	5,191,113	84		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-1305 | Component CCN: 15-Z305 | Period: From 10/01/2017 To 09/30/2018 | Worksheet D Part V Date/Time Prepared: 7/31/2019 3:12 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.286433	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.512516	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.040511	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.164724	0	0	0	0	54.00
60.00	06000	LABORATORY	0.188891	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.323419	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.465370	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.530109	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.479551	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.861693	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.065405	0	0	0	0	69.00
69.01	06901	CARDIAC REHABILITATION	1.243610	0	0	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.325954	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.743128	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.305782	0	0	0	0	73.00
76.00	03020	ONCOLOGY	1.423312	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC - WINAMAC	0.000000				0	88.00
88.01	08801	RURAL HEALTH CLINIC - NORTH JUDSON	0.000000				0	88.01
88.02	08802	RURAL HEALTH CLINIC - FRANCESVILLE	0.000000				0	88.02
90.00	09000	CLINIC	1.764538	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.843267	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.896315	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: 15-1305 | Component CCN: 15-Z305 | Period: From 10/01/2017 To 09/30/2018 | Worksheet D Part V Date/Time Prepared: 7/31/2019 3:12 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
60.00	06000	LABORATORY	0	0		60.00
60.01	06001	BLOOD LABORATORY	0	0		60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0		63.00
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
69.01	06901	CARDIAC REHABILITATION	0	0		69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
76.00	03020	ONCOLOGY	0	0		76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC - WINAMAC	0	0		88.00
88.01	08801	RURAL HEALTH CLINIC - NORTH JUDSON	0	0		88.01
88.02	08802	RURAL HEALTH CLINIC - FRANCESVILLE	0	0		88.02
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
200.00		Subtotal (see instructions)	0	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: 15-1305 | Period: From 10/01/2017 To 09/30/2018 | Worksheet D-1 | Date/Time Prepared: 7/31/2019 3:12 pm

Title XVIII | Hospital

	Cost Center Description	Cost	
		1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	3,563	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,346	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)	2,015	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	207	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)	742	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	63	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)	205	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	1,057	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)	207	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)	690	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)	4,643,905	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)	9,766	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)	31,779	25.00
26.00	Total swing-bed cost (see instructions)	1,367,080	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	3,276,825	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)	3,276,825	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)	1,396.77	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,476,386	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)	1,476,386	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1305 | Period: From 10/01/2017 To 09/30/2018 | Worksheet D-1 | Date/Time Prepared: 7/31/2019 3:12 pm

Title XVIII | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	0	0	0.00	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)	1,258,770	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	2,735,156	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)	289,131	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	963,771	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	1,252,902	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)	331	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,396.77	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	462,331	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1305 | Period: From 10/01/2017 To 09/30/2018 | Worksheet D-1 | Date/Time Prepared: 7/31/2019 3:12 pm

Title XVIII | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	367,002	4,643,905	0.079029	462,331	36,538	90.00
91.00	Nursing School cost	0	4,643,905	0.000000	462,331	0	91.00
92.00	Allied health cost	0	4,643,905	0.000000	462,331	0	92.00
93.00	All other Medical Education	0	4,643,905	0.000000	462,331	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1305 | Period: From 10/01/2017 To 09/30/2018 | Worksheet D-1 | Date/Time Prepared: 7/31/2019 3:12 pm

Title XIX | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	3,563	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,346	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)	2,015	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)	949	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)	268	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	20	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)	147	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)	4,643,905	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)	1,337,502	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	3,306,403	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)	3,306,403	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)	1,409.38	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	28,188	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)	28,188	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1305 | Period: From 10/01/2017 To 09/30/2018 | Worksheet D-1 | Date/Time Prepared: 7/31/2019 3:12 pm

Title XIX | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	117,132	147	796.82	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	0	0	0.00	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)	31,426	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	59,614	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)	331	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,409.38	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	466,505	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1305 | Period: From 10/01/2017 To 09/30/2018 | Worksheet D-1 | Date/Time Prepared: 7/31/2019 3:12 pm

Title XIX | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	367,002	4,643,905	0.079029	466,505	36,867	90.00
91.00	Nursing School cost	0	4,643,905	0.000000	466,505	0	91.00
92.00	Allied health cost	0	4,643,905	0.000000	466,505	0	92.00
93.00	All other Medical Education	0	4,643,905	0.000000	466,505	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1305 | Period: From 10/01/2017 To 09/30/2018 | Worksheet D-3 | Date/Time Prepared: 7/31/2019 3:12 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		939,168		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.286433	287,862	82,453	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.512516	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.040511	34,427	1,395	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.164724	574,493	94,633	54.00
60.00	06000	LABORATORY	0.188891	657,617	124,218	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.323419	37,777	12,218	63.00
65.00	06500	RESPIRATORY THERAPY	0.465370	437,139	203,431	65.00
66.00	06600	PHYSICAL THERAPY	0.530109	107,389	56,928	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.479551	42,184	20,229	67.00
68.00	06800	SPEECH PATHOLOGY	0.861693	6,658	5,737	68.00
69.00	06900	ELECTROCARDIOLOGY	0.065405	25,333	1,657	69.00
69.01	06901	CARDIAC REHABILITATION	1.243610	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.325954	224,419	73,150	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.743128	30,977	23,020	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.305782	1,701,900	520,410	73.00
76.00	03020	ONCOLOGY	1.423312	1,066	1,517	76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC - WINAMAC	0.000000		0	88.00
88.01	08801	RURAL HEALTH CLINIC - NORTH JUDSON	0.000000		0	88.01
88.02	08802	RURAL HEALTH CLINIC - FRANCESVILLE	0.000000		0	88.02
90.00	09000	CLINIC	1.764538	0	0	90.00
91.00	09100	EMERGENCY	0.843267	44,795	37,774	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.896315	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		4,214,036	1,258,770	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		4,214,036		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-1305 | Period: From 10/01/2017 To 09/30/2018 | Worksheet D-3

Component CCN: 15-Z305 | Date/Time Prepared: 7/31/2019 3:12 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.286433	13,171	3,773	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.512516	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.040511	638	26	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.164724	64,009	10,544	54.00
60.00	06000	LABORATORY	0.188891	159,809	30,186	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.323419	10,991	3,555	63.00
65.00	06500	RESPIRATORY THERAPY	0.465370	145,154	67,550	65.00
66.00	06600	PHYSICAL THERAPY	0.530109	278,196	147,474	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.479551	108,254	51,913	67.00
68.00	06800	SPEECH PATHOLOGY	0.861693	7,657	6,598	68.00
69.00	06900	ELECTROCARDIOLOGY	0.065405	3,073	201	69.00
69.01	06901	CARDIAC REHABILITATION	1.243610	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.325954	53,803	17,537	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.743128	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.305782	175,753	53,742	73.00
76.00	03020	ONCOLOGY	1.423312	49	70	76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC - WINAMAC	0.000000		0	88.00
88.01	08801	RURAL HEALTH CLINIC - NORTH JUDSON	0.000000		0	88.01
88.02	08802	RURAL HEALTH CLINIC - FRANCESVILLE	0.000000		0	88.02
90.00	09000	CLINIC	1.764538	0	0	90.00
91.00	09100	EMERGENCY	0.843267	6,246	5,267	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.896315	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		1,026,803	398,436	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)		1,026,803		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1305 | Period: From 10/01/2017 To 09/30/2018 | Worksheet D-3 | Date/Time Prepared: 7/31/2019 3:12 pm

Title XIX | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		14,666		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
43.00	04300	NURSERY		3,744		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.286433	10,470	2,999	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.512516	7,335	3,759	52.00
53.00	05300	ANESTHESIOLOGY	0.040511	1,965	80	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.164724	8,949	1,474	54.00
60.00	06000	LABORATORY	0.188891	16,963	3,204	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.323419	1,186	384	63.00
65.00	06500	RESPIRATORY THERAPY	0.465370	5,718	2,661	65.00
66.00	06600	PHYSICAL THERAPY	0.530109	850	451	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.479551	291	140	67.00
68.00	06800	SPEECH PATHOLOGY	0.861693	690	595	68.00
69.00	06900	ELECTROCARDIOLOGY	0.065405	219	14	69.00
69.01	06901	CARDIAC REHABILITATION	1.243610	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.325954	9,028	2,943	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.743128	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.305782	29,816	9,117	73.00
76.00	03020	ONCOLOGY	1.423312	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC - WINAMAC	1.576719	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC - NORTH JUDSON	1.538163	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC - FRANCESVILLE	1.559538	0	0	88.02
90.00	09000	CLINIC	1.764538	0	0	90.00
91.00	09100	EMERGENCY	0.843267	4,275	3,605	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.896315	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		97,755	31,426	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)		97,755		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-1305 | Period: From 10/01/2017 To 09/30/2018 | Worksheet D-3

Component CCN: 15-Z305 | Date/Time Prepared: 7/31/2019 3:12 pm

Title XIX | Swing Beds - SNF | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
43.00	04300	NURSERY		0		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.000000	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	0	0	54.00
60.00	06000	LABORATORY	0.000000	0	0	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.000000	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	69.00
69.01	06901	CARDIAC REHABILITATION	0.000000	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	0	0	73.00
76.00	03020	ONCOLOGY	0.000000	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC - WINAMAC	0.000000	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC - NORTH JUDSON	0.000000	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC - FRANCESVILLE	0.000000	0	0	88.02
90.00	09000	CLINIC	0.000000	0	0	90.00
91.00	09100	EMERGENCY	0.000000	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		0	0	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)		0		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1305	Period: From 10/01/2017 To 09/30/2018	Worksheet E Part B Date/Time Prepared: 7/31/2019 3:12 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	5,191,197	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	OPPS payments	0	3.00
4.00	Outlier payment (see instructions)	0	4.00
4.01	Outlier reconciliation amount (see instructions)	0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	5,191,197	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)	5,243,109	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)	66,533	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	2,328,605	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)	2,847,971	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)	2,847,971	30.00
31.00	Primary payer payments	2,096	31.00
32.00	Subtotal (line 30 minus line 31)	2,845,875	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)	325,802	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	211,771	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	290,849	36.00
37.00	Subtotal (see instructions)	3,057,646	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)	3,057,646	40.00
40.01	Sequestration adjustment (see instructions)	61,153	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
41.00	Interim payments	2,806,985	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	189,508	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: 15-1305 | Period: From 10/01/2017 To 09/30/2018 | Worksheet E-1 Part I Date/Time Prepared: 7/31/2019 3:12 pm

Title XVIII | Hospital | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		2,190,229		2,667,685	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	05/14/2018	139,300	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		139,300	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)		2,190,229		2,806,985	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		213,584		189,508	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		2,403,813		2,996,493	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: 15-1305 | Component CCN: 15-Z305 | Period: From 10/01/2017 To 09/30/2018 | Worksheet E-1 Part I | Date/Time Prepared: 7/31/2019 3:12 pm

Title XVIII | Swing Beds - SNF | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,532,470		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	05/14/2018	29,900		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)		29,900		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)		1,562,370		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		42,229		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,604,599		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: 15-1305	Period: From 10/01/2017 To 09/30/2018	Worksheet E-1 Part II Date/Time Prepared: 7/31/2019 3:12 pm
	Title XVIII	Hospital	Cost

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

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS | Provider CCN: 15-1305 | Component CCN: 15-Z305 | Period: From 10/01/2017 To 09/30/2018 | Worksheet E-2 | Date/Time Prepared: 7/31/2019 3:12 pm

Title XVIII | Swing Beds - SNF | Cost

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	1,265,431	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)	402,420	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	897	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)	1,667,851	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	1,667,851	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	10,991	0	11.00
12.00	Subtotal (line 10 minus line 11)	1,656,860	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	19,514	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)	1,637,346	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)	1,637,346	0	19.00
19.01	Sequestration adjustment (see instructions)	32,747	0	19.01
19.02	Demonstration payment adjustment amount after sequestration)	0	0	19.02
20.00	Interim payments	1,562,370	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)	42,229	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 - SWING BEDS

Provider CCN: 15-1305 | Component CCN: 15-Z305 | Period: From 10/01/2017 To 09/30/2018 | Worksheet E-2 | Date/Time Prepared: 7/31/2019 3:12 pm

Title XIX | Swing Beds - SNF | PPS

		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)	0		1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)	0		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)	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	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)	0		8.00
9.00	Primary payer payments (see instructions)	0		9.00
10.00	Subtotal (line 8 minus line 9)	0		10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0		11.00
12.00	Subtotal (line 10 minus line 11)	0		12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	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)	0		15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	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)			16.55
16.99	Demonstration payment adjustment amount before sequestration	0		16.99
17.00	Allowable bad debts (see instructions)	0		17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0		17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0		18.00
19.00	Total (see instructions)	0		19.00
19.01	Sequestration adjustment (see instructions)	0		19.01
19.02	Demonstration payment adjustment amount after sequestration)	0		19.02
20.00	Interim payments	0		20.00
21.00	Tentative settlement (for contractor use only)	0		21.00
22.00	Balance due provider/program (line 19 minus lines 19.01, 20, and 21)	0		22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	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: 15-1305	Period: From 10/01/2017 To 09/30/2018	Worksheet E-3 Part V Date/Time Prepared: 7/31/2019 3:12 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	2,735,156	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)	2,735,156	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	2,762,508	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)	2,762,508	19.00
20.00	Deductibles (exclude professional component)	340,503	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	2,422,005	22.00
23.00	Coinsurance	0	23.00
24.00	Subtotal (line 22 minus line 23)	2,422,005	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	47,484	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	30,865	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	38,008	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	2,452,870	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)	2,452,870	30.00
30.01	Sequestration adjustment (see instructions)	49,057	30.01
30.02	Demonstration payment adjustment amount after sequestration	0	30.02
31.00	Interim payments	2,190,229	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)	213,584	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: 15-1305 | Period: From 10/01/2017 To 09/30/2018 | Worksheet E-3 Part VII | Date/Time Prepared: 7/31/2019 3:12 pm

Title XIX | Hospital | Cost

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	59,614		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)	59,614	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)	59,614	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	18,409		8.00
9.00	Ancillary service charges	97,755	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)	116,164	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)	116,164	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	56,550	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)	59,614	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)	59,614	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)	59,614	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)	59,614	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	59,614	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)	59,614	0	40.00
41.00	Interim payments	44,608	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	15,006	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: 15-1305 | Period: From 10/01/2017 To 09/30/2018 | Worksheet G | Date/Time Prepared: 7/31/2019 3:12 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	2,994,321	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	10,096,049	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-6,164,054	0	0	0	6.00
7.00	Inventory	514,315	0	0	0	7.00
8.00	Prepaid expenses	8,863	0	0	0	8.00
9.00	Other current assets	2,641,522	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)	10,091,016	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	348,302	0	0	0	12.00
13.00	Land improvements	432,594	0	0	0	13.00
14.00	Accumulated depreciation	-366,250	0	0	0	14.00
15.00	Buildings	13,232,909	0	0	0	15.00
16.00	Accumulated depreciation	-7,415,148	0	0	0	16.00
17.00	Leasehold improvements	187,055	0	0	0	17.00
18.00	Accumulated depreciation	-176,932	0	0	0	18.00
19.00	Fixed equipment	7,434,636	0	0	0	19.00
20.00	Accumulated depreciation	-4,948,389	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	8,699,714	0	0	0	23.00
24.00	Accumulated depreciation	-7,805,520	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	9,622,971	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	0	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	3,451,344	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	3,451,344	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	23,165,331	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	1,075,443	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,657,835	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	685,123	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	326,848	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	3,745,249	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	5,399,438	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	2,617,785	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	8,017,223	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	11,762,472	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	11,402,859				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	11,402,859	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	23,165,331	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-1305 | Period: From 10/01/2017 To 09/30/2018 | Worksheet G-1 | Date/Time Prepared: 7/31/2019 3:12 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		11,804,441		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-401,582				2.00
3.00	Total (sum of line 1 and line 2)		11,402,859		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		11,402,859		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		11,402,859		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: 15-1305 | Period: From 10/01/2017 To 09/30/2018 | Worksheet G-2 Parts I & II | Date/Time Prepared: 7/31/2019 3:12 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	2,259,071		2,259,071	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	2,259,071		2,259,071	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	0		0	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	2,259,071		2,259,071	17.00
18.00	Ancillary services	12,385,961	36,664,768	49,050,729	18.00
19.00	Outpatient services	294,864	4,565,620	4,860,484	19.00
20.00	RURAL HEALTH CLINIC - WINAMAC	0	4,651,066	4,651,066	20.00
20.01	RURAL HEALTH CLINIC - NORTH JUDSON	0	402,519	402,519	20.01
20.02	RURAL HEALTH CLINIC - FRANCESVILLE	0	214,284	214,284	20.02
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		804,177	804,177	22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE	0	0	0	26.00
27.00	PROFESSIONAL FEES	325,077	59,317	384,394	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	15,264,973	47,361,751	62,626,724	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		34,539,820		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)		34,539,820		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 15-1305 | Period: From 10/01/2017 To 09/30/2018 | Worksheet G-3 | Date/Time Prepared: 7/31/2019 3:12 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	62,626,724	1.00
2.00	Less contractual allowances and discounts on patients' accounts	29,732,088	2.00
3.00	Net patient revenues (line 1 minus line 2)	32,894,636	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	34,539,820	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-1,645,184	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER INCOME	993,053	24.00
24.01	INVESTMENT INCOME	35,423	24.01
24.02	OTHER NON-OP	215,126	24.02
25.00	Total other income (sum of lines 6-24)	1,243,602	25.00
26.00	Total (line 5 plus line 25)	-401,582	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)	-401,582	29.00

ANALYSIS OF HOSPITAL-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 15-1305 | HHA CCN: 15-7078 | Period: From 10/01/2017 To 09/30/2018 | Worksheet H | Date/Time Prepared: 7/31/2019 3:12 pm

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		Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased Services	Other Costs	Total (sum of cols. 1 thru 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures			0		0	0	1.00
2.00	Capital Related - Movable Equipment			0		0	0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0	0	0	3.00
4.00	Transportation	0	0	0	0	0	0	4.00
5.00	Administrative and General	133,712	0	68,950	0	37,391	240,053	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	277,613	0	0	0	0	277,613	6.00
7.00	Physical Therapy	76,321	0	0	0	0	76,321	7.00
8.00	Occupational Therapy	26,011	0	0	0	0	26,011	8.00
9.00	Speech Pathology	3,308	0	0	0	0	3,308	9.00
10.00	Medical Social Services	0	0	0	0	0	0	10.00
11.00	Home Health Aide	91,522	0	0	0	0	91,522	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	608,487	0	68,950	0	37,391	714,828	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	-73,950	166,103	0	166,103			5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	277,613	0	277,613			6.00
7.00	Physical Therapy	0	76,321	0	76,321			7.00
8.00	Occupational Therapy	0	26,011	0	26,011			8.00
9.00	Speech Pathology	0	3,308	0	3,308			9.00
10.00	Medical Social Services	0	0	0	0			10.00
11.00	Home Health Aide	0	91,522	0	91,522			11.00
12.00	Supplies (see instructions)	0	0	0	0			12.00
13.00	Drugs	0	0	0	0			13.00
14.00	DME	0	0	0	0			14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0			15.00
16.00	Respiratory Therapy	0	0	0	0			16.00
17.00	Private Duty Nursing	0	0	0	0			17.00
18.00	Clinic	0	0	0	0			18.00
19.00	Health Promotion Activities	0	0	0	0			19.00
20.00	Day Care Program	0	0	0	0			20.00
21.00	Home Delivered Meals Program	0	0	0	0			21.00
22.00	Homemaker Service	0	0	0	0			22.00
23.00	All Others (specify)	0	0	0	0			23.00
23.50	Telemedicine	0	0	0	0			23.50
24.00	Total (sum of lines 1-23)	-73,950	640,878	0	640,878			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: 15-1305 | HHA CCN: 15-7078 | Period: From 10/01/2017 To 09/30/2018 | Worksheet H-1 Part I | Date/Time Prepared: 7/31/2019 3:12 pm

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		Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Capital Related Costs: Bldgs & Fixtures	Capital Related Costs: Movable Equipment	Plant Operation & Maintenance	Transportation	Subtotal (cols. 0-4)	
		0	1.00	2.00	3.00	4.00	4A.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0				0	1.00
2.00	Capital Related - Movable Equipment	0		0			0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0		0	3.00
4.00	Transportation	0	0	0	0	0		4.00
5.00	Administrative and General	166,103	0	0	0	0	166,103	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	277,613	0	0	0	0	277,613	6.00
7.00	Physical Therapy	76,321	0	0	0	0	76,321	7.00
8.00	Occupational Therapy	26,011	0	0	0	0	26,011	8.00
9.00	Speech Pathology	3,308	0	0	0	0	3,308	9.00
10.00	Medical Social Services	0	0	0	0	0	0	10.00
11.00	Home Health Aide	91,522	0	0	0	0	91,522	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0		0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	640,878	0	0	0	0	640,878	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	166,103		5.00
	HHA REIMBURSABLE SERVICES			
6.00	Skilled Nursing Care	97,125	374,738	6.00
7.00	Physical Therapy	26,701	103,022	7.00
8.00	Occupational Therapy	9,100	35,111	8.00
9.00	Speech Pathology	1,157	4,465	9.00
10.00	Medical Social Services	0	0	10.00
11.00	Home Health Aide	32,020	123,542	11.00
12.00	Supplies (see instructions)	0	0	12.00
13.00	Drugs	0	0	13.00
14.00	DME	0	0	14.00
	HHA NONREIMBURSABLE SERVICES			
15.00	Home Dialysis Aide Services	0	0	15.00
16.00	Respiratory Therapy	0	0	16.00
17.00	Private Duty Nursing	0	0	17.00
18.00	Clinic	0	0	18.00
19.00	Health Promotion Activities	0	0	19.00
20.00	Day Care Program	0	0	20.00
21.00	Home Delivered Meals Program	0	0	21.00
22.00	Homemaker Service	0	0	22.00
23.00	All Others (specify)	0	0	23.00
23.50	Telemedicine	0	0	23.50
24.00	Total (sum of lines 1-23)		640,878	24.00

COST ALLOCATION - HHA STATISTICAL BASIS | Provider CCN: 15-1305 | HHA CCN: 15-7078 | Period: From 10/01/2017 To 09/30/2018 | Worksheet H-1 Part II Date/Time Prepared: 7/31/2019 3:12 pm

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		Capital Related Costs						
		Bldgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)	Plant Operation & Maintenance (SQUARE FEET)	Transportation (MILEAGE)	Reconciliation	Administrative & General (ACCUM. COST)	
		1.00	2.00	3.00	4.00	5A.00	5.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0				0		1.00
2.00	Capital Related - Movable Equipment		0			0		2.00
3.00	Plant Operation & Maintenance	0	0	0		0		3.00
4.00	Transportation (see instructions)	0	0	0	0			4.00
5.00	Administrative and General	0	0	0	0	-166,103	474,775	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	0	277,613	6.00
7.00	Physical Therapy	0	0	0	0	0	76,321	7.00
8.00	Occupational Therapy	0	0	0	0	0	26,011	8.00
9.00	Speech Pathology	0	0	0	0	0	3,308	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	91,522	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	0	12.00
13.00	Drugs	0	0	0		0	0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	0	0	0	0	-166,103	474,775	24.00
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0	0		166,103	25.00
26.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000		0.349856	26.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 15-1305 | HHA CCN: 15-7078 | Period: From 10/01/2017 To 09/30/2018 | Worksheet H-2 Part I | Date/Time Prepared: 7/31/2019 3:12 pm

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	Cost Center Description	HHA Trial Balance (1)	CAPITAL RELATED COSTS NEW BLDG & FIXT	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	
		0	1.00	4.00	4A	5.00	7.00	
1.00	Administrative and General	0	15,461	184,068	199,529	38,545	14,493	1.00
2.00	Skilled Nursing Care	374,738	0	0	374,738	72,391	0	2.00
3.00	Physical Therapy	103,022	0	0	103,022	19,902	0	3.00
4.00	Occupational Therapy	35,111	0	0	35,111	6,783	0	4.00
5.00	Speech Pathology	4,465	0	0	4,465	863	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	123,542	0	0	123,542	23,866	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)	640,878	15,461	184,068	840,407	162,350	14,493	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	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
		8.00	9.00	10.00	13.00	14.00	15.00	
1.00	Administrative and General	0	4,295	0	0	0	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	0	4,295	0	0	0	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 15-1305 HHA CCN: 15-7078

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

Worksheet H-2 Part I Date/Time Prepared: 7/31/2019 3:12 pm

Home Health Agency I

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	Cost Center Description	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	Allocated HHA A&G (see Part II)	
		16.00	17.00	24.00	25.00	26.00	27.00	
1.00	Administrative and General	8,287	0	265,149	0	265,149		1.00
2.00	Skilled Nursing Care	0	0	447,129	0	447,129	155,040	2.00
3.00	Physical Therapy	0	0	122,924	0	122,924	42,623	3.00
4.00	Occupational Therapy	0	0	41,894	0	41,894	14,526	4.00
5.00	Speech Pathology	0	0	5,328	0	5,328	1,847	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	147,408	0	147,408	51,113	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)	8,287	0	1,029,832	0	1,029,832	265,149	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.						0.346744	21.00

	Cost Center Description	Total HHA Costs	
		28.00	
1.00	Administrative and General		1.00
2.00	Skilled Nursing Care	602,169	2.00
3.00	Physical Therapy	165,547	3.00
4.00	Occupational Therapy	56,420	4.00
5.00	Speech Pathology	7,175	5.00
6.00	Medical Social Services	0	6.00
7.00	Home Health Aide	198,521	7.00
8.00	Supplies (see instructions)	0	8.00
9.00	Drugs	0	9.00
10.00	DME	0	10.00
11.00	Home Dialysis Aide Services	0	11.00
12.00	Respiratory Therapy	0	12.00
13.00	Private Duty Nursing	0	13.00
14.00	Clinic	0	14.00
15.00	Health Promotion Activities	0	15.00
16.00	Day Care Program	0	16.00
17.00	Home Delivered Meals Program	0	17.00
18.00	Homemaker Service	0	18.00
19.00	All Others (specify)	0	19.00
19.50	Telemedicine	0	19.50
20.00	Total (sum of lines 1-19) (2)	1,029,832	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 STATISTICAL BASIS

Provider CCN: 15-1305 | HHA CCN: 15-7078 | Period: From 10/01/2017 To 09/30/2018 | Worksheet H-2 Part II | Date/Time Prepared: 7/31/2019 3:12 pm

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	Cost Center Description	CAPITAL RELATED COSTS NEW BLDG & FIXT (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	
		1.00	4.00	5A	5.00	7.00	8.00	
1.00	Administrative and General	652	534,537	0	199,529	652	0	1.00
2.00	Skilled Nursing Care	0	0	0	374,738	0	0	2.00
3.00	Physical Therapy	0	0	0	103,022	0	0	3.00
4.00	Occupational Therapy	0	0	0	35,111	0	0	4.00
5.00	Speech Pathology	0	0	0	4,465	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	123,542	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)	652	534,537		840,407	652	0	20.00
21.00	Total cost to be allocated	15,461	184,068		162,350	14,493	0	21.00
22.00	Unit cost multiplier	23.713190	0.344350		0.193180	22.228528	0.000000	22.00

	Cost Center Description	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (100%)	PHARMACY (100%)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	
		9.00	10.00	13.00	14.00	15.00	16.00	
1.00	Administrative and General	652	0	0	0	0	804,177	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)	652	0	0	0	0	804,177	20.00
21.00	Total cost to be allocated	4,295	0	0	0	0	8,287	21.00
22.00	Unit cost multiplier	6.587423	0.000000	0.000000	0.000000	0.000000	0.010305	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 15-1305
HHA CCN: 15-7078

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

Worksheet H-2
Part II
Date/Time Prepared:
7/31/2019 3:12 pm

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

APPORTIONMENT OF PATIENT SERVICE COSTS | Provider CCN: 15-1305 | HHA CCN: 15-7078 | Period: From 10/01/2017 To 09/30/2018 | Worksheet H-3 Part I | Date/Time Prepared: 7/31/2019 3:12 pm

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	Cost Center Description	From, Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Visits	Average Cost Per Visit (col. 3 ÷ col. 4)	
		0	1.00	2.00	3.00	4.00	5.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	2.00	602,169		602,169	1,299	463.56	1.00
2.00	Physical Therapy	3.00	165,547	0	165,547	669	247.45	2.00
3.00	Occupational Therapy	4.00	56,420	0	56,420	228	247.46	3.00
4.00	Speech Pathology	5.00	7,175	0	7,175	29	247.41	4.00
5.00	Medical Social Services	6.00	0		0	0	0.00	5.00
6.00	Home Health Aide	7.00	198,521		198,521	1,382	143.65	6.00
7.00	Total (sum of lines 1-6)		1,029,832	0	1,029,832	3,607		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	1,192			8.00
9.00	Physical Therapy		99915	0	663			9.00
10.00	Occupational Therapy		99915	0	233			10.00
11.00	Speech Pathology		99915	0	36			11.00
12.00	Medical Social Services		99915	0	0			12.00
13.00	Home Health Aide		99915	0	804			13.00
14.00	Total (sum of lines 8-13)			0	2,928			14.00

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

	Cost Center Description	Program Visits: Part A	Program Visits: Part B Not Subject to Deductibles & Coinsurance	Program Visits: Part B Subject to Deductibles & Coinsurance	Cost of Services: Part A	Cost of Services: Part B Not Subject to Deductibles & Coinsurance	Cost of Services: Part B Subject to Deductibles & Coinsurance	
		6.00	7.00	8.00	9.00	10.00	11.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	0	1,192		0	552,564		1.00
2.00	Physical Therapy	0	663		0	164,059		2.00
3.00	Occupational Therapy	0	233		0	57,658		3.00
4.00	Speech Pathology	0	36		0	8,907		4.00
5.00	Medical Social Services	0	0		0	0		5.00
6.00	Home Health Aide	0	804		0	115,495		6.00
7.00	Total (sum of lines 1-6)	0	2,928		0	898,683		7.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 15-1305 | HHA CCN: 15-7078 | Period: From 10/01/2017 To 09/30/2018 | Worksheet H-3 Part I | Date/Time Prepared: 7/31/2019 3:12 pm

Title XVIII | Home Health Agency I | PPS

	Cost Center Description							
		6.00	7.00	8.00	9.00	10.00	11.00	
	Limitation Cost Computation							
8.00	Skilled Nursing Care							8.00
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	552,564						1.00
2.00	Physical Therapy	164,059						2.00
3.00	Occupational Therapy	57,658						3.00
4.00	Speech Pathology	8,907						4.00
5.00	Medical Social Services	0						5.00
6.00	Home Health Aide	115,495						6.00
7.00	Total (sum of lines 1-6)	898,683						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: 15-1305 | HHA CCN: 15-7078 | Period: From 10/01/2017 To 09/30/2018 | Worksheet H-3 Part II | Date/Time Prepared: 7/31/2019 3:12 pm

Title XVIII | Home Health Agency I | PPS

	Cost Center Description	From Wkst. C, Part I, col. 9, line	Cost to Charge Ratio	Total HHA Charge (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)	Transfer to Part I as Indicated	
		0	1.00	2.00	3.00	4.00	
	PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS						
1.00	Physical Therapy	66.00	0.530109	0	0	col. 2, line 2.00	1.00
2.00	Occupational Therapy	67.00	0.479551	0	0	col. 2, line 3.00	2.00
3.00	Speech Pathology	68.00	0.861693	0	0	col. 2, line 4.00	3.00
4.00	Cost of Medical Supplies	71.00	0.325954	0	0	col. 2, line 15.00	4.00
5.00	Cost of Drugs	73.00	0.305782	0	0	col. 2, line 16.00	5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT

Provider CCN: 15-1305 | HHA CCN: 15-7078 | Period: From 10/01/2017 To 09/30/2018 | Worksheet H-4 Part I-II | Date/Time Prepared: 7/31/2019 3:12 pm

Title XVIII | Home Health Agency I | PPS

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

		Part A Services	Part B Services	
		1.00	2.00	
	PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT			
10.00	Total reasonable cost (see instructions)	0	0	10.00
11.00	Total PPS Reimbursement - Full Episodes without Outliers	0	347,787	11.00
12.00	Total PPS Reimbursement - Full Episodes with Outliers	0	29,446	12.00
13.00	Total PPS Reimbursement - LUPA Episodes	0	5,313	13.00
14.00	Total PPS Reimbursement - PEP Episodes	0	0	14.00
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers	0	7,965	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	390,511	22.00
23.00	Excess reasonable cost (from line 8)	0	0	23.00
24.00	Subtotal (line 22 minus line 23)	0	390,511	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	390,511	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	390,511	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	390,511	31.00
31.01	Sequestration adjustment (see instructions)	0	7,810	31.01
31.02	Demonstration payment adjustment amount after sequestration	0	0	31.02
32.00	Interim payments (see instructions)	0	382,700	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	1	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: 15-1305 | HHA CCN: 15-7078 | Period: From 10/01/2017 To 09/30/2018 | Worksheet H-5 | Date/Time Prepared: 7/31/2019 3:12 pm

Home Health Agency I | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		0		382,700	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		382,700	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		1	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		0		382,701	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: 15-1305 | Component CCN: 15-8512 | Period: From 10/01/2017 To 09/30/2018 | Worksheet M-1 | Date/Time Prepared: 7/31/2019 3:12 pm

RHC I | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	2,743,540	47,500	2,791,040	-358,024	2,433,016	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	518,771	12,800	531,571	-51,733	479,838	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	102,821	0	102,821	0	102,821	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	493,271	0	493,271	0	493,271	9.00
10.00	Subtotal (sum of lines 1 through 9)	3,858,403	60,300	3,918,703	-409,757	3,508,946	10.00
11.00	Physician Services Under Agreement	0	49,306	49,306	-5,719	43,587	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	49,306	49,306	-5,719	43,587	14.00
15.00	Medical Supplies	0	33,807	33,807	-3,423	30,384	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	33,807	33,807	-3,423	30,384	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	3,858,403	143,413	4,001,816	-418,899	3,582,917	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	102,295	102,295	-11,898	90,397	29.00
30.00	Administrative Costs	747,698	170,447	918,145	-338,441	579,704	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	747,698	272,742	1,020,440	-350,339	670,101	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	4,606,101	416,155	5,022,256	-769,238	4,253,018	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1305 | Component CCN: 15-8512 | Period: From 10/01/2017 To 09/30/2018 | Worksheet M-1 | Date/Time Prepared: 7/31/2019 3:12 pm

RHC I | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	2,433,016		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	479,838		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	102,821		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	493,271		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	3,508,946		10.00
11.00	Physician Services Under Agreement	0	43,587		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	43,587		14.00
15.00	Medical Supplies	0	30,384		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	30,384		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	3,582,917		22.00
	COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
25.01	Telehealth	0	0		25.01
25.02	Chronic Care Management	0	0		25.02
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs				27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	90,397		29.00
30.00	Administrative Costs	-13,081	566,623		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-13,081	657,020		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-13,081	4,239,937		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1305 | Component CCN: 15-8527 | Period: From 10/01/2017 To 09/30/2018 | Worksheet M-1 | Date/Time Prepared: 7/31/2019 3:12 pm

RHC II | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	216,517	0	216,517	-110,375	106,142	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	0	0	0	13,606	13,606	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	74,959	0	74,959	0	74,959	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	47,363	0	47,363	0	47,363	9.00
10.00	Subtotal (sum of lines 1 through 9)	338,839	0	338,839	-96,769	242,070	10.00
11.00	Physician Services Under Agreement	0	0	0	4,017	4,017	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	4,017	4,017	14.00
15.00	Medical Supplies	0	9,976	9,976	2,404	12,380	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	9,976	9,976	2,404	12,380	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	338,839	9,976	348,815	-90,348	258,467	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	70,934	70,934	8,356	79,290	29.00
30.00	Administrative Costs	34,208	6,770	40,978	3,246	44,224	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	34,208	77,704	111,912	11,602	123,514	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	373,047	87,680	460,727	-78,746	381,981	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1305 | Component CCN: 15-8527 | Period: From 10/01/2017 To 09/30/2018 | Worksheet M-1 | Date/Time Prepared: 7/31/2019 3:12 pm

RHC II | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	106,142		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	13,606		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	74,959		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	47,363		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	242,070		10.00
11.00	Physician Services Under Agreement	0	4,017		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	4,017		14.00
15.00	Medical Supplies	0	12,380		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	12,380		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	258,467		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	79,290		29.00
30.00	Administrative Costs	0	44,224		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	123,514		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	381,981		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1305
Component CCN: 15-8528

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

Worksheet M-1
Date/Time Prepared: 7/31/2019 3:12 pm

RHC III | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	0	0	0	9,562	9,562	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	100,643	20,000	120,643	-51,014	69,629	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	0	0	0	0	0	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	67,599	0	67,599	0	67,599	9.00
10.00	Subtotal (sum of lines 1 through 9)	168,242	20,000	188,242	-41,452	146,790	10.00
11.00	Physician Services Under Agreement	0	0	0	1,703	1,703	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	1,703	1,703	14.00
15.00	Medical Supplies	0	4,571	4,571	1,019	5,590	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	4,571	4,571	1,019	5,590	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	168,242	24,571	192,813	-38,730	154,083	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	12,240	12,240	3,542	15,782	29.00
30.00	Administrative Costs	26,803	5,797	32,600	1,376	33,976	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	26,803	18,037	44,840	4,918	49,758	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	195,045	42,608	237,653	-33,812	203,841	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1305 | Component CCN: 15-8528 | Period: From 10/01/2017 To 09/30/2018 | Worksheet M-1 | Date/Time Prepared: 7/31/2019 3:12 pm

RHC III | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	9,562		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	69,629		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	0		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	67,599		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	146,790		10.00
11.00	Physician Services Under Agreement	0	1,703		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	1,703		14.00
15.00	Medical Supplies	0	5,590		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	5,590		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	154,083		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	15,782		29.00
30.00	Administrative Costs	0	33,976		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	49,758		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	203,841		32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 15-1305 | Component CCN: 15-8512 | Period: From 10/01/2017 To 09/30/2018 | Worksheet M-2 | Date/Time Prepared: 7/31/2019 3:12 pm

RHC I | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	4.95	16,198	4,200	20,790		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	3.86	6,538	2,100	8,106		3.00
4.00	Subtotal (sum of lines 1 through 3)	8.81	22,736		28,896	28,896	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)	8.81	22,736			28,896	8.00
9.00	Physician Services Under Agreements		203			203	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)					3,582,917	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					3,582,917	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					1.000000	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					657,020	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					3,093,485	15.00
16.00	Total overhead (sum of lines 14 and 15)					3,750,505	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					3,750,505	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					3,750,505	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					7,333,422	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 15-1305 | Component CCN: 15-8527 | Period: From 10/01/2017 To 09/30/2018 | Worksheet M-2 | Date/Time Prepared: 7/31/2019 3:12 pm

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	RHC II Minimum Visits (col. 1 x col. 3)	Cost Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	0.36	1,655	4,200	1,512		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	0.11	459	2,100	231		3.00
4.00	Subtotal (sum of lines 1 through 3)	0.47	2,114		1,743	2,114	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)	0.47	2,114			2,114	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)					258,467	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)					258,467	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)					123,514	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					237,159	15.00
16.00	Total overhead (sum of lines 14 and 15)					360,673	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					360,673	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					360,673	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					619,140	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 15-1305 | Component CCN: 15-8528 | Period: From 10/01/2017 To 09/30/2018 | Worksheet M-2 | Date/Time Prepared: 7/31/2019 3:12 pm

RHC III | 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	0.07	59	4,200	294		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	0.36	837	2,100	756		3.00
4.00	Subtotal (sum of lines 1 through 3)	0.43	896		1,050	1,050	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)	0.43	896			1,050	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)					154,083	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)					154,083	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)					49,758	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					130,343	15.00
16.00	Total overhead (sum of lines 14 and 15)					180,101	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					180,101	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					180,101	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					334,184	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 15-1305 Component CCN: 15-8512	Period: From 10/01/2017 To 09/30/2018	Worksheet M-3 Date/Time Prepared: 7/31/2019 3:12 pm
	Title XVIII	RHC I	Cost

			1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES			
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)		7,333,422	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)		94,624	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		7,238,798	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		28,896	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)		203	5.00
6.00	Total adjusted visits (line 4 plus line 5)		29,099	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		248.76	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)	248.76	248.76	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	6,264	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	1,558,233	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	33	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	8,209	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	8,209	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)			15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *	0	1,566,442	16.00
16.01	Total program charges (see instructions)(from contractor's records)		800,496	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		23,570	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		46,122	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.)		1,145,943	16.04
16.05	Total program cost (see instructions)	0	1,192,065	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		87,891	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		137,807	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		1,192,065	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		41,909	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		1,233,974	22.00
23.00	Allowable bad debts (see instructions)		732	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		476	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	25.50
25.99	Demonstration payment adjustment amount before sequestration		0	25.99
26.00	Net reimbursable amount (see instructions)		1,234,450	26.00
26.01	Sequestration adjustment (see instructions)		24,689	26.01
26.02	Demonstration payment adjustment amount after sequestration		0	26.02
27.00	Interim payments		1,039,692	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)		170,069	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0	30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 15-1305 Component CCN: 15-8527	Period: From 10/01/2017 To 09/30/2018	Worksheet M-3 Date/Time Prepared: 7/31/2019 3:12 pm
	Title XVIII	RHC II	Cost

				1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES				
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			619,140	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			5,883	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			613,257	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			2,114	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)			2,114	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			290.09	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)	290.09	290.09		9.00
	CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	0	903		10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	261,951		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	261,951		16.00
16.01	Total program charges (see instructions)(from contractor's records)		102,993		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		3,905		16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		9,932		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.)		198,414		16.04
16.05	Total program cost (see instructions)	0	208,346		16.05
17.00	Primary payer amounts		0		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		4,001		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		19,017		19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		208,346		20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		2,036		21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		210,382		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)		210,382		26.00
26.01	Sequestration adjustment (see instructions)		4,208		26.01
26.02	Demonstration payment adjustment amount after sequestration		0		26.02
27.00	Interim payments		146,184		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)		59,990		29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0		30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 15-1305 Component CCN: 15-8528	Period: From 10/01/2017 To 09/30/2018	Worksheet M-3 Date/Time Prepared: 7/31/2019 3:12 pm
	Title XVIII	RHC III	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)			334,184	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			0	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			334,184	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			1,050	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)			1,050	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			318.27	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)	318.27	318.27		9.00
	CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	0	223		10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	70,974		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	70,974		16.00
16.01	Total program charges (see instructions)(from contractor's records)		23,616		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		2,320		16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		6,972		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.)		49,534		16.04
16.05	Total program cost (see instructions)	0	56,506		16.05
17.00	Primary payer amounts		0		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		2,085		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		3,842		19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		56,506		20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		0		21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		56,506		22.00
23.00	Allowable bad debts (see instructions)		0		23.00
23.01	Adjusted reimbursable bad debts (see instructions)		0		23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0		24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0		25.50
25.99	Demonstration payment adjustment amount before sequestration		0		25.99
26.00	Net reimbursable amount (see instructions)		56,506		26.00
26.01	Sequestration adjustment (see instructions)		1,130		26.01
26.02	Demonstration payment adjustment amount after sequestration		0		26.02
27.00	Interim payments		33,480		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)		21,896		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: 15-1305 Component CCN: 15-8512	Period: From 10/01/2017 To 09/30/2018	Worksheet M-4 Date/Time Prepared: 7/31/2019 3:12 pm
	Title XVIII	RHC I	Cost

		Pneumococcal	Influenza	
		1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	3,508,946	3,508,946	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000821	0.002022	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	2,881	7,095	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	23,924	12,331	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	26,805	19,426	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	3,582,917	3,582,917	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	3,750,505	3,750,505	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.007481	0.005422	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	28,058	20,335	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	54,863	39,761	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	281	692	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	195.24	57.46	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	119	325	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	23,234	18,675	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)		94,624	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)		41,909	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA VACCINE COST	Provider CCN: 15-1305 Component CCN: 15-8527	Period: From 10/01/2017 To 09/30/2018	Worksheet M-4 Date/Time Prepared: 7/31/2019 3:12 pm
	Title XVIII	RHC II	Cost

		Pneumococcal	Influenza	
		1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	242,070	242,070	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000999	0.000000	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	242	0	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	2,214	0	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	2,456	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	258,467	258,467	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	360,673	360,673	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.009502	0.000000	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	3,427	0	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	5,883	0	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	26	0	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	226.27	0.00	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	9	0	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	2,036	0	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)		5,883	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)		2,036	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 15-1305 Component CCN: 15-8512	Period: From 10/01/2017 To 09/30/2018	Worksheet M-5 Date/Time Prepared: 7/31/2019 3:12 pm
		RHC I	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		1,039,692	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)		1,039,692	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		170,069	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		1,209,761	7.00

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

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES

Provider CCN: 15-1305 | Component CCN: 15-8527 | Period: From 10/01/2017 To 09/30/2018 | Worksheet M-5 | Date/Time Prepared: 7/31/2019 3:12 pm

RHC II | Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		146,184	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)		146,184	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		59,990	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		206,174	7.00

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

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES

Provider CCN: 15-1305 | Component CCN: 15-8528 | Period: From 10/01/2017 To 09/30/2018 | Worksheet M-5 | Date/Time Prepared: 7/31/2019 3:12 pm

RHC III | Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		33,480	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)		33,480	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		21,896	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		55,376	7.00

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